

# OPUS2

Grenfell Tower Inquiry

Day 114

March 29, 2021

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1 Monday, 29 March 2021  
 2 (10.00 am)  
 3 SIR MARTIN MOORE–BICK: Good morning, everyone, and welcome  
 4 to today’s hearing, at which I am joined as usual by my  
 5 fellow panel members, Ms Thouria Istephan and  
 6 Mr Ali Akbor.  
 7 MS ISTEPHAN: Good morning.  
 8 MR AKBOR: Good morning, everyone.  
 9 SIR MARTIN MOORE–BICK: Today marks another step in the  
 10 progress of the Inquiry, because we’re going to hear  
 11 opening statements in relation to Module 3.  
 12 A number of core participants are going to make oral  
 13 statements, although a greater number have also provided  
 14 some written opening statements which will be available  
 15 to view in due course.  
 16 Before we hear them, however, I’m going to invite  
 17 Counsel to the Inquiry, Mr Richard Millett, to make  
 18 an opening statement of his own.  
 19 Yes, Mr Millett.  
 20 Opening statement by COUNSEL TO THE INQUIRY  
 21 MR MILLETT: Mr Chairman, thank you, good morning, and good  
 22 morning, members of the panel.  
 23 Today we start Module 3 of Phase 2 of the Inquiry’s  
 24 investigation.  
 25 In March 2020, the Inquiry set out the structure of

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1 Module 3. It is to be divided into three distinct but  
 2 closely—related topics. In summary, topic 1 will  
 3 consider fire—related complaints; topic 2 will consider  
 4 the extent to which the Royal Borough of Kensington and  
 5 Chelsea Council, RBKC, and the Kensington and Chelsea  
 6 Tenant Management Organisation, the TMO, complied with  
 7 their respective obligations under the Regulatory Reform  
 8 (Fire Safety) Order 2005, the RRO; and topic 3 will  
 9 address active and passive fire safety measures within  
 10 Grenfell Tower.  
 11 Although the ambit of Module 3 is broad, there is  
 12 a single unifying theme, that is whether and to what  
 13 extent RBKC and the TMO and others performed the duties  
 14 they each owed in respect of fire safety.  
 15 That unifying theme will be investigated from  
 16 a number of different perspectives, starting in topic 1  
 17 with the evidence of those who lived in the tower. It  
 18 is, in the Inquiry’s view, vital that consideration of  
 19 fire safety matters affecting the building and those who  
 20 lived there begins with the evidence of those whose  
 21 health and safety was, or should have been, the primary  
 22 aim of the fire safety duties of the relevant  
 23 duty holders.  
 24 We will examine communications between residents and  
 25 the TMO in which the residents drew attention to defects

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1 in design, choice of materials or quality of workmanship  
 2 which they said increased the risk of fire, or which the  
 3 evidence suggests may, in the event, have contributed  
 4 directly or indirectly to the outbreak or development of  
 5 the fire. That examination will be conducted through  
 6 the live evidence of residents and by reading into the  
 7 record relevant extracts from BSRs’ statements and  
 8 consideration of contemporaneous documents.  
 9 The examination will cast light on the nature of the  
 10 relationship, in particular between RBKC and the TMO on  
 11 the one hand, and residents of the tower on the other.  
 12 In particular, the evidence will focus on whether the  
 13 TMO’s response to residents’ concerns regarding  
 14 fire safety before 14 June 2017 was appropriate and  
 15 effective.  
 16 After the residents’ evidence, the Inquiry will then  
 17 hear from those at the TMO who were responsible for, or  
 18 who were involved in consideration of, complaints  
 19 concerning fire safety matters, whether operationally,  
 20 strategically or otherwise, and also from others, such  
 21 as RBKC councillors and other officers of RBKC who were  
 22 responsible for scrutinising the TMO’s activities and  
 23 for discharging RBKC’s own fire safety related duties.  
 24 In that respect, the Inquiry notes and welcomes the  
 25 various admissions made by RBKC in its opening

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1 statement. In particular, the Inquiry notes RBKC’s  
 2 acknowledgement that the number of its officers devoted  
 3 to monitoring the TMO was insufficient, given the number  
 4 of residents whose properties were managed by the TMO,  
 5 and the scale and importance of the task delegated to  
 6 the TMO.  
 7 RBKC has also made other concessions and admissions  
 8 in its written opening statement, for which the Inquiry  
 9 team is grateful. For example, RBKC has recognised  
 10 that, as part of its arrangements for scrutinising the  
 11 TMO, it never made fire safety the subject of a key  
 12 performance indicator. It has also accepted that its  
 13 audit arrangements consistently failed to identify the  
 14 absence of key performance indicators governing the  
 15 TMO’s completion of fire risk assessments, outstanding  
 16 significant actions identified in fire risk assessments,  
 17 or enforcement of deficiency notices served by the  
 18 London Fire and Emergency Planning Authority.  
 19 On any view, these are significant deficiencies in  
 20 RBKC’s arrangements for monitoring and scrutinising the  
 21 effectiveness of the TMO’s compliance with its  
 22 fire safety obligations.  
 23 The Inquiry also notes that the TMO has made no  
 24 concessions in its opening statement. Whether that  
 25 remains its position following the conclusion of the

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1 evidence will remain to be seen.  
 2 Whether the concessions by RBKC go far enough will  
 3 be an important question when the Inquiry turns, in  
 4 topic 2, to consider the extent to which those bodies  
 5 performed their respective obligations imposed under the  
 6 RRO. Inevitably, this aspect of the Inquiry's  
 7 investigation will be wide-ranging.  
 8 We will examine the adequacy of the TMO's management  
 9 of fire safety and the effectiveness of its arrangements  
 10 for carrying out fire risk assessments. We will also  
 11 investigate the competence of Mr Carl Stokes, the TMO's  
 12 retained fire risk assessor, and the adequacy of his  
 13 fire risk assessments, and also, in particular, the  
 14 adequacy of his advice regarding the cladding and the  
 15 TMO's consideration of that advice.  
 16 We will also consider and investigate the acts and  
 17 omissions of those responsible for implementing,  
 18 supervising, monitoring and scrutinising the  
 19 effectiveness of the TMO's fire risk assessment  
 20 arrangements.  
 21 The evidence will focus on three principal  
 22 questions:  
 23 First, whether the TMO maintained an adequate  
 24 evacuation plan for the tower or identified those  
 25 residents of the tower who were vulnerable, and if not,

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1 why not. Whether it assessed the risks that those  
 2 individuals would face in the event of a fire, or take  
 3 steps to mitigate those risks, and if not, why not.  
 4 Importantly, whether the TMO ever prepared personal  
 5 emergency evacuation plans, or PEEPs, for vulnerable  
 6 residents of the tower. If not, why not?  
 7 Secondly, we will focus on whether there was  
 8 a suitable and sufficient fire risk assessment programme  
 9 for Grenfell Tower, including the effectiveness of the  
 10 arrangements for ensuring that significant actions  
 11 identified in fire risk assessments, or FRAs, were  
 12 implemented efficiently, effectively and expeditiously.  
 13 Thirdly, whether the arrangements for maintaining  
 14 active and passive fire safety systems were effective,  
 15 with particular attention to the inspection and  
 16 maintenance of self-closing devices on flat entrance  
 17 doors in the tower.  
 18 The factual evidence regarding fire risk assessment  
 19 will be followed, in topic 3, by consideration of the  
 20 active and passive fire safety measures in the tower,  
 21 and will do so in the following order: gas, smoke  
 22 control, repairs and maintenance, fire doors, especially  
 23 flat entrance doors, and lifts. Experts have been  
 24 retained to assist the Inquiry's investigation of gas,  
 25 smoke control and lifts. That expert advice will be

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1 adduced after the factual evidence that is relevant to  
 2 each of those matters has been heard. So Mr Hancox's  
 3 evidence will follow that of the two gas witnesses, the  
 4 evidence of Dr Lane and Ms Menzies on smoke control will  
 5 follow that of the smoke control witnesses, and  
 6 Mr Howkins' evidence on lifts will follow that of the  
 7 factual witnesses about lifts.  
 8 Module 3 will conclude with the evidence of  
 9 Mr Colin Todd and Dr Barbara Lane on fire risk  
 10 assessment.  
 11 There are some housekeeping matters that I should  
 12 highlight.  
 13 First, the Inquiry will not sit on 14 June this  
 14 year, which will be the fourth anniversary of the fire.  
 15 We will not sit on that day out of respect for those who  
 16 died and to allow those who grieve to remember their  
 17 loved ones, and for all of us to reflect privately on  
 18 the tragedy.  
 19 Secondly, the Inquiry will not sit on the two bank  
 20 holidays that fall in May.  
 21 Thirdly, the Inquiry Secretary has written to core  
 22 participants setting out the plans for attendance at the  
 23 Inquiry's venue. As matters currently stand, we will  
 24 restart limited attendance hearings at the Inquiry's  
 25 premises at the start of the witness evidence for

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1 Module 3. That will be on Monday, 19 April.  
 2 In order to comply with Government restrictions and  
 3 the risk assessment for the building which has been  
 4 carried out by the Government Property Agency,  
 5 attendance will need to be strictly limited at that  
 6 stage, in exactly the same way as it was before  
 7 Christmas, to the Panel, Counsel to the Inquiry, the  
 8 witnesses and their representatives, and a small Inquiry  
 9 operations and support team.  
 10 If Government restrictions then permit, after 17 May  
 11 we plan to open the Inquiry premises more widely, our  
 12 first priority being to allow a number of BSRs to attend  
 13 to watch the proceedings in person. We are giving  
 14 careful thought to the practicalities of how we can do  
 15 that, both safely and fairly, and the Inquiry Secretary  
 16 will write to core participants further about that in  
 17 due course.  
 18 We will have to consider further relaxation of the  
 19 measures governing attendance at the premises in the  
 20 light of any on going Government restrictions and  
 21 guidance in force over the summer. We will of course  
 22 keep core participants and the wider public informed of  
 23 our plans.  
 24 Fourthly, Jonathan Sakula, the Inquiry's cladding  
 25 expert, will give evidence on Thursday, 29 April for

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1 one day. Mr Sakula’s evidence is relevant to Module 1  
 2 and so, to allow core participants to complete the  
 3 drafting of their written closing statement for  
 4 Module 1, the Inquiry has decided to call Mr Sakula as  
 5 soon as his schedule and the Inquiry’s timetable allows.  
 6 Fifthly and finally, the expert evidence of Dr Lane  
 7 and Ms Menzies concerning smoke control will be  
 8 disclosed as soon as possible. The Inquiry will then  
 9 give directions for the service of written opening  
 10 statements on the topics of smoke control and, if  
 11 needed, a half day has been allowed for oral opening  
 12 statements on that topic. We will keep core  
 13 participants and the public updated as we go.  
 14 Mr Chairman, members of the panel, that concludes my  
 15 opening statement for Module 3.  
 16 SIR MARTIN MOORE–BICK: Thank you very much, Mr Millett.  
 17 Well, at that point, I am in a position to invite  
 18 Ms Stephanie Barwise to make an opening statement on  
 19 behalf of those bereaved, survivors and residents whom  
 20 she represents.  
 21 Now, Ms Barwise, can you tell me whether you are in  
 22 contact? Can you see me and can you hear me?  
 23 MS BARWISE: Good morning, Mr Chairman, yes, I can.  
 24 SIR MARTIN MOORE–BICK: Ah, good morning, good. Well, we  
 25 are all ready to go if you are.

1 MS BARWISE: Fantastic, thank you.  
 2 SIR MARTIN MOORE–BICK: So take your time and make your  
 3 statement when you’re ready.  
 4 Opening statement on behalf of BSRs Team 1 by MS BARWISE  
 5 MS BARWISE: Thank you, and good morning, Ms Istephan and  
 6 Mr Akbor.  
 7 You have our written submissions on all three topics  
 8 within Module 3. I propose to address you on aspects of  
 9 topics 1 and 2, but will first summarise the module and  
 10 its themes.  
 11 Module 3 is a tale of lessons unlearned, despite the  
 12 teachings of successive fires. The failure of the  
 13 physical and managerial controls at Grenfell which  
 14 should have mitigated the extent of fire was as  
 15 predictable as it was preventable. Central to ensuring  
 16 these controls are adequate are the fire risk  
 17 assessments required by the Regulatory Reform (Fire  
 18 Safety) Order 2005, which should have informed RBKC and  
 19 TMO of the measures required to mitigate fire and to  
 20 facilitate evacuation.  
 21 The principal managerial failures at Grenfell  
 22 included a failure to identify the occupancy profile,  
 23 coupled with a lack of any emergency or evacuation plan,  
 24 still less evacuation plans for the disabled, PEEPs.  
 25 Weaknesses in the physical controls, such as compromised

1 compartmentation, including defective fire doors,  
 2 rendered the stay–put strategy lethal and impacted the  
 3 means of escape. These failings materially contributed  
 4 to the extent and severity of the disaster.  
 5 The bereaved, survivors and residents from whom  
 6 the Inquiry will hear are but a few of the many  
 7 residents who made up a richly diverse community. Their  
 8 diversity is highly relevant to Module 3 issues, since  
 9 age, disability and ability to read English are all  
 10 factors which should have informed both the assessment  
 11 of the degree of risk and potential harm posed by fire,  
 12 and accordingly the fire safety measures at Grenfell.  
 13 A significant proportion of residents suffered from  
 14 some form of disability or were vulnerable, which should  
 15 have been addressed when considering the means of escape  
 16 and evacuation strategy. Both TMO and its fire risk  
 17 assessor, Carl Stokes, failed to identify vulnerable  
 18 residents at Grenfell, despite this being a recognised  
 19 parameter in fire risk management, as the risk profile  
 20 of a building is a function of its occupancy and fire  
 21 growth rate.  
 22 There is no evidence that TMO assessed the needs of  
 23 any vulnerable person in Grenfell in the event of fire.  
 24 This failure resulted in TMO not recognising the fire  
 25 precautions required to protect vulnerable residents and

1 failing to advise LFB of the need to assist the  
 2 vulnerable.  
 3 The lack of appropriate precautions is reflected in  
 4 the deaths. Dr Lane calculates that a quarter of the  
 5 67 child residents present on the night died, and 41% of  
 6 the 37 vulnerable adult residents died. These groups  
 7 suffered higher death rates than any other on the night.  
 8 Yet TMO’s spreadsheet, emailed during the fire, showed  
 9 only ten residents with disabilities out of 225 listed.  
 10 In this respect, Grenfell shines a light on an aspect of  
 11 fire safety crying out for reform. Dr Lane considers  
 12 there is an urgent need for guidance and focus on the  
 13 fire risk assessments, or FRAs, for the vulnerable in  
 14 the event of fire.  
 15 Three key themes which span across the topics which  
 16 the Inquiry will wish to explore include, first, RBKC’s  
 17 leadership, culture and purpose insofar as they  
 18 influenced fire safety, and engagement on that subject  
 19 with residents; second, RBKC’s scrutiny of TMO; and,  
 20 third, TMO’s fire safety management.  
 21 Starting with the first theme, RBKC’s leadership and  
 22 its influence on fire safety.  
 23 RBKC’s prioritisation of cost over fire safety is  
 24 a contributing factor to the extent of the disaster.  
 25 Appointing TMO as an arm’s length management

1 organisation, or ALMO, did not relieve RBKC of its  
 2 common law duties as landlord, nor of its statutory  
 3 duties, including responsibility under the Fire Safety  
 4 Order. RBKC's failure to show leadership and adopt  
 5 a rigorous approach to fire safety management inevitably  
 6 affected TMO's approach. As Lord Cullen found in his  
 7 Ladbroke Grove rail crash inquiry report, a successful  
 8 safety culture depends upon the leadership driving that  
 9 agenda.

10 It has long been clear, as stated in the 2007 good  
 11 governance framework, that it is the role of a local  
 12 authority's leadership to clearly articulate its vision  
 13 of its purpose and intended outcomes for its citizens.  
 14 RBKC accepted this principle by its 2014 bi-borough  
 15 corporate fire safety policy, which expressed its desire  
 16 to champion fire safety through strong, visible  
 17 leadership.

18 Far from championing fire safety, RBKC prioritised  
 19 cost over safety on leaseholder doors, door-closers and  
 20 sprinklers. It seems if the LFB had made a firm  
 21 recommendation or requirement for sprinklers, RBKC would  
 22 have considered it. This is to misunderstand that the  
 23 Fire Safety Order required RBKC to make its building  
 24 safe for the residents. Thus, different buildings  
 25 require different measures.

1 RBKC failed to prioritise fire safety in  
 2 refurbishment, despite the Lakanal House coroner's 2013  
 3 recommendations. RBKC's leader, Councillor Paget-Brown,  
 4 failed to implement the LFB audit tool sent to him in  
 5 2015, which was specifically designed to ensure  
 6 refurbishments did not impact fire safety, and had been  
 7 designed by the Lakanal House working group for adoption  
 8 by councils.

9 This criticism does not derive from mere hindsight.  
 10 RBKC was aware of the Lakanal fire issues from  
 11 July 2009, and acutely so from 2013, when it considered  
 12 the coroner's recommendations. In 2014, RBKC's  
 13 building control received notes on Lakanal, warning it  
 14 could happen again in social housing, citing cladding  
 15 and overall worsening of conditions through years of  
 16 neglect. Despite these warnings, RBKC did not issue  
 17 guidance to its ALMO on such matters.

18 As late as April 2017, RBKC's Laura Johnson received  
 19 LFB's letter entitled "Tall Buildings – External Fire  
 20 Spread", warning that cladding panels often did not  
 21 comply with Building Regulations, were prone to  
 22 delaminating, and could potentially spread fire from  
 23 flat to flat. The letter urged RBKC to address how it  
 24 achieved compliance and "consider this issue as part of  
 25 the risk assessment process for premises under your

1 control".

2 RBKC failed to investigate how TMO ensured  
 3 compliance of façades but, contrary to LFB's advice,  
 4 RBKC also failed to require that façades should be  
 5 included in future fire risk assessments, this despite  
 6 Grenfell's recent refurbishment and it being one of  
 7 RBKC's highest risk properties. Instead, RBKC forwarded  
 8 LFB's letter to TMO without instruction, simply "FYI".  
 9 This lack of proactivity is extraordinary in a project  
 10 RBKC witnesses describe as "a big deal", widely seen as  
 11 a positive thing by RBKC officers.

12 Only after the fire did RBKC issue a draft  
 13 fire safety management system which finally acknowledged  
 14 the need for housing management to comply with existing  
 15 guidance by preparing fire strategies for existing  
 16 buildings in accordance with PAS 911, and put in place  
 17 a robust system of fire risk assessments to industry  
 18 best practice under PAS 79.

19 The failure to require such strategies and systems  
 20 before the fire is a serious failing, given Dr Lane's  
 21 opinion that it is impossible for the responsible person  
 22 to discharge their fire safety duties without  
 23 an existing fire safety strategy which would inform the  
 24 significant findings in FRAs.

25 The Inquiry will need to determine the question

1 whether both RBKC and TMO were responsible persons under  
 2 the Fire Safety Order. Both qualify, since, as occupier  
 3 or otherwise, both have significant control in the  
 4 carrying on of an undertaking, namely housing provision.

5 TMO's fire safety strategies consistently from  
 6 October 2012 to June 2017 described itself and RBKC as  
 7 both being responsible persons. As from 2010, LFB  
 8 regarded RBKC as a responsible person. RBKC  
 9 acknowledged its responsibility as a responsible person  
 10 by participating with TMO and LFB in the 2009 programme  
 11 to improve fire safety of RBKC's stock. While TMO had  
 12 day-to-day control, RBKC had ultimate control, since  
 13 TMO's funding entirely derived from RBKC.

14 The second theme is the quality and degree of RBKC's  
 15 scrutiny of TMO. Although RBKC, delegated various  
 16 functions to TMO by virtue of section 27 of the  
 17 Housing Act 1985, Right to Manage Regulations and form  
 18 of agreement approved by the Secretary of State under  
 19 those regulations, namely the modular management  
 20 agreement, or MMA, RBKC's legal relationship with its  
 21 tenants or leaseholders and its statutory, contractual  
 22 and common law obligations towards them remained. RBKC  
 23 was obliged to scrutinise TMO's exercise of those  
 24 functions delegated to it, in order to ensure compliance  
 25 with the Fire Safety Order and the council's common law

1 duties. RBKC also had a scrutiny function under the  
 2 Localism Act 2011.  
 3 The four core principles of good scrutiny proposed  
 4 by the Centre for Public Scrutiny provide for "critical  
 5 friend" challenge, enabling the voice and concerns of  
 6 the public in a process led and owned by  
 7 independent-minded councillors, which drives improvement  
 8 in public services.  
 9 RBKC's principal vehicle for scrutiny of TMO was the  
 10 MMA, but it lacked specificity as to the degree of  
 11 monitoring RBKC was entitled or obliged to carry out.  
 12 The key mechanism for scrutiny under the MMA was the  
 13 setting of key performance indicators, or KPIs, but RBKC  
 14 failed to ensure there were KPIs governing safety,  
 15 despite fire safety always being a pressing criterion  
 16 for RBKC, given the vulnerable tenants it housed. This  
 17 link between vulnerable tenants and fire outcomes is  
 18 enshrined both in British Standards governing the design  
 19 and use of buildings and other guidance.  
 20 The failure is also surprising, given RBKC mooted  
 21 accessibility for the disabled as a possible KPI in  
 22 an internal email in 2009, noting "there are some  
 23 serious brownie points to be gained in all this, as  
 24 members understandably feel very strongly about  
 25 disability and meeting need".

1 The failure to ensure fire safety KPIs were in place  
 2 is all the more extraordinary given that, as RBKC knew,  
 3 TMO was proposing KPIs for fire for its own monitoring  
 4 purposes from 2015 onwards, albeit they were never  
 5 in fact implemented. RBKC admits, as Counsel to the  
 6 Inquiry has said, by its opening submissions that it  
 7 should have imposed KPIs on TMO for FRAs and work  
 8 required under them.  
 9 There was an appearance of scrutiny, but it lacked  
 10 substance. RBKC's yearly and half-yearly reviews of  
 11 TMO's compliance with KPIs were based on reports, the  
 12 vast majority of which RBKC now admits were written by  
 13 TMO. This was also true of the health and safety  
 14 reports which TMO's health and safety adviser,  
 15 Janice Wray, had prepared, thereby marking her own  
 16 homework. RBKC candidly admits that this fact was not  
 17 made clear to those scrutinising and should have been.  
 18 RBKC also admits that the number of officers devoted  
 19 to monitoring TMO was insufficient, given the scale of  
 20 the task delegated to TMO, and that in certain key  
 21 respects, RBKC's monitoring of TMO was not carried out  
 22 in accordance with RBKC's own monitoring procedure  
 23 guide. RBKC also admits that it failed to convene the  
 24 six-weekly meeting with TMO's complaints team.  
 25 RBKC was aware, at latest from 2010, of its

1 responsibility to take a hands-on role in fire safety  
 2 rather than simply relying on paper briefings from its  
 3 ALMO. RBKC endorsed a note called "Extinguishing the  
 4 risk, a councillor's guide to fire safety" at a scrutiny  
 5 meeting in 2010. That guide made clear that a council's  
 6 responsibility, whether for retained stock or via  
 7 an ALMO, was the same as any other landlord, namely that  
 8 the council needed to ensure the fire strategy was being  
 9 taken seriously and FRAs done competently. The  
 10 scrutiny committee recorded that the guide reflected the  
 11 expectations on this council.  
 12 The third theme is TMO's fire safety management.  
 13 The adequacy of this requires close examination.  
 14 The responsibility for fire safety across RBKC's  
 15 entire estate of some 9,400 properties rested on  
 16 Janice Wray as health and safety manager. Dr Lane  
 17 considers Wray should have been capable of designing and  
 18 delivering a fire risk management system, and if not,  
 19 should have sought assistance.  
 20 While Lane finds TMO's policy documents did address  
 21 some relevant fire safety objectives, they failed to  
 22 plan how to achieve their policy intent. Critically,  
 23 TMO failed to identify its intent in relation to  
 24 occupancy profiling, and although some monitoring was  
 25 done, there is no evidence that this was done to inform

1 the FRAs. Furthermore, TMO failed to articulate its  
 2 intent as to the implementation of general fire  
 3 precautions and control of construction work. As  
 4 a result, these activities were haphazard.  
 5 These fundamental failures were compounded by TMO's  
 6 reliance for all aspects of fire safety advice at  
 7 Grenfell on a single risk assessor, Stokes, who lacked  
 8 any professional registration and invented some of his  
 9 professional qualifications.  
 10 TMO was overwhelmed by the sheer volume of  
 11 outstanding FRA actions due to its failure to address  
 12 how they should be actioned. As a result, it sought to  
 13 deliberately conceal this from RBKC.  
 14 TMO's focus on completion of FRA action items  
 15 without monitoring the level of risk posed thereby is  
 16 a critical failing. This problem originated with  
 17 Stokes, whose FRAs did not state the impact on risk if  
 18 TMO failed to undertake the actions he identified within  
 19 the required timescale. In turn, Stokes failed to  
 20 interrogate TMO's fire safety management or maintenance  
 21 regime, which meant that his opinion of the consequences  
 22 of a fire and overall risk level could never be  
 23 accurate.  
 24 Critically, TMO failed to monitor Stokes'  
 25 activities, despite being aware that a different fire

1 risk assessor in 2014 had taken a different approach,  
 2 giving Grenfell a moderate as opposed to tolerable risk  
 3 pending resolution of his action items. This should  
 4 have alerted TMO to Stokes' failure to evaluate the risk  
 5 posed by outstanding FRA items.  
 6 Stokes' failings were absolutely plain by the time  
 7 of the Adair fire in 2015, and Wray received various  
 8 criticisms of him in 2016 and 2017, yet TMO failed to  
 9 question the performance of the risk assessor on whom  
 10 they were very heavily dependent.  
 11 As to the first topic, complaints, a functional  
 12 complaints process is a key element of the four core  
 13 principles of scrutiny I have already mentioned.  
 14 Complaints help inform management of true performance.  
 15 TMO's and RBKC's dismissive attitude towards residents'  
 16 complaints was symptomatic of their approach to  
 17 governance which led directly to the devastating  
 18 failures of controls at Grenfell.  
 19 TMO avoided classifying expressions of  
 20 dissatisfaction as complaints, characterising them  
 21 instead as service requests. The complaints policy  
 22 contemplated an investigation procedure of up to three  
 23 internal stages, creating the illusion that complaints  
 24 would be considered afresh at each stage, whereas  
 25 in fact responses to complaints were drafted by those

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1 complained about, but sent out by others in TMO, giving  
 2 a semblance of impartiality. The first two stages were  
 3 subsequently amalgamated following instructions from  
 4 TMO's CEO, Robert Black, in 2014 to "make sure we are  
 5 all on the same page".  
 6 Residents considered the process unduly cumbersome  
 7 and difficult to navigate. During the refurbishment,  
 8 residents were initially referred to Rydon before  
 9 engaging TMO's own process, such that, as TMO's then  
 10 complaints manager Joanne Burke noted, "by the time that  
 11 they get to the complaints team, they are thoroughly fed  
 12 up". Burke also felt that there is a defensive culture  
 13 in the capital team about complaints.  
 14 TMO's approach disincentivised complaints.  
 15 Maddison's descriptions of closing down, closing off or  
 16 shutting down complaints reflect TMO's strategy of  
 17 merely dealing with complaints but without genuine  
 18 consideration.  
 19 Resident concerns were dismissed as rhetoric.  
 20 Maddison dismissed Daffarn and O'Connor's GAG blog as  
 21 scaremongering. Following a residents' petition in 2015  
 22 asking RBKC to exercise scrutiny, TMO, in collusion with  
 23 RBKC officers and councillors, engineered a situation  
 24 where TMO could deal with itself and avoid scrutiny by  
 25 RBKC. The resulting TMO board report lacked

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1 independence and failed to address residents'  
 2 complaints.  
 3 TMO briefed councillors against residents, making  
 4 clear complaints had been rejected, were without  
 5 foundation, and suggesting residents had acted  
 6 unreasonably. This concerted effort to manage  
 7 councillors' perceptions of TMO came from the top. It  
 8 was led by Black, who cultivated a relationship with  
 9 RBKC's Laura Johnson, which gave him advice and  
 10 influence over councillors.  
 11 Johnson's March 2017 email in response to Black's  
 12 about a post-refurbishment complaint in which he  
 13 characterised the complaint as "an echo of the fight we  
 14 have been in for the last two years" epitomises her  
 15 advice and her negative attitude towards Grenfell  
 16 residents. She said {RBK00000149}:  
 17 "Be robust to [Councillor Feilding-Mellen], he is  
 18 not minded to attend a public meeting with a group of  
 19 people who are moaning about minor issues.  
 20 "He is fully aware ... about Eddie [Daffarn] so you  
 21 can rest assured he is not taken seriously.  
 22 " ...  
 23 "This doesn't go back two years this goes back  
 24 20 years, it has always been a bad tempered place ...  
 25 and for some reason that general crossness has lingered

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1 and is stoked by various individuals with their own  
 2 agenda".  
 3 Understandably, residents were not fire safety  
 4 experts, but they did identify three important issues  
 5 which should have alerted TMO to an obvious threat to  
 6 Grenfell's fire safety.  
 7 First, the replacement riser in the stairwell. TMO  
 8 procured the installation of the riser by National Grid  
 9 following a leak in a gas riser in 2016. Between March  
 10 and May 2017 residents, including Lee Chapman, secretary  
 11 of the Grenfell Tower Leaseholders' Association, voiced  
 12 concern about the fire safety of installing gas pipes in  
 13 their only escape route, and repeatedly asked that  
 14 an independent expert be engaged.  
 15 These concerns were well-founded. TMO had been  
 16 warned by Stokes' letter in January 2017 to ensure that  
 17 compartment penetrations were sealed and that  
 18 an application to building control for the works was  
 19 required. Yet both RBKC and TMO instead relied on vague  
 20 assurances of compliance.  
 21 Resident concerns were dismissed with derision,  
 22 epitomised by Laura Johnson in March 2017. Lee Chapman  
 23 had given Johnson and Black a clear and correct warning  
 24 that, as a result of the installation, the building's  
 25 integrity has been compromised. Mr Chapman's email also

24

1 alerted Johnson and Black to vulnerable residents  
 2 {RBK00002365/2};  
 3 "There are many people in this building who are  
 4 immobile, very young or suffer from mental health  
 5 issues ..."  
 6 A moment's reflection, particularly in the wake of  
 7 Lakanal, should have caused these senior figures in TMO  
 8 and RBKC to reflect on the possibility of compartment  
 9 breach, and should have served as a timely reminder of  
 10 the needs of vulnerable residents which had not been  
 11 addressed. Instead, Johnson told Black, "When the pipe  
 12 issue has gone away they will find something else to  
 13 write about".  
 14 Second, reports of broken door—closers or damage to  
 15 seals on flat entrance doors should also have alerted  
 16 TMO, yet did not. Daffarn's complaint in August 2015  
 17 that flat 136's door had been left open all weekend and  
 18 had a broken door—closer was met with the suggestion  
 19 that he simply close it. TMO considered the issue  
 20 resolved. This overlooked the fundamental problem that  
 21 open doors equate to breached compartmentation.  
 22 Betty Kasote and others record that when their doors  
 23 were reported as difficult to close, TMO's repairing  
 24 contractors simply removed the closer.  
 25 Third, the lift. Although residents' complaints,

25

1 including those with disabilities, concerned the  
 2 inconvenience of breakdowns rather than safety in fire,  
 3 these complaints were obvious alerts to the dependence  
 4 of those with disabilities on the lift. This should  
 5 have triggered further investigation as to the use of  
 6 lifts as evacuation lifts and the need for PEEPs.  
 7 Turning to topic 2, the Fire Safety Order imposes  
 8 a requirement that a building, regardless of age or  
 9 compliance with regulations, be safe for the relevant  
 10 persons, namely residents and visitors. This is  
 11 achieved by procuring FRAs to identify the preventative  
 12 and protective measures required to keep relevant  
 13 persons safe. An evacuation plan is necessary in  
 14 certain circumstances, such as compartment breach,  
 15 regardless of the evacuation strategy of the building  
 16 and including if it is stay—put.  
 17 The Inquiry will wish to address how it is that one  
 18 of the principal pieces of guidance applicable to  
 19 purpose—built blocks, approved by the  
 20 Secretary of State, detracts in key respects from  
 21 obligations imposed by the order. This LGA guide was  
 22 sector led and, albeit produced in the wake of Lakanal,  
 23 fails to require an evacuation strategy, and assumes  
 24 that PEEPs are not required in general—needs blocks.  
 25 The guide also created the concept of a notional

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1 FD30 door, namely one with an assumed fire resistance of  
 2 30 minutes, and suggested it was not practical to  
 3 destructively test a door in order to establish the  
 4 actual fire resistance of doors for which no  
 5 certification now existed. This ran counter to other  
 6 post—Lakanal guidance by the Leasehold Excellence  
 7 Network. Despite incorporating PAS 79 by reference, the  
 8 LGA guide runs counter to PAS 79 methodology for  
 9 preparing an FRA.  
 10 The Inquiry will wish to explore the divergence of  
 11 its two experts, Dr Lane and Mr Todd, as to the adequacy  
 12 of Stokes' FRAs and on the topic of legislative  
 13 requirements for people with disabilities, on which  
 14 Todd's views are at odds with the requirement of the  
 15 Fire Safety Order. Todd's vindication of Stokes is, we  
 16 suggest, unlikely to withstand scrutiny, and begs the  
 17 question whether the competent standard for fire risk  
 18 assessors is far too low.  
 19 Dr Lane concludes that Stokes erred in four key  
 20 respects: first, failing to identify the occupancy  
 21 profile of the building, which is both a failure to  
 22 identify the relevant persons and a failure to evaluate  
 23 the risks to those persons and necessary mitigation;  
 24 second, failure to link his proposed corrective measures  
 25 to the risk they posed if not cured; third, failure to

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1 probe TMO's fire safety management in order to evaluate  
 2 the risks; fourth, failure to request and review the  
 3 emergency plans for evacuation. These failures meant he  
 4 failed to assess the risks posed by Grenfell to  
 5 residents and visitors, and his risk rating of  
 6 "tolerable" should have been "intolerable".  
 7 Stokes' treatment of the façade was also flawed.  
 8 While there is a debate as to whether a risk assessor  
 9 must assess the façade, given that the Fire Safety Order  
 10 does not define the external wall as a common part, both  
 11 schedule 1, part 3 of the order and the approved  
 12 methodology, PAS 79, require risk assessors to evaluate  
 13 the risks which cannot be avoided. That includes  
 14 factors such as combustible façades, which should be  
 15 included in the significant findings.  
 16 In any event, Stokes, by his FRAs, purported to have  
 17 assessed the cladding, describing it as "fire rated",  
 18 a meaningless term, but he also suggested compliance  
 19 with Building Regulations. It is now clear from Stokes'  
 20 statement that he did not know what the composition of  
 21 the cladding was and therefore had not assessed the  
 22 risks posed by it.  
 23 Stokes' treatment of lifts was deplorable. In 2009,  
 24 he reported that he didn't know whether the lifts were  
 25 firefighter or evacuation lifts, but his 2010 and all

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1 subsequent FRAs described both as evacuation or  
 2 firefighter lifts which could be used to evacuate  
 3 disabled residents, this despite Stokes having been told  
 4 that TMO’s senior lift engineer did not consider the  
 5 Grenfell lifts to be firefighter lifts .  
 6 Again, Dr Lane and Mr Todd’s opinions are in sharp  
 7 contrast. While both agree Stokes did not understand  
 8 lift standards, Lane considers his failure to recognise  
 9 the lifts were not firefighter lifts resulted in the  
 10 loss of a vital opportunity to identify necessary  
 11 mitigating measures. Todd, however, considers Stokes’  
 12 lack of knowledge of lift standards does not detract  
 13 from his competence as a fire risk assessor, and that  
 14 the lift ’s design did not affect the risk to relevant  
 15 persons. That is unlikely. Had the lifts been  
 16 firefighter lifts, either no key at all would have been  
 17 required or an emergency unlocking triangle key would  
 18 have been required, and in either case it would not have  
 19 been possible to use the incorrect key, which Howkins  
 20 tentatively concludes is most likely what happened. At  
 21 least three lives might have been saved.  
 22 Perhaps Stokes’ most egregious failing was not to  
 23 ask for an evacuation plan or address the lack of PEEPs.  
 24 Instead, he repeated for six years that the data would  
 25 be inputted into a TP tracker with a view to preparing

1 PEEPs, but as he knew, he had not been asked to prepare  
 2 PEEPs for Grenfell. Lane considers he should have been  
 3 proactive in obtaining such information.  
 4 RBKC and TMO’s principal failures as the responsible  
 5 persons related to fire doors and failures to facilitate  
 6 evacuation of the disabled. TMO’s fire risk management  
 7 suffered from systemic failures, despite TMO being told  
 8 in 2009 that it was in statutory breach on almost half  
 9 of the procedures reviewed. The review advised TMO it  
 10 needed a fire safety policy setting objectives for  
 11 compliance with the Fire Safety Order. TMO suffered  
 12 from a lack of transparency which meant it lauded itself  
 13 as having been given a clean bill of health by external  
 14 audits in 2013, even though those audits had alerted TMO  
 15 to its poor management systems.  
 16 TMO did not have proper structures in place to  
 17 address the volume of action items arising from FRAs,  
 18 but rather than resolving the issues, resorted to  
 19 "cleansing" the revealing data. This lack of  
 20 transparency resulted in the FRAs not being a reliable  
 21 review of TMO’s system and not assessing risk.  
 22 TMO’s systems did not encourage learning lessons or  
 23 change. Although Wray reported to the TMO health and  
 24 safety committee concerning fire safety by high-level  
 25 exception reports, these were not shared with the TMO’s

1 board and therefore there was no mechanism for making  
 2 changes to the fire risk management system.  
 3 As to doors, RBKC sought from 2011, and still  
 4 ongoing in May 2017, to avoid using its powers under the  
 5 Housing Act to ensure leaseholder doors were compliant,  
 6 and instead sought to persuade LFB to prosecute  
 7 leaseholders under the Fire Safety Order. RBKC clearly  
 8 recognised it was in breach of the Fire Safety Order, as  
 9 it made a submission in 2013 to the Secretary of State  
 10 acknowledging 68 potentially non-compliant doors and,  
 11 jointly with TMO, obtained advice from counsel, which  
 12 apparently suggested TMO’s notification to leaseholders  
 13 of non-compliance constituted due diligence, namely  
 14 a defence to successful prosecution under the order.  
 15 Despite being acutely aware that defective doors  
 16 mean compartmentation breaches, RBKC’s approach was to  
 17 cynically calculate potential cost versus the cost of  
 18 replacing leaseholder doors. In an email in which  
 19 RBKC’s Roger Keane had noted there was no realistic  
 20 prospect of Southwark being criminally prosecuted for  
 21 Lakanal, he said:  
 22 " ... if something did happen at one of our  
 23 properties, we are still likely to be the organisation  
 24 that faces prosecution. We therefore have to weigh up  
 25 the potential cost of dealing with this issue, against

1 the situation we would face if something happened and we  
 2 were found liable."  
 3 There can be no room for any form of cost/benefit  
 4 analysis given RBKC’s obligation to keep the protected  
 5 route safe and given lives were at stake. Even as late  
 6 as May 2017, when councillors suggested RBKC should  
 7 replace leaseholder doors at Trellick Tower, regardless  
 8 of whether they would be reimbursed, Laura Johnson  
 9 overruled them, describing it as a "non-issue". This  
 10 demonstrates a staggering lack of concern only tolerable  
 11 in a culture with scant regard for safety.  
 12 TMO also knew it was in breach of the order and had  
 13 been advised by Stokes that landlords were being  
 14 prosecuted for non-compliant doors on the protected  
 15 route. It seems RBKC’s and TMO’s focus was on avoiding  
 16 liability, instead of on fire safety.  
 17 RBKC was similarly irresponsible in relation to the  
 18 absence of door-closers. Cost management took priority  
 19 over safety. RBKC did not decide to instigate  
 20 a door-closer installation programme until March 2017,  
 21 despite understanding from as early as 2009 the  
 22 criticality of door-closers to the stay-put policy.  
 23 In October 2015, a serious fire occurred at  
 24 Adair Tower in which the flat of origin’s door failed to  
 25 close due to the lack of a door-closer, filling the

1 lobby with hot gases and heavy smoke, resulting in 24  
 2 fire survival calls and, in that respect, resonant of  
 3 Lakanal. A deficiency notice had been issued prior to  
 4 the fire identifying a failure to address the absence of  
 5 self-closing devices. Thereafter, enforcement notices  
 6 were issued in 2015 and 2016 on Adair and Hazlewood  
 7 Towers, including for failure to fit door-closers, and  
 8 a deficiency notice was issued on Grenfell in  
 9 November 2016, again for failure to fit door-closers.  
 10 RBKC therefore had full knowledge of the extensive  
 11 fire risks posed by the lack of door-closers, yet failed  
 12 to commit to install closers across its estate until  
 13 nearly two years after it had seen the serious  
 14 consequences of this omission. No door-closer programme  
 15 was in place by the time of the fire. RBKC now accepts  
 16 that an installation programme should have been in place  
 17 before then.  
 18 At the 1 March 2017 meeting at which Laura Johnson  
 19 gave approval for a door-closer installation programme,  
 20 she pushed the installation of closers from a three to  
 21 a five-year programme to "make funding the programme  
 22 more manageable". At that meeting she is recorded as  
 23 agreeing to hold off recommending inspections programme  
 24 at present, not being convinced of the need for  
 25 an inspection programme which, in her own words

1 {RBK00046603}:  
 2 "... would have to be ongoing and therefore  
 3 an additional expense to the [housing revenue account]  
 4 indefinitely, without any identifiable evidence that it  
 5 impacted positively on the fire safety of residents."  
 6 This was a misguided and perverse perspective, given  
 7 that, two years earlier, RBKC had at Adair witnessed the  
 8 best evidence of the devastation which ensues in fire if  
 9 a door fails to close.  
 10 RBKC now accepts that guidance required regular  
 11 inspections of door-closers. Regardless of whether the  
 12 decision not to instigate an inspection programme  
 13 emanated from RBKC or TMO, both parties are equally at  
 14 fault.  
 15 TMO had been warned by Stokes in 2011 that the  
 16 removal of door-closers on the protected route was  
 17 placing relevant persons at risk of death or serious  
 18 injury in fire. If a reminder of this were needed, then  
 19 the 2015 Adair fire should have sufficed.  
 20 Nevertheless, even faced with prosecutions on Adair,  
 21 Maddison resisted the installation of door-closers at  
 22 all properties and instructed counsel to consider  
 23 whether they were only required where fundamental to the  
 24 fire strategy, and wondered, "How can we best transfer  
 25 responsibility for maintenance of door-closers on to the

1 tenant?"  
 2 Both RBKC and TMO failed to ensure the required  
 3 means of escape for the disabled, despite RBKC having  
 4 originally been a trailblazer for accessible housing and  
 5 being aware that inclusive design requires that  
 6 buildings must cater for all. As RBKC's Claire Wise  
 7 said in 2010, specifying that disabled people should not  
 8 live above ground floor is an unacceptable  
 9 acknowledgement that existing fire safety procedures are  
 10 not inclusive.  
 11 TMO consulted with an access consultant and obtained  
 12 a report addressing wheelchair access and door-closers  
 13 for those with limited upper body strength, but ignored  
 14 these considerations, despite being made aware in 2017  
 15 that new doors at Grenfell were too heavy for the  
 16 elderly or disabled. As TMO had no policy for  
 17 identifying the needs of the disabled or processes for  
 18 achieving the necessary protective measures, there were  
 19 no such measures.  
 20 In conclusion, the failure of controls at every  
 21 level requires a thorough examination of the ambit of  
 22 the order, associated guidance and the competency  
 23 requirements of fire risk assessors. The order requires  
 24 that buildings be safe and accessible to residents and  
 25 visitors and, to that extent, neuters the provisions of

1 the Building Regulations which do not require  
 2 retrospective change. Nevertheless, the Inquiry may  
 3 wish to address the adequacy of ADB which, albeit  
 4 premised on inclusive design, offers limited guidance on  
 5 the topic.  
 6 The multiple managerial and systems failures at  
 7 Grenfell, which also include inadequately fire-rated  
 8 doors, systems maintenance failures, and inability to  
 9 rapidly isolate the gas supply during the fire, speak in  
 10 favour of a safety case covering all aspects of  
 11 a building's safety which could be audited by those with  
 12 the relevant specialist knowledge and available to  
 13 emergency services.  
 14 Those are my submissions, sir.  
 15 SIR MARTIN MOORE-BICK: Well, thank you very much indeed,  
 16 Ms Barwise. There is a lot for us to think about there,  
 17 and we're very grateful to you. Thank you very much.  
 18 Well, now it's time for me to invite Mr Friedman  
 19 Queen's Counsel to address us and make an opening  
 20 statement on behalf of the same group of bereaved,  
 21 survivors and residents.  
 22 So, Mr Friedman, are you in touch with us? Can you  
 23 see me? Can you hear me?  
 24 MR FRIEDMAN: I can, sir, I hope you can hear me?  
 25 SIR MARTIN MOORE-BICK: Ah, good morning, Mr Friedman. Yes,

1 certainly we can.  
 2 MR FRIEDMAN: Good morning to you and Ms Istephan and  
 3 Mr Akbor.  
 4 SIR MARTIN MOORE–BICK: Now, we’re running slightly ahead of  
 5 time, but there is nothing wrong with that, and if  
 6 you’re ready to make your statement, then please carry  
 7 on.  
 8 MR FRIEDMAN: I am.  
 9 Opening statement on behalf of BSRs Team 1 by MR FRIEDMAN  
 10 MR FRIEDMAN: We address you especially now on behalf of two  
 11 groups of Bhatt Murphy core participants: first, those  
 12 who campaigned for a greater voice and agency in matters  
 13 relating to their homes and safety, which they were  
 14 knowingly denied; second, those who lost relatives whose  
 15 disability or vulnerability meant that they could not  
 16 escape without pre–planning and provision, as was  
 17 foreseen before the fire, but nothing was done.  
 18 We want to particularly draw your attention to the  
 19 significance of the organisational and cultural context,  
 20 and to consider that part of the disaster which was the  
 21 product of imbalance of power and disregard of the  
 22 vulnerable.  
 23 The Inquiry has reached the point where the causal  
 24 role of these inequalities cannot be ignored  
 25 consistently with its terms of reference. The missing

1 fire safety measures were not just in the dangerously  
 2 defective construction and lack of compliance, but in  
 3 defective political and administrative system that no  
 4 less significantly failed to prevent this unprecedented  
 5 mass fatality.  
 6 The political and administrative context under RBKC  
 7 and the TMO is dealt with in part 2 of our written  
 8 submission. We take it as a given that you will study  
 9 and report on the legal, contractual and regulatory  
 10 structure that these organisations acted under. But we  
 11 want you to reflect on the way they behaved and why that  
 12 was so, starting with the TMO.  
 13 On paper, it declared, "We keep residents at the  
 14 centre of everything we do". It committed to giving  
 15 them maximum involvement in areas like major improvement  
 16 work. In practice, resident participation was at most  
 17 tokenistic or, more often, suppressed whenever there was  
 18 disagreement.  
 19 As a social housing manager, the TMO was large and  
 20 powerful. It presided over nearly 10,000 households  
 21 across some of the most expensive real estate in the  
 22 world. Its size and monopoly had no equivalent across  
 23 the United Kingdom.  
 24 The TMO was not a democracy. The number of members  
 25 who voted for it to continue managing RBKC’s housing

1 stock at each AGM throughout the relevant period was, on  
 2 average, never more than 10% of the households under its  
 3 powers.  
 4 The TMO had a single client and patron: RBKC. It  
 5 treated the council as the boss, its chairperson’s word,  
 6 not mine. If anything was centre stage, it was the  
 7 wishes of the RBKC, and you will see this dynamic was  
 8 exacerbated during the Grenfell refurbishment project.  
 9 RBKC was the product of the leadership of the  
 10 governing party that had led the borough for  
 11 generations. Panel, the wisdom of different approaches  
 12 to social housing policy may be for other forums, but  
 13 you don’t need to judge the politics in order to examine  
 14 the causative effect of values and ideas. If  
 15 the Inquiry finds that an ethos of indifference or  
 16 hostility came to permeate the non–negotiable matters of  
 17 fire safety, as all the evidence suggests it did, then  
 18 it must surely say as much.  
 19 The key to the terrible handling of the Grenfell  
 20 refurbishment lies in its deeply ambivalent origins and  
 21 motivations. The project was, from the outset,  
 22 a reluctant concession to vocal residents who drew the  
 23 politically inconvenient contrast between the  
 24 expenditure on the school and sports centre on their  
 25 doorstep and the dilapidation of their estate.

1 Conceivably, it only ever got the green light from RBKC  
 2 because it was thought to mitigate the perceived blight  
 3 Grenfell cast on the KALC neighbouring investment. Its  
 4 cladding façade was sold as a combination of aesthetic  
 5 and environmental progress, which it seems served to  
 6 remove the need to ask about dangers and downsides.  
 7 The investment needed to be sold to those who saw  
 8 these units not as homes but as assets in the context of  
 9 an identified £30 million funding shortfall in the  
 10 ringfenced housing revenue account. Grenfell was  
 11 considered one of RBKC’s worst performing assets,  
 12 presumptively to be knocked down, not refurbished.  
 13 Lucrative mixed housing regeneration was identified by  
 14 RBKC as the solution to the funding shortfall. The TMO  
 15 believed, with a degree of existential anxiety, that it  
 16 had to prove itself to RBKC as able to deliver on such  
 17 ambitious regeneration projects for fear of being  
 18 replaced by someone else. The TMO’s desperation or, in  
 19 Peter Maddison’s words, a seat at the table on such  
 20 future projects, made it hypersensitive to the  
 21 preferences of its single client. Meanwhile, RBKC left  
 22 the TMO in no doubt that its priorities were delivery on  
 23 time and in budget, and not resident satisfaction and  
 24 safety.  
 25 That is all essential context for how the

1 authorities behaved in the face of criticisms that were  
 2 made by residents who campaigned to be treated as equals  
 3 in planning, procurement and scrutiny of the  
 4 refurbishment. They tried and failed to take on RBKC  
 5 and the TMO with regard to the defects and dangers in  
 6 the works that they could see. They did everything they  
 7 could to compel transparency and accountability for the  
 8 things that were not shown to them.

9 The defeat of the residents' campaign for  
 10 accountability is dealt with in part 3 of the written  
 11 submission. It was achieved for a systematic and  
 12 concerted denial of residents' entitlements to be  
 13 consulted, informed and listened to.

14 Modern administrative law establishes basic  
 15 standards for any consultation exercise undertaken by  
 16 a political body and provides a measure to judge RBKC  
 17 and the TMO in this case. These standards serve the  
 18 valuable purposes of both improving decision-making by  
 19 properly testing proposals, and avoiding a legitimate  
 20 sense of injustice arising from a denial of a fair  
 21 opportunity to influence an outcome.

22 To serve these purposes, consultation must occur at  
 23 a formative stage of relevant decision-making, provide  
 24 sufficient time and information to enable intelligent  
 25 response, and the decision-maker must then

1 conscientiously and with an open mind take into account  
 2 what they are told.

3 Schedule 3 of the modular management agreement  
 4 between the TMO and RBKC, and section 7 of the TMO's  
 5 contracts, regulations and guidance, mandated that any  
 6 major works project should include consultation,  
 7 involvement and oversight by affected residents. The  
 8 duties under schedule 3 contained specific prescriptive  
 9 requirements for close involvement of a relevant  
 10 residents' association that was entitled to establish  
 11 a client review group to, in effect, act as the client.  
 12 This gave it representation on the project team,  
 13 involvement in the decision to appoint consultants,  
 14 including architects, and attendance at site meetings to  
 15 ensure "that tenants' concerns were addressed".

16 What is plain is that the TMO, supported on this by  
 17 RBKC, were entirely opposed to a residents' association  
 18 being permitted to scrutinise the Grenfell works, and we  
 19 have asked you to look at how these residents' rights  
 20 under the foundation TMO documents were deliberately  
 21 stonewalled and frustrated over a number of years.

22 The counterfactual exercise of just imagining  
 23 a proper consultation on procurement in the works in  
 24 this case is a powerful thing. The architect, Studio E,  
 25 were appointed without tendering or establishing their

1 experience and competence. They have told you  
 2 themselves in their evidence that, had a proper  
 3 procurement exercise taken place, they should not have  
 4 got the job. Residents were simply told of their  
 5 appointment after the event. They immediately queried  
 6 it but were brushed aside.

7 Neither was there any meaningful consultation on the  
 8 appointment of Rydon as the main contractor. When the  
 9 suggestion was raised internally with the TMO that it  
 10 was necessary to involve residents in the March 2014  
 11 tender interviews, the response was to ask if this was  
 12 some kind of a joke. That pretty much says it all. We  
 13 will see that resident involvement was deliberately kept  
 14 to the absolute minimum.

15 The evidence in Module 1 and 2 has shown you that  
 16 there is an inextricable link between the appointment of  
 17 Rydon and cuts that were made to the tendered budget  
 18 leading to the downgrade in cladding material. Sir, the  
 19 simple fact is that no properly informed resident, given  
 20 the opportunity to choose between Reynobond ACM and the  
 21 slightly more expensive zinc FR, would ever have opted  
 22 for the cheaper version without at least asking the  
 23 question: what are the downsides? Grenfell residents,  
 24 of course, were never given the opportunity to ask.

25 As a matter of organisational culture, the TMO had

1 a fundamentally misconceived understanding of the  
 2 purpose of resident engagement. The primary aim was to  
 3 achieve what it called "buy-in and support for the  
 4 project". It countenanced a joint approach with RBKC to  
 5 "keep concerns in-house". The overall outcome of this  
 6 approach was that managers, experts and contractors  
 7 dominated to the exclusion of residents. Lay persons,  
 8 particularly residents, were treated as having little or  
 9 nothing of value to add, therefore no right to comment  
 10 on budget, no right to ask about potential negative  
 11 consequences of substituting materials for reasons of  
 12 cost, no right to quiz the credentials of a would-be  
 13 architect or main contractor, no rights, no utility, no  
 14 dignity in relation to what was being done to their own  
 15 homes.

16 But you will also see from the evidence that the TMO  
 17 deliberately withheld important information with the bad  
 18 faith intention to cover things up. On 30 October 2014  
 19 Edward Daffarn requested minutes of monthly project  
 20 meetings between Rydon, the TMO, Studio E and others.  
 21 The application was disingenuously refused by blanket  
 22 indication of commercial sensitivity. This was not  
 23 a one-off. As we address in our written submissions, it  
 24 was part of a wider practice of deliberate misuse of the  
 25 commercial confidentiality exception, a practice

1 persisted in despite a complaint upheld by the TMO's  
2 company secretary and legal advice given to the TMO on  
3 the proper approach.

4 What was the real reason? Claire Williams recorded  
5 it in terms in respect of Mr Daffarn's October 2014  
6 request: it was to avoid critical scrutiny of problems.  
7 She cited, among other things, problems of residual  
8 asbestos in flats, and what the TMO's own contractors  
9 described as the "bombshell" of residents remaining  
10 unprotected due to a non-functioning ventilation system  
11 despite an LFB deficiency notice. Claire Williams  
12 advised that knowledge of these problems would "cause  
13 Mr Daffarn to raise more queries either on his blog or  
14 via further freedom of information requests".

15 Panel, we say the October 2014 refusal to provide  
16 information was a genuine "what if?" moment. By the  
17 summer of 2014, Edward Daffarn and Francis O'Connor had  
18 posted a blog of a letter to Ben Dewis of the local LFB  
19 to say that "residents of Grenfell Tower do not have any  
20 confidence that our building has been satisfactorily  
21 assessed to cope with the new improvement works".

22 The TMO sought, and still seeks today, to  
23 characterise the blog as alarmist. But what was known  
24 to the TMO, but undisclosed to residents, is that by  
25 that time Exova had produced three editions of a draft

1 outline fire safety strategy for the refurbishment, all  
2 of which expressly left of the question of potential  
3 external fire spread to be answered in a future issue of  
4 the document. No such issue ever came.

5 When GAG then made the October request for  
6 information, five consecutive monthly project meetings  
7 had tasked Simon Lawrence of Rydon with formally  
8 appointing a fire consultant, but nothing was done. On  
9 seeing those minutes, residents could have insisted on  
10 a final report being prepared to complete what Exova had  
11 obviously left unfinished.

12 Yet further, also in the autumn of 2014, Carl Stokes  
13 produced a high-priority action plan which was never  
14 disclosed to residents or, it seems, the LFB. This  
15 required Rydon to detail the fire rating of the cladding  
16 and the fixings, and obtain confirmation of the  
17 building control officer's acceptance of this fixing  
18 system and the cladding used. This too was not properly  
19 actioned.

20 Drawing it all together, the Grenfell Action Group,  
21 which had already queried whether the fire safety of the  
22 refurbishment had been properly assessed, was denied  
23 critical information demonstrating that it hadn't.  
24 Edward Daffarn and the TMO could at least agree on one  
25 thing: if the Grenfell Action Group had found this out,

1 of course they would have publicised it, and of course  
2 they would have asked more questions. Instead, they and  
3 others who survived must live with the fact that they  
4 were denied the opportunity to keep themselves and their  
5 homes safe.

6 Many of the BSRs have shared experiences in their  
7 Inquiry statements of how the TMO rejected, diminished  
8 and managed residents' concerns and complaints. As  
9 Dr Lane describes it, resident interventions were "seen  
10 as a hurdle to get over, a paperwork problem to close  
11 out, such that time and time again when the proper  
12 opportunity arose the potential risk to life was not  
13 evaluated".

14 One strand of this failure to listen was  
15 an obsessive defensiveness towards Edward Daffarn. In  
16 August 2015, when he reported the door to flat 136 on  
17 the 16th floor to be wide open, because its self-closing  
18 device was broken, it seems that the TMO really did care  
19 more about dismissing his complaints than just fixing  
20 the actual door. The door did not automatically close  
21 when Hamid Wahbi moved into flat 136 in February 2016.  
22 On the night of the fire, the door still did not  
23 self-close, causing smoke to fill the lobby.  
24 Joseph Daniels and Sheila died on that floor.  
25 Edward Daffarn survived only because he was dragged from

1 the lobby by firefighters. People coming down the  
2 stairs saw smoke filling their path, most likely from  
3 floor 16, and we know that this is one of the reasons  
4 why they then went back upstairs to their death.

5 Sir, criticism can be a good thing, and it certainly  
6 was at Grenfell, given the extent of the dangers that  
7 were being incubated by neglect. For the TMO to  
8 withhold information because they did not like what  
9 their critics would do with it was unlawfully perverse  
10 and a patent abuse of power.

11 It is remarkable and telling that the TMO, after  
12 everything, still seeks to perpetuate their criticisms  
13 of Edward Daffarn in their opening submissions for this  
14 module. That is indeed the advocacy of  
15 a non-functional, amoral organisation that was and is  
16 more interested in its reputation than keeping people  
17 safe.

18 At the beginning of 2015, there was a building-wide  
19 anxiety about the refurbishment and opposition to how  
20 residents were being treated. Rather than engaging with  
21 it, the TMO did everything they could to deny it. By  
22 March of that year, residents across the tower of all  
23 backgrounds, ages and interests had come together. They  
24 asked to be recognised as a formal entity, supported by  
25 a letter from the trade union Unite. There are poignant

1 pictures of their meetings across that year that show  
 2 a number of women and men who died in the fire, as well  
 3 as several survivors that the Inquiry has come to know.  
 4 The response of Robert Black, the CEO, to that Unite  
 5 letter was to make clear his and the TMO's preference to  
 6 not even meet the group because he regarded it as  
 7 a showcase for Mr Daffarn.  
 8 In December 2015, the same group lodged a petition  
 9 with RBKC. The initiative involved Councillor Blakeman,  
 10 who had come to support its aims. The document was  
 11 signed by 60 residents. It called for urgent  
 12 independent investigation by the RBKC housing and  
 13 property scrutiny committee of the conduct of the works  
 14 and the treatment of residents. Of those 60  
 15 signatories, 20 either died in the fire or were  
 16 bereaved. Again, despite the number of signatures, the  
 17 evidence shows residents' views were still apparently  
 18 dismissed within RBKC and the TMO as somehow  
 19 unrepresentative due to it being organised or engineered  
 20 by Edward Daffarn. Among many other fallacies with this  
 21 critique, it discounted that the signatories genuinely  
 22 believed what they had put their name to or that there  
 23 could be any value to what they were saying.  
 24 What followed before the scrutiny committee was  
 25 a further shameful lost opportunity. Rather than

1 commissioning and independent investigation, the TMO,  
 2 council officers and the committee orchestrated the  
 3 outcome to allow the TMO to investigate itself. The TMO  
 4 duly reported back, despite Councillor Blakeman's  
 5 efforts to correct its errors and omissions, in  
 6 a document that was originally classified, which  
 7 dismissed residents' concerns in their entirety, without  
 8 interviewing a single resident, and instead glowingly  
 9 commended itself and its contractor.  
 10 This was not Edward Daffarn charting his own path.  
 11 He was there alongside many. To name just a few, there  
 12 was Willie Thompson, Mariem Elgwhary, Denis Murphy,  
 13 Berkti Haftom, and Sheila, who told Peter Maddison in  
 14 a meeting, "I am here because I am a vulnerable person".  
 15 There were leaseholder advocates like Shah Ahmed and  
 16 Tunde Awoderu, residents with a pertinent professional  
 17 background to see what was going wrong like  
 18 David Collins, and there was Judith Blakeman, as  
 19 an elected councillor and TMO board member who was  
 20 increasingly bullied for supporting these people, even  
 21 though that was her job, and the TMO was supposed to be  
 22 resident-led and resident-centred. The TMO took her  
 23 words at face value when it suited them and marginalised  
 24 her when it didn't.  
 25 Panel, organisational exclusivity and disregard for

1 non-member input is a classically understood feature of  
 2 human-made disasters, and this is a textbook case. The  
 3 outsider is dismissed as a crank, a misfit or  
 4 a manipulator of others. The stigmatisation of the  
 5 dissident creates a blind spot to the criticism being  
 6 made. They did this to Ed Daffarn, but don't for  
 7 a moment think that they didn't do it to Shah Ahmed,  
 8 David Collins, Judith Blakeman, and anyone else who told  
 9 them that they were wrong.  
 10 To make matters worse, there was an irresponsible  
 11 assumption that anyone else was either being supinely  
 12 led by these critics or otherwise content. It ought to  
 13 be obvious to anyone involved in social housing that  
 14 residents may be reluctant to complain personally for  
 15 a multitude of reasons, including but in no way limited  
 16 to immigration or housing status, or experience as  
 17 a member of a minority race or ethnicity. They must be  
 18 entitled to rely on collective advocacy, rather than be  
 19 given the invidious choice of bearing the burden of  
 20 speaking up alone, being silent or indeed silenced.  
 21 A functioning system of governance committed to  
 22 listening without prejudice to its residents needed to  
 23 be conscious and responsive to this in a way that the  
 24 TMO and RBKC were deliberately not. In the end, even  
 25 the most fearless of residents could only address on

1 fire safety what they could see or were told about. As  
 2 a result of a deliberate withholding of information,  
 3 they were sometimes just able to communicate an inchoate  
 4 tacit awareness that they were unsafe from fire at  
 5 Grenfell. Again, rather than respecting and acting on  
 6 it, founded as it was on the intelligence of those who  
 7 actually dwelt in the lived environment, the TMO took  
 8 advantage of the information deficit it had created to  
 9 repeatedly dismiss residents' fears as unwarranted and  
 10 unsubstantiated.  
 11 Our final subject for today is the neglect of  
 12 disabled and vulnerable residents that is set out in  
 13 part 5 of our submission. We note, with respect, that  
 14 all BSR submissions have made this a centrepiece of  
 15 their opening. They and we have done so because  
 16 although the Grenfell Tower fire is many things, it is  
 17 surely a landmark act of discrimination against disabled  
 18 and vulnerable people.  
 19 The law does not appear to be in significant  
 20 dispute. These were special categories of at-risk  
 21 relevant persons to be identified, planned and provided  
 22 for by the responsible persons under the Fire Safety  
 23 Order 2005. The discharge of the fire safety functions  
 24 had to be informed both by the public sector equality  
 25 duty in section 149 of the Equality Act, and the

1 internationally and domestically protected human rights  
 2 to life and non-discrimination. None of this happened.  
 3 As Ms Barwise has highlighted, the TMO and RBKC now  
 4 seek cover for the breaches of statutory duty in a few  
 5 short passages in guidance developed by the sector and  
 6 published by the Local Government Association in 2011.  
 7 Colin Todd is an expert witness in this Inquiry, but  
 8 his role in formulating and perpetrating the offending  
 9 advice in the guide must itself be the subject of  
 10 a scrutiny. That advice states that there is usually  
 11 nothing to be done for vulnerable residents in high-rise  
 12 buildings operating a stay-put policy because it is  
 13 unrealistic to make any special arrangements for them.  
 14 No serious legal or moral defence of the wholesale  
 15 denial of fire safety to a class of residents especially  
 16 in need of protection is offered in the guide or to this  
 17 Inquiry. Instead, first, a transparently false  
 18 dichotomy between maintenance of a stay-put strategy and  
 19 simultaneous evacuation is floated to imply outrageously  
 20 that the status quo was in fact favourable to vulnerable  
 21 persons. As is plain to see, the real issue is denial  
 22 of planning and provision for evacuation when it is no  
 23 longer safe to stay put.  
 24 Next, it is suggested that evacuation should, all  
 25 being well with compartmentation, rarely be required.

1 This is simply not an acceptable answer to the situation  
 2 when all is not well, which even the LGA guide  
 3 contemplates. That is why the Fire Safety Order so  
 4 clearly imposes non-delegable duties requiring planning  
 5 and provision for all residents, not just those without  
 6 additional needs.  
 7 As it happens, the three other Inquiry experts,  
 8 Dr Lane, Professor Galea and Professor Torero, strongly  
 9 disagree with Mr Todd regarding the limited risk of  
 10 compartmentation breach in high-rise buildings as  
 11 a class.  
 12 Colin Todd and those in the sector and Government  
 13 who agree with him have demonstrated themselves unable  
 14 or unwilling to stand back and reflect on the  
 15 status quo. Remarkably in the immediate aftermath of  
 16 the Phase 1 PEEP recommendation, Mr Todd and industry  
 17 rushed out new draft national guidance in the form of  
 18 PAS 79:2020 doubling down on the "do nothing" approach  
 19 and deliberately deleting positive provision for  
 20 disabled and vulnerable residents found in their  
 21 predecessor edition.  
 22 The BSI has recently seen the wisdom of withdrawing  
 23 PAS 79:2020 and reconsidering the issue, and so too the  
 24 Home Office, despite initially being lobbied to  
 25 contemplate a departure from the Inquiry's Phase 1 PEEP

1 recommendation by a sector special interest group  
 2 submission that Mr Todd had again contributed to.  
 3 A major fault of the dogmatic sector stance is its  
 4 lack of openness to existing and new ways to improve the  
 5 safety of disabled and vulnerable residents. It pays no  
 6 regard to the idea that disabled residents could be  
 7 important experts in the pre-planning of their own  
 8 evacuation, that responsible persons could meet and  
 9 learn from them, and it shuts its eyes to available best  
 10 practice on inclusive evacuation planning across the  
 11 country and the world. It also raises troubling  
 12 questions as to the underlying motivations. Budgetary  
 13 concerns can no longer be allowed to uncritically trump  
 14 a matter as important as equal enjoyment of safety in  
 15 the event of a fire.  
 16 Ultimately, the view that nothing can be done, as  
 17 well as being unevicted and wrong, sanctions an  
 18 outcome, even if that is not its aim, that treats  
 19 disabled residents in high-rise buildings as if their  
 20 lives don't matter.  
 21 I want to finish, if I may, by reflecting that there  
 22 is a link between the closed nature of discussion  
 23 between Government, managers and specialists at this  
 24 national level and what went on with the RBKC, TMO and  
 25 its contractors at Grenfell. No one was particularly

1 interested in involving ordinary people. Quite the  
 2 opposite. The results are profoundly anti-democratic  
 3 and disrespectful. Grenfell residents had no part in  
 4 the choice of their architect, contractor, design  
 5 amendments or access to fire risk documents, nor any  
 6 chance to be informed and co-operate in the pre-design  
 7 of their own evacuation.  
 8 Edward Daffarn's statement to this Inquiry  
 9 eloquently tells how this tragedy played out in three  
 10 acts, before, during and after the fire. Each of those  
 11 acts involved a markedly negative view about the wisdom  
 12 and resilience of people when they come together as  
 13 groups. Before, the TMO and RBKC were desperate not to  
 14 recognise collective community representation. During,  
 15 the firefighters thought that mass evacuation would only  
 16 cause panic and injury. After, the authorities feared  
 17 that there would be uprising on Kensington streets.  
 18 In fact, each part of the Inquiry's evidence  
 19 indicates the possibilities when ordinary people come  
 20 together. They speak truth to power, prompt new ways of  
 21 seeing old problems, save themselves and others as the  
 22 real first responders in an emergency, and create the  
 23 first and most enduring forms of support and recovery.  
 24 Just as culture, values and ideas were among the key  
 25 causes of the fire, a more co-operative and

1 co-productive approach, involving dialogue with and  
 2 participation of residents, must become a fundamental  
 3 aspect of fire safety in the future.  
 4 But to make a firm foundation for such progress,  
 5 the Inquiry needs first to clearly and unequivocally  
 6 identify the root cause of this disaster in the  
 7 disempowerment and unequal treatment of residents.  
 8 People with less influence, money and expertise were  
 9 essentially rolled over, and the various tools of human  
 10 rights, health and safety, and public protest, were not  
 11 sufficient to save them.  
 12 Thank you, sir. Those are our submissions.  
 13 SIR MARTIN MOORE-BICK: Well, thank you very much indeed,  
 14 Mr Friedman. A very powerful statement which will give  
 15 us a lot of food for thought. Thank you very much.  
 16 We've got to the point in the morning at which  
 17 I think we should take a short break. We are running  
 18 slightly ahead of ourselves, which is always welcome.  
 19 So what I'm going to say is we will break now, we will  
 20 resume at 11.40, provided Mr Mansfield, who is due to  
 21 speak next, is ready at 11.40. If he is not, that  
 22 doesn't matter, we will take him at the time advertised,  
 23 which is 11.45.  
 24 So we may resume at 11.40, all being well, and we  
 25 will see you then.

1 (11.25 am)  
 2 (A short break)  
 3 (11.40 am)  
 4 SIR MARTIN MOORE-BICK: Welcome back, everyone. I'm now  
 5 going to invite Mr Mansfield Queen's Counsel to address  
 6 the panel on behalf of the other group of bereaved,  
 7 survivors and residents.  
 8 Mr Mansfield, good morning. Can I just check that  
 9 you can see me and hear me well?  
 10 MR MANSFIELD: Very much so, sir, yes, thank you.  
 11 SIR MARTIN MOORE-BICK: Very good. Well, good morning, it's  
 12 good to see you, and when you're ready, I think we are  
 13 ready to kick off.  
 14 MR MANSFIELD: Yes, thank you, sir.  
 15 Opening statement on behalf of BSRs Team 2 by MR MANSFIELD  
 16 MR MANSFIELD: Well, sir, Thouria Istephan and Ali Akbor,  
 17 your co-panelists, we are much obliged for this  
 18 opportunity to open for Team 2.  
 19 I have listened very carefully, as I'm sure everyone  
 20 has, to what has already been said, and I will try and  
 21 avoid repeating the detail of the two previous  
 22 submissions to you, with which we agree, so there would  
 23 be little point in duplication.  
 24 In addition to that, of course, we have already  
 25 submitted questions, as well as a written opening. So

1 again, no purpose would be served in repeating all of  
 2 that.  
 3 But what I would like to do is just to pause for  
 4 a moment before using a rather different approach, in  
 5 the hope of illustrating, in a sense, what you have  
 6 heard by way of criticism of the regulations, of the  
 7 people who are supposed to implement the regulations, of  
 8 attitudes and so on, before dealing with a particular  
 9 approach and perspective, which is to bring it to life  
 10 through the eyes of the families. I'm going to avoid  
 11 using the term "BSRs", if you'll forgive me, but the  
 12 families, and the voices of the families, because the  
 13 first reflective moment -- because this is a historic  
 14 moment in this Inquiry, when, after so long, we return  
 15 to the families themselves and what they have to say.  
 16 What one has to bear in mind, I would ask everyone  
 17 to bear in mind, and the reason why their voices at this  
 18 moment, at this juncture, are so important, is, firstly,  
 19 you have to remember -- it's easy to just override it  
 20 and forget because so much else is happening as we  
 21 speak -- they, and particularly one of the people I want  
 22 to mention in more detail, Shah Ahmed, had suffered  
 23 a great deal before this fire. They had suffered -- and  
 24 somebody's already mentioned it this morning --  
 25 20 years, 20 years of neglect. And the neglect isn't

1 just concerned with fire safety. If I may, I just want  
 2 to illustrate it. It's in one sense minor, but it  
 3 really tells you everything about what's been going on  
 4 there. It's not fire related. It didn't cause the  
 5 fire. It didn't cause the death. But it tells you  
 6 everything in one short cameo of what had been going on  
 7 for years before this fire.  
 8 A gentleman whose name I will not mention who lived  
 9 on floor 15, so one of the upper floors, he suffered  
 10 from bowel cancer, and that was known. For six months  
 11 he had a flat in which there was no functioning  
 12 lavatory. Think about that for this person. What did  
 13 this gentleman have to do to get something done? And  
 14 I think Stephanie Barwise said staggering lack of  
 15 concern; it's worse than that. He, that is this  
 16 individual, had to go to North Kensington Law Centre in  
 17 order to get legal help, and also get his physician to  
 18 intervene in order to have a working lavatory, and then  
 19 we wonder why the tower suffered in the way that it did,  
 20 because that's the suffering, that's the kind of  
 21 suffering. It indicates an attitude of mind that  
 22 happened over that 20-year period.  
 23 But then on top of that, these residents and  
 24 families suffered the fire itself, and you have heard  
 25 something of that and I want to, in a very short while,

1 just reflect on a small passage of that which  
 2 illustrates what's happened.  
 3 But they suffered the fire , and then afterwards,  
 4 of course, they go through a terrible period in which  
 5 there are more housing problems and difficulties for  
 6 them, just in daily living . And then on top of that  
 7 comes the pandemic and the difficulties of the hearings  
 8 and not being able to attend. And, of course, Modules 1  
 9 and 2 did not include the voices of the families ,  
 10 although they have plenty to say about the issues in  
 11 Modules 1 and 2.  
 12 Instead, they had to sit at home, usually, and  
 13 watch — and I hope this is not an understatement, or  
 14 even an overstatement — a parade of arrogance. There  
 15 may be one pandemic outside the hearing; there's another  
 16 inside it, and it's the pandemic of lies, of  
 17 manipulation, of deceit, of jocularity , of pride in what  
 18 they're joking about. And one has to ask, obviously,  
 19 how that has come about.  
 20 We are approaching a different stage. It's one  
 21 thing to work out how the fire was caused, and how the  
 22 deaths were caused; the bigger question is: why did this  
 23 happen?  
 24 So, therefore, one way of encapsulating what has  
 25 happened over these 20 years, and it's epitomised in the

1 construction industry and the race to the bottom, the  
 2 description you've heard before, is what we now have,  
 3 and I'm going to characterise it if I may in this way:  
 4 that what the council, the Royal Borough of Kensington,  
 5 created was a chronic culture of neglect — of that  
 6 there can be little doubt — of indifference and  
 7 discrimination underpinned by, as you've already heard,  
 8 a theme of dishonesty in the sense of not revealing  
 9 information.  
 10 How is it that the construction industry in a sense  
 11 and the authorities you're about to hear are conjoined  
 12 in one continuum? There's this bigger question of: what  
 13 is lying behind the construction industry's approach and  
 14 the local authorities' approach?  
 15 Before moving into some of the illustrative  
 16 examples, there is another reflection which may have  
 17 struck you this morning, if not before — probably  
 18 before, well before — and that is this: the staggering  
 19 lack of concern leads one to believe and leads one to  
 20 examine what we've put in our written submissions, that  
 21 whatever happens in this Inquiry, it is important that  
 22 any recommendations, and it's important that any themes  
 23 that come out are enacted and implemented, but, as you  
 24 have seen, if those in a position of authority, whether  
 25 it's in the construction industry or the local

1 authority, are of a particular mindset, it doesn't  
 2 matter what the regulations are, it doesn't matter what  
 3 the statutory duties are, because at the end of the day,  
 4 they think they're immune. They think they can laugh  
 5 about it. They think, as they did in the construction  
 6 industry, "Well, that's what we do, lie". Is that  
 7 a society that has been created over the last  
 8 10/20 years?  
 9 We say there's a risk of that continuing unless  
 10 there's a real attempt to change the mindset, so that  
 11 whatever one says ought to happen, and even if you set  
 12 it in law, you ensure that it is enforced and people are  
 13 made accountable.  
 14 So those are the reflections before I even begin the  
 15 examination, because what I would like to do is to go  
 16 back to the night in question just for a moment, and  
 17 I want to, as it were, bring to life all those  
 18 deficiencies and defaults you've heard about in the  
 19 written submissions as well as the spoken today.  
 20 You were there for the pen portraits, and you have  
 21 been to the tower. May I — I don't ask for answers,  
 22 it's a rhetorical question, but your co-panelists, if  
 23 they haven't watched the pen portraits, would they be  
 24 kind enough to do so, because it brings to life the  
 25 lives of those who died, and the eclectic quality of the

1 lives that died, the diversity already mentioned of  
 2 those who died in this remarkable — I've called it the  
 3 vertical village, which has been destroyed, although the  
 4 people who live on still have it in their hearts.  
 5 But the pen portraits are one thing, and, again, to  
 6 your co-panelists, Thouria Istephan and Ali Akbor, if  
 7 you haven't been to the tower, may I ask that you do  
 8 visit the tower, provided it's safe, obviously, I'm not  
 9 sure what the present situation is and you may have  
 10 already visited it. It's important to understand just  
 11 how serious the — not just the happening on the night,  
 12 but what went before it as well. And then it's put in  
 13 a context, once you've walked up that stairwell, you've  
 14 walked up the staircase, you've seen the conditions,  
 15 just the space conditions, it then takes on a new  
 16 dimension.  
 17 So I'm going to, if I may, just read a portion —  
 18 it's only a small portion, and I'll make it clear at the  
 19 end, if it doesn't become clear straightaway, about whom  
 20 I'm speaking in relation to this, and it will bear upon  
 21 what we say are the important findings in this  
 22 particular module:  
 23 "On the Tuesday evening before the fire [13 June],  
 24 it was a normal night for me. We went to bed around  
 25 11.30, but I couldn't really sleep. I must have fallen

1 asleep, but it wasn't a very deep sleep. I think our  
 2 bedroom door was slightly open that night because it was  
 3 hot. My kitchen window was open too."  
 4 I'm going to miss certain sections which don't bear  
 5 upon the immediate points I want to make.  
 6 "I got up. I didn't see any smoke until I went into  
 7 the kitchen. As soon as I got into the kitchen and  
 8 looked down out of the window, I saw a big fireball  
 9 coming up from the outside of the building. It was the  
 10 colour of burning sunset. I initially thought it must  
 11 have been a fire in the flat below. The kitchen window  
 12 then exploded inwards. I was lucky I wasn't close to  
 13 the window. I dialled 999 on the house phone from the  
 14 living room. However, before completing the call and  
 15 speaking to anybody, I threw the handset down and  
 16 decided to get out. Until recently I believed I had not  
 17 completed the call. However, the police have informed  
 18 me that I did in fact complete the call, although  
 19 I didn't speak to anyone before I threw the handset  
 20 down."  
 21 This is important for this section:  
 22 "I'm glad I didn't speak to the operator, as I might  
 23 have been told to stay put."  
 24 Well, that's a point I want to come back to.  
 25 In fact, what he didn't realise was that what he then

1 did was overheard by the operator.  
 2 "My wife and I banged on the door of flat 155 and  
 3 shouted 'Fire! Fire! Fire!' I then went to 154. The  
 4 man there opened the door a little bit. I told him to  
 5 get out because there was a fire. Then I banged on 153,  
 6 but I can't remember if there was an answer. Then  
 7 I banged on 152, I think someone answered, although  
 8 I can't remember clearly. Then I banged on 151. A lady  
 9 with a walking frame answered. I told her there was  
 10 a fire, to get out. There is a smoke alarm [another  
 11 point you may wish to pick up on this] in the lift  
 12 lobby, but it wasn't ringing, otherwise the other flats  
 13 would have heard it and I wouldn't have had to tell them  
 14 there was a fire."  
 15 It goes on, of course, and it may be clear about who  
 16 it is.  
 17 He goes back to his flat to get his mobile phone.  
 18 He tried to go back, but when he opened the door he saw  
 19 thick white/black mixed smoke, smelt smoke:  
 20 "Something like burning, I don't know what exactly.  
 21 I didn't feel the heat coming. I shut the door  
 22 straightaway, then I thought we have to get out. It was  
 23 fight or flight. Through my years of fighting for the  
 24 health and safety of the building I had the instinct to  
 25 know the building was not safe and that it was a ticking

1 time bomb."  
 2 Now, the person at the root of this and his wife,  
 3 Sayeda, is Shah Ahmed. Now, I'm going to use his, if  
 4 one likes, prism of what happened to him in order to  
 5 illustrate just how serious this chronic culture  
 6 fostered by the local council had been, because he knew  
 7 what he was in for if he stayed put. Not only did he  
 8 know, he had very clearly signposted what was wrong with  
 9 the block. So in a sense he's an expert, and the  
 10 families are experts in terms of what they knew.  
 11 We have it in the building sector, the construction  
 12 sector, whereby companies knew full well, some of them,  
 13 that they were providing combustible materials but they  
 14 went ahead. Why? Profit. And in this area, we have  
 15 a very similar situation. The similar situation here is  
 16 where they are being told -- that is the authority --  
 17 what is wrong and what is going to happen, but they do  
 18 nothing. That is why we say it's a chronic culture all  
 19 the way through, whether it's a lavatory or anything  
 20 else. This is where essentially there's discrimination  
 21 of a class of people, and I'll come back to that as  
 22 well.  
 23 Just pausing again on that particular chronicle, if  
 24 I may put it that way, so that it can be seen in another  
 25 context, he, that is Shah Ahmed, lived in flat 156,

1 which is why I've mentioned all the other flats he went  
 2 to, on the 18th floor. Between -- and this is in your  
 3 Phase 1 report -- 1.20, so we're dealing with  
 4 a situation obviously in the middle of the night, and  
 5 1.30, that's ten minutes, the fire had enveloped -- and  
 6 anyone -- I'm not asking for scenes to be shown, but  
 7 that's why it's so important to keep going back to what  
 8 happened here. The fire enveloped all the 6s, by which  
 9 I mean all the flats ending in 6 who were one above  
 10 another in the tower, between floors 10 and 23, and  
 11 in fact his telephone call to the operator was at  
 12 1.27.56, and he exited with his wife at 1.31. So he got  
 13 out just in time, but without, again, going through, and  
 14 it would take too long and it would take the number of  
 15 days it did at the start and in Phase 1, you then have  
 16 the picture of what happened to everybody else. Some  
 17 survived, and a large number didn't.  
 18 But what were they facing, the ones who were not  
 19 able to get out in the way that he did? They were  
 20 facing, as you will recall, a situation in which the  
 21 stairwell was filled with increasing amounts of black,  
 22 acrid smoke, with the difficulty of walking down the  
 23 stairs in the night, badly lit, badly signed. In fact,  
 24 refurbishment, what had they done? Nothing, absolutely  
 25 nothing to the means of escape. It was still in the

1 same condition. And this again tells you how bad the  
 2 neglect had been. And there are those who are making  
 3 phone calls, who are being told to stay put, and others,  
 4 the operator says, "Well, just open the door, you've got  
 5 to go, you've got to go", and they're talked down.  
 6 Others can't do it, others are left to die. That's the  
 7 chronic situation that has been created on the night,  
 8 and those doors that he tapped on, two of them are  
 9 significant, because they tie in with what we say is  
 10 a dereliction of duty here, now well before you.  
 11 In flat 154, where the door opened, there was  
 12 in fact just one man living. He died. He had  
 13 a mobility problem that was known. He was disabled. He  
 14 didn't die in his flat, he managed to go up, and you  
 15 will recall a number did do that in the hope that there  
 16 might be a rescue from above. So he unfortunately --  
 17 mainly because, of course, no one had thought about:  
 18 how's he going to get out, then? Too much trouble to  
 19 think about that?  
 20 One has to pause for a minute. What are we saying,  
 21 it's necessary to have protocols and regulations before  
 22 you begin to think about who's living in the block you  
 23 own? If that's what it takes, that's what it takes.  
 24 But the problem here is whether the caring society has,  
 25 as it were, left certain people at the door, including

1 the authorities. But he died.  
 2 In fact, six occupants on this floor died, five of  
 3 them -- he was one of them -- went to floor 23 above.  
 4 Flat 151, where he tapped, two sisters, they were -- I'm  
 5 not going to name them all the time -- one with the  
 6 frame. Those two sisters, they went up as well to  
 7 floor 23, and they died.  
 8 Just reflecting here on the total situation for  
 9 a moment, out of the 120 flats, how many flats contained  
 10 people who were disabled in various definitions, dealing  
 11 with age, either old or young, or mental difficulties,  
 12 physical difficulties, reading difficulties, hearing  
 13 difficulties, seeing difficulties: 52 out of the 120  
 14 flats. I won't, obviously either on screen or off at  
 15 the moment, deal with -- there is a schedule that you  
 16 have, we I think submitted it with our written opening,  
 17 which indicates the number of individuals who had  
 18 an impairment.  
 19 This you would think is common sense: you would  
 20 want, as a caring authority, to ensure that you look  
 21 after and provide safety. Why do we have to write it  
 22 out? Well, apparently we do. But there is -- and it  
 23 hasn't been mentioned extensively, but I just want to  
 24 mention it, it's in our written submissions so I don't  
 25 develop it -- there's an obligation upon the Inquiry

1 itself under Article 2 and Article 14 in relation to  
 2 human rights, the protection of life and the prevention  
 3 of discrimination, and that you make enquiries and you  
 4 investigate the extent to which, besides the protected  
 5 characteristics here, whether there is a racial  
 6 characteristic which enters this arena, because you have  
 7 to ask why for so long a whole diverse community have  
 8 been ignored, basically. That is a question that has to  
 9 be asked.  
 10 They have a duty, again under the statutory duty,  
 11 2010, the Equality Act, a public sector equality duty,  
 12 and that must not be shirked. It can't be delegated.  
 13 It's not negotiable. And we say they must have known  
 14 about that, but were not -- 2010, it's an interesting  
 15 year, happens to coincide with some occurrences I'm  
 16 going to come to in a moment, 2010.  
 17 So that's a very important -- one of many statutes.  
 18 We've put them all in our written submissions, but that  
 19 perhaps rises to the surface. And we give other  
 20 examples of the disabled who died because there was no  
 21 provision.  
 22 I'm citing, I think to move on in one moment to the  
 23 experiences of Shah Ahmed, but before I do, it was part  
 24 of his experience as well, I'm going to go back from the  
 25 night itself, in other words we're moving back from the

1 14th through the 13th.  
 2 There is an irony here that you might have reflected  
 3 upon at some point. On 10 June -- it's only four days  
 4 before -- there were a series of visits, home  
 5 fire safety visits, four firemen from the  
 6 North Kensington White Watch visited a number of flats.  
 7 Not all of them, but a number. 25 altogether they  
 8 visited.  
 9 Now, the object usually of a home fire safety visit,  
 10 two prime ones, it's obviously to make sure the alarms  
 11 are working, and also if there are people who have  
 12 particular vulnerabilities of the kind I've already  
 13 described, they should be getting advice.  
 14 Now, of the 25 flats visited, 15 of those flats gave  
 15 rise to 32 people dying on the night, and 20 of those 32  
 16 were vulnerable in the various categories. One of the  
 17 flats that they did go to -- interestingly, they didn't  
 18 go to the two I've mentioned next to Shah Ahmed, that's  
 19 154 and 151, they didn't go there, but they did go to  
 20 his. What's important about the visit to him -- and you  
 21 may remember that there was a witness in Phase 1 who  
 22 remembered Shah Ahmed, and it's interesting, because  
 23 Shah Ahmed's name is not well known, in fact, and I want  
 24 to come to him in a moment as an individual representing  
 25 essentially so many people in the block. But the point

1 he wanted to make, a point he was utterly correct in  
 2 making, but the fire officer who spoke to him said, "I'm  
 3 not an expert, I can't help you about that, you persist  
 4 with your enquiries with the council", well, that advice  
 5 was certainly right, because what he was talking about  
 6 were the pipes, the gas pipes that had been inserted  
 7 without consultation up the only means of escape,  
 8 a protected means of escape, and then inserted into  
 9 flats. If one morning you suddenly saw this kind of  
 10 work happening where you lived, I think you would be  
 11 worried. Highly dangerous, inflammable gas inserted in  
 12 this way. Of course, where should it have been?  
 13 Outside. It couldn't be outside. They were more  
 14 concerned with flammable cladding, of course, so they  
 15 couldn't put it outside. However, I want to return to  
 16 that. But that's just in passing.

17 Also, before we get to a next major event I want to  
 18 mention to you, going back in time, it's only a few  
 19 days — just before the 10th, vents. Vents is a key  
 20 element of what happened on the night and why it  
 21 happened on the night as well. Vents not working.

22 Between 6 and 8 June, there's plenty of  
 23 documentation to indicate it was known that the  
 24 automatic opening vents were not operating. A few days  
 25 before the fire. One of the reasons: they hadn't been

1 serviced. The service record for that indicates that  
 2 they should be every six months, but this hadn't  
 3 happened, and of course they hadn't been tested, and  
 4 of course the whole of the system hadn't been tested, or  
 5 as an integral whole properly assessed.

6 So one has here, therefore, the fire, fire visits,  
 7 knowledge that the vents are not working, but then we  
 8 get to what I call a key moment. Now, I'm mentioning  
 9 Ahmed himself, but he would want it known that what he  
 10 says, he said on behalf of residents as a whole. I'm  
 11 doing this in particular, with particular emphasis,  
 12 because as you will be aware, he's taken  
 13 an extraordinarily responsible approach to the block, to  
 14 the authority, because he is concerned and cares about  
 15 the environment in which he lives. It's not just about  
 16 fire, it is also about general health, welfare and the  
 17 environment as a whole.

18 When he made submissions, they were always detailed,  
 19 they were always reasoned, and admittedly he put them in  
 20 more than once because of course he wasn't actually  
 21 being listened to anyway, until it got to the end. The  
 22 only reason things happened to move just before the  
 23 fire, as we now know, as Barbara Lane has vindicated  
 24 him, is because he was making a fuss. He never gave up,  
 25 he persisted.

1 It's taken its toll, which is why we say this  
 2 detail. It's taken its toll. He is now no longer able  
 3 to give live evidence. That's what he wanted to do. He  
 4 wanted to bring it to life himself, but he can't do  
 5 that. But he has, as you know, contributed three  
 6 statements: one in Phase 1, two in Phase 2, one very,  
 7 very recently in answer to a large number of extremely  
 8 pertinent questions that were posed to him, and he's  
 9 produced a dossier, if I can call it that, running to  
 10 several volumes, in my case printed off to four volumes,  
 11 of documentation he's assembled to assist the Inquiry.

12 So it's not only his assiduous approach and  
 13 responsible approach, he's probably one of the few who  
 14 have experienced it almost from the beginning. 25 years  
 15 he's been there with his wife, his son was born there,  
 16 and he established the association of leaseholders in  
 17 2010, that very year, and I will have to return to that  
 18 in a moment.

19 But what happened just before the date I've got to,  
 20 the date being the revelation about the vents on 6 and  
 21 8 June, probably discovered before that, at the end of  
 22 May he did something — well, not remarkable in one  
 23 sense, but it just demonstrates how far, as you've  
 24 already heard in the previous two openings, the neglect,  
 25 the, in a sense, dismissive nature has got. But what he

1 does at the end of May — so it's two weeks to go before  
 2 the fire — he puts together a bundle of documents —  
 3 it's all there for you to see — indicating his worries.

4 As before, because there have been surges and other  
 5 things he has had to complain about, he doesn't go on  
 6 his own, he doesn't only do the leaseholders, of which  
 7 there are 15 flats, three are housing associations, he's  
 8 not just doing it for them, he goes, he knocks on every  
 9 door that he can within the block, and he achieves over  
 10 90%. Each time he does it, over 90% of the occupants  
 11 support what he's doing and know him well and respect  
 12 him well for what he's doing. The voice of the people  
 13 unheard, unheeded, heard maybe but certainly unheeded.

14 So he puts together a dossier. It isn't just about  
 15 the fire, the possibility of fire safety. Of course  
 16 he's got that point. He has other concerns which relate  
 17 back to issues I've already mentioned that go over the  
 18 years, the power surges that happened in 2013, and  
 19 of course the fire that did happen in 2010, the year he  
 20 formed the association.

21 So he takes the dossier in person. He doesn't trust  
 22 sending it, because he's tried all that. You will see  
 23 on his emails, he copies in pretty well everybody you  
 24 can think of. So Judith Blakeman, the local councillor,  
 25 essentially, lives nearby, has a surgery nearby, knows

1 well what's going on, so that's a familiar name and will  
 2 become more familiar. But he doesn't restrict it to  
 3 her; he goes to the MP, he goes to ministers. What he's  
 4 been forced to do at this late stage, because he  
 5 believes they're not doing anything -- all he was  
 6 wanting -- when I say "all" -- he wanted reassurance  
 7 from the council that they were getting on with the job,  
 8 because he knew from reports he'd got in relation to the  
 9 2010 fire they weren't telling the truth.

10 In 2010 -- I'll come to it in one second -- there  
 11 was a fire which he was unfortunately not himself  
 12 present, but his wife was, but he knew that they  
 13 eventually conceded on that fire that in fact he had  
 14 suffered. But it took a legal action then to get them  
 15 to recognise. So he felt from the Fire Brigade report,  
 16 which clearly indicated then vents were a problem, he  
 17 wouldn't trust what the council were palming him off  
 18 with, so that he had decided to take legal action and go  
 19 to the Housing Ombudsman at the end of May. He was  
 20 preparing, essentially, a brief. He had employed  
 21 lawyers to go and do this. And of course Laura Johnson  
 22 sitting in the background saying, "Oh, well, let them do  
 23 whatever they want", kind of thing. Essentially, "We're  
 24 not going to do" -- well, they started to do something,  
 25 but in fact it wasn't without this prompting that we say

1 the boxing--in started.

2 Now, it's a simple point: if you put pipes through  
 3 a communal stairway, as I've already indicated, and into  
 4 flats, there are all sorts of risks. If you're going to  
 5 box it in, you have to ventilate it properly. You're  
 6 breaking the seal of compartmentation, possibly breaking  
 7 the seal. You have a highly inflammable situation  
 8 should a fire break out on the stairs or anywhere else,  
 9 for that matter, and you will recall that it took  
 10 18 hours to find where to switch it all off. And when  
 11 they did, what did they say? Fire went out like  
 12 a light. It had probably mainly gone out by then  
 13 anyway.

14 But in any event, this is why this was so important,  
 15 and he was quite right. Even though it may not have  
 16 caused this fire, even though it may not itself have  
 17 contributed to the smoke and the deaths, nevertheless,  
 18 as he's now supported by the expert opinions of  
 19 Barbara Lane, he undoubtedly can rest that he has done  
 20 a very fine job in what he did.

21 This was because, in addition, would the council  
 22 meet him to deal with this, and Daffarn and others?  
 23 Because he wasn't alone, he was doing it with others.  
 24 No, wouldn't meet. Wouldn't give him -- what he wanted  
 25 was the assurance of a fire safety certificate to show

1 that what the National Grid were doing was all right.  
 2 As the fireman had come to his flat said, "Continue,  
 3 continue pressing". Well, he did continue pressing.  
 4 Nothing was forthcoming to indicate what assessments  
 5 they'd had, so he had no idea what they were doing, so  
 6 he had to do it almost in a vacuum, but -- and the  
 7 ultimate test, in a sense, was he asked the council:  
 8 well, how about -- he had said this from the  
 9 beginning -- an independent investigation? How about  
 10 an independent assessor, somebody who's qualified to do  
 11 the job? He asked for funding by the council for  
 12 somebody independent, not somebody commissioned by  
 13 the council, not somebody paid for by the council;  
 14 somebody that was instructed externally. They wouldn't  
 15 countenance it, they wouldn't allow him any funding, so  
 16 he decided in the end at this late stage that he would  
 17 have to fund it himself or try and get others within the  
 18 block to help fund.

19 So these legitimate concerns took him to the  
 20 Town Hall and other places on the 30th to ensure that  
 21 everybody had a bundle of fire risk and the rest sitting  
 22 on their desk in the hope that it might make  
 23 a difference.

24 And that, in a sense, brings me conveniently to what  
 25 is possibly, and I hope again not overrating it too

1 much, one of the most compelling documents in the case  
 2 as a whole. I've asked for this one to be put up,  
 3 because I think otherwise, because Mr Shah's not going  
 4 to be able to give evidence himself, his evidence no  
 5 doubt will be read at some stage, certain items can get  
 6 submerged and perhaps forgotten, or they don't assume  
 7 the importance that they deserve. But this -- and  
 8 I have given the references, which I will give now -- is  
 9 a letter that he wrote in 2010 to the newly appointed  
 10 chief executive, Mr Robert Black.

11 I will give the reference: it's {TMO10037439/1}. So  
 12 if that first page could come up, please, and if it  
 13 could be enlarged, it might be possible for me to read  
 14 it off the screen, but I have a hard copy.

15 The first page -- it's from the Grenfell Tower  
 16 Leaseholder Association. It had been set up earlier in  
 17 the year. It was earlier in the year of 2010 that he  
 18 suffered the fire. It's that same year that I've  
 19 already mentioned in another context, but it is a year  
 20 that will come back to haunt this Inquiry, 2010, for  
 21 what was happening politically and globally.

22 You will see at the start, even then, when they  
 23 first started, he made a habit of ensuring that he wrote  
 24 to everybody who really mattered, or should have  
 25 mattered, and there they are listed. So this isn't

1 something where he keeps it to himself or he only does  
 2 it in particular -- and he is having to do all this, as  
 3 he did on 30 May, because the complaints system was  
 4 outdated, cumbersome, not simple and was used to shut  
 5 them off, that's the phrase, lock them out, essentially,  
 6 we can reduce this class to non-existence by having  
 7 a complaints procedure, which is why he used the  
 8 members' request route via Judith Blakeman, who  
 9 sometimes managed to achieve a little more.

10 Now, the letter itself -- I'm only going to read  
 11 certain passages, not the whole -- is extensive and goes  
 12 over, I think, eight pages, and it has signatures other  
 13 than his own, because he got support. This is what he  
 14 writes:

15 "We received a written response dated 20th August  
 16 2010 from Mr. Daniel Wood from the Head of Home  
 17 Ownership. However, we were expecting a direct response  
 18 either from you or Mr. Anthony Parkes. We have chosen  
 19 to respond to you directly instead of Mr. Wood for the  
 20 simple fact you originally made the commitment to look  
 21 into our issues and concerns.

22 "Mr. Wood, in effect, refuted and flatly ignored our  
 23 long suffering and serious issues. This demonstrates as  
 24 Head of Home Ownership he is not aware of the reality of  
 25 the situation at Grenfell Tower and is out of touch as

1 to what is going on. It seems he has based his response  
 2 on what appears to be common answers.

3 "If we simply take the issue of block aesthetics, it  
 4 is clear to see how Grenfell Tower has been neglected  
 5 for decades. The letter we received indicates that the  
 6 TMO does not adhere to its promise of being a tenant-led  
 7 organisation."

8 May we pause: the TMO was never tenant-led and,  
 9 in fact, was quite the reverse.

10 If we could just turn over the page very quickly to  
 11 {TMO10037439/2} at the top, second point he wants to  
 12 make:

13 "... we will argue that the recent fire at  
 14 Grenfell Tower has raised so many Health and Safety  
 15 issues with the building that it demands an independent  
 16 investigation and enquiry into the safety of the  
 17 building."

18 Well, that's echoed all down the years. He is  
 19 constantly asking and is constantly refused.

20 Now, on that page he goes on to other issues, and on  
 21 succeeding pages, including -- I'm not going to read it  
 22 all -- obviously the lifts come into it, maintenance of  
 23 the lift, garden maintenance.

24 Can we please turn to a very important  
 25 section headed "fire Alarm and Health and Safety"

1 {TMO10037439/5}. Perhaps it could be enlarged for those  
 2 who want to follow it:

3 "We are very shocked to learn from you that you  
 4 considered the defects in the building exposed by the  
 5 fire as a minor fault when it had potentially fatal  
 6 consequences. The minor fault caused so much damage to  
 7 individuals living in Grenfell Tower it is difficult to  
 8 [imagine] how serious an event has to be for you to  
 9 consider it a major fault. If the alarm system is not  
 10 functioning and the vents are not working ..."

11 I pause. We compare that to 2017, what's changed?  
 12 Very little.

13 "... then it should be considered no doubt as a  
 14 major fault. They are used as measures to save lives;  
 15 so if they are not working then obviously you are  
 16 endangering the lives of residents of the building.  
 17 What's more, we are certain that out of 120 families  
 18 living in the block, no-one is aware of the evacuation  
 19 procedure."

20 Why? Because of course there isn't one.

21 "We have never had an evacuation procedure booklet  
 22 sent to us for the past 36 years. Is it not necessary  
 23 by law, to test the Fire Alarm and associated equipment  
 24 on a regular basis to check whether the system is fully  
 25 functional?"

1 Then there is a paragraph about people not hearing  
 2 fire alarms, nothing's changed on that front, and smoke  
 3 and suffocation. He alights upon in the next paragraph:

4 "... devastating consequences. As you know fire  
 5 does not kill as much as the effects of smoke ..."

6 Of course, that's this case, that is 2017. The  
 7 majority of people were suffocated by the acrid smoke  
 8 that went around, and to our knowledge some of the  
 9 residents in relation to 2010 nearly died due to smoke  
 10 inhalation and suffocation. Many residents found the  
 11 whole experience traumatic and mentally damaging.

12 Then there comes the paragraph just below:

13 "The staircases of the surrounding high rise  
 14 buildings are exposed to open air and natural light and  
 15 so in case of a fire the smoke can easily escape. But  
 16 Grenfell Tower with its interior staircase and  
 17 malfunctioning ventilation system, there is certainly a  
 18 high probability that in the event of another fire, the  
 19 whole building can become an inferno. Furthermore,  
 20 should a fire occur in the staircase of Grenfell Tower,  
 21 there will be no escape route for the residents as and  
 22 rightly so the lift ..."

23 And so on.

24 I end this with the last sentence right at the  
 25 bottom here, before "Proposed School". Scroll down

1 a little bit to the heading, "Proposed School", just  
 2 above that:  
 3 "The residents of Grenfell Tower have been treated  
 4 as sub-human and your handling of the incident has been  
 5 unacceptable."  
 6 That letter has everything in it. That letter is  
 7 warning, seven years before, the same chief executive  
 8 officer, the same TMO, that there will be an inferno.  
 9 It is exactly what was said in the Daffarn blog, which  
 10 you heard in Phase 1.  
 11 I appreciate the time, and I'm going to, as it were,  
 12 concertina my final remarks into a few seconds rather  
 13 than minutes.  
 14 The question is: why has this been allowed to  
 15 happen? I'm going to encapsulate it in very short form.  
 16 It's been allowed to happen because of a climate,  
 17 a political climate, and the political climate in 2010  
 18 and 2013 was one in which -- and we use the analogy with  
 19 the Florentine 15th century burning bonfires, Bonfire of  
 20 the Vanities -- yes, well, what David Cameron actually  
 21 said was to get rid of the safety culture. Why? It  
 22 gets in the way of profit. Those were the words that he  
 23 was using, and one can't baulk at this at all, because  
 24 if you're going to change a culture, you have to look at  
 25 where the culture is coming from.

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1 But he wasn't standing alone, and I opened Phase 1  
 2 with that comment about a meeting on the very day of the  
 3 fire about deregulation. That's what it was all about  
 4 then, and one has to remember that all these events were  
 5 happening, and of course, who was the Mayor of London at  
 6 the time? The now Prime Minister. What was he doing in  
 7 2013, just as all this was taking off? Austerity cuts  
 8 to Fire Brigade, fire engines, work and jobs, and even  
 9 the training facilities, of which there still isn't in  
 10 London a training facility allowing for high-rise. When  
 11 he was taxed about this by Andrew Dismore in 2013 --  
 12 again, it's all part of an attitude of mind --  
 13 Boris Johnson's response: "Get stuffed".  
 14 We're living, we were living and hopefully we might  
 15 come out of that "Get stuffed" when it comes to safety.  
 16 And of course you link it to something else that Boris  
 17 has recently said, as a motivating force. He may regret  
 18 he said it. He may want to retract it. We will see.  
 19 Greed. Greed as a motivating force. Not in relation to  
 20 this issue, another issue altogether.  
 21 So we say until you roll back the avarice, until you  
 22 roll back the culture of neglect, the culture of  
 23 discrimination that has gone on here, then there will be  
 24 no real change, and no real hope for those who have had  
 25 so much faith in this Inquiry, including Shah Ahmed.

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1 Thank you.  
 2 I'm sorry, I think I have run over by a bit.  
 3 SIR MARTIN MOORE-BICK: Well, only a fraction, if you have  
 4 at all, Mr Mansfield, so thank you very much for your  
 5 opening statement.  
 6 I'm now going to invite Mr Williamson  
 7 Queen's Counsel to make a supplementary opening  
 8 statement on behalf of the same core participants. So  
 9 I'll just check that you can see me and hear me,  
 10 Mr Williamson.  
 11 MR WILLIAMSON: I can, sir.  
 12 SIR MARTIN MOORE-BICK: Good, thank you very much.  
 13 Can I just mention this: on the programme that I've  
 14 got, you are down to have half an hour before lunch at  
 15 1 o'clock and quarter of an hour at 2 o'clock. I don't  
 16 know quite how your statement is going to work out --  
 17 perhaps you don't either, I don't know -- but if at  
 18 1 o'clock you think you could finish within a reasonable  
 19 time, by which I mean, let's say, ten minutes or so,  
 20 I think we would all be perfectly happy to let you do  
 21 that. On the other hand, that's not to put pressure on  
 22 you. If you would rather break at 1 o'clock or at  
 23 a convenient point around then and finish after lunch,  
 24 that's equally acceptable.  
 25 MR WILLIAMSON: Yes, thank you, sir. I have a carefully

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1 worked out timing and I will take a view as to where we  
 2 are when we get to that stage.  
 3 SIR MARTIN MOORE-BICK: Exactly, take that course.  
 4 Opening statement on behalf of BSRs Team 2 by MR WILLIAMSON  
 5 MR WILLIAMSON: Thank you very much.  
 6 Mr Chairman, Ms Istephan, Mr Akbor, I shall deal  
 7 first with topic 2, and the core issue for this topic is  
 8 for the Inquiry to ask itself how the tower, itself home  
 9 to many vulnerable residents, came to be a building that  
 10 was so defenceless when it came to the risk of fire. It  
 11 was of course unprotected in the face of what we now  
 12 know was a massive risk, namely a situation in which, as  
 13 the Phase 1 report made clear, the external walls of the  
 14 building actively promoted the spread of fire.  
 15 Standing back from the detail, there is a stark and  
 16 simple question: if the tower had been the subject of  
 17 adequate fire risk assessment in the years leading up to  
 18 2017, how was it that 72 people died in a catastrophic  
 19 fire? This was a fire safety failure on a monumental  
 20 scale.  
 21 At the heart of this failure was the TMO. Its  
 22 personnel lacked the relevant skills to provide a safety  
 23 strategy to protect the tower against fire, and they  
 24 took no adequate steps to ensure that other suitably  
 25 skilled persons were engaged to carry out fire safety

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1 work. There was in fact at all relevant times no  
 2 fire safety strategy in place. Without such a strategy,  
 3 the basis of an integrated approach could not exist.  
 4 Exova failed to provide a strategy, a failing which  
 5 was not recognised by them, the TMO, RBKC, or Rydon.  
 6 Indeed, from at least 2010 onwards, Grenfell's  
 7 fire safety was in a perilous state. The TMO then  
 8 reached an agreement with the Fire Brigade that any  
 9 remedial works identified in fire risk assessments would  
 10 be made fully compliant within five years.  
 11 This was an extraordinarily lax and leisurely  
 12 timetable showing how complacent at best the TMO were  
 13 about fire safety. This approach was entirely contrary  
 14 to the interests of the residents and demonstrated also  
 15 a reluctance on the part of the LFB to utilise their  
 16 enforcement powers. In fact, as Dr Lane states in her  
 17 report, over the next five years the risk level rose  
 18 from medium to intolerable, meaning that the premises  
 19 should not have been occupied at all until the risk was  
 20 reduced. Over these years, the TMO essentially  
 21 entrusted all fire risk matters to Carl Stokes as the  
 22 fire risk assessor. He was not a chartered  
 23 fire engineer and he lacked the necessary skills to  
 24 carry out the work.  
 25 As regards his qualifications, we emphatically do

1 not agree with the view expressed by Mr Todd, one of the  
 2 Inquiry's experts, that "little if any special  
 3 competence is required in relation to the principles of  
 4 fire safety to enable a competent fire risk assessor to  
 5 carry out a type 1 FRA for a high-rise block of flats  
 6 such as Grenfell Tower".  
 7 Indeed, I should make it clear at this stage that we  
 8 do not agree with Mr Todd's general approach and do not  
 9 accept that he is an appropriate expert to guide  
 10 the Inquiry. We echo the criticisms made in relation to  
 11 his evidence this morning by Ms Barwise and Mr Friedman.  
 12 In relation to all relevant matters, the Inquiry  
 13 should therefore take its cue from Dr Barbara Lane. In  
 14 any event, the TMO's faith in Stokes was not universally  
 15 held by others. In a meeting between the TMO and the  
 16 LFB in January 2016, Rebecca Burton of the Fire Brigade  
 17 "raised her concern that our fire risk assessor  
 18 sometimes makes statements which are not justified or  
 19 supported and that the FRA reports need to include  
 20 justification for statements made".  
 21 The TMO, however, relied on Stokes to give advice on  
 22 the refurbishment works that would have been more  
 23 appropriate if he had been a consulting engineer, rather  
 24 than an unregulated fire assessor with no formal  
 25 engineering qualifications.

1 As Dr Lane puts it, the TMO appears to have  
 2 instructed Mr Stokes:  
 3 "... to undertake ad hoc inspections of the works.  
 4 Mr Stokes recorded these inspections in letters to  
 5 KCTMO. I have seen no evidence as to how Ms Wray or the  
 6 TMO addressed issues raised by Mr Stokes in these  
 7 letters, which do not appear to have been part of any of  
 8 KCTMO's formal processes or procedures."  
 9 Crucially, and compounding this error, the TMO  
 10 excluded the building's façade from Stokes' scope of  
 11 work. He did not take exception to this, despite the  
 12 fact that his brief asked him to consider the  
 13 compartmentation of the building and any possible  
 14 shortcomings with it. Compartmentation simply cannot be  
 15 considered when a wall is excluded from scope.  
 16 On any view, the exclusion of the façade from the  
 17 assessment was an extraordinary omission. Clearly the  
 18 façade was of critical importance and urgency. In  
 19 August 2016 a fire had occurred on the 18th floor of  
 20 Shepherds Court, an 18-storey tower block in  
 21 Shepherd's Bush. Cladding on the outside of that  
 22 building compromised polystyrene and plywood insulation  
 23 panels. Tests concluded they were the likely cause of  
 24 the fire spreading up the outside. The similarities to  
 25 Grenfell were striking. Flames began pouring from the

1 open window of a 7th floor kitchen, quickly spreading up  
 2 the side of the building. At the time, the publication  
 3 Inside Housing described the fire as a "stark warning  
 4 for social landlords".  
 5 Eight months later, in April 2017, the LFB wrote to  
 6 Laura Johnson of RBKC to say that testing showed that  
 7 the combustibility of the panels at Shepherds Court did  
 8 not meet the levels expected to comply with  
 9 Building Regulations. This letter caused Wray to ask  
 10 Stokes whether the cladding recently installed at  
 11 Grenfell complied with Building Regulation requirements.  
 12 He replied in an email sent from his mobile phone that:  
 13 "Grenfell was clad but the cladding complied with  
 14 the requirements of the Building Regulations. Lots of  
 15 questions asked of Rydon's and answers received back from  
 16 them."  
 17 In an internal email the next day, Wray reported  
 18 that she had:  
 19 "... checked with Carl Stokes who had investigated  
 20 the details of the installation with Rydon when the  
 21 works were on site and he confirmed that the  
 22 installation complied with the current requirement of  
 23 the Building Regulations".  
 24 In fact, Wray had misrepresented Stokes' two-line  
 25 email, which had not addressed the nature of the

1 cladding at all .  
 2 The last FRA completed before the fire, shortly  
 3 after the completion of the refurbishment, noted that  
 4 the tower appeared to have appropriate fire separation  
 5 and compartmentation and, from a visual inspection of  
 6 the structure, no areas appeared to raise concerns.  
 7 Stokes felt it appropriate to make these unqualified  
 8 comments, but he did not, firstly, assess the materials  
 9 used in the construction of the cladding; secondly,  
 10 complete or recommend any invasive assessment of the  
 11 materials; thirdly, seek the input of a chartered  
 12 fire engineer; fourthly, consider material  
 13 classification or material safety datasheets for the  
 14 cladding; or, fifthly, make any enquiry of the basis  
 15 upon which building control had passed the cladding.  
 16 Both Williams and Wray of the TMO now rely heavily  
 17 on the words in Stokes' FRA assessment that the building  
 18 appeared to have appropriate fire separation and  
 19 compartmentation. This reliance is clearly misplaced,  
 20 given they were both aware that Stokes had not been  
 21 instructed to consider the external façade of the tower.  
 22 As to all this, Dr Lane concludes, not surprisingly,  
 23 that neither Mr Stokes nor Ms Wray, nor her superiors in  
 24 the TMO, demonstrated competent understanding of the  
 25 hazards posed by the works at the time, and they did not

1 make a suitable and sufficient assessment of the risks  
 2 to relevant persons.  
 3 Moreover, in relation to this building, clad as it  
 4 was in combustible cladding, and in respect of which  
 5 Stokes had never been asked to consider the external  
 6 façade, evacuation planning had never been made part of  
 7 the TMO's procedures for tower residents.  
 8 Indeed, in her witness statement, Wray takes  
 9 a dismissive view of any requirement for evacuation  
 10 plans, saying {TMO00000890/38}:  
 11 "It was also not our role to capture where disabled  
 12 and vulnerable people might be living in the Tower.  
 13 This type of information, where available, was kept by  
 14 the Neighbourhood Management Teams, which were part of  
 15 the Operations department."  
 16 That approach is clearly contrary to the  
 17 non-delegable, strict duty the TMO were under to ensure,  
 18 so far as reasonably practicable, that residents were  
 19 safe from harm. It also ignored the relevant guidance  
 20 on the topic.  
 21 As the responsible person safety officer under the  
 22 2005 FSO, Wray should have ensured that the TMO  
 23 discharged its evacuation planning safety duties. The  
 24 TMO did not engage with this at all. It did not take  
 25 residents' safety in the event of fire seriously.

1 For example, Councillor Blakeman, to whom Mr Mansfield  
 2 has already referred, whose area included the tower,  
 3 notes in her witness statement {MET00045751/7} that  
 4 following the refurbishment:  
 5 "... residents received no advice about fire safety  
 6 and only after several representations were instructions  
 7 as to what to do in the event of a fire installed on the  
 8 walls of the communal hallways ... It was left to the  
 9 residents themselves to be proactive in order to obtain  
 10 this advice."  
 11 Indeed, the statements which have been given across  
 12 the entire group of the bereaved, survivors and  
 13 residents suggest that the TMO's practice in relation to  
 14 the provision of fire safety information was grossly  
 15 deficient. Many residents reported they were not given  
 16 fire safety advice or information about what to do in  
 17 the event of fire.  
 18 The FRAs suggest that Stokes did in fact understand  
 19 that evacuation planning was essential in the event of  
 20 fire. However, he appears to have thought that  
 21 evacuation planning could be effected ad hoc by either  
 22 the fire service or residents themselves, which is  
 23 contrary to Government guidance and represents  
 24 a flagrant disregard for residents' safety.  
 25 There is no reference in any FRA of a documented

1 emergency plan, neither did the TMO produce any document  
 2 on the subject. This was a serious breach of their  
 3 legal duties to the BSRs.  
 4 Furthermore, as Ms Barwise has explained, there were  
 5 no TMO drafted PEEPs, ie individual plans for means of  
 6 escape from fire, in place in the tower for any of the  
 7 residents. This was despite the existence of well known  
 8 and long-established guidance on vulnerability. Some 20  
 9 or so tower residents were vulnerable in one way or  
 10 another.  
 11 Stokes did not prepare any PEEPs at Grenfell. He  
 12 apparently understood that Wray's team were drafting  
 13 them. As with so many of those involved with the tower,  
 14 he relied upon an unjustified assumption.  
 15 The TMO's non-delegable duty to keep the residents  
 16 safe was not in any way diluted by any resident's mental  
 17 health issues or physical vulnerability. On the  
 18 contrary, it placed a burden on the TMO to ensure that  
 19 any such vulnerabilities were accommodated. The TMO  
 20 should therefore have ensured that there were in place  
 21 adequate PEEPs for disabled and vulnerable residents.  
 22 It failed to do so.  
 23 Furthermore, Stokes advised the TMO in 2014 that the  
 24 lifts were firefighter lifts, even though this was not  
 25 the case. On the night of the fire, this caused

1 an avoidable loss of life . Others with limited mobility  
 2 and mental health vulnerabilities may have lost their  
 3 lives because they did not feel able to utilise the  
 4 lifts to evacuate.  
 5 I will return to the issue of the lifts in a moment.  
 6 The evidence on topic 2 will show, therefore, the  
 7 following things: (1) there was at all relevant times no  
 8 fire safety strategy, ie no overarching basis of  
 9 fire safety engineering in place; (2) Stokes was not  
 10 qualified academically, vocationally or by experience to  
 11 carry out the complex FRAs that Grenfell required; (3)  
 12 the FRAs were wholly inadequate, in particular in that  
 13 they did not deal with the façade and external envelope  
 14 of the building; (4) there was no, or no adequate,  
 15 evacuation plan and no emergency plan; (5) no proper  
 16 consideration was given to vulnerable residents; and (6)  
 17 no PEEPs were prepared.  
 18 I turn now to topic 3.  
 19 Topic 3 deals with a diverse range of issues  
 20 concerned with the operation and maintenance of the  
 21 tower. Although these issues are various, they have  
 22 a unifying theme: the failure of the TMO to ensure that  
 23 the tower was properly and safely operated and  
 24 maintained. The TMO then carried out works, as we have  
 25 seen in Modules 1 and 2, which involved fixing to the

1 tower highly flammable cladding products, turning the  
 2 tower into a death trap.  
 3 The building was, in view of the series of failings  
 4 I'm about to consider, singularly ill –equipped to  
 5 respond to or withstand a catastrophic fire .  
 6 Dealing first with the doors.  
 7 The TMO and a company called Manse entered into  
 8 contracts for flat entrance door replacements in 2011.  
 9 This was an ideal opportunity to ensure that all the  
 10 doors were fire safe. It was not taken. Indeed,  
 11 instead, the contracts failed to specify the doors'  
 12 performance requirements.  
 13 The TMO was well aware that it was necessary to  
 14 ensure that all the doors in their estate were fire  
 15 safe. Indeed, in January 2010, Wray had informed  
 16 a meeting of the TMO's health and safety subcommittee  
 17 that:  
 18 "The main issues being raised were in relation to:  
 19 "1. Inspection and if necessary replacement of flat  
 20 entrance doors in enclosed blocks to ensure they present  
 21 a sufficient level of fire resistance, are self –closing  
 22 and fitted with intumescent strips and cold smoke  
 23 seals."  
 24 And, as another point:  
 25 "Where flat entrance doors are demised to lessees,

1 can they be persuaded to replace them with the  
 2 appropriate fire rated door? Can we enforce this in  
 3 respect of leaseholders? If not it is the fire  
 4 assessor's view that we would need to adopt  
 5 an 'evacuation strategy' within our blocks and not  
 6 'defend in place' and this has significant implications  
 7 for the installation of automatic detection ..."  
 8 In the event, the leaseholders' doors were not  
 9 subsequently replaced, and neither was an evacuation  
 10 plan put in place. It is likely that many of the  
 11 leaseholders would not have been able to afford new  
 12 doors. Given the relatively low number of leaseholders,  
 13 the TMO should surely have included them in the  
 14 replacement programme. No doubt they did not do so  
 15 because of concerns over cost.  
 16 By February 2013, by which time the door replacement  
 17 programme for the tenants was substantially complete,  
 18 the TMO reported to the GTLA, the Grenfell Tower  
 19 Leaseholders' Association that:  
 20 "We have recently had a fire risk assessment for  
 21 Grenfell Tower reviewed and the assessor advises that  
 22 none of the properties at Grenfell Tower are highlighted  
 23 as having potentially non –compliant entrance doors. It  
 24 seems, therefore, that the doors currently installed  
 25 provide sufficient fire resistance."

1 This was dangerously complacent advice. It also  
 2 ignored or forgot the concerns expressed in 2010.  
 3 Furthermore, various non –compliances were noted in  
 4 Stokes' June 2016 significant findings and action plan,  
 5 including non –compliant entrance doors and newly fitted  
 6 doors which did not have cold smoke seals. Some of the  
 7 doors had had their intumescent strips painted over,  
 8 some staircase doors did not fully close, and the  
 9 16th floor door was damaged. There were, therefore,  
 10 multiple examples of fire safety breaches.  
 11 Indeed, on 17 November 2016, the London Fire and  
 12 Emergency Planning Authority sent a notification of  
 13 fire safety deficiencies in respect of Grenfell Tower to  
 14 Wray in her capacity as the health and safety manager of  
 15 RBKC. This set out numerous alleged breaches of the  
 16 FSO.  
 17 These failures highlight a systemic failure on the  
 18 TMO's part to take action. Indeed, this was not just at  
 19 Grenfell, but also in other blocks. In December 2016,  
 20 a TMO safety board update was issued following  
 21 deficiency notices issued against four TMO properties,  
 22 including the tower. This referred to several notices  
 23 queried with the LFB and expressed surprise at having  
 24 received the notices.  
 25 On 16 March 2017, just three months before the fire,

1 the TMO's health and safety committee met to review the  
 2 fire strategy and provide an update on self-closers.  
 3 The minutes record -- and could we have up  
 4 CST00000065/5.  
 5 (Pause)  
 6 SIR MARTIN MOORE-BICK: Mr Williamson, we have it on our  
 7 screens.  
 8 MR WILLIAMSON: We do, but that's not the right document.  
 9 I'll just move on because time is short.  
 10 I was referring to the minutes of March 2017, which  
 11 in summary recorded that there had been a discussion  
 12 with RBKC in March of 2017 in relation to the issue of  
 13 self-closing devices, and it had been agreed that there  
 14 was no need to deal with them, and if the LFB were to  
 15 make that a priority, then the TMO "would take legal  
 16 advice and make representations to the GLA in advance of  
 17 instigating any inspection programme".  
 18 What is so striking is that the TMO were determined  
 19 to do nothing if they could possibly do so, and to spend  
 20 money if they had to on lawyers rather than on improving  
 21 fire safety.  
 22 LFB's senior fire safety officer, Mr Finn,  
 23 subsequently visited the tower and produced a report.  
 24 This is dated 18 June 2017, but was clearly prepared  
 25 before the fire. He noted that a significant number of

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1 the self-closing devices on the composite fire doors to  
 2 dwellings above the third floor had either had the  
 3 self-closing device removed or this device was broken  
 4 and still in place but ineffective.  
 5 It is unclear what action was taken by the TMO to  
 6 rectify the many outstanding fire door failures prior to  
 7 the fire. However, in view of the history of  
 8 non-compliance, it is likely that either no action or  
 9 insufficient action was taken.  
 10 On a related issue, in April 2018, the Government  
 11 Legal Department, on behalf of the MHCLG, wrote to this  
 12 Inquiry setting out the results they had obtained,  
 13 having tested Manse doors in various London boroughs to  
 14 ascertain their fire resistance. Of 14 doors tested,  
 15 only one survived longer than 30 minutes. The only  
 16 compliant door was manufactured in 2009, indicating that  
 17 Manse's manufacturing after 2009 had a direct effect on  
 18 door quality.  
 19 Manse's technical manager, Mr Duncan, is noted by  
 20 other witnesses to have instructed changes to  
 21 manufacturing that affected the doors' integrity, and  
 22 the company's production team leader, Mr Whitton,  
 23 confirms in his witness statement the impetus behind the  
 24 drop in manufacturing standards was to save money.  
 25 The experience of those we represent underlines all

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1 these failures. They speak of replacement doors where  
 2 door-closers broke shortly after being installed and  
 3 were never fixed, and the doors never functioned  
 4 properly. They speak of lobby fire doors that would not  
 5 close.  
 6 In short, there was a long and sorry history of  
 7 defective and inadequate fire doors at Grenfell Tower.  
 8 The TMO never addressed this satisfactorily or at all.  
 9 The LFB attempted to do so, but ineffectually. The  
 10 doors' poor quality had a significant impact on the  
 11 spread of smoke and flames throughout the building.  
 12 Returning then to the lifts.  
 13 The lifts at Grenfell Tower should have been  
 14 firefighting lifts, but they were not. In 2004,  
 15 Apex Lifts were appointed by Butler & Young Lift  
 16 Consultants to refurbish all three tower lifts to the  
 17 latter's specification. However, this refurbishment did  
 18 not specify firefighting lifts, even though the concept  
 19 of a firefighting lift had been in force for some years  
 20 prior to this first lift project. The TMO,  
 21 Butler & Young and Apex do not seem to have considered  
 22 compliance with the objectives of firefighting lift  
 23 requirements. All of them should have been keenly aware  
 24 of the requirement for the lifts at Grenfell to have  
 25 such a capability.

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1 The failure to upgrade the lifts in 2004 and the  
 2 lack of consideration in the intervening years was  
 3 a grievous safety breach, the ramifications of which had  
 4 grave consequences in 2017.  
 5 What is particularly poignant is that this upgrade  
 6 could have been achieved for a cost of about £20,000, or  
 7 3% of the total contract price. 3% is a small price to  
 8 pay, particularly given the importance of these  
 9 firefighting lift features.  
 10 The Inquiry's lift expert, Mr Howkins, has observed  
 11 that he would have expected a reasonably competent lift  
 12 consultant to have considered modernising the lifts to  
 13 the firefighting standard, and we agree.  
 14 There was then a further lift project in 2014/2015.  
 15 This too did not address the issue of an upgrade to  
 16 modernise the lifts to the firefighting standard. It  
 17 should have done so.  
 18 In May 2015, the TMO produced an internal document  
 19 called "The KCTMO fire safety policy and strategy".  
 20 Section 18 of that document dealt very briefly with  
 21 fire safety and lifts. However, it did not reference  
 22 a single standard. Having regard to the standards that  
 23 should have been considered, the combined effect which  
 24 give definition to the concept of a firefighting lift,  
 25 the TMO document is clearly inadequate. The TMO

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1 undertook no reasonable review when compiling it. Many  
2 essential features were omitted.

3 Furthermore, the lifts were not adequately inspected  
4 or maintained. The report prepared by WSP on the lifts  
5 in 2018, after the fire, confirmed that the tower's  
6 lifts were not interfaced with the lobby smoke detection  
7 systems, the level 2 fireman's switch was disconnected  
8 and the ground level switch inoperable. It is clear  
9 from the witness evidence that the TMO did not test the  
10 fire control switches weekly as required under the  
11 British Standard. Had they been tested, the TMO would  
12 have identified that the switches were inoperative and  
13 should have fixed or replaced them. This became  
14 an important issue on the night of the fire.

15 In summary, the lifts were, at all relevant times,  
16 not firefighting or evacuation lifts, and they were,  
17 furthermore, defective and inadequate. Those with  
18 mobility issues depended on these lifts to  
19 self-evacuate. The TMO were fully aware of these  
20 shortcomings but took no adequate steps to address the  
21 same.

22 Sir, I've got about another 10 to 12 minutes, so  
23 shall I continue?

24 SIR MARTIN MOORE-BICK: Would you prefer to do that? I'm  
25 quite happy that you should if you ---

1 MR WILLIAMSON: I think it would be better to do it all in  
2 one piece, if I may. I'm not absolutely promising  
3 12 minutes, but that's what I'm hoping for.

4 SIR MARTIN MOORE-BICK: You carry on, thank you.

5 MR WILLIAMSON: So I turn then to maintenance.

6 From 1996 onwards, RBKC had delegated to the TMO all  
7 the relevant repair responsibilities through  
8 a management agreement contract. It is apparent that  
9 these responsibilities were not well discharged. As  
10 long ago as 2009, following a detailed investigation,  
11 Maria Memoli reported that there were a number of  
12 tenants, leaseholders and freeholders within the borough  
13 who felt aggrieved that their problems had not been  
14 resolved by the TMO despite several years of  
15 complaining. The concerns dealt with included repairs,  
16 service charges and the like. The report went on to say  
17 that the TMO now needed to tackle not only the  
18 governance, but the real operational issues around the  
19 services it provided to meet the demands of the  
20 residents within the borough.

21 She said this:

22 "The new board needs to win the hearts and minds of  
23 these disgruntled residents who have had grievances  
24 going back several years. The board must understand its  
25 constitutional and legal role and take collective

1 responsibility to spearhead the TMO in its improvement  
2 plan."

3 In December 2009 Mr Black, already referred to,  
4 reported to the TMO board that the RBKC adjudication  
5 report had now been published and the RBKC and the TMO  
6 have an agreed strategy to manage any issues which are  
7 arising. This was a reference to another report by  
8 Mr Butler on long-standing complaints of residents of  
9 the TMO.

10 Despite the so-called agreed strategy, matters did  
11 not improve over the next few years. Tenants and  
12 leaseholders were in frequent communication with the TMO  
13 with a view to persuading them to carry out their  
14 obligations in respect of maintenance adequately.  
15 However, the TMO often seemed unwilling or unable to do  
16 so.

17 This lack of attention to maintenance had disturbing  
18 consequences. For example, in 2014, RGE Services,  
19 a specialist company engaged by Max Fordham to report on  
20 the vent system, told them that they had advised of  
21 "every service to the TMO that in the event of  
22 an activation we cannot guarantee that the system will  
23 work".

24 In March 2014, the LFB carried out an inspection and  
25 noted a number of maintenance failures with worrying

1 effects. For example, that no suitable system of  
2 monitoring was in evidence to identify deficiencies with  
3 the smoke ventilation system, and that about 30% of the  
4 AOV vents were in the open position, all this indicating  
5 a general failure to maintain the system. The LFB gave  
6 formal notice of these and other deficiencies regarding  
7 Grenfell Tower to the TMO on 24 March 2014.

8 Moreover, as with so many other aspects of the  
9 refurbishment, there was a striking lack of clarity as  
10 to who was supposed to be dealing with maintenance  
11 issues during the currency of the works or thereafter.  
12 Indeed, as early as October 2016, issues relating to the  
13 maintenance of the completed system were apparent.  
14 An inspection noted that the actuators were not working  
15 correctly on the AOV system. There are multiple  
16 examples from our clients of the lifts being commonly  
17 out of use and the lift doors not closing over extended  
18 periods of time, resulting in service outages.

19 Nonetheless, the TMO seems to have taken the view  
20 that it could handle maintenance issues entirely  
21 in-house. On a site visit with Williams on 24 October  
22 2016, Mr Whyte of JSW, a company engaged in this area,  
23 recalls in his witness statement that he:

24 "... mentioned to her that it was important to set  
25 up a maintenance log and use people who understood the

1 plant and equipment. This involved regular, sometimes  
 2 daily, physical checks of the equipment and the display  
 3 panels to see if anything was out of the ordinary.  
 4 I formed the impression that the TMO would get these  
 5 checks done by their on-site caretaker rather than by  
 6 their external maintenance contractor ...”  
 7 This complacency was not justified by events.  
 8 Moreover, there was a lack of clarity as to which  
 9 company was obliged to carry out regular maintenance.  
 10 This lack of clarity extended to the maintenance of  
 11 the lifts as well. Mr Wallis of PDERS, the company  
 12 responsible for lift maintenance who inspected the lifts  
 13 in April and May 2017, has confirmed in his witness  
 14 statement that he did not see a copy of any operational  
 15 maintenance manual when he began working on the lifts at  
 16 Grenfell Tower.  
 17 In conclusion as to maintenance, what is noticeable,  
 18 as with so many other aspects of the TMO’s performance,  
 19 is its inability to get to grips with maintenance  
 20 problems. The tower needed a systematic plan, the  
 21 planned preventative maintenance and reactive  
 22 maintenance put in place by the TMO. The TMO then  
 23 needed to follow up assiduously to ensure that what was  
 24 planned and agreed was put into practice. None of this  
 25 happened. At best, various organisations responded

1 ad hoc as problems arose. Often this response consisted  
 2 of little more than the assertion that some other body  
 3 needed to deal with the issue. All of this contributed  
 4 to the poor state of the building on the night of  
 5 14 June 2017.  
 6 Indeed, a post-fire audit report on TMO’s  
 7 Repairs Direct organisation is an indictment of just how  
 8 poor the TMO’s own in-house repairs and maintenance  
 9 organisation was, concluding:  
 10 “It is a reasonable statement that the service (1)  
 11 isn’t good quality; (2) performs poorly; (3) is  
 12 expensive.”  
 13 Dealing finally with gas, on the night of the fire  
 14 the time taken to isolate the gas supply was woefully  
 15 prolonged. As Mr Mansfield mentioned, as soon as the  
 16 gas was isolated, the fire went out like a light.  
 17 The background is that, due to a failure in the  
 18 existing gas supply line, a new line had to be installed  
 19 by tRIIO. These works were carried out in a chaotic  
 20 fashion. In the early part of 2017, residents raised  
 21 concerns about the newly installed exposed gas pipework  
 22 in communal areas and stairwells. It seemed to take  
 23 emails from the residents for either the TMO or the  
 24 contractor, Cadent, to do anything about the gas pipe  
 25 works. The TMO were, as ever, purely reactive.

1 As Dr Lane observes in her recent report, it  
 2 therefore appears that the residents’ complaint prompted  
 3 the TMO’s top management into pursuing Cadent and tRIIO  
 4 to expedite the commencement of the fire protection  
 5 works to the gas replacement riser. However, KCTMO top  
 6 management failed to seek assurance that the risk to  
 7 relevant persons pending completion of those works was  
 8 being adequately controlled.  
 9 Moreover, a riser survey undertaken by Cadent at the  
 10 end of September 2016 did not locate any isolation or  
 11 service valves on either of the two gas supplies  
 12 entering the tower. A subsequent hazard and operability  
 13 study specified the investigation of the reported  
 14 absence of those valves. It seems, however, that  
 15 nothing was done about it. This was a clear breach of  
 16 regulation 13 of the Pipeline Safety Regulations of  
 17 1996, ie a failure to maintain the gas supply in good  
 18 order.  
 19 The replacement service installed in 2017 suffered  
 20 a similar fate. No trace was found of a valve surface  
 21 box at the expected location of the pressure isolation  
 22 valve, either by Mr Hancox, the police or CORGI  
 23 Technical Services. This is an extremely basic safety  
 24 provision. It is highly unlikely isolation valves were  
 25 not installed. The failure to locate the valves on both

1 occasions was likely to have been due to contractors  
 2 building over areas where the valves were installed.  
 3 The evidence shows in fact a complete lack of  
 4 information that would have assisted Cadent or the LFB  
 5 in locating the isolation valves.  
 6 The effect of this litany of failures is that the  
 7 tower’s gas supply took much longer to isolate than  
 8 should otherwise have been taken. Our clients consider  
 9 this a very important point. The fact that this supply  
 10 could not be isolated for many hours was as a direct  
 11 result of incompetent design decisions and inadequate  
 12 construction management decisions taken many months  
 13 before the fire.  
 14 So, to conclude on topic 3, we say that the evidence  
 15 shows that the TMO and its advisers never got to grips  
 16 with a range of key issues, in particular: (1) the fire  
 17 doors were defective and dangerous in numerous respects,  
 18 and as the LFB reported at the time of the fire, they  
 19 likely provided no protection; (2) due to  
 20 a pre-considered decision not to plan escape routes,  
 21 there was no evacuation plan; (3) none of the lifts were  
 22 firefighting or evacuation lifts; (4) a litany of  
 23 failures meant the tower’s gas supply took much longer  
 24 to isolate than it should have done; and (5) the tower  
 25 was not adequately maintained.

1 Much has gone wrong, and this will no doubt be  
 2 investigated at length in the weeks to come. However,  
 3 this Inquiry needs to think about the future as well as  
 4 the past to ensure that failings of this kind do not  
 5 happen in the future. Its recommendations should, we  
 6 suggest, include the following matters.  
 7 First of all, the obligations on local authorities  
 8 and other social landlords to consult and inform  
 9 residents and residents' organisations on fire and other  
 10 safety matters need to be strengthened.  
 11 Secondly, those who conduct FRAs should be required  
 12 to have specified appropriate qualifications and should  
 13 be subject to a professional code of conduct.  
 14 Thirdly, in high-rise blocks there should be clear  
 15 requirements for the fire safety of all doors, whether  
 16 those of social tenants, leaseholders or in communal  
 17 areas.  
 18 Fourthly, lifts in such blocks should be  
 19 firefighting lifts.  
 20 With those observations, that concludes my oral  
 21 opening submissions.  
 22 Thank you very much, sir, and thank you very much to  
 23 the panel for listening to us.  
 24 SIR MARTIN MOORE-BICK: Well, thank you very much indeed,  
 25 Mr Williamson, and you have done very well, you finished

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1 within the time that you suggested you were aiming for.  
 2 Well, that's a convenient point for us to break for  
 3 some lunch. We will resume at 2.15, and the next  
 4 speaker, who is going to be Mr Maxwell-Scott, is  
 5 expecting to start at 2.15, so that will suit everyone  
 6 very well.  
 7 So 2.15, then, please. Thank you very much.  
 8 (1.15 pm)  
 9 (The short adjournment)  
 10 (2.15 pm)  
 11 SIR MARTIN MOORE-BICK: Good afternoon, everyone. Welcome  
 12 back. We are now going to hear further opening  
 13 statements from other core participants.  
 14 The next person I'm going to invite to address us is  
 15 Mr Maxwell-Scott QC, and I'm just going to check ---  
 16 I think I can see him there --- that he can see me and  
 17 hear me.  
 18 Good afternoon, Mr Maxwell-Scott.  
 19 MR MAXWELL-SCOTT: Yes, I can indeed. Good afternoon.  
 20 SIR MARTIN MOORE-BICK: Good, thank you very much.  
 21 I think there is nothing more to be said, other than  
 22 to invite you to make the opening statement on behalf of  
 23 the council.  
 24 Opening statement on behalf of the Royal Borough of  
 25 Kensington and Chelsea by MR MAXWELL-SCOTT

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1 MR MAXWELL-SCOTT: Mr Chairman, panel members, I, together  
 2 with Katie Sage and Bethany Condron, represent the Royal  
 3 Borough of Kensington and Chelsea, instructed by  
 4 DWF Solicitors. As you know, we have submitted  
 5 a 50-page written opening, which I anticipate  
 6 the Inquiry will make public later today. We also, last  
 7 week, provided the Inquiry with a document identifying  
 8 some key changes made within the council since the fire  
 9 that are relevant to Module 3 issues.  
 10 I do not intend in this oral statement to repeat all  
 11 of the points made in our written opening; rather,  
 12 I wish to identify some themes which are likely to be  
 13 important during Module 3.  
 14 Before doing so, may I take this opportunity to say  
 15 that the council is truly sorry for the suffering and  
 16 tragic loss of life caused by the Grenfell Tower fire.  
 17 As the leader of the council has previously stated,  
 18 the council could have and should have done more to stop  
 19 it happening. The council has adopted the Charter for  
 20 Families Bereaved through Public Tragedy. It is  
 21 committed to candour in its approach to this Inquiry.  
 22 There are six topics which I will address you on in  
 23 this opening. The first is the council's role in  
 24 relation to Module 3 issues and the council's monitoring  
 25 of the TMO. About half of this opening will focus on

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1 this topic. The other topics will be: expert evidence  
 2 and guidance documents; the role of professional fire  
 3 risk assessors in the years before the Grenfell fire;  
 4 residents with vulnerabilities; flat entrance doors and  
 5 self-closers; and, finally, complaints.  
 6 In our Phase 1 opening statement, we identified ten  
 7 principal ways in which the council was involved with  
 8 Grenfell Tower and its residents, both before and after  
 9 the fire. In this module, we are concerned with four of  
 10 them, which I can summarise in this way: the council was  
 11 the owner of Grenfell Tower, the residents were its  
 12 tenants and leaseholders. The council was their  
 13 landlord. Both before and after the refurbishment,  
 14 the council worked closely with and monitored the TMO's  
 15 performance.  
 16 In Module 1, some of the council's involvement was  
 17 in areas in which the TMO had no involvement. Planning  
 18 was an example of that. But the most important example  
 19 was building control. You will recall that the council  
 20 identified and apologised for a number of failings in  
 21 the way the council's building control service processed  
 22 and considered the application for building control  
 23 approval.  
 24 In this module, we have identified a number of  
 25 specific failings in the council's monitoring of the

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1 TMO. They are set out in the council's written opening  
2 statement, and I will mention some of them later in this  
3 oral statement. The council apologises for its  
4 failings .

5 Module 3 will be different to Module 1, because in  
6 Module 3, whenever you are considering the council's  
7 involvement, you will also be considering the TMO's  
8 involvement in relation to the same issue. The TMO  
9 managed Grenfell Tower for the council, and the council  
10 paid it a management fee for doing so.

11 As your expert, Dr Lane, explains in her expert  
12 report, the effect of this management arrangement was  
13 that the TMO has consistently been the responsible  
14 person for Grenfell Tower since the Fire Safety Order  
15 was introduced in 2006. TMO was the most significant of  
16 the responsible persons for Grenfell Tower due to the  
17 extent of its control over the premises. The TMO was  
18 responsible for the formulation, planning,  
19 implementation and operation of a fire risk management  
20 system for Grenfell Tower and the other properties that  
21 it managed on behalf of the council.

22 We appreciate that, at the time, many residents saw  
23 the council and the TMO as a single organisation, rather  
24 than two separate organisations. This is entirely  
25 understandable for a range of reasons, one of those

1 reasons being the fact that the council worked closely  
2 with the TMO. But they were separate organisations, and  
3 that will need to be borne in mind when analysing the  
4 issues in this module.

5 When considering the council's role in this module,  
6 you will very largely be considering how the council  
7 monitored what the TMO was doing on its behalf. But  
8 Dr Lane is right when she says that she has found  
9 evidence of specific interventions made by the council  
10 regarding fire risk management. I suggest that the most  
11 important example of this was the discussions in 2016  
12 and 2017 about a stock-wide programme to install  
13 self-closers on flat entrance doors. I will say more  
14 about that later. For the moment, I want to focus on  
15 the council's monitoring of the TMO.

16 The council's legal relationship with the TMO was  
17 governed by the modular management agreement. This was  
18 a long, complex document, based on a template approved  
19 and issued by central government. It set out what was  
20 delegated to the TMO for it to manage on behalf of the  
21 council. It also had provisions on how the council  
22 would monitor the TMO's performance. This was  
23 supplemented by a TMO monitoring procedure guide agreed  
24 between the council and the TMO. These documents  
25 envisaged that the council would use a range of

1 mechanisms to monitor the TMO's performance. In  
2 practice, as we explain in some detail in our written  
3 opening, the council did use a range of mechanisms to  
4 monitor the TMO's performance. I'm not going to go into  
5 all that detail now, but I will highlight some key  
6 points about the council's monitoring.

7 The monitoring was done by officers and councillors  
8 but, as you would expect, more of it was done by  
9 officers. The council failed to follow some of the  
10 procedures set out in the MMA and TMO monitoring  
11 procedure guide. The most formal monitoring mechanism  
12 was the annual performance report in July and a mid-year  
13 report in November. These documents were formally  
14 reported to the cabinet member who held the housing  
15 portfolio, the TMO board and the council's housing and  
16 property scrutiny committee. The reports drew together  
17 performance data, the outcomes of audits undertaken by  
18 the council's internal audit team, and other  
19 information.

20 In the years before the fire, the overall assessment  
21 of the TMO in these reports was positive. Someone  
22 reading the reports would have been left with the  
23 impression that the TMO's performance did not give cause  
24 for concern. The reports always included a section on  
25 health and safety. Commentary in those sections tended

1 to be positive. But it is right to acknowledge that the  
2 sections on health and safety were brief and tended not  
3 to cite evidence or empirical data in support of the  
4 points made in them.

5 On reflection, the council considers that the number  
6 of council officers devoted to monitoring the TMO was  
7 insufficient given the number of residents whose  
8 properties were managed by the TMO and the scale and  
9 importance of the task delegated to the TMO.

10 The TMO reported key performance indicators to  
11 the council, but at no time did either of the two sets  
12 of KPIs reported to the council measure the TMO's  
13 fire safety performance. The council acknowledges that  
14 there were aspects of fire safety performance which  
15 could have been measured empirically and which could  
16 therefore have been made the subject of a KPI.  
17 The council should have told the TMO that it needed to  
18 have in place some KPIs to measure fire safety  
19 performance. It failed to do so.

20 Mr Chairman, you and others may be wondering why  
21 the council didn't monitor the TMO more than it did.  
22 I cannot point you to one single answer, but there are  
23 a number of matters of background which, taken together,  
24 help to provide an explanation. I will outline some of  
25 the key ones.

1 The TMO was an independent organisation, owned by  
 2 its members and accountable to its board. Residents  
 3 elected to the board at all times made up a majority of  
 4 the board members.  
 5 From 2002 onwards, the TMO was an arm's length  
 6 management organisation. When the TMO was set up in  
 7 1996, approximately 250 employees transferred from  
 8 the council to the TMO. In 2017, the TMO employed over  
 9 200 people, including many in managerial positions.  
 10 Those TMO managers were themselves monitoring the TMO's  
 11 performance and reporting it to the TMO board.  
 12 The council officers involved in monitoring the TMO were  
 13 conscious that it was an independent organisation.  
 14 Their work was not intended to duplicate the work of the  
 15 TMO managers and board.  
 16 The agreement between the council and the TMO did  
 17 contain provisions that could be used to exert greater  
 18 control over the TMO if it was underperforming, and  
 19 the council had shown a willingness to use them where  
 20 necessary. In 2008, the TMO agreed a deed of variation  
 21 which temporarily varied the TMO's obligations under the  
 22 MMA and an improvement plan was put in place. This  
 23 temporary process ended in 2010. After that, there were  
 24 a number of indications that, overall, the TMO had  
 25 healthy governance arrangements and that its performance

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1 was improving. In 2013, the TMO management agreement  
 2 full systems audit and a five-year review report both  
 3 reached positive conclusions about the TMO.  
 4 There was required to be a test of opinion of the  
 5 residents every five years. The last one before the  
 6 fire was in 2013. It was run by an external  
 7 organisation, and the results were reported to the TMO  
 8 board. They were informed that the number of residents  
 9 who participated was the highest ever. 86% of those who  
 10 voted, voted for the TMO to continue managing their  
 11 homes, and the results were better than those of  
 12 neighbouring boroughs and had also improved.  
 13 One of the TMO's aims was to increase its  
 14 membership. In the period 2012 to 2016, it did so by  
 15 almost 500 members per year. At the TMO's last annual  
 16 general meeting before the fire, over 95% of those who  
 17 voted were in favour of the TMO continuing to manage  
 18 their homes.  
 19 I'm moving now to my second topic: expert evidence  
 20 and guidance documents.  
 21 In this module, you have the benefit of expert  
 22 evidence from two distinguished experts on fire risk  
 23 assessment, Colin Todd and Barbara Lane. Mr Todd has  
 24 been probably the country's most well known expert on  
 25 fire risk assessment for many years. His advice has

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1 been sought by a range of governmental and  
 2 non-governmental organisations, including the  
 3 British Standards Institution, the Local Government  
 4 Association, the Institution of Fire Engineers, the Fire  
 5 Industry Association and the Fire Service College.  
 6 Dr Lane is the global fire safety engineering technical  
 7 lead at one of the world's leading engineering  
 8 practices. She has proved herself to be a highly  
 9 competent expert in the course of this Inquiry.  
 10 One of the themes running through this module will  
 11 be the fact that Mr Todd and Dr Lane do not agree on all  
 12 points. Similarly, the guidance documents that existed  
 13 before the fire did not all give identical advice.  
 14 Where there is disagreement between the experts, the  
 15 panel will need to decide how best to resolve it. But  
 16 there is a second aspect to this: prior to the fire,  
 17 there was one guidance document specifically designed  
 18 for those managing purpose-built blocks of flats for  
 19 local authorities. This guidance was published by the  
 20 Local Government Association in 2011, following  
 21 an extensive consultation exercise and input from the  
 22 Department for Communities and Local Government and the  
 23 Chief Fire Officers Association. It described itself as  
 24 the "more appropriate guide to use for purpose-built  
 25 blocks of flats". In 2013 it was re-endorsed by DCLG

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1 after the inquest into the Lakeland House fire, and was  
 2 never revised or withdrawn before the Grenfell Tower  
 3 fire.  
 4 With the assistance of its assessors, with social  
 5 housing and local government expertise, the panel will  
 6 need to consider the extent to which it would have been  
 7 reasonable for those involved in the management of  
 8 Grenfell Tower to focus on the LGA guide in preference  
 9 to other guidance documents. Industry practice is  
 10 likely to be a relevant consideration when analysing  
 11 this issue.  
 12 Industry practice is likely also to be relevant to  
 13 your consideration of the fire risk assessments carried  
 14 out on Grenfell Tower. In an ideal world, fire risk  
 15 assessments would always be carried out by someone of  
 16 the calibre of Mr Todd or Dr Lane. But this is not  
 17 an ideal world, and it was never intended that the task  
 18 of carrying out fire risk assessments be reserved to  
 19 qualified fire safety engineers. For it to have been,  
 20 the Government would have needed to pass legislation  
 21 regulating the sector. In fact, the sector was and  
 22 remains completely unregulated. No qualifications are  
 23 required by law. No training is required by law. There  
 24 was and is no bar whatsoever to anyone seeking to go  
 25 into business as a fire risk assessor.

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1 When one combines this absence of regulatory  
 2 framework with what was going on in the sector at the  
 3 time, one can see why Mr Todd says the following about  
 4 Carl Stokes, who carried out all the fire risk  
 5 assessments on Grenfell Tower:  
 6 "His FRAs are amongst the most detailed of the many  
 7 thousands of FRAs I have studied. Within the FRAs,  
 8 there are many 'tell-tale' indications that Mr Stokes is  
 9 competent to carry out a suitable and sufficient FRA in  
 10 general, and, more specifically, FRAs of high-rise  
 11 blocks of flats such as Grenfell Tower.  
 12 "In conclusion, in my opinion, Carl Stokes was  
 13 competent to carry out FRAs for Grenfell Tower, taking  
 14 into account his training, skills and qualifications in  
 15 the practice of fire safety and the FRAs that he  
 16 documented."  
 17 There can be no doubt that, at the time, the TMO  
 18 genuinely believed that Mr Stokes was a competent fire  
 19 risk assessor providing it with a professional service,  
 20 and that presumably explains why the TMO sought his  
 21 advice on such a wide range of issues. Because  
 22 Mr Stokes didn't just do fire risk assessments for the  
 23 TMO, he also advised on issues that applied generally to  
 24 the properties managed by the TMO and on issues specific  
 25 to Grenfell Tower.

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1 Mr Stokes' fire risk assessments and advice to the  
 2 TMO will be central to many of the issues to be  
 3 considered in this module. The panel will need to  
 4 consider whether he was a competent fire risk assessor,  
 5 and whether his fire risk assessments for Grenfell Tower  
 6 were suitable and sufficient. But it will also need to  
 7 consider whether anyone at the time had reason to doubt  
 8 his competence or the adequacy of his fire risk  
 9 assessments, and if so, who.  
 10 I now turn to the topic of residents with  
 11 vulnerabilities in the event of fire. This is not  
 12 a phrase used in the Fire Safety Order, but it is  
 13 a helpful phrase used by Dr Lane to cover adults with  
 14 cognitive impairment, adults with sensory impairment,  
 15 adults with mobility impairment, and children. This is  
 16 an important issue, because the evidence suggests that  
 17 a higher proportion of adult residents with such  
 18 vulnerabilities died in the fire.  
 19 Here, the different approaches recommended in the  
 20 different guidance documents is particularly stark.  
 21 Most of the guidance documents advised that specific  
 22 measures be taken to protect, for example, disabled  
 23 residents. But in contrast, the guidance in the  
 24 LGA guide, which was current at the time of the fire,  
 25 stated that:

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1 "... it is reasonable to expect that the occupants  
 2 of a 'general needs' block of flats will reflect the  
 3 diverse range of physical and mental capabilities of the  
 4 general population as a whole ...  
 5 "It should be determined as to whether the number of  
 6 disabled people is likely to be different from a typical  
 7 general needs block of flats ...  
 8 "It is usually unrealistic to expect landlords and  
 9 other responsible persons to have in place special  
 10 arrangements, such as 'personal emergency evacuation  
 11 plans'."  
 12 The position at Grenfell Tower was that no resident  
 13 had a personal emergency evacuation plan, and none of  
 14 the fire safety advice from the TMO to residents  
 15 contained advice tailored to the needs of persons who  
 16 would be vulnerable in the event of fire.  
 17 Here again, with the assistance of its assessors,  
 18 the panel will need to consider the extent to which it  
 19 would have been reasonable for those involved in the  
 20 management of Grenfell Tower to focus on the advice in  
 21 the LGA guide in preference to that given in other  
 22 guidance documents. They will also be able to assist  
 23 you with whether the occupancy profile of Grenfell Tower  
 24 was different from other general-needs blocks of flats.  
 25 I now turn to the topic of flat entrance doors and

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1 self-closers.  
 2 Phase 1 established that a major route for the  
 3 spread of toxic smoke within Grenfell Tower was from  
 4 individual flats through flat entrance doors into  
 5 communal areas. At the time of the fire, there were 120  
 6 flats in the tower located on floors 4 to 23. The flat  
 7 entrance doors to 106 of those flats had been replaced  
 8 in 2011. There are three main reasons why those  
 9 comparatively new doors did not prevent the spread of  
 10 smoke.  
 11 The first reason is that some of them were open  
 12 rather than shut on the night of the fire because they  
 13 did not have a working self-closing device. All of them  
 14 had been fitted with self-closers when installed, but  
 15 for various reasons some of them were no longer working  
 16 or no longer present some six years later.  
 17 Not all of the council's tower blocks were fitted  
 18 with self-closers in 2011. One of those that was not  
 19 was Adair Tower, where fire broke out in October 2015.  
 20 After that fire, self-closers were installed in Adair  
 21 and consideration was given to introducing a self-closer  
 22 programme through all of the properties managed by the  
 23 TMO.  
 24 The council acknowledges that there should have been  
 25 such a programme in place before the Grenfell Tower

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1 fire. In fact, there had been a decision in principle  
2 to implement a programme. It had not begun to be rolled  
3 out.

4 The TMO and the council were both involved in the  
5 decision-making process. Where responsibility lies for  
6 the delay in implementation is something that can only  
7 be decided once you have heard from the relevant  
8 witnesses from the TMO and the council.

9 The second reason why the doors did not prevent the  
10 spread of smoke is that testing done since the fire has  
11 established that many of the doors were not compliant  
12 and did not resist fire and smoke for 30 minutes, as  
13 they should have done under the contract between the TMO  
14 and its supplier, Manse Masterdor.

15 The purchase of the doors was a sizeable procurement  
16 exercise, and the TMO were assisted in it by the London  
17 Housing Consortium and Mr Stokes. Sadly, the problems  
18 with the fire performance of the doors were not limited  
19 to one batch or even one manufacturer. Subsequent  
20 events have revealed that these problems occurred on  
21 a national scale and were so serious and widespread  
22 that, in 2018, they resulted in major disruption to the  
23 supply of composite fire doors to the UK market.

24 The third reason why the doors did not prevent the  
25 spread of smoke should not be overlooked. It is this:

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1 the doors were never intended to withstand fire and  
2 smoke indefinitely, nor were they required by law to do  
3 so.

4 My final topic is complaints.

5 It is clear that a significant number of residents  
6 of Grenfell Tower felt very strongly that it was not  
7 being managed as well as it could and should have been.  
8 Some of them were frustrated by how they were treated by  
9 the TMO, Rydon and the council. Some of them  
10 complained. Some of those who complained were  
11 dissatisfied with how their complaints were handled, and  
12 did not feel respected. Matters which led to high  
13 volumes of frustration and complaints included: the  
14 power surges in 2013, issues which arose during the  
15 refurbishment, lifts breaking down, and the gas riser  
16 works in 2016 and 2017. It is entirely understandable  
17 that residents were frustrated by these matters, and  
18 complained about them.

19 We say something about each of those individual  
20 matters in our written opening. Today I'm going to  
21 concentrate on the systems for addressing complaints.

22 The TMO and the council had separate complaints  
23 systems. Each organisation's complaints system had  
24 three formal stages. The two complaint systems were not  
25 interlinked. There was no right of appeal from the TMO

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1 complaints system to the council's complaints system.  
2 The council's monitoring of complaints submitted by  
3 residents to the TMO was limited. For example, the TMO  
4 only formally reported a complaint's KPI to the council  
5 for two years ending in 2015.

6 In practice, many Grenfell Tower related complaints  
7 were submitted in emails sent to recipients within both  
8 the TMO and the council. What then tended to happen was  
9 that the complaints were referred back to the TMO to  
10 address or left to the TMO to address. The TMO was  
11 better placed to address matters of detail raised in  
12 complaints about services managed by the TMO. We  
13 therefore consider that, in general, this approach made  
14 sense. But it also had a weakness. The weakness was  
15 that it increased the risk of patterns in complaints  
16 about the TMO or its services being missed by  
17 the council in its monitoring of the TMO.

18 This brings me to the end of the themes in Module 3  
19 that I wish to address you on today. As you are aware,  
20 we cover a wider range of topics in our written opening  
21 statement, and also analyse the evidence in more detail  
22 there. That evidence will be added to by the evidence  
23 of witnesses due to be called in April, May, June and  
24 July. In our closing statement, we will take account of  
25 that evidence and set out the council's position in

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1 further detail and in accordance with the council's  
2 commitment to candour.

3 Thank you, that concludes my opening statement.

4 SIR MARTIN MOORE-BICK: Thank you very much indeed,  
5 Mr Maxwell-Scott.

6 At this point, we would expect to hear from  
7 Mr Ageros on behalf of the Tenant Management  
8 Organisation. He was due to appear at 3.15, and I don't  
9 know whether he's actually --

10 MR AGEROS: I'm here, sir.

11 SIR MARTIN MOORE-BICK: Oh, Mr Ageros, good afternoon.

12 MR AGEROS: Yes, good afternoon.

13 SIR MARTIN MOORE-BICK: Is it convenient to you to make  
14 a statement at this point?

15 MR AGEROS: Yes, if we may, please, sir.

16 SIR MARTIN MOORE-BICK: We would normally have a break some  
17 time during the afternoon. You're currently scheduled  
18 to have an hour, if you want to use it. Would you like  
19 to see how you're going round about 3.15? If you reach  
20 a point, broadly speaking, somewhere between 3.15 and  
21 3.30 when it would be convenient to take a break,  
22 perhaps you would let me know.

23 MR AGEROS: Yes, thank you very much, sir.

24 SIR MARTIN MOORE-BICK: Thank you very much. You can  
25 obviously hear me and see me.

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1 MR AGEROS: I can see you all.  
 2 SIR MARTIN MOORE-BICK: Good. It just remains, therefore,  
 3 for me to invite you to make your statement.  
 4 Opening statement on behalf of the Tenant Management  
 5 Organisation by MR AGEROS  
 6 MR AGEROS: So, Mr Chairman, panel members, we too have  
 7 submitted a near 50-page written opening statement.  
 8 These oral submissions represent an abbreviated version  
 9 of that statement, and they develop themes which are set  
 10 out there, and so we invite the Inquiry to refer to  
 11 those written submissions when considering the detail of  
 12 any oral submissions made here.  
 13 Sir, may I say at the outset that the TMO and all  
 14 that worked for it acknowledge the immense tragedy of  
 15 the Grenfell Tower fire, and nothing in these  
 16 submissions is intended to diminish or detract from that  
 17 tragedy. All those who give evidence on behalf of TMO,  
 18 and there will be many of them in Module 3, sir,  
 19 continue to express their profound sympathies and  
 20 condolences to the bereaved, survivors and residents.  
 21 Sir, topic 1 of Module 3 is primarily concerned with  
 22 the TMO's systems for communication with residents;  
 23 consultation concerning the refurbishment; residents'  
 24 complaints regarding fire safety risks; doors and the  
 25 quality of workmanship during the refurbishment; and the

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1 response and degree of engagement, I think as you put  
 2 it, of the TMO and RBKC to those complaints.  
 3 Sir, you will hear first from former residents of  
 4 Grenfell Tower and then from witnesses from the TMO and  
 5 RBKC at varying levels of seniority regarding the  
 6 systems, policies and procedures each body had  
 7 implemented to deal with residents' complaints and their  
 8 response to those complaints as well as the management  
 9 of the building.  
 10 Sir, you're also going to hear evidence about the  
 11 governance arrangements between RBKC and the TMO and, in  
 12 particular, how they worked during the refurbishment.  
 13 To that end, you will hear from senior representatives  
 14 from TMO and RBKC.  
 15 Sir, we acknowledge that, when considering the issue  
 16 of complaints and concerns, the Inquiry's primary focus  
 17 will be on matters causally connected with the fire, but  
 18 the Inquiry will also consider the way in which  
 19 complaints more broadly were managed. Sir, this being  
 20 the case, the TMO intends to briefly address some of the  
 21 wider issues touching on that topic here.  
 22 At the outset -- and it's right that we say this,  
 23 sir -- the TMO acknowledges that the relationship with  
 24 some residents was sometimes strained and difficult,  
 25 both before and during the refurbishment, and we have no

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1 doubt that you will scrutinise the reasons for this.  
 2 However, sir, this is not to say that all residents were  
 3 always at odds with the TMO, and the Inquiry may wish to  
 4 consider whether views expressed by some more vociferous  
 5 residents were truly representative of the views of  
 6 a majority of residents.  
 7 Sir, can we say in a nutshell that the TMO doesn't  
 8 accept that it ever adopted a dismissive attitude  
 9 towards residents or indeed to their complaints and  
 10 concerns.  
 11 Sir, we suggest that when you look at the nature of  
 12 the relationship between TMO and the residents during  
 13 the relevant period, the Inquiry should have particular  
 14 regard to the following three factors.  
 15 Sir, first, there had been vehement opposition from  
 16 some residents at Grenfell Tower to the KALC project --  
 17 and forgive the abbreviation, but it's for the sake of  
 18 time -- from its very inception, and strong criticism of  
 19 RBKC in particular, and much of this criticism was  
 20 voiced in the Grenfell Action Group blog, which I'm  
 21 going to refer to as the GAG blog, sir, going on. The  
 22 Inquiry may consider whether this soured the  
 23 relationship between some tenants and the TMO and RBKC,  
 24 but also, indeed, whether this strong opposition was  
 25 representative of the Lancaster West community as

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1 a whole, given that the KALC project was to build a much  
 2 needed school and leisure facilities for children in the  
 3 borough.  
 4 Second, the TMO finally took over in 2014 from the  
 5 Estate Management Board, referred to as the EMB, for the  
 6 Lancaster West estate. The EMB was a tenant-led  
 7 organisation separate to and pre-dating the TMO which  
 8 was first registered in 1993.  
 9 There came a point when the EMB was not functioning  
 10 well, and there was a strongly held view that its  
 11 members were unaware of what was expected of them.  
 12 Although it's right to say that residents voted at one  
 13 point to retain the EMB, concerns remained about its  
 14 performance and RBKC worked on an improvement plan,  
 15 a step which was prescribed by the MMA. This failed to  
 16 result in progress and RBKC eventually terminated the  
 17 contractual relationship with EMB in 2014.  
 18 Despite a widespread perception of mismanagement --  
 19 and, sir, there are various emails which relate to  
 20 this -- some residents thought it had been shut down,  
 21 and this is a quote, "in an underhand and duplicitous  
 22 manner by RBKC". Sir, of course, it's a matter for  
 23 the Inquiry, but we would submit that this probably  
 24 created a breakdown in trust between the TMO, RBKC and  
 25 some residents, and impaired TMO achieving a good

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1 relationship with some tenants going forward.  
 2 Sir, third, when considering the nature and volume  
 3 of complaints made by residents during the  
 4 refurbishment, it should be kept in mind that, for  
 5 residents, continuing to live in situ when major works  
 6 were occurring both inside and outside their flats can  
 7 only have been extremely difficult. The construction  
 8 work was intrusive and noisy, and one lift was often  
 9 unavailable to residents because it was being used by  
 10 builders. Sir, against this background, it's possibly  
 11 unsurprising that there was an increased number of  
 12 complaints and expressions of dissatisfaction from  
 13 residents.  
 14 Indeed, consideration was given to the possibility  
 15 of rehousing residents during the refurbishment, but  
 16 this was not thought practicable or desirable. Indeed,  
 17 some residents had concerns that if they left the area  
 18 they would be rehoused in an unfamiliar location and  
 19 would not be able to return. Whilst such concerns were  
 20 certainly baseless, they are indicative of the level of  
 21 mistrust that existed between some residents and the  
 22 TMO/RBKC.  
 23 Sir, we have an eye to the evidence that you will be  
 24 hearing in this module, and one of the parts of the  
 25 evidence in relation to fire-related complaints will be

1 the contents of the Grenfell Action Group blog dated  
 2 20 November 2016. Just to say a couple of the things  
 3 about the blog. In fact, the language often used in the  
 4 blog was indicative of the levels of mistrust that had  
 5 built up in the minds of some residents towards the TMO.  
 6 What we on behalf of the TMO submit is that  
 7 the Inquiry should be cautious about the contents of the  
 8 GAG blog because it contained a highly personalised  
 9 narrative, including a number of personal attacks on TMO  
 10 and RBKC employees, and because indeed the authors never  
 11 identified themselves, the blog often uses the word "we"  
 12 in connection with the residents of Grenfell Tower and,  
 13 so far as the TMO is concerned, it appeared to be the  
 14 work of at most a handful of authors.  
 15 Sir, we summarise one part of the blog, and the  
 16 November blog said -- and this is a quote, and we've  
 17 abbreviated the quote, and I hope not unfairly so --  
 18 that the TMO was:  
 19 "... an [irresponsible] mini-mafia ... [and] only an  
 20 incident that results in serious loss of life to KCTMO  
 21 residents will allow the external scrutiny to occur that  
 22 will shine a light on the practices that characterise  
 23 the malign governance of this non-functioning  
 24 organisation."  
 25 Sir, what we say about that is this: despite the

1 appearance of prophecy, and we acknowledge that, the  
 2 writers were certainly not predicting a cladding fire of  
 3 the type that occurred on 14 June 2017. So far as the  
 4 TMO is aware, no witness or organisation connected with  
 5 this Inquiry predicted such a fire at Grenfell Tower,  
 6 despite the fact that similar cladding fires had  
 7 apparently occurred abroad and about which you have  
 8 heard evidence in Phase 1.  
 9 Sir, ultimately it's a matter for you, but we would  
 10 submit that the evidence that you have heard in previous  
 11 modules bears out that the fire was not caused by "the  
 12 malign governance of a non-functioning organisation", ie  
 13 referable to the TMO; rather, it arose from the  
 14 widespread and deep-rooted blindness within the private  
 15 and public sector to the inherent dangers of materials  
 16 regularly used in the building industry, or, even worse,  
 17 by deception for commercial gain on the part of those  
 18 companies that marketed and supplied cladding and  
 19 insulation.  
 20 Sir, the evidence the Inquiry's heard in Module 2  
 21 thus far was, it is submitted, truly shocking, and shows  
 22 that even those with responsibility for safety  
 23 certification did not uncover the combustible nature of  
 24 the products used in the refurbishment.  
 25 Sir, a measure of the extent of the blindness, as

1 I've referred to it, is the fact that some 2,000  
 2 buildings across the UK had been clad in and insulated  
 3 with similarly combustible materials. Although the fire  
 4 happened at Grenfell Tower, it could as easily have  
 5 happened at another building clad in combustible  
 6 materials. Sir, it's no doubt for this reason, among  
 7 others, that fire marshals maintain vigils at numerous  
 8 buildings even to this day.  
 9 Sir, the debate about how to solve this systemic and  
 10 far-reaching problem continues even now between the  
 11 Government, the construction industry and building  
 12 managers and their tenants, including who will bear the  
 13 cost for removal and replacement of cladding.  
 14 Sir, when considering the role of the TMO, we invite  
 15 the Inquiry and you, the panel members, to bear this in  
 16 mind: the TMO was an organisation staffed by  
 17 non-construction professionals with a background in  
 18 social housing. This was a design and build contract,  
 19 and the TMO relied on various specialists and industry  
 20 professionals throughout the refurbishment project, and  
 21 its reliance on professional advisers represented the  
 22 norm for contract procurement and capital works within  
 23 the public sector.  
 24 Sir, while, if I may say rightly, as you have put  
 25 it -- and I hope I quote you correctly -- the TMO was

1 an educated client, it operated only with the reasonable  
 2 foresight of a social housing manager, and in not  
 3 foreseeing such a terrible tragedy, it was no different  
 4 to hundreds of other organisations across the UK. The  
 5 question must be whether the TMO is to be judged  
 6 differently to organisations in a similar position.  
 7 Sir, Dr Lane particularly criticises the TMO for not  
 8 uncovering the risk the refurbishment posed following  
 9 warnings arising from two fires, the Lakanal House fire  
 10 in 2009 and the Shepherds Court fire in 2016, and the  
 11 warning letter from LFEPA as a result of the  
 12 Shepherds Court fire in April 2017.  
 13 Sir, the TMO invites the Inquiry to consider whether  
 14 it alone should have been expected to see through the  
 15 deceptions practised by the manufacturers of the  
 16 cladding and insulation, especially when certifying  
 17 bodies such as the BRE and BBA approved their  
 18 suitability for use in construction and/or provided  
 19 misleading certificates which inspired trust in  
 20 materials used on the tower.  
 21 Sir, hundreds of other building owners or managing  
 22 organisations did not untangle this subterfuge, even  
 23 when, like the TMO, they were advised by teams of  
 24 professionals.  
 25 Sir, I'm going to deal now with the issue of

1 resident engagement. May we say this: the TMO put  
 2 considerable effort and resources into resident  
 3 engagement, which we define as the drive to ensure  
 4 residents were involved in decisions surrounding the  
 5 management of their homes.  
 6 The TMO was and was designed to be a resident-led  
 7 organisation, and its constitution made it a requirement  
 8 that the board consisted of a majority of residents,  
 9 including the Chair. From the time that Robert Black  
 10 was appointed chief executive in 2009, the TMO sought to  
 11 stimulate meaningful resident engagement, recognising  
 12 that had fallen to a low level, especially following the  
 13 demise of the EMB in 2014.  
 14 Initially, a door-knocking exercise was carried out  
 15 across all properties in the TMO estate to understand  
 16 what residents' main issues and concerns were.  
 17 Following this, the TMO sought to increase resident  
 18 membership in a number of ways, for example by holding  
 19 roadshows, annual conferences, the senior citizens'  
 20 annual party, the youth engagement project and the TMO  
 21 live "Up Your Game" projects. It also promoted the  
 22 creation of residents' associations, which numbered  
 23 something like 53 across the borough, with ten alone set  
 24 up in 2015/2016. All of this work was done by  
 25 a dedicated resident engagement team, which included

1 a resident engagement manager.  
 2 Sir, we appreciate that reference to figures that  
 3 demonstrate levels of resident engagement may not be  
 4 helpful without context, which we're not going to  
 5 provide fully here, it's in the written submissions, but  
 6 the drive to increase resident engagement was certainly  
 7 successful. An example is the increase in turnout for  
 8 the TMO board member elections, as well as increased  
 9 participation in the AGM. At the 2016 AGM, 96% of the  
 10 over 1,200 people who voted were in favour of TMO  
 11 continuing to manage their properties.  
 12 Possibly the most telling measure of resident  
 13 engagement, and indeed of resident approval, was the  
 14 test of opinion which was carried out every five years,  
 15 where TMO members were asked if they wanted the TMO to  
 16 continue to manage their homes. The most recent test of  
 17 opinion before the fire involved an increase in  
 18 participation of 122%, and there was an overwhelming  
 19 vote in favour of the TMO continuing in its management  
 20 role. Sir, in very real terms, if it had been the  
 21 residents' wish, the TMO could almost literally have  
 22 been voted out of existence or other management  
 23 arrangements put in place.  
 24 Sir, resident engagement was monitored by RBKC, and  
 25 it received a substantial assurance result in the

1 minutes of the HRA performance meeting in February 2017.  
 2 Turning now to the question of resident consultation  
 3 for the refurbishment, sir, we anticipate you will hear  
 4 that the TMO sought actively to consult with residents  
 5 concerning the refurbishment from the earliest stages.  
 6 This included giving residents a choice about how they  
 7 would like to be consulted.  
 8 Consultation on design proposals for the  
 9 refurbishment took place in 2012 and 2013 in particular,  
 10 in many different ways, including -- we list these here,  
 11 sir, they're listed in the submissions -- through  
 12 meetings in both the daytime and the evening to  
 13 accommodate as many residents as possible, newsletters  
 14 which invited residents to roadshows and consultations,  
 15 and questionnaires where residents were asked about  
 16 a number of matters, including their priorities for  
 17 windows, ie whether they should be self-cleaning and  
 18 options for the operation of the windows, ie pivot,  
 19 reversible, sliding or tilt-and-turn; whether  
 20 Grenfell Tower would benefit from thermal insulation  
 21 cladding, and, sir, there was a high "yes" vote for  
 22 this, but no clear opinion was expressed about the  
 23 colour or type of cladding; whether homes would benefit  
 24 from new individual boilers which could be controlled by  
 25 each flat individually, and again there was a high "yes"

1 vote for this.  
 2 Residents were also kept up to date via newsletters.  
 3 For example, there were three in 2013 which advised of  
 4 any changes to the plans submitted and reported on the  
 5 results of surveys, et cetera. Sir, we've referred to  
 6 those in detail in the written submissions.  
 7 In addition to the above, Rydon, the principal  
 8 contractor, hosted coffee mornings and arranged home  
 9 visits from their resident liaison officer ,  
 10 Lynda Prentice.  
 11 Sir, throughout its consultation process, the TMO  
 12 sought to obtain as many resident views as possible on  
 13 the refurbishment. Moreover, as an example of how the  
 14 TMO listened to resident views, it did adapt the project  
 15 after listening to residents. For example, it changed  
 16 the design of the windows when it became apparent that  
 17 the initial proposals would result in more intrusive  
 18 work being done internally to flats ; it recognised and  
 19 engaged with a new residents' compact when it was  
 20 suggested that residents' concerns were not being heard  
 21 properly by the existing Lancaster West Residents'  
 22 Association; and it eventually moved the HIU after  
 23 residents challenged TMO about its revised position, and  
 24 we will go into that in a little bit more detail later .  
 25 Sir, dealing now with complaints and service

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1 enquiries .  
 2 The TMO certainly had in place systems for dealing  
 3 with residents' concerns and complaints, including those  
 4 concerned with the refurbishment. However — and we  
 5 acknowledge this, sir — the content of many of the  
 6 statements from resident witnesses and the TMO evidence  
 7 may be difficult for the Inquiry always to reconcile .  
 8 The picture painted in those statements is sometimes  
 9 very different . Of course, that will be a matter for  
 10 the Inquiry to consider carefully in Module 3.  
 11 However, complaints handling was always a priority  
 12 for the TMO, and its performance was monitored both  
 13 internally and externally, internally by the operations  
 14 team, the senior management team, the executive team and  
 15 the board, and externally by RBKC.  
 16 The TMO's complaints policy required it to apply the  
 17 Housing Ombudsman principles for effective complaint  
 18 handling. The portfolio was overseen on a day—to—day  
 19 basis by the TMO's policy and improvement manager and  
 20 there was a dedicated complaints manager and two  
 21 complaints officers .  
 22 The complaints team had monthly meetings where all  
 23 issues were discussed and a quarterly report on  
 24 complaints was prepared containing KPIs and statistics.  
 25 The complaints policy distinguished between

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1 a complaint and an enquiry. An enquiry was to find  
 2 out — and I hope the quote is accurate — a first time  
 3 request for information, advice or for an action to be  
 4 undertaken, eg estate cleaning not undertaken, estate  
 5 lighting not working or a repair request.  
 6 On a practical level , an enquiry would be passed on  
 7 by the staff member receiving it to either the customer  
 8 service centre or directly to the relevant team for  
 9 action. The intention of the TMO was always to resolve  
 10 enquiries as soon as possible without them escalating  
 11 into formal complaints. Sir, of course, we've seen some  
 12 of the submissions made by the BSRs, but we would say  
 13 this: this wasn't in an attempt to bypass or avoid  
 14 formal complaints, but because informal resolution was  
 15 always preferable .  
 16 By contrast, a complaint was defined as  
 17 an expression of dissatisfaction about a KCTMO service,  
 18 or a service provided by a KCTMO contractor, not  
 19 resolved immediately to the customer's satisfaction  
 20 about the level , quality or nature of a service which  
 21 the customer feels should have been provided. The TMO  
 22 publicised the complaints procedure widely to residents  
 23 on its website, at roadshows, in the Link magazine and  
 24 through leaflets and posters in the housing offices .  
 25 Against this background, sir, we invite the Inquiry

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1 to consider whether some of the BSRs' contention, ie  
 2 that the complaints policy was not widely known or  
 3 understood, is correct .  
 4 Residents with concerns or complaints could contact  
 5 the TMO by a number of means, including emailing  
 6 a dedicated complaints email address, calling the  
 7 customer service centre or visiting the local housing  
 8 office . Complaints and enquiries were logged and  
 9 progressed through the W2 system initially and, from  
 10 2016, through the CRM system.  
 11 The complaint would first be assigned to the  
 12 complaints team and then re—assigned to the relevant TMO  
 13 team, for example Repairs Direct, but the complaints  
 14 team would always monitor outstanding complaints to  
 15 ensure compliance, including time limits , et cetera, and  
 16 would use an interactive complaints dashboard to monitor  
 17 this .  
 18 The complaints policy set out a three—stage process.  
 19 Stage 1 involved an investigation by the manager of the  
 20 relevant service area, and if a resident was not happy  
 21 with the outcome of the investigation, they could  
 22 escalate their complaint to stage 2. Stage 2 involved  
 23 an investigation by the head of service. Residents who  
 24 were still dissatisfied at stage 2 could request  
 25 a stage 3 review, which was the final stage of the

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1 procedure, and involved a formal panel meeting  
 2 comprising of an independent board member or a council  
 3 appointed board member, a resident board member and  
 4 an executive director . A board member chaired the  
 5 panel, and in the later years the complainant could  
 6 attend the panel in person. If dissatisfied with the  
 7 outcome of the stage 3 review, the resident could appeal  
 8 to the Housing Ombudsman.

9 Complaints performance was monitored using a set of  
 10 KPIs and was reported to the executive team and the  
 11 operations committee. The complaints and the procedure  
 12 were subject to an internal audit by an RBKC team, and  
 13 RBKC maintained independent oversight of complaints.

14 Sir, can we touch on now a few complaints arising  
 15 from the refurbishment, some particular complaints, but  
 16 make this point at the outset: it's important to note  
 17 that the primary mechanism for raising concerns during  
 18 the refurbishment was through Rydon, who had a permanent  
 19 resident liaison officer , RLO, based in the tower to  
 20 deal with any day-to-day issues. The RLO details,  
 21 including when they were available, were communicated in  
 22 each newsletter. There was also a Rydons email address  
 23 via which residents could express their written concerns  
 24 to Rydon.

25 Claire Williams, from whom you have heard and from

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1 whom you will hear, from the TMO also liaised closely  
 2 with Rydons RLO both during and after the works and,  
 3 sir , always sought to ensure that residents' concerns  
 4 and requests for repairs were dealt with. The TMO and  
 5 Rydon also held regular liaison meetings to discuss  
 6 concerns and housing management issues impacting upon  
 7 residents .

8 Sir, dealing with formal complaints, there were  
 9 seven formal complaints of from four separate residents  
 10 during the period of the refurbishment. Of these seven  
 11 complaints, four were submitted by the same resident.  
 12 Four were not upheld, two were upheld, and one was  
 13 partially upheld.

14 Sir, may we say straightaway that we recognise that  
 15 this simple figure, this simple number, does not fully  
 16 capture the level of concern expressed by residents  
 17 about the refurbishment, and their concerns were often  
 18 conveyed in different ways. But what we do say, sir, is  
 19 that it demonstrates there was a system in place which  
 20 residents were able to use and, indeed, the outcome was  
 21 not always in the TMO's favour.

22 We deal now with the history of a particular formal  
 23 complaint made to TMO and, sir, it's this: in  
 24 December 2015, Edward Daffarn made a complaint relating  
 25 to the refurbishment works. It was heard at stage 1 by

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1 Peter Maddison and not upheld. Mr Daffarn escalated his  
 2 complaint to stage 2, where it was considered by  
 3 Mr Maddison's line manager, Sacha Jevans, the director  
 4 of operations. She concluded that the handling of the  
 5 matters Mr Daffarn was complaining about had been  
 6 appropriate and did not uphold the complaint.  
 7 Mr Daffarn escalated his complaint to stage 3 and it was  
 8 heard by a stage 3 panel in February 2016. There was  
 9 a unanimous decision not to uphold it.

10 As was his right, Mr Daffarn took his complaint to  
 11 the independent Housing Ombudsman, and the Ombudsman  
 12 also concluded that there had been no maladministration  
 13 and no service failure .

14 Sir, you have the Ombudsman's report, and it's  
 15 a long document, but in summary, the conclusion was that  
 16 the TMO had acted reasonably, rearranging commencement  
 17 dates for works, and there had been no  
 18 maladministration.

19 Sir, turning now to the consideration of complaints  
 20 that didn't go through the complaints procedure.

21 There was, as I've said earlier, an existing  
 22 Residents' Association for Grenfell Tower and the  
 23 Lancaster West Estate which had been established in  
 24 2015. Some residents were unhappy about the way in  
 25 which it operated and wished to start a separate

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1 organisation and, as a result, the residents' compact  
 2 came into existence in 2015.

3 At a residents' compact meeting in June 2015, it was  
 4 suggested by members that the TMO — and again, sir,  
 5 this is a quote — had harassed, lied and intimidated  
 6 residents over the duration of the works. At the  
 7 meeting, the TMO gave a commitment that any specific  
 8 allegations would be investigated in accordance with the  
 9 complaints procedure and appropriate action taken to  
 10 resolve the matter.

11 A petition signed by 51 residents was presented to  
 12 the joint TMO/RBKC meeting on 2 December 2015 asking  
 13 the Chairman of the housing and property  
 14 scrutiny committee to undertake — and again we quote,  
 15 sir :

16 "... urgent scrutiny of the TMO and Rydon's  
 17 management of the refurbishment project currently  
 18 underway at [Grenfell Tower] ... our day-to-day concerns  
 19 are belittled and side-lined. While we recognise that,  
 20 once completed, the Tower will at long last be fit for  
 21 the 21st Century, during this process we have had to  
 22 endure living conditions that at times have been  
 23 intolerable ... "

24 Sir, of course, we accepted at the beginning of the  
 25 submissions that the conditions for the residents must

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1 have been extremely difficult and nobody is doubting  
 2 that.  
 3 Following receipt of the petition, the TMO undertook  
 4 a door-knocking exercise and spoke to 77 of the 120  
 5 households in Grenfell Tower. By contrast to the  
 6 petition, the door-knocking exercise disclosed a high  
 7 level of satisfaction concerning the refurbishment and  
 8 no resident raised any issues relating to bullying or  
 9 harassment.

10 Mr Daffarn made a speech to the housing and property  
 11 scrutiny committee on 6 January 2016 when he raised  
 12 similar concerns to those in the petition, and in the  
 13 light of this the TMO convened a formal inquiry and  
 14 review to examine the Grenfell project overall while the  
 15 works were still occurring. The panel chosen to conduct  
 16 the inquiry was chosen to be representative and  
 17 unbiased, and included a number of resident board  
 18 members. The review had wide terms of reference and  
 19 examined issues such as resident consultation and  
 20 engagement; the position of the HIU in the hallways;  
 21 allegations of threats, lies and intimidation; response  
 22 to complaints; quality of work; site management; and  
 23 compensation. There were presentations and a tour of  
 24 Grenfell Tower.

25 The group recognised that there were significant

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1 challenges with the project and acknowledged that  
 2 residents would have experienced inconvenience due to  
 3 the nature of the construction. However, it concluded  
 4 that there had been comprehensive consultation with  
 5 residents, including over HIUs, and the TMO had  
 6 responded adequately to complaints, and it concluded  
 7 that controls were sufficient to manage a construction  
 8 project of this size and nature.

9 But it's right to say, sir -- and they're set out in  
 10 detail -- the group did make certain recommendations  
 11 regarding the need for changes for future projects,  
 12 an example being the recording of names of residents who  
 13 attended consultation meetings.

14 Sir, dealing lastly with one other matter in  
 15 relation to complaints, and then, if I may, I will ask  
 16 for a break, because I think it follows naturally  
 17 according to where we are. These are complaints which  
 18 were made by and on behalf of the Grenfell Tower  
 19 Leaseholders' Association, which we abbreviate to GTLA.

20 An example of a complaint raised by the GTLA is from  
 21 Mr Tunde Awoderu, who in April 2017 sent an email to TMO  
 22 and RBKC requesting an independent expert investigate  
 23 the gas works at Grenfell Tower. The background to this  
 24 is the tower's gas supply was historically introduced by  
 25 four risers, one of which ruptured and had to be

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1 replaced. This was done by the statutory gas utility  
 2 company tRiIO pursuant to its statutory powers. While  
 3 consulted, neither TMO nor RBKC had final say over how,  
 4 when and where the work was done, and residents, as,  
 5 sir, you will hear, became understandably concerned  
 6 about the work, particularly that a new gas pipe was  
 7 left exposed in the stairway.

8 In response to the complaint, the TMO instructed  
 9 Carl Stokes to visit the tower and inspect the newly  
 10 installed gas riser and laterals. He visited the tower  
 11 in January 2017 and published a report which was  
 12 provided to tRiIO with eight recommendations relating to  
 13 firestopping and gas safety. TRIIO in turn provided an  
 14 assurance to the TMO that the newly installed lateral  
 15 pipework would be boxed in for ventilation purposes and  
 16 holes sealed where they were not needed for ventilation.  
 17 Sir, this was work which was ongoing at the time of the  
 18 fire, and we have no doubt that the Inquiry will look at  
 19 this issue extremely carefully.

20 Sir, the Inquiry will also be hearing from the  
 21 resident David Collins, and it's accepted and recognised  
 22 that Mr Collins also raised a number of concerns and  
 23 complaints with TMO at different times during the  
 24 refurbishment on behalf of himself and other residents.

25 Mr Collins stated after the fire, ie in his

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1 statement, that:

2 "... a lack of engagement [and again, we quote, so  
 3 hopefully accurately] with the TMO and their agents  
 4 meant that residents never learnt in detail about the  
 5 cladding materials or other aspects of the project which  
 6 were a risk to resident safety and wellbeing."

7 He predicted -- I said this before -- a "bad  
 8 outcome" for the TMO if resident engagement was not more  
 9 effective and monitored externally.

10 Sir, the TMO accepts the Inquiry will give careful  
 11 consideration to the complaints made by Mr Collins and  
 12 will examine whether they were dealt with appropriately,  
 13 but we would say this: in relation to any complaint  
 14 raised by him regarding consultation over the cladding,  
 15 the residents were consulted about the cladding, albeit  
 16 not about its fire retardant properties, as it was  
 17 legitimately assumed by the TMO that its professional  
 18 advisers had given proper consideration to compliance  
 19 with safety standards.

20 Following the works, residents were spoken to  
 21 directly to ascertain what defects remained outstanding  
 22 by Rydon's RLO and by Claire Williams. The defects in  
 23 the main said to be outstanding, windows and kitchen  
 24 fans, are closely consistent with the defects list  
 25 compiled by Rydon and, sir, you know that the defects

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1 period expired on 4 July 2017, ie after the fire .  
 2 Sir , of course it 's a matter for the Inquiry , and we  
 3 acknowledge the strength of the evidence from the BSRs,  
 4 but the TMO submits that, in overall terms, complaints  
 5 and concerns were dealt with and responded to in  
 6 an appropriate and generally timely manner. In addition  
 7 to the complaints process, there was scrutiny by a panel  
 8 of board members and oversight by RBKC. The fact that  
 9 some complaints which were formally escalated up were  
 10 eventually upheld illustrates the point that this was  
 11 a process and a system in place which was transparent  
 12 and effective to a degree at least .

13 Sir , I 'm moving on now to the topics in 2 and 3, and  
 14 I 'm conscious of having been going for about half  
 15 an hour, so if this would be suitable for you and the  
 16 panel members to have a break, it would be suitable for  
 17 me.

18 SIR MARTIN MOORE—BICK: Yes. Good, thank you very much.  
 19 Well, you have a little bit further to go, anyway,  
 20 haven't you?

21 MR AGEROS: I have a bit further. Could I just say for all  
 22 those who are listening , I would anticipate the  
 23 remainder of my oral submissions would be about half  
 24 an hour.

25 SIR MARTIN MOORE—BICK: Yes. Well, I think it probably

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1 would be convenient to have a break at this point. If  
 2 we came back at 3.35, that would still mean we'd finish  
 3 roughly within the time.  
 4 MR AGEROS: Thank you very much, sir.  
 5 SIR MARTIN MOORE—BICK: Thank you very much. We will break  
 6 now and resume at 3.35, please.

7 MR AGEROS: Thank you.

8 SIR MARTIN MOORE—BICK: Thank you.  
 9 (3.18 pm)

10 (A short break)

11 (3.35 pm)  
 12 SIR MARTIN MOORE—BICK: Welcome back, everyone. I'm going  
 13 to invite Mr Ageros to continue his opening statement.

14 MR AGEROS: Thank you very much, sir.

15 Dealing now with topics 2 and 3. Topic 2 will  
 16 consider the TMO and RBKC's obligations under the  
 17 Regulatory Reform (Fire Safety) Order 2005 and their  
 18 compliance with those obligations. Topic 3 will  
 19 consider the active and passive fire safety measures  
 20 inside Grenfell Tower and the management and maintenance  
 21 of the building.

22 As it 's likely that the Inquiry will invite  
 23 witnesses giving evidence in topics 2 and 3 to address  
 24 propositions and opinions expressed by Dr Lane in her  
 25 recent reports , for the purposes of this opening, the

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1 TMO will focus on some of her key findings, as well as  
 2 giving due regard to the reports prepared by other  
 3 experts commissioned by the Inquiry, such as Colin Todd  
 4 and Roger Howkins.

5 We make the following general observations about  
 6 Dr Lane's Phase 2 report. It 's only recently been  
 7 served and it 's long, dense and complex. Dr Lane, along  
 8 with numerous assistants, has carried out a full  
 9 forensic audit of the TMO's fire risk assessments and  
 10 action plans, measuring its performance against  
 11 legislation , statutory instruments and sector guidance.  
 12 Her report has been produced with the benefit of  
 13 extensive time, resources and, importantly, with the  
 14 full benefit of hindsight.

15 Separately, her report has been served piecemeal  
 16 within the last month without its conclusion chapter,  
 17 leaving the TMO with, we respectfully submit, limited  
 18 time to address it fully in this opening statement.  
 19 Sir, this has been compounded by the fact that the TMO  
 20 is no longer an active organisation, and therefore, to  
 21 the extent necessary, the TMO may address further issues  
 22 in its closing statement for Modules 1, 2 and 3.

23 Sir, when the Inquiry examines what TMO employees  
 24 did and did not do in relation to Module 3 topics, it  
 25 should bear in mind that when devising its

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1 fire strategy, no individual at TMO, nor apparently any  
 2 of its professional advisers, had an inkling the tower  
 3 would ever be engulfed entirely in flames from the  
 4 outside, which then rapidly infiltrated back into each  
 5 flat , and finally , as you have observed, sir, completely  
 6 overwhelming the active and passive fire measures,  
 7 whatever their state of repair .

8 Rather, when devising and maintaining the active and  
 9 passive fire measures, TMO's expectation was that, at  
 10 worst, there would be a fire in one flat , which would  
 11 cause the occupant of that flat to leave, but that all  
 12 other residents would be protected in their own flats by  
 13 compartmentation, without the need for simultaneous  
 14 building-wide evacuation.

15 It is submitted the Inquiry should assess the TMO  
 16 and its employees' actions in the light of what was  
 17 reasonably foreseeable to them at the time and not with  
 18 the bright illumination of hindsight.

19 Sir, next, the TMO also considers that Dr Lane is  
 20 sometimes over-harsh in her criticisms of Janice Wray in  
 21 particular . This may be because she's not always  
 22 accurately described Janice Wray's role at the TMO, and  
 23 sometimes appears to fundamentally misunderstand it.

24 Janice Wray was employed as the health and safety  
 25 facilities manager, which was an occupational health and

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1 safety role. Her remit was not just Grenfell Tower, but  
2 the whole of the property portfolio managed by TMO,  
3 which included 19 tower blocks and over 10,000  
4 properties.

5 One of the things said by Dr Lane is Janice Wray had  
6 unique responsibility for ensuring active and passive  
7 fire measures were properly maintained at the tower,  
8 when in fact a large part of this fell to the contracts  
9 management team. Sir, in this regard — and, of course,  
10 it's a matter for you — we note the Inquiry is not  
11 proposing to hear live evidence from an individual from  
12 within the contracts management team, and we  
13 respectfully invite you to consider doing so.

14 The TMO submits that Janice Wray was a hard-working  
15 and dedicated health and safety professional who acted  
16 in an organised and efficient manner, always seeking to  
17 gain full visibility of the health, safety and fire  
18 issues occurring within the TMO, and then to address  
19 them expeditiously with the resources available to her  
20 and her team.

21 Further, she was not and never purported to be  
22 a specialist in fire safety or herself a fire risk  
23 assessor, and while of course she was involved in  
24 producing the fire safety strategy, this was in  
25 consultation with other professionals. When it came to

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1 the production of the fire risk assessments, it was  
2 necessary for her and the TMO to engage and rely on  
3 professional fire risk assessors, such as  
4 Salvus Consulting Limited and Carl Stokes Associates  
5 Limited.

6 Dr Lane also makes numerous criticisms of  
7 Carl Stokes, and it's for the Inquiry to decide whether  
8 these are justified or not, but the TMO observes that  
9 many of her criticisms run contrary to the views of  
10 Colin Todd, who is an expert in fire risk assessment,  
11 which Dr Lane, although eminent, is not. Indeed,  
12 Mr Todd says of Carl Stokes:

13 " ... were Mr Stokes to apply for registration by the  
14 IFE on their Register of Fire Risk Assessors, I would  
15 have no hesitation, on the basis of his training,  
16 experience and examination of his FRAs, in recommending  
17 him ..."

18 Sir, further, we submit that when criticising the  
19 TMO, Dr Lane does not always give proper account to the  
20 practical realities for those managing social housing  
21 within budgetary constraints in the public sector. This  
22 is not of course to say that any decision taken by the  
23 TMO put cost before safety, but that TMO never had the  
24 means to develop its fire safety strategy in all of the  
25 ways Dr Lane suggests.

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1 Indeed, sir — again, it's a matter for you — we  
2 consider it's unfortunate that the Inquiry's main expert  
3 does not obtain any evidence of the practice of  
4 comparable social housing managers when making  
5 judgements about the TMO. If the Inquiry is to make  
6 significant findings about the TMO's performance, we  
7 submit this should be in the light of what other social  
8 housing managers did to develop a fire safety strategy.

9 Turning now to the TMO's system for fire risk  
10 management and the suitability and competence of  
11 Carl Stokes.

12 The TMO accepts it was the responsible person for  
13 the purposes of Article 3 of the Regulatory Reform (Fire  
14 Safety) Order 2005, and had responsibility for  
15 identifying the general fire precautions for premises  
16 under its control. There may well have been other  
17 persons who could also fulfil the role of responsible  
18 person, but the TMO accepts its own primary  
19 responsibility.

20 It is submitted the TMO had a fire safety strategy  
21 and policy which was appropriate to its nature and size.  
22 This policy and safety strategy had been developed in  
23 consultation with LFB and RBKC, at least to an extent.  
24 Indeed, Dr Lane herself considers that the arrangements  
25 set out in the fire safety strategy were compliant with

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1 Article 9 of the RRO, if implemented, including the  
2 provisions for review. The backbone of the strategy was  
3 to have fire risk assessments produced by a competent  
4 fire risk assessor, a plan for raising actions  
5 identified and a tracker to monitor the closing out of  
6 such actions.

7 Looking at some other ways in which the TMO managed  
8 fire risks, its systems, including the fire risk  
9 assessments, were points of discussion in health and  
10 safety committee meetings, they were a standing item in  
11 its annual health and safety reports and were a point of  
12 discussion at the meetings between LFB and the TMO.  
13 They were also subject of scrutiny at the RBKC  
14 scrutiny committee.

15 The fire safety strategy was reviewed on a regular  
16 basis, including following significant events, such as  
17 the introduction of W2, the Adair and Grenfell Tower  
18 notices of deficiencies and concerns raised by RBKC, and  
19 the TMO made appropriate changes when problems were  
20 identified.

21 Dealing now with the question of Carl Stokes'  
22 competence to carry out FRAs on behalf of TMO and the  
23 way in which he did them.

24 In general terms, the TMO considered him to be  
25 a competent fire risk assessor and fire consultant, and

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1 there is strong evidence to confirm this was the case.  
 2 For example, Colin Todd says of his FRAs:  
 3 "The level of detail is, in my experience, well in  
 4 excess of that normally included in ... FRAs ... The  
 5 documented FRAs are amongst the most detailed of the  
 6 many thousands of FRAs I have studied; in my opinion,  
 7 the level of detail goes well beyond that necessary for  
 8 the FRA to be regarded as suitable and sufficient."

9 So while the TMO accepts that there are some  
 10 anomalies and possibly some redundancies in his fire  
 11 risk assessment, overall it's submitted the TMO was and  
 12 was entitled to conclude that he was competent and  
 13 producing suitable and sufficient risk assessments, and  
 14 there was never a point reached where it should have  
 15 concluded that he was not competent and dispensed with  
 16 his services.

17 Can I deal briefly with how he came first to be  
 18 TMO's fire risk assessor for Grenfell Tower. Sir, as  
 19 you know, the Fire Safety Order 2005 heralded a change  
 20 of approach towards fire safety, wherein the previous  
 21 regime was replaced with a system mandating a risk-based  
 22 approach to fire safety by the responsible person.

23 In late 2008/early 2009, the TMO, RBKC and LFEPA  
 24 entered into discussions about the suitability and  
 25 sufficiency of the TMO's FRA programme, which resulted

1 in a joint decision to procure specialist consultants to  
 2 undertake FRAs across the TMO stock. The contract was  
 3 put out to competitive tender and four tenderers  
 4 submitted bids to the TMO. The company  
 5 Salvus Consulting Limited was successful and was  
 6 appointed to carry out the high-risk premises assessment  
 7 programme. Salvus was introduced to the LFB, who  
 8 approved its approach. Further, LFB accompanied Salvus'  
 9 assessors on FRA visits to monitor their performance and  
 10 ensure that agreed standards were consistently being  
 11 applied.

12 The TMO put the contract for medium and low-risk  
 13 properties out to tender, and Salvus and a number of  
 14 other companies applied, with all interviews conducted  
 15 jointly with RBKC, who had requested to be involved in  
 16 the process.

17 The TMO interviewed around six organisations and, in  
 18 August 2010, Carl Stokes and Associates was appointed by  
 19 the TMO and RBKC. Sir, as you know, Carl Stokes had  
 20 previously worked for Salvus and had done the initial  
 21 risk assessment for Grenfell Tower.

22 In terms of experience, Carl Stokes had been  
 23 employed in the fire and rescue services for 23 years  
 24 before carrying out his first fire risk assessment for  
 25 the TMO, and had engaged in substantial academic and

1 practical training beyond his operational firefighting  
 2 role.

3 Overall, Colin Todd considers that Carl Stokes' work  
 4 experience, academic and practical training and  
 5 experience as a fire risk assessor was more than  
 6 adequate to equip him for the role of fire risk assessor  
 7 for Grenfell Tower. In reaching this conclusion, he  
 8 notes that Carl Stokes had undertaken audits of the  
 9 common parts of high-rise residential tower blocks and  
 10 been part of a working group that drafted very well  
 11 known and established guidance on fire safety in certain  
 12 types of housing.

13 Sir, while, of course, the TMO accepts that, as  
 14 responsible person under the RRO, it ought to have kept  
 15 Carl Stokes' FRAs and ad hoc advice under review, the  
 16 TMO submits that it's unreasonable to think that it  
 17 should have continually second-guessed his approach in  
 18 the way that Dr Lane has suggested. First, for  
 19 a non-specialist organisation such as the TMO to  
 20 disregard specialist advice is a dangerous course for  
 21 which it might rightly be criticised. Second, while  
 22 there may have been times when it was right to question  
 23 his approach, such as, for example, when LFEPA expressed  
 24 their concerns in January 2016, it is submitted that TMO  
 25 did follow up on these concerns and took steps to

1 satisfy itself that he was producing suitable and  
 2 sufficient risk assessments.

3 The TMO is aware that the Inquiry will examine its  
 4 response to the queries raised by LFEPA in April 2017 in  
 5 connection with the fire performance of the cladding and  
 6 what Dr Lane describes as its shallow response, which  
 7 she characterises as a quick email exchange absent of  
 8 technical fact.

9 The TMO submits that Dr Lane's view places  
 10 unrealistic expectations on it. She appears to be  
 11 saying that the TMO, uniquely among the 2,000 clients  
 12 whose buildings were clad in unsuitable materials,  
 13 should have itself been able to unpick the systemic  
 14 misconceptions and misrepresentations concerning the  
 15 suitability of this type of cladding and insulation.

16 Sir, in fact, Carl Stokes did investigate the fire  
 17 performance of the cladding. He states that he noted on  
 18 the previous risk assessment -- again, I quote --  
 19 "Cladding external Non-Combustible Metal Fixings  
 20 signed off by B/C", ie building control, and he says  
 21 that he understood that the system and component parts  
 22 would have been compliant with the requirements of the  
 23 Building Regulations and ADB.

24 Thus when Dr Lane says in her phase 3(sic),  
 25 chapter 10 report that LFEPA concerns regarding cladding

1 should have been addressed within the FRA process, it's  
 2 submitted this was done at least to an extent, although,  
 3 sir, we note that there is a significant debate within  
 4 professional circles, or certainly was a significant  
 5 debate within professional circles, about whether the  
 6 external wall of a building should indeed form part of  
 7 a fire risk assessment at all.

8 Sir, now turning to the system the TMO had for  
 9 dealing with actions identified by its fire risk  
 10 assessments and notices of deficiency.

11 After an FRA, action points identified were  
 12 initially put on to the W2 system by Janice Wray or  
 13 Cyril Morris. Janice Wray was then able to assign FRA  
 14 actions to departments and individuals within  
 15 departments for completion. Staff assigned actions  
 16 would be expected to update the entry on the W2  
 17 platform, but only Janice Wray could mark the actions  
 18 complete or partially complete.

19 Sir, we understand that if, when actions were  
 20 identified and targets set for closing them out, those  
 21 targets were sometimes missed, it will be a matter of  
 22 concern to the Inquiry, but would submit this: it is  
 23 partly a function of the number of historical actions  
 24 that existed and of the limitation on resources. Of  
 25 course, the TMO's aim was always to close out actions in

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1 time, but the failure to have done so should not be  
 2 taken to imply or connote a lack of urgency or disregard  
 3 for safety by the TMO and its staff.

4 Sir, we accept that the picture surrounding the  
 5 closing out of actions is statistically complex, and  
 6 it's accepted that the rate at which they were closed  
 7 out varied quite substantially between 2013 and 2017.  
 8 However, to give an overall picture, from December 2013  
 9 to June 2017, the total number of actions that had been  
 10 assigned was, according to Dr Lane, 3,300, and the total  
 11 number completed was 2,993.

12 The TMO's programming for closing out action was  
 13 scrutinised at senior levels. For example, the number  
 14 of actions outstanding was regularly reported to the  
 15 health and safety committee and, in 2016, this resulted  
 16 in Robert Black pressing for actions older than  
 17 six months to be completed urgently.

18 At the health and safety meeting on 19 January 2017,  
 19 Barbara Matthews also raised a concern over the large  
 20 number of actions which had been outstanding for over  
 21 12 months, emphasising the need to clear them urgently.  
 22 In fact, she requested that each team with outstanding  
 23 actions prepare a written report setting out the detail  
 24 of each action assigned, the steps taken and when the  
 25 action would be fully completed, and, sir, the minutes

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1 of the health and safety committee meeting on 16 March  
 2 show that this was done.

3 Focusing now on the most recent fire risk  
 4 assessments for Grenfell Tower by Carl Stokes, and the  
 5 extent to which actions identified there were closed out  
 6 before the fire.

7 The action plan for the June 2016 FRA indicated that  
 8 there were 47 items requiring action, and by  
 9 19 October 2016, just before inspection by the LFB, only  
 10 22 actions were outstanding.

11 The TMO acknowledges that Dr Lane says that some  
 12 items were wrongly closed out, and of course the Inquiry  
 13 will have to assess whether this was correct and, if so,  
 14 what were its effects.

15 Dr Lane states that, by the night of the fire, of  
 16 the seven items that remained open on the tracker, five  
 17 were marked as not fully completed and two completed.

18 While of course it will be a matter for the Inquiry,  
 19 of the five items not closed out, it is submitted that  
 20 none was relevant to the causes of the fire and only one  
 21 was potentially relevant to the question of mitigation  
 22 of the fire once it had started.

23 Sir, now dealing with notices of deficiency,  
 24 following the LFB visit in October 2016, the LFEPA  
 25 issued a notice of deficiency for Grenfell Tower. The

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1 NOD listed actions which, according to the notice,  
 2 should be taken by 18 May 2017 and related to seven  
 3 issues, which Dr Lane summarises in five issues. All of  
 4 the issues were identified as minor deficiencies by the  
 5 LFEPA.

6 While it is correct that, by the time of the fire,  
 7 the TMO had not resolved all of the issues, all had been  
 8 given substantial attention. Sir, one of the issues  
 9 raised by LFEPA was in relation to self-closers on flat  
 10 entrance doors, and the TMO fully accepts that  
 11 the Inquiry will subject this particular issue to great  
 12 scrutiny.

13 In overall terms, the TMO acknowledges that, while  
 14 there was undoubtedly a problem with door-closers, it  
 15 did have visibility of the problem and a programme was  
 16 under way to retrofit them across the RBKC estate.

17 Sir, the following history is relevant to that  
 18 consideration: in March 2011, TMO entered into  
 19 a contract with Manse Masterdor for the renewal of flat  
 20 entrance doors across its estate, including  
 21 Grenfell Tower. Between 2011 and 2013, Manse Masterdor  
 22 replaced 106 flat entrance doors to tenanted flats at  
 23 Grenfell Tower. It was a condition of the contract that  
 24 the replacement doors would be FD30S, that is capable of  
 25 resisting fire under test conditions for a minimum of

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1 30 minutes and limiting the leakage of smoke to  
 2 a prescribed extent.  
 3 Carl Stokes himself was involved in a programme to  
 4 fit new doors, and he later confirmed to the TMO that,  
 5 so far as he was concerned, the new fire doors met the  
 6 requirements of the Building Regulations in terms of  
 7 fire protection.  
 8 Sir, the TMO notes the evidence suggesting that,  
 9 almost immediately after the doors were installed, it  
 10 was observed that some self-closing devices were  
 11 insecure. There is evidence, in fact, that the problem  
 12 was brought to the attention of Manse Masterdor, who  
 13 returned to remediate the problem, although it is noted  
 14 that there does not appear to be any clear evidence to  
 15 say what steps Manse Masterdor took and how many  
 16 door-closers were inoperative. Again, sir, we accept  
 17 that the Inquiry will look at this particular issue  
 18 closely.  
 19 Sir, there is also the evidence of Seamus Dunlea,  
 20 who was an ESA, an estate services assistant who is now  
 21 sadly deceased, the evidence being to the effect that he  
 22 disconnected a number of door-closers at residents'  
 23 request. Sir, this is plainly concerning, but it's  
 24 noted the issue was raised in correspondence between  
 25 Janice Wray and Siobhan Rumble, both of whom you will

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1 hear from in topic 2 of Module 3, and it's understood  
 2 that Seamus Dunlea was told to desist.  
 3 Sir, when in late 2015 the TMO received a notice in  
 4 respect of Adair Tower, which included recommendations  
 5 in relation to fire doors, it sought to introduce  
 6 a borough-wide replacement programme. It also responded  
 7 to the matters concerning flat doors in the notice of  
 8 deficiency issued for Grenfell in November 2016.  
 9 The TMO did not have money in its existing budget to  
 10 replace the fire doors and it was necessary to revert  
 11 therefore to RBKC for additional funding. While it's  
 12 absolutely right that RBKC agreed to funding, it's said  
 13 that the period within which the door-closers would be  
 14 retrofitted would be five years, not the three years the  
 15 TMO wanted.  
 16 The TMO also applied for funding to instigate  
 17 a programme of periodic inspection and repair after the  
 18 replacement programme, but this was not agreed to by  
 19 RBKC.  
 20 Sir, tests conducted after the fire showed there  
 21 were serious discrepancies between the fire performance  
 22 of the doors and the evidence submitted to the testing  
 23 body. In the simplest terms, they didn't have the  
 24 30 minutes' fire resistance represented by  
 25 Manse Masterdor, and, sir, it's difficult to overstate

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1 the seriousness of this misrepresentation.  
 2 With this in mind, the TMO queries the Inquiry's  
 3 recent decision not to hear oral evidence from witnesses  
 4 from Manse Masterdor. The TMO would submit there is  
 5 a strong argument for saying that these witnesses should  
 6 be called to explain the situation and their conduct,  
 7 just as witnesses from Celotex, Arconic and Kingspan  
 8 were asked to explain their own products, particularly,  
 9 sir, as after the fire evidence has emerged of more  
 10 widespread failures in the performance of fire doors,  
 11 which led the then Communities Secretary,  
 12 James Brokenshire, to conclude that there is evidence of  
 13 a broader issue across the fire door market.  
 14 Sir, turning now to the provisions the TMO made for  
 15 dealing with vulnerable residents.  
 16 The TMO fully accepts it was necessary to make  
 17 provisions for the protection of vulnerable persons in  
 18 a fire scenario through its fire risk management system.  
 19 It notes the criticisms made in the opening statements  
 20 by the BSRs and accepts that the Inquiry will subject  
 21 the arrangements it did make and the basis on which they  
 22 were made to great scrutiny in this module.  
 23 The TMO invites the Inquiry to consider the  
 24 provisions it did make for vulnerable residents against  
 25 the background of the stay-put policy and its adherence

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1 to the LGA guide. These affected and largely determined  
 2 its policy, including its approach towards personal  
 3 emergency evacuation plans, or PEEPs.  
 4 In her report, Dr Lane assesses and compares the  
 5 wider guidance documents regarding vulnerable persons  
 6 and fire risk, opining that the TMO and/or Carl Stokes  
 7 should, as a minimum, have been required to consider the  
 8 body of guidance, as she puts it, available and not  
 9 focus on the LGA guide. She recognises that the  
 10 LGA guide provides substantially different advice to  
 11 other guidance and, by applying it, a duty holder would  
 12 take a different approach towards safeguarding of  
 13 vulnerable persons.  
 14 The Inquiry will note that the guidance was produced  
 15 by the LGA or at least developed by the LGA following  
 16 the fire at Lakanal House in July 2009, and published  
 17 after wide consultation, including with DCLG and the  
 18 Chief Fire Officers Association. The LGA guide was  
 19 substantially written, indeed, by the Inquiry's own  
 20 expert, Colin Todd.  
 21 Apropos of its adherence to the guide, the TMO was  
 22 a statutory body whose lawful obligation would be to  
 23 follow guidance produced by DCLG and LGA. Sir, further,  
 24 the LGA guidance postdates all of the other guidance  
 25 that Dr Lane refers to having been produced in 2011.

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1 You heard these quotes, I believe, from  
 2 Mr Maxwell—Scott just before my oral submissions, sir,  
 3 but can I repeat them here. The LGA guide states that  
 4 while there may be vulnerable persons in blocks of  
 5 flats :  
 6 "It is usually unrealistic to expect landlords and  
 7 other responsible persons to plan for this or to have in  
 8 place special arrangements, such as [PEEPs]. Such plans  
 9 rely on the presence of staff or others available to  
 10 assist the person to escape in a fire ."  
 11 Paragraph 19 of the guide says the alternative to  
 12 a stay—put strategy is one that involves simultaneous  
 13 evacuation, and notes that this requires a means of  
 14 alerting residents of the need to leave the building.  
 15 It observes that purpose—built blocks of flats such as  
 16 Grenfell Tower are not normally provided with general  
 17 fire detection and alarm systems, because experience has  
 18 shown that most residents do not need to leave their  
 19 flats when there is a fire elsewhere in the building.  
 20 Indeed, it says, in some circumstances they may place  
 21 themselves at greater risk if they were to do so.  
 22 The guide also suggests that the risk inherent in  
 23 the absence of a fire detection alarm system in  
 24 high—rise blocks is acceptable because it's very rare  
 25 for there to be an extensive failure of

1 compartmentation, and this is consistent with the  
 2 absence in Approved Document B of the requirements for  
 3 high—rise residential buildings to be fitted with  
 4 a means of communicating with all occupants  
 5 simultaneously in order to facilitate a total  
 6 evacuation.  
 7 Indeed, the stay—put policy had been in place for  
 8 many years at Grenfell Tower and was extensively  
 9 communicated to the residents of the tower. It was  
 10 well known to LFB and LFEPA and it was never suggested  
 11 by either that the TMO should implement a full  
 12 evacuation policy either in place or in addition to  
 13 a stay—put policy. The stay—put policy remains to date  
 14 one approved for similar high—rise blocks by the  
 15 National Fire Chiefs Council.  
 16 Sir, in her report, Dr Lane sets out three scenarios  
 17 in which vulnerable residents may be affected where  
 18 a fire occurs in a block with a stay—put strategy.  
 19 These are where the fire occurs in a resident's flat ,  
 20 where it occurs in a neighbouring flat or where the fire  
 21 has spread to the common parts. She says that the  
 22 duty holder should make provision for three  
 23 corresponding scenarios: the occupants of the flat of  
 24 fire origin make their escape, occupants in any adjacent  
 25 flats make their escape, and all other occupants in the

1 building leave should a simultaneous evacuation strategy  
 2 become necessary.  
 3 Sir, the TMO accepts that you will no doubt assess  
 4 whether, in the light of the stay—put policy  
 5 and adherence to the LGA guide, the TMO should have  
 6 prepared for all of these scenarios, but it's  
 7 respectfully submitted that when making provisions for  
 8 vulnerable residents, the TMO was entitled, if indeed  
 9 not bound, to work on the basis that compartmentation  
 10 would not fail and all residents would stay put save for  
 11 those in the flat of fire origin .  
 12 Sir, may I deal now lastly with lifts and, in  
 13 particular, the inability of LFB to take control of the  
 14 lifts .  
 15 Sir, in your Phase 1 report you said:  
 16 "When the firefighters attended the fire at  
 17 Grenfell Tower, they were unable to operate the  
 18 mechanism which should have allowed them to take control  
 19 of the lifts . Why that was so is not yet known, but it  
 20 meant that they were unable to make use of the lifts in  
 21 carrying out firefighting and search and rescue  
 22 operations. It also meant that occupants of the tower  
 23 were able to make use of the lifts in trying to escape,  
 24 in some cases with fatal consequences. The ability of  
 25 fire and rescue services take control of firefighting or

1 fire lifts in a high—rise building is often key to  
 2 successful operations."  
 3 Sir, may we echo your intention to examine this  
 4 serious issue with the greatest intensity .  
 5 Sir, following the Phase 1 report, you, the Inquiry,  
 6 obtained evidence from various parties associated with  
 7 the replacement of the lifts at Grenfell Tower in 2002  
 8 to 2005 and the maintenance of them following the  
 9 refurbishment, including the maintenance of the fire  
 10 control switch.  
 11 As the Inquiry is aware, between 2003 and 2006, the  
 12 lifts at Grenfell Tower were replaced by Apex Lift and  
 13 Escalator Engineers Limited pursuant to a specification  
 14 by Butler & Young Consultants Limited. Butler & Young  
 15 did not specify that the replacement lifts should be  
 16 firefighting lifts, something the Inquiry's lift expert,  
 17 Roger Howkins, criticises. In the event, fully  
 18 compliant firefighting lifts were not installed .  
 19 At a later stage, Carl Stokes represented in his  
 20 FRAs that the lifts were firefighting lifts, which was  
 21 not correct. In fact, Janice Wray and Robin Cahalarn  
 22 were both aware that they were not firefighting lifts ,  
 23 despite Carl Stokes' representations, and so they in  
 24 particular were not in fact misled. Janice Wray always  
 25 understood that the lifts would not be used to evacuate

1 residents in the event of a fire as the strategy for  
 2 Grenfell Tower was stay put.  
 3 Turning to the maintenance of the lifts ,  
 4 Roger Howkins states that although there were some  
 5 failures overall , the lifts appear to have been  
 6 maintained to an appropriate standard and were generally  
 7 in compliance with the relevant standards and industry  
 8 practice. He did not think it likely that a maintenance  
 9 failure caused the problems with the fire control  
 10 switch.

11 Following their installation , the lifts at  
 12 Grenfell Tower fell under a maintenance contract  
 13 overseen by a contract manager within the building  
 14 services team. The lift maintenance contractor was  
 15 Apex Lifts Limited, and the contract included monthly  
 16 inspections.

17 Sir , you're going to hear witnesses from PDERS,  
 18 I think Porn Dunwoody, who will say that planned  
 19 maintenance visits were carried out on a monthly basis  
 20 in accordance with the maintenance schedule. The  
 21 witness from PDERS will say that engineers would follow  
 22 a standard checklist when conducting a service. As well  
 23 as ensuring that items listed on the schedule were in  
 24 good working order, the engineers would ensure that the  
 25 fire control switch was in good and proper working order

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1 by inserting the correct key, which at Grenfell Tower  
 2 was an express drop key. He says that they would insert  
 3 the key into the switch, activate the system and check  
 4 the lifts would immediately move to the ground floor  
 5 before opening the doors. They would then check that  
 6 the lift operated in the desired manner, ie it moved to  
 7 the chosen floor before the doors would open when the  
 8 correct buttons were pressed.

9 Sir , we note the criticisms of Dr Lane and,  
 10 of course, the TMO accepts that records of checks would  
 11 have been desirable, of course, and that the checking of  
 12 the fire switch could have been a specific item on the  
 13 ESA's checklist. But, sir , we say that the absence of  
 14 such records is not to be equated with the checks not  
 15 having occurred.

16 Sir , in conclusion, again to repeat what I said at  
 17 the beginning, the TMO acknowledges the immense tragedy  
 18 of the Grenfell Tower fire, and nothing that I have said  
 19 is intended to diminish or detract from that tragedy.

20 Sir , the TMO is not saying that it got everything  
 21 right regarding the refurbishment or that its  
 22 fire strategy and the way that it was applied was not  
 23 capable of criticism , and the TMO is certainly not  
 24 seeking to do this. However, we do urge the Inquiry to  
 25 ensure that the TMO and its staff are judged by

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1 an appropriate standard and not one which was higher  
 2 than was applied elsewhere at the relevant time.

3 Sir , you know that these submissions have been in  
 4 draft in order to set out the general position of the  
 5 TMO in advance of the important evidence that will be  
 6 heard in Module 3 of Phase 2 of this Inquiry. Of  
 7 course, they have been prepared with the statements in  
 8 mind but without hearing that evidence, and anything  
 9 said here is subject to review once that evidence has  
 10 been heard.

11 Finally , sir , may the TMO and all the witnesses to  
 12 give evidence in Module 3 continue to offer their full  
 13 support to the Inquiry in fulfilling its important  
 14 statutory functions.

15 SIR MARTIN MOORE–BICK: Well, thank you very much indeed,  
 16 Mr Ageros. That is extremely helpful.

17 We have three more oral opening statements to hear,  
 18 but they've all been programmed in for tomorrow's  
 19 hearing, and I think it would not be reasonably  
 20 practicable to invite any of those whom we're going to  
 21 hear later to make their statements this afternoon.

22 So we are going to call a halt at that stage. We  
 23 will resume at 10 o'clock tomorrow morning, when, as  
 24 I say, we'll hear some further opening statements.

25 Good, thank you all very much.

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1 MR AGEROS: Thank you, sir.  
 2 (4.11 pm)

3 (The hearing adjourned until 10 am  
 4 on Tuesday, 30 March 2021)

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