Grenfell Tower Inquiry

Day 114

March 29, 2021

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(10.00 am)

SIR MARTIN MOORE-BICK: Good morning, everyone, and welcome to today's hearing, at which I am joined as usual by my fellow panel members, Ms Thouria Istephan and Mr Ali Akbor.

MS ISTEPHAN: Good morning.

MR AKBOR: Good morning, everyone.

SIR MARTIN MOORE-BICK: Today marks another step in the progress of the Inquiry, because we're going to hear opening statements in relation to Module 3.

A number of core participants are going to make oral statements, although a greater number have also provided some written opening statements which will be available to view in due course.

Before we hear them, however, I'm going to invite Counsel to the Inquiry, Mr Richard Millett, to make an opening statement of his own.

Yes, Mr Millett.

Opening statement by COUNSEL TO THE INQUIRY

MR MILLETT: Mr Chairman, thank you, good morning, and good morning, members of the panel.

Today we start Module 3 of Phase 2 of the Inquiry's investigation.

In March 2020, the Inquiry set out the structure of

Module 3. It is to be divided into three distinct but closely-related topics. In summary, topic 1 will consider fire-related complaints; topic 2 will consider the extent to which the Royal Borough of Kensington and Chelsea Council, RBKC, and the Kensington and Chelsea Tenant Management Organisation, the TMO, complied with their respective obligations under the Regulatory Reform (Fire Safety) Order 2005, the RRO; and topic 3 will address active and passive fire safety measures within Grenfell Tower.

Although the ambit of Module 3 is broad, there is a single unifying theme, that is whether and to what extent RBKC and the TMO and others performed the duties they each owed in respect of fire safety.

That unifying theme will be investigated from a number of different perspectives, starting in topic 1 with the evidence of those who lived in the tower. It is, in the Inquiry's view, vital that consideration of fire safety matters affecting the building and those who lived there begins with the evidence of those whose health and safety was, or should have been, the primary aim of the fire safety duties of the relevant duty holders.

We will examine communications between residents and the TMO in which the residents drew attention to defects

in design, choice of materials or quality of workmanship which they said increased the risk of fire, or which the evidence suggests may, in the event, have contributed directly or indirectly to the outbreak or development of the fire. That examination will be conducted through the live evidence of residents and by reading into the record relevant extracts from BSRs' statements and consideration of contemporaneous documents.

The examination will cast light on the nature of the relationship, in particular between RBKC and the TMO on the one hand, and residents of the tower on the other. In particular, the evidence will focus on whether the TMO's response to residents' concerns regarding fire safety before 14 June 2017 was appropriate and effective.

After the residents' evidence, the Inquiry will then hear from those at the TMO who were responsible for, or who were involved in consideration of, complaints concerning fire safety matters, whether operationally, strategically or otherwise, and also from others, such as RBKC councillors and other officers of RBKC who were responsible for scrutinising the TMO's activities and for discharging RBKC's own fire safety related duties.

In that respect, the Inquiry notes and welcomes the various admissions made by RBKC in its opening

statement. In particular, the Inquiry notes RBKC's acknowledgement that the number of its officers devoted to monitoring the TMO was insufficient, given the number of residents whose properties were managed by the TMO, and the scale and importance of the task delegated to the TMO.

RBKC has also made other concessions and admissions in its written opening statement, for which the Inquiry team is grateful. For example, RBKC has recognised that, as part of its arrangements for scrutinising the TMO, it never made fire safety the subject of a key performance indicator. It has also accepted that its audit arrangements consistently failed to identify the absence of key performance indicators governing the TMO's completion of fire risk assessments, outstanding significant actions identified in fire risk assessments, or enforcement of deficiency notices served by the London Fire and Emergency Planning Authority.

On any view, these are significant deficiencies in RBKC's arrangements for monitoring and scrutinising the effectiveness of the TMO's compliance with its fire safety obligations.

The Inquiry also notes that the TMO has made no concessions in its opening statement. Whether that remains its position following the conclusion of the

evidence will remain to be seen.

Whether the concessions by RBKC go far enough will be an important question when the Inquiry turns, in topic 2, to consider the extent to which those bodies performed their respective obligations imposed under the RRO. Inevitably, this aspect of the Inquiry's investigation will be wide-ranging.

We will examine the adequacy of the TMO's management of fire safety and the effectiveness of its arrangements for carrying out fire risk assessments. We will also investigate the competence of Mr Carl Stokes, the TMO's retained fire risk assessor, and the adequacy of his fire risk assessments, and also, in particular, the adequacy of his advice regarding the cladding and the TMO's consideration of that advice.

We will also consider and investigate the acts and omissions of those responsible for implementing, supervising, monitoring and scrutinising the effectiveness of the TMO's fire risk assessment arrangements.

The evidence will focus on three principal questions:

First, whether the TMO maintained an adequate evacuation plan for the tower or identified those residents of the tower who were vulnerable, and if not,

why not. Whether it assessed the risks that those individuals would face in the event of a fire, or take steps to mitigate those risks, and if not, why not. Importantly, whether the TMO ever prepared personal emergency evacuation plans, or PEEPs, for vulnerable residents of the tower. If not, why not?

Secondly, we will focus on whether there was a suitable and sufficient fire risk assessment programme for Grenfell Tower, including the effectiveness of the arrangements for ensuring that significant actions identified in fire risk assessments, or FRAs, were implemented efficiently, effectively and expeditiously.

Thirdly, whether the arrangements for maintaining active and passive fire safety systems were effective, with particular attention to the inspection and maintenance of self-closing devices on flat entrance doors in the tower.

The factual evidence regarding fire risk assessment will be followed, in topic 3, by consideration of the active and passive fire safety measures in the tower, and will do so in the following order: gas, smoke control, repairs and maintenance, fire doors, especially flat entrance doors, and lifts. Experts have been retained to assist the Inquiry's investigation of gas, smoke control and lifts. That expert advice will be

adduced after the factual evidence that is relevant to each of those matters has been heard. So Mr Hancox's evidence will follow that of the two gas witnesses, the evidence of Dr Lane and Ms Menzies on smoke control will follow that of the smoke control witnesses, and Mr Howkins' evidence on lifts will follow that of the factual witnesses about lifts.

Module 3 will conclude with the evidence of Mr Colin Todd and Dr Barbara Lane on fire risk assessment.

There are some housekeeping matters that I should highlight.

First, the Inquiry will not sit on 14 June this year, which will be the fourth anniversary of the fire. We will not sit on that day out of respect for those who died and to allow those who grieve to remember their loved ones, and for all of us to reflect privately on the tragedy.

Secondly, the Inquiry will not sit on the two bank holidays that fall in May.

Thirdly, the Inquiry Secretary has written to core participants setting out the plans for attendance at the Inquiry's venue. As matters currently stand, we will restart limited attendance hearings at the Inquiry's premises at the start of the witness evidence for

Module 3. That will be on Monday, 19 April.

In order to comply with Government restrictions and the risk assessment for the building which has been carried out by the Government Property Agency, attendance will need to be strictly limited at that stage, in exactly the same way as it was before Christmas, to the Panel, Counsel to the Inquiry, the witnesses and their representatives, and a small Inquiry operations and support team.

If Government restrictions then permit, after 17 May we plan to open the Inquiry premises more widely, our first priority being to allow a number of BSRs to attend to watch the proceedings in person. We are giving careful thought to the practicalities of how we can do that, both safely and fairly, and the Inquiry Secretary will write to core participants further about that in due course.

We will have to consider further relaxation of the measures governing attendance at the premises in the light of any on going Government restrictions and guidance in force over the summer. We will of course keep core participants and the wider public informed of our plans.

Fourthly, Jonathan Sakula, the Inquiry's cladding expert, will give evidence on Thursday, 29 April for

one day. Mr Sakula's evidence is relevant to Module 1 and so, to allow core participants to complete the drafting of their written closing statement for Module 1, the Inquiry has decided to call Mr Sakula as soon as his schedule and the Inquiry's timetable allows.

Fifthly and finally, the expert evidence of Dr Lane and Ms Menzies concerning smoke control will be disclosed as soon as possible. The Inquiry will then give directions for the service of written opening statements on the topics of smoke control and, if needed, a half day has been allowed for oral opening statements on that topic. We will keep core participants and the public updated as we go.

Mr Chairman, members of the panel, that concludes my opening statement for Module 3.

SIR MARTIN MOORE-BICK: Thank you very much, Mr Millett.

Well, at that point, I am in a position to invite Ms Stephanie Barwise to make an opening statement on behalf of those bereaved, survivors and residents whom she represents.

Now, Ms Barwise, can you tell me whether you are in contact? Can you see me and can you hear me?

MS BARWISE: Good morning, Mr Chairman, yes, I can.

SIR MARTIN MOORE-BICK: Ah, good morning, good. Well, we are all ready to go if you are.

MS BARWISE: Fantastic, thank you.

SIR MARTIN MOORE-BICK: So take your time and make your statement when you're ready.

Opening statement on behalf of BSRs Team 1 by MS BARWISE

MS BARWISE: Thank you, and good morning, Ms Istephan and Mr Akbor.

You have our written submissions on all three topics within Module 3. I propose to address you on aspects of topics 1 and 2, but will first summarise the module and its themes.

Module 3 is a tale of lessons unlearnt, despite the teachings of successive fires. The failure of the physical and managerial controls at Grenfell which should have mitigated the extent of fire was as predictable as it was preventable. Central to ensuring these controls are adequate are the fire risk assessments required by the Regulatory Reform (Fire Safety) Order 2005, which should have informed RBKC and TMO of the measures required to mitigate fire and to facilitate evacuation.

The principal managerial failures at Grenfell included a failure to identify the occupancy profile, coupled with a lack of any emergency or evacuation plan, still less evacuation plans for the disabled, PEEPs. Weaknesses in the physical controls, such as compromised

compartmentation, including defective fire doors, rendered the stay-put strategy lethal and impacted the means of escape. These failings materially contributed to the extent and severity of the disaster.

The bereaved, survivors and residents from whom the Inquiry will hear are but a few of the many residents who made up a richly diverse community. Their diversity is highly relevant to Module 3 issues, since age, disability and ability to read English are all factors which should have informed both the assessment of the degree of risk and potential harm posed by fire, and accordingly the fire safety measures at Grenfell.

A significant proportion of residents suffered from some form of disability or were vulnerable, which should have been addressed when considering the means of escape and evacuation strategy. Both TMO and its fire risk assessor, Carl Stokes, failed to identify vulnerable residents at Grenfell, despite this being a recognised parameter in fire risk management, as the risk profile of a building is a function of its occupancy and fire growth rate.

There is no evidence that TMO assessed the needs of any vulnerable person in Grenfell in the event of fire. This failure resulted in TMO not recognising the fire precautions required to protect vulnerable residents and

failing to advise LFB of the need to assist the vulnerable.

The lack of appropriate precautions is reflected in the deaths. Dr Lane calculates that a quarter of the 67 child residents present on the night died, and 41% of the 37 vulnerable adult residents died. These groups suffered higher death rates than any other on the night. Yet TMO's spreadsheet, emailed during the fire, showed only ten residents with disabilities out of 225 listed. In this respect, Grenfell shines a light on an aspect of fire safety crying out for reform. Dr Lane considers there is an urgent need for guidance and focus on the fire risk assessments, or FRAs, for the vulnerable in the event of fire.

Three key themes which span across the topics which the Inquiry will wish to explore include, first, RBKC's leadership, culture and purpose insofar as they influenced fire safety, and engagement on that subject with residents; second, RBKC's scrutiny of TMO; and, third, TMO's fire safety management.

Starting with the first theme, RBKC's leadership and its influence on fire safety.

RBKC's prioritisation of cost over fire safety is a contributing factor to the extent of the disaster. Appointing TMO as an arm's length management

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

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

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

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

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

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

control".

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

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

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

The Inquiry will need to determine the question

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

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

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

duties. RBKC also had a scrutiny function under the Localism Act 2011.

The four core principles of good scrutiny proposed by the Centre for Public Scrutiny provide for "critical friend" challenge, enabling the voice and concerns of the public in a process led and owned by independent-minded councillors, which drives improvement in public services.

RBKC's principal vehicle for scrutiny of TMO was the MMA, but it lacked specificity as to the degree of monitoring RBKC was entitled or obliged to carry out. The key mechanism for scrutiny under the MMA was the setting of key performance indicators, or KPIs, but RBKC failed to ensure there were KPIs governing safety, despite fire safety always being a pressing criterion for RBKC, given the vulnerable tenants it housed. This link between vulnerable tenants and fire outcomes is enshrined both in British Standards governing the design and use of buildings and other guidance.

The failure is also surprising, given RBKC mooted accessibility for the disabled as a possible KPI in an internal email in 2009, noting "there are some serious brownie points to be gained in all this, as members understandably feel very strongly about disability and meeting need".

The failure to ensure fire safety KPIs were in place is all the more extraordinary given that, as RBKC knew, TMO was proposing KPIs for fire for its own monitoring purposes from 2015 onwards, albeit they were never in fact implemented. RBKC admits, as Counsel to the Inquiry has said, by its opening submissions that it should have imposed KPIs on TMO for FRAs and work required under them.

There was an appearance of scrutiny, but it lacked substance. RBKC's yearly and half-yearly reviews of TMO's compliance with KPIs were based on reports, the vast majority of which RBKC now admits were written by TMO. This was also true of the health and safety reports which TMO's health and safety adviser, Janice Wray, had prepared, thereby marking her own homework. RBKC candidly admits that this fact was not made clear to those scrutinising and should have been.

RBKC also admits that the number of officers devoted to monitoring TMO was insufficient, given the scale of the task delegated to TMO, and that in certain key respects, RBKC's monitoring of TMO was not carried out in accordance with RBKC's own monitoring procedure guide. RBKC also admits that it failed to convene the six-weekly meeting with TMO's complaints team.

RBKC was aware, at latest from 2010, of its

responsibility to take a hands-on role in fire safety rather than simply relying on paper briefings from its ALMO. RBKC endorsed a note called "Extinguishing the risk, a councillor's guide to fire safety" at a scrutiny meeting in 2010. That guide made clear that a council's responsibility, whether for retained stock or via an ALMO, was the same as any other landlord, namely that the council needed to ensure the fire strategy was being taken seriously and FRAs done competently. The scrutiny committee recorded that the guide reflected the expectations on this council.

The third theme is TMO's fire safety management. The adequacy of this requires close examination.

The responsibility for fire safety across RBKC's entire estate of some 9,400 properties rested on Janice Wray as health and safety manager. Dr Lane considers Wray should have been capable of designing and delivering a fire risk management system, and if not, should have sought assistance.

While Lane finds TMO's policy documents did address some relevant fire safety objectives, they failed to plan how to achieve their policy intent. Critically, TMO failed to identify its intent in relation to occupancy profiling, and although some monitoring was done, there is no evidence that this was done to inform

the FRAs. Furthermore, TMO failed to articulate its intent as to the implementation of general fire precautions and control of construction work. As a result, these activities were haphazard.

These fundamental failures were compounded by TMO's reliance for all aspects of fire safety advice at Grenfell on a single risk assessor, Stokes, who lacked any professional registration and invented some of his professional qualifications.

TMO was overwhelmed by the sheer volume of outstanding FRA actions due to its failure to address how they should be actioned. As a result, it sought to deliberately conceal this from RBKC.

TMO's focus on completion of FRA action items without monitoring the level of risk posed thereby is a critical failing. This problem originated with Stokes, whose FRAs did not state the impact on risk if TMO failed to undertake the actions he identified within the required timescale. In turn, Stokes failed to interrogate TMO's fire safety management or maintenance regime, which meant that his opinion of the consequences of a fire and overall risk level could never be accurate.

Critically, TMO failed to monitor Stokes' activities, despite being aware that a different fire

risk assessor in 2014 had taken a different approach, giving Grenfell a moderate as opposed to tolerable risk pending resolution of his action items. This should have alerted TMO to Stokes' failure to evaluate the risk posed by outstanding FRA items.

Stokes' failings were absolutely plain by the time of the Adair fire in 2015, and Wray received various criticisms of him in 2016 and 2017, yet TMO failed to question the performance of the risk assessor on whom they were very heavily dependent.

As to the first topic, complaints, a functional complaints process is a key element of the four core principles of scrutiny I have already mentioned. Complaints help inform management of true performance. TMO's and RBKC's dismissive attitude towards residents' complaints was symptomatic of their approach to governance which led directly to the devastating failures of controls at Grenfell.

TMO avoided classifying expressions of dissatisfaction as complaints, characterising them instead as service requests. The complaints policy contemplated an investigation procedure of up to three internal stages, creating the illusion that complaints would be considered afresh at each stage, whereas in fact responses to complaints were drafted by those

complained about, but sent out by others in TMO, giving a semblance of impartiality. The first two stages were subsequently amalgamated following instructions from TMO's CEO, Robert Black, in 2014 to "make sure we are all on the same page".

Residents considered the process unduly cumbersome and difficult to navigate. During the refurbishment, residents were initially referred to Rydon before engaging TMO's own process, such that, as TMO's then complaints manager Joanne Burke noted, "by the time that they get to the complaints team, they are thoroughly fed up". Burke also felt that there is a defensive culture in the capital team about complaints.

TMO's approach disincentivised complaints. Maddison's descriptions of closing down, closing off or shutting down complaints reflect TMO's strategy of merely dealing with complaints but without genuine consideration.

Resident concerns were dismissed as rhetoric. Maddison dismissed Daffarn and O'Connor's GAG blog as scaremongering. Following a residents' petition in 2015 asking RBKC to exercise scrutiny, TMO, in collusion with RBKC officers and councillors, engineered a situation where TMO could deal with itself and avoid scrutiny by RBKC. The resulting TMO board report lacked

independence and failed to address residents' complaints.

TMO briefed councillors against residents, making clear complaints had been rejected, were without foundation, and suggesting residents had acted unreasonably. This concerted effort to manage councillors' perceptions of TMO came from the top. It was led by Black, who cultivated a relationship with RBKC's Laura Johnson, which gave him advice and influence over councillors.

Johnson's March 2017 email in response to Black's about a post-refurbishment complaint in which he characterised the complaint as "an echo of the fight we have been in for the last two years" epitomises her advice and her negative attitude towards Grenfell residents. She said {RBK00000149}:

"Be robust to [Councillor Feilding-Mellen], he is not minded to attend a public meeting with a group of people who are moaning about minor issues.

"He is fully aware ... about Eddie [Daffarn] so you can rest assured he is not taken seriously.

"...

"This doesn't go back two years this goes back 20 years, it has always been a bad tempered place ... and for some reason that general crossness has lingered

and is stoked by various individuals with their own agenda".

Understandably, residents were not fire safety experts, but they did identify three important issues which should have alerted TMO to an obvious threat to Grenfell's fire safety.

First, the replacement riser in the stairwell. TMO procured the installation of the riser by National Grid following a leak in a gas riser in 2016. Between March and May 2017 residents, including Lee Chapman, secretary of the Grenfell Tower Leaseholders' Association, voiced concern about the fire safety of installing gas pipes in their only escape route, and repeatedly asked that an independent expert be engaged.

These concerns were well-founded. TMO had been warned by Stokes' letter in January 2017 to ensure that compartment penetrations were sealed and that an application to building control for the works was required. Yet both RBKC and TMO instead relied on vague assurances of compliance.

Resident concerns were dismissed with derision, epitomised by Laura Johnson in March 2017. Lee Chapman had given Johnson and Black a clear and correct warning that, as a result of the installation, the building's integrity has been compromised. Mr Chapman's email also

alerted Johnson and Black to vulnerable residents {RBK00002365/2}:

"There are many people in this building who are immobile, very young or suffer from mental health issues ..."

A moment's reflection, particularly in the wake of Lakanal, should have caused these senior figures in TMO and RBKC to reflect on the possibility of compartment breach, and should have served as a timely reminder of the needs of vulnerable residents which had not been addressed. Instead, Johnson told Black, "When the pipe issue has gone away they will find something else to write about".

Second, reports of broken door-closers or damage to seals on flat entrance doors should also have alerted TMO, yet did not. Daffarn's complaint in August 2015 that flat 136's door had been left open all weekend and had a broken door-closer was met with the suggestion that he simply close it. TMO considered the issue resolved. This overlooked the fundamental problem that open doors equate to breached compartmentation. Betty Kasote and others record that when their doors were reported as difficult to close, TMO's repairing contractors simply removed the closer.

Third, the lift. Although residents' complaints,

including those with disabilities, concerned the inconvenience of breakdowns rather than safety in fire, these complaints were obvious alerts to the dependence of those with disabilities on the lift. This should have triggered further investigation as to the use of lifts as evacuation lifts and the need for PEEPs.

Turning to topic 2, the Fire Safety Order imposes a requirement that a building, regardless of age or compliance with regulations, be safe for the relevant persons, namely residents and visitors. This is achieved by procuring FRAs to identify the preventative and protective measures required to keep relevant persons safe. An evacuation plan is necessary in certain circumstances, such as compartment breach, regardless of the evacuation strategy of the building and including if it is stay-put.

The Inquiry will wish to address how it is that one of the principal pieces of guidance applicable to purpose-built blocks, approved by the Secretary of State, detracts in key respects from obligations imposed by the order. This LGA guide was sector led and, albeit produced in the wake of Lakanal, fails to require an evacuation strategy, and assumes that PEEPs are not required in general-needs blocks.

The guide also created the concept of a notional

FD30 door, namely one with an assumed fire resistance of 30 minutes, and suggested it was not practical to destructively test a door in order to establish the actual fire resistance of doors for which no certification now existed. This ran counter to other post-Lakanal guidance by the Leasehold Excellence Network. Despite incorporating PAS 79 by reference, the LGA guide runs counter to PAS 79 methodology for preparing an FRA.

The Inquiry will wish to explore the divergence of its two experts, Dr Lane and Mr Todd, as to the adequacy of Stokes' FRAs and on the topic of legislative requirements for people with disabilities, on which Todd's views are at odds with the requirement of the Fire Safety Order. Todd's vindication of Stokes is, we suggest, unlikely to withstand scrutiny, and begs the question whether the competent standard for fire risk assessors is far too low.

Dr Lane concludes that Stokes erred in four key respects: first, failing to identify the occupancy profile of the building, which is both a failure to identify the relevant persons and a failure to evaluate the risks to those persons and necessary mitigation; second, failure to link his proposed corrective measures to the risk they posed if not cured; third, failure to

probe TMO's fire safety management in order to evaluate the risks; fourth, failure to request and review the emergency plans for evacuation. These failures meant he failed to assess the risks posed by Grenfell to residents and visitors, and his risk rating of "tolerable" should have been "intolerable".

Stokes' treatment of the façade was also flawed. While there is a debate as to whether a risk assessor must assess the façade, given that the Fire Safety Order does not define the external wall as a common part, both schedule 1, part 3 of the order and the approved methodology, PAS 79, require risk assessors to evaluate the risks which cannot be avoided. That includes factors such as combustible façades, which should be included in the significant findings.

In any event, Stokes, by his FRAs, purported to have assessed the cladding, describing it as "fire rated", a meaningless term, but he also suggested compliance with Building Regulations. It is now clear from Stokes' statement that he did not know what the composition of the cladding was and therefore had not assessed the risks posed by it.

Stokes' treatment of lifts was deplorable. In 2009, he reported that he didn't know whether the lifts were firefighter or evacuation lifts, but his 2010 and all

subsequent FRAs described both as evacuation or firefighter lifts which could be used to evacuate disabled residents, this despite Stokes having been told that TMO's senior lift engineer did not consider the Grenfell lifts to be firefighter lifts.

Again, Dr Lane and Mr Todd's opinions are in sharp contrast. While both agree Stokes did not understand lift standards, Lane considers his failure to recognise the lifts were not firefighter lifts resulted in the loss of a vital opportunity to identify necessary mitigating measures. Todd, however, considers Stokes' lack of knowledge of lift standards does not detract from his competence as a fire risk assessor, and that the lift's design did not affect the risk to relevant persons. That is unlikely. Had the lifts been firefighter lifts, either no key at all would have been required or an emergency unlocking triangle key would have been required, and in either case it would not have been possible to use the incorrect key, which Howkins tentatively concludes is most likely what happened. At least three lives might have been saved.

Perhaps Stokes' most egregious failing was not to ask for an evacuation plan or address the lack of PEEPs. Instead, he repeated for six years that the data would be inputted into a TP tracker with a view to preparing

PEEPs, but as he knew, he had not been asked to prepare PEEPs for Grenfell. Lane considers he should have been proactive in obtaining such information.

RBKC and TMO's principal failures as the responsible persons related to fire doors and failures to facilitate evacuation of the disabled. TMO's fire risk management suffered from systemic failures, despite TMO being told in 2009 that it was in statutory breach on almost half of the procedures reviewed. The review advised TMO it needed a fire safety policy setting objectives for compliance with the Fire Safety Order. TMO suffered from a lack of transparency which meant it lauded itself as having been given a clean bill of health by external audits in 2013, even though those audits had alerted TMO to its poor management systems.

TMO did not have proper structures in place to address the volume of action items arising from FRAs, but rather than resolving the issues, resorted to "cleansing" the revealing data. This lack of transparency resulted in the FRAs not being a reliable review of TMO's system and not assessing risk.

TMO's systems did not encourage learning lessons or change. Although Wray reported to the TMO health and safety committee concerning fire safety by high-level exception reports, these were not shared with the TMO's

board and therefore there was no mechanism for making changes to the fire risk management system.

As to doors, RBKC sought from 2011, and still ongoing in May 2017, to avoid using its powers under the Housing Act to ensure leaseholder doors were compliant, and instead sought to persuade LFB to prosecute leaseholders under the Fire Safety Order. RBKC clearly recognised it was in breach of the Fire Safety Order, as it made a submission in 2013 to the Secretary of State acknowledging 68 potentially non-compliant doors and, jointly with TMO, obtained advice from counsel, which apparently suggested TMO's notification to leaseholders of non-compliance constituted due diligence, namely a defence to successful prosecution under the order.

Despite being acutely aware that defective doors mean compartmentation breaches, RBKC's approach was to cynically calculate potential cost versus the cost of replacing leaseholder doors. In an email in which RBKC's Roger Keane had noted there was no realistic prospect of Southwark being criminally prosecuted for Lakanal, he said:

"... if something did happen at one of our properties, we are still likely to be the organisation that faces prosecution. We therefore have to weigh up the potential cost of dealing with this issue, against

the situation we would face if something happened and we were found liable."

There can be no room for any form of cost/benefit analysis given RBKC's obligation to keep the protected route safe and given lives were at stake. Even as late as May 2017, when councillors suggested RBKC should replace leaseholder doors at Trellick Tower, regardless of whether they would be reimbursed, Laura Johnson overruled them, describing it as a "non-issue". This demonstrates a staggering lack of concern only tolerable in a culture with scant regard for safety.

TMO also knew it was in breach of the order and had been advised by Stokes that landlords were being prosecuted for non-compliant doors on the protected route. It seems RBKC's and TMO's focus was on avoiding liability, instead of on fire safety.

RBKC was similarly irresponsible in relation to the absence of door-closers. Cost management took priority over safety. RBKC did not decide to instigate a door-closer installation programme until March 2017, despite understanding from as early as 2009 the criticality of door-closers to the stay-put policy.

In October 2015, a serious fire occurred at Adair Tower in which the flat of origin's door failed to close due to the lack of a door-closer, filling the

lobby with hot gases and heavy smoke, resulting in 24 fire survival calls and, in that respect, resonant of Lakanal. A deficiency notice had been issued prior to the fire identifying a failure to address the absence of self-closing devices. Thereafter, enforcement notices were issued in 2015 and 2016 on Adair and Hazlewood Towers, including for failure to fit door-closers, and a deficiency notice was issued on Grenfell in November 2016, again for failure to fit door-closers.

RBKC therefore had full knowledge of the extensive fire risks posed by the lack of door-closers, yet failed to commit to install closers across its estate until nearly two years after it had seen the serious consequences of this omission. No door-closer programme was in place by the time of the fire. RBKC now accepts that an installation programme should have been in place before then.

At the 1 March 2017 meeting at which Laura Johnson gave approval for a door-closer installation programme, she pushed the installation of closers from a three to a five-year programme to "make funding the programme more manageable". At that meeting she is recorded as agreeing to hold off recommending inspections programme at present, not being convinced of the need for an inspection programme which, in her own words

{RBK00046603}:

"... would have to be ongoing and therefore an additional expense to the [housing revenue account] indefinitely, without any identifiable evidence that it impacted positively on the fire safety of residents."

This was a misguided and perverse perspective, given that, two years earlier, RBKC had at Adair witnessed the best evidence of the devastation which ensues in fire if a door fails to close.

RBKC now accepts that guidance required regular inspections of door-closers. Regardless of whether the decision not to instigate an inspection programme emanated from RBKC or TMO, both parties are equally at fault.

TMO had been warned by Stokes in 2011 that the removal of door-closers on the protected route was placing relevant persons at risk of death or serious injury in fire. If a reminder of this were needed, then the 2015 Adair fire should have sufficed.

Nevertheless, even faced with prosecutions on Adair, Maddison resisted the installation of door-closers at all properties and instructed counsel to consider whether they were only required where fundamental to the fire strategy, and wondered, "How can we best transfer responsibility for maintenance of door-closers on to the

tenant?"

Both RBKC and TMO failed to ensure the required means of escape for the disabled, despite RBKC having originally been a trailblazer for accessible housing and being aware that inclusive design requires that buildings must cater for all. As RBKC's Claire Wise said in 2010, specifying that disabled people should not live above ground floor is an unacceptable acknowledgement that existing fire safety procedures are not inclusive.

TMO consulted with an access consultant and obtained a report addressing wheelchair access and door-closers for those with limited upper body strength, but ignored these considerations, despite being made aware in 2017 that new doors at Grenfell were too heavy for the elderly or disabled. As TMO had no policy for identifying the needs of the disabled or processes for achieving the necessary protective measures, there were no such measures.

In conclusion, the failure of controls at every level requires a thorough examination of the ambit of the order, associated guidance and the competency requirements of fire risk assessors. The order requires that buildings be safe and accessible to residents and visitors and, to that extent, neuters the provisions of

the Building Regulations which do not require retrospective change. Nevertheless, the Inquiry may wish to address the adequacy of ADB which, albeit premised on inclusive design, offers limited guidance on the topic.

The multiple managerial and systems failures at Grenfell, which also include inadequately fire-rated doors, systems maintenance failures, and inability to rapidly isolate the gas supply during the fire, speak in favour of a safety case covering all aspects of a building's safety which could be audited by those with the relevant specialist knowledge and available to emergency services.

Those are my submissions, sir.

SIR MARTIN MOORE-BICK: Well, thank you very much indeed, Ms Barwise. There is a lot for us to think about there, and we're very grateful to you. Thank you very much.

Well, now it's time for me to invite Mr Friedman Queen's Counsel to address us and make an opening statement on behalf of the same group of bereaved, survivors and residents.

So, Mr Friedman, are you in touch with us? Can you see me? Can you hear me?

MR FRIEDMAN: I can, sir, I hope you can hear me?

SIR MARTIN MOORE-BICK: Ah, good morning, Mr Friedman. Yes,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As a matter of organisational culture, the TMO had

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

pictures of their meetings across that year that show a number of women and men who died in the fire, as well as several survivors that the Inquiry has come to know.

The response of Robert Black, the CEO, to that Unite letter was to make clear his and the TMO's preference to not even meet the group because he regarded it as a showcase for Mr Daffarn.

In December 2015, the same group lodged a petition with RBKC. The initiative involved Councillor Blakeman, who had come to support its aims. The document was signed by 60 residents. It called for urgent independent investigation by the RBKC housing and property scrutiny committee of the conduct of the works and the treatment of residents. Of those 60 signatories, 20 either died in the fire or were bereaved. Again, despite the number of signatures, the evidence shows residents' views were still apparently dismissed within RBKC and the TMO as somehow unrepresentative due to it being organised or engineered by Edward Daffarn. Among many other fallacies with this critique, it discounted that the signatories genuinely believed what they had put their name to or that there could be any value to what they were saying.

What followed before the scrutiny committee was a further shameful lost opportunity. Rather than

commissioning and independent investigation, the TMO, council officers and the committee orchestrated the outcome to allow the TMO to investigate itself. The TMO duly reported back, despite Councillor Blakeman's efforts to correct its errors and omissions, in a document that was originally classified, which dismissed residents' concerns in their entirety, without interviewing a single resident, and instead glowingly commended itself and its contractor.

This was not Edward Daffarn charting his own path. He was there alongside many. To name just a few, there was Willie Thompson, Mariem Elgwahry, Denis Murphy, Berkti Haftom, and Sheila, who told Peter Maddison in a meeting, "I am here because I am a vulnerable person".

There were leaseholder advocates like Shah Ahmed and Tunde Awoderu, residents with a pertinent professional background to see what was going wrong like David Collins, and there was Judith Blakeman, as an elected councillor and TMO board member who was increasingly bullied for supporting these people, even though that was her job, and the TMO was supposed to be resident-led and resident-centred. The TMO took her words at face value when it suited them and marginalised her when it didn't.

Panel, organisational exclusivity and disregard for

non-member input is a classically understood feature of human-made disasters, and this is a textbook case. The outsider is dismissed as a crank, a misfit or a manipulator of others. The stigmatisation of the dissident creates a blind spot to the criticism being made. They did this to Ed Daffarn, but don't for a moment think that they didn't do it to Shah Ahmed, David Collins, Judith Blakeman, and anyone else who told them that they were wrong.

To make matters worse, there was an irresponsible assumption that anyone else was either being supinely led by these critics or otherwise content. It ought to be obvious to anyone involved in social housing that residents may be reluctant to complain personally for a multitude of reasons, including but in no way limited to immigration or housing status, or experience as a member of a minority race or ethnicity. They must be entitled to rely on collective advocacy, rather than be given the invidious choice of bearing the burden of speaking up alone, being silent or indeed silenced.

A functioning system of governance committed to listening without prejudice to its residents needed to be conscious and responsive to this in a way that the TMO and RBKC were deliberately not. In the end, even the most fearless of residents could only address on

fire safety what they could see or were told about. As a result of a deliberate withholding of information, they were sometimes just able to communicate an inchoate tacit awareness that they were unsafe from fire at Grenfell. Again, rather than respecting and acting on it, founded as it was on the intelligence of those who actually dwelt in the lived environment, the TMO took advantage of the information deficit it had created to repeatedly dismiss residents' fears as unwarranted and unsubstantiated.

Our final subject for today is the neglect of disabled and vulnerable residents that is set out in part 5 of our submission. We note, with respect, that all BSR submissions have made this a centrepiece of their opening. They and we have done so because although the Grenfell Tower fire is many things, it is surely a landmark act of discrimination against disabled and vulnerable people.

The law does not appear to be in significant dispute. These were special categories of at-risk relevant persons to be identified, planned and provided for by the responsible persons under the Fire Safety Order 2005. The discharge of the fire safety functions had to be informed both by the public sector equality duty in section 149 of the Equality Act, and the

internationally and domestically protected human rights to life and non-discrimination. None of this happened.

As Ms Barwise has highlighted, the TMO and RBKC now seek cover for the breaches of statutory duty in a few short passages in guidance developed by the sector and published by the Local Government Association in 2011.

Colin Todd is an expert witness in this Inquiry, but his role in formulating and perpetrating the offending advice in the guide must itself be the subject of a scrutiny. That advice states that there is usually nothing to be done for vulnerable residents in high-rise buildings operating a stay-put policy because it is unrealistic to make any special arrangements for them.

No serious legal or moral defence of the wholesale denial of fire safety to a class of residents especially in need of protection is offered in the guide or to this Inquiry. Instead, first, a transparently false dichotomy between maintenance of a stay-put strategy and simultaneous evacuation is floated to imply outrageously that the status quo was in fact favourable to vulnerable persons. As is plain to see, the real issue is denial of planning and provision for evacuation when it is no longer safe to stay put.

Next, it is suggested that evacuation should, all being well with compartmentation, rarely be required.

This is simply not an acceptable answer to the situation when all is not well, which even the LGA guide contemplates. That is why the Fire Safety Order so clearly imposes non-delegable duties requiring planning and provision for all residents, not just those without additional needs.

As it happens, the three other Inquiry experts, Dr Lane, Professor Galea and Professor Torero, strongly disagree with Mr Todd regarding the limited risk of compartmentation breach in high-rise buildings as a class.

Colin Todd and those in the sector and Government who agree with him have demonstrated themselves unable or unwilling to stand back and reflect on the status quo. Remarkably in the immediate aftermath of the Phase 1 PEEP recommendation, Mr Todd and industry rushed out new draft national guidance in the form of PAS 79:2020 doubling down on the "do nothing" approach and deliberately deleting positive provision for disabled and vulnerable residents found in their predecessor edition.

The BSI has recently seen the wisdom of withdrawing PAS 79:2020 and reconsidering the issue, and so too the Home Office, despite initially being lobbied to contemplate a departure from the Inquiry's Phase 1 PEEP

recommendation by a sector special interest group submission that Mr Todd had again contributed to.

A major fault of the dogmatic sector stance is its lack of openness to existing and new ways to improve the safety of disabled and vulnerable residents. It pays no regard to the idea that disabled residents could be important experts in the pre-planning of their own evacuation, that responsible persons could meet and learn from them, and it shuts its eyes to available best practice on inclusive evacuation planning across the country and the world. It also raises troubling questions as to the underlying motivations. Budgetary concerns can no longer be allowed to uncritically trump a matter as important as equal enjoyment of safety in the event of a fire.

Ultimately, the view that nothing can be done, as well as being unevidenced and wrong, sanctions an outcome, even if that is not its aim, that treats disabled residents in high-rise buildings as if their lives don't matter.

I want to finish, if I may, by reflecting that there is a link between the closed nature of discussion between Government, managers and specialists at this national level and what went on with the RBKC, TMO and its contractors at Grenfell. No one was particularly

interested in involving ordinary people. Quite the opposite. The results are profoundly anti-democratic and disrespectful. Grenfell residents had no part in the choice of their architect, contractor, design amendments or access to fire risk documents, nor any chance to be informed and co-operate in the pre-design of their own evacuation.

Edward Daffarn's statement to this Inquiry eloquently tells how this tragedy played out in three acts, before, during and after the fire. Each of those acts involved a markedly negative view about the wisdom and resilience of people when they come together as groups. Before, the TMO and RBKC were desperate not to recognise collective community representation. During, the firefighters thought that mass evacuation would only cause panic and injury. After, the authorities feared that there would be uprising on Kensington streets.

In fact, each part of the Inquiry's evidence indicates the possibilities when ordinary people come together. They speak truth to power, prompt new ways of seeing old problems, save themselves and others as the real first responders in an emergency, and create the first and most enduring forms of support and recovery. Just as culture, values and ideas were among the key causes of the fire, a more co-operative and

co−productive approach, involving dialogue with and participation of residents, must become a fundamental aspect of fire safety in the future.

But to make a firm foundation for such progress, the Inquiry needs first to clearly and unequivocally identify the root cause of this disaster in the disempowerment and unequal treatment of residents. People with less influence, money and expertise were essentially rolled over, and the various tools of human rights, health and safety, and public protest, were not sufficient to save them.

Thank you, sir. Those are our submissions.

SIR MARTIN MOORE−BICK: Well, thank you very much indeed, Mr Friedman. A very powerful statement which will give us a lot of food for thought. Thank you very much.

We've got to the point in the morning at which I think we should take a short break. We are running slightly ahead of ourselves, which is always welcome. So what I'm going to say is we will break now, we will resume at 11.40, provided Mr Mansfield, who is due to speak next, is ready at 11.40. If he is not, that doesn't matter, we will take him at the time advertised, which is 11.45.

So we may resume at 11.40, all being well, and we will see you then.

(11.25 am)

(A short break)

(11.40 am)

SIR MARTIN MOORE−BICK: Welcome back, everyone. I'm now going to invite Mr Mansfield Queen's Counsel to address the panel on behalf of the other group of bereaved, survivors and residents.

Mr Mansfield, good morning. Can I just check that you can see me and hear me well?

MR MANSFIELD: Very much so, sir, yes, thank you.

SIR MARTIN MOORE−BICK: Very good. Well, good morning, it's good to see you, and when you're ready, I think we are ready to kick off.

MR MANSFIELD: Yes, thank you, sir.

Opening statement on behalf of BSRs Team 2 by MR MANSFIELD

MR MANSFIELD: Well, sir, Thouria Istephan and Ali Akbor, your co−panelists, we are much obliged for this opportunity to open for Team 2.

I have listened very carefully, as I'm sure everyone has, to what has already been said, and I will try and avoid repeating the detail of the two previous submissions to you, with which we agree, so there would be little point in duplication.

In addition to that, of course, we have already submitted questions, as well as a written opening. So

again, no purpose would be served in repeating all of that.

But what I would like to do is just to pause for a moment before using a rather different approach, in the hope of illustrating, in a sense, what you have heard by way of criticism of the regulations, of the people who are supposed to implement the regulations, of attitudes and so on, before dealing with a particular approach and perspective, which is to bring it to life through the eyes of the families. I'm going to avoid using the term "BSRs", if you'll forgive me, but the families, and the voices of the families, because the first reflective moment −− because this is a historic moment in this Inquiry, when, after so long, we return to the families themselves and what they have to say.

What one has to bear in mind, I would ask everyone to bear in mind, and the reason why their voices at this moment, at this juncture, are so important, is, firstly, you have to remember −− it's easy to just override it and forget because so much else is happening as we speak −− they, and particularly one of the people I want to mention in more detail, Shah Ahmed, had suffered a great deal before this fire. They had suffered −− and somebody's already mentioned it this morning −− 20 years, 20 years of neglect. And the neglect isn't

just concerned with fire safety. If I may, I just want to illustrate it. It's in one sense minor, but it really tells you everything about what's been going on there. It's not fire related. It didn't cause the fire. It didn't cause the death. But it tells you everything in one short cameo of what had been going on for years before this fire.

A gentleman whose name I will not mention who lived on floor 15, so one of the upper floors, he suffered from bowel cancer, and that was known. For six months he had a flat in which there was no functioning lavatory. Think about that for this person. What did this gentleman have to do to get something done? And I think Stephanie Barwise said staggering lack of concern; it's worse than that. He, that is this individual, had to go to North Kensington Law Centre in order to get legal help, and also get his physician to intervene in order to have a working lavatory, and then we wonder why the tower suffered in the way that it did, because that's the suffering, that's the kind of suffering. It indicates an attitude of mind that happened over that 20−year period.

But then on top of that, these residents and families suffered the fire itself, and you have heard something of that and I want to, in a very short while,

just reflect on a small passage of that which illustrates what's happened.

But they suffered the fire, and then afterwards, of course, they go through a terrible period in which there are more housing problems and difficulties for them, just in daily living. And then on top of that comes the pandemic and the difficulties of the hearings and not being able to attend. And, of course, Modules 1 and 2 did not include the voices of the families, although they have plenty to say about the issues in Modules 1 and 2.

Instead, they had to sit at home, usually, and watch —— and I hope this is not an understatement, or even an overstatement —— a parade of arrogance. There may be one pandemic outside the hearing; there's another inside it, and it's the pandemic of lies, of manipulation, of deceit, of jocularity, of pride in what they're joking about. And one has to ask, obviously, how that has come about.

We are approaching a different stage. It's one thing to work out how the fire was caused, and how the deaths were caused; the bigger question is: why did this happen?

So, therefore, one way of encapsulating what has happened over these 20 years, and it's epitomised in the

construction industry and the race to the bottom, the description you've heard before, is what we now have, and I'm going to characterise it if I may in this way: that what the council, the Royal Borough of Kensington, created was a chronic culture of neglect —— of that there can be little doubt —— of indifference and discrimination underpinned by, as you've already heard, a theme of dishonesty in the sense of not revealing information.

How is it that the construction industry in a sense and the authorities you're about to hear are conjoined in one continuum? There's this bigger question of: what is lying behind the construction industry's approach and the local authorities' approach?

Before moving into some of the illustrative examples, there is another reflection which may have struck you this morning, if not before —— probably before, well before —— and that is this: the staggering lack of concern leads one to believe and leads one to examine what we've put in our written submissions, that whatever happens in this Inquiry, it is important that any recommendations, and it's important that any themes that come out are enacted and implemented, but, as you have seen, if those in a position of authority, whether it's in the construction industry or the local

authority, are of a particular mindset, it doesn't matter what the regulations are, it doesn't matter what the statutory duties are, because at the end of the day, they think they're immune. They think they can laugh about it. They think, as they did in the construction industry, "Well, that's what we do, lie". Is that a society that has been created over the last 10/20 years?

We say there's a risk of that continuing unless there's a real attempt to change the mindset, so that whatever one says ought to happen, and even if you set it in law, you ensure that it is enforced and people are made accountable.

So those are the reflections before I even begin the examination, because what I would like to do is to go back to the night in question just for a moment, and I want to, as it were, bring to life all those deficiencies and defaults you've heard about in the written submissions as well as the spoken today.

You were there for the pen portraits, and you have been to the tower. May I —— I don't ask for answers, it's a rhetorical question, but your co—panelists, if they haven't watched the pen portraits, would they be kind enough to do so, because it brings to life the lives of those who died, and the eclectic quality of the

lives that died, the diversity already mentioned of those who died in this remarkable —— I've called it the vertical village, which has been destroyed, although the people who live on still have it in their hearts.

But the pen portraits are one thing, and, again, to your co—panelists, Thouria Istephan and Ali Akbor, if you haven't been to the tower, may I ask that you do visit the tower, provided it's safe, obviously, I'm not sure what the present situation is and you may have already visited it. It's important to understand just how serious the —— not just the happening on the night, but what went before it as well. And then it's put in a context, once you've walked up that stairwell, you've walked up the staircase, you've seen the conditions, just the space conditions, it then takes on a new dimension.

So I'm going to, if I may, just read a portion —— it's only a small portion, and I'll make it clear at the end, if it doesn't become clear straightaway, about whom I'm speaking in relation to this, and it will bear upon what we say are the important findings in this particular module:

"On the Tuesday evening before the fire [13 June], it was a normal night for me. We went to bed around 11.30, but I couldn't really sleep. I must have fallen

asleep, but it wasn't a very deep sleep. I think our bedroom door was slightly open that night because it was hot. My kitchen window was open too."

I'm going to miss certain sections which don't bear upon the immediate points I want to make.

"I got up. I didn't see any smoke until I went into the kitchen. As soon as I got into the kitchen and looked down out of the window, I saw a big fireball coming up from the outside of the building. It was the colour of burning sunset. I initially thought it must have been a fire in the flat below. The kitchen window then exploded inwards. I was lucky I wasn't close to the window. I dialled 999 on the house phone from the living room. However, before completing the call and speaking to anybody, I threw the handset down and decided to get out. Until recently I believed I had not completed the call. However, the police have informed me that I did in fact complete the call, although I didn't speak to anyone before I threw the handset down."

This is important for this section:

"I'm glad I didn't speak to the operator, as I might have been told to stay put."

Well, that's a point I want to come back to. In fact, what he didn't realise was that what he then

did was overheard by the operator.

"My wife and I banged on the door of flat 155 and shouted 'Fire! Fire! Fire!' I then went to 154. The man there opened the door a little bit. I told him to get out because there was a fire. Then I banged on 153, but I can't remember if there was an answer. Then I banged on 152, I think someone answered, although I can't remember clearly. Then I banged on 151. A lady with a walking frame answered. I told her there was a fire, to get out. There is a smoke alarm [another point you may wish to pick up on this] in the lift lobby, but it wasn't ringing, otherwise the other flats would have heard it and I wouldn't have had to tell them there was a fire."

It goes on, of course, and it may be clear about who it is.

He goes back to his flat to get his mobile phone. He tried to go back, but when he opened the door he saw thick white/black mixed smoke, smelt smoke:

"Something like burning, I don't know what exactly. I didn't feel the heat coming. I shut the door straightaway, then I thought we have to get out. It was fight or flight. Through my years of fighting for the health and safety of the building I had the instinct to know the building was not safe and that it was a ticking

time bomb."

Now, the person at the root of this and his wife, Sayeda, is Shah Ahmed. Now, I'm going to use his, if one likes, prism of what happened to him in order to illustrate just how serious this chronic culture fostered by the local council had been, because he knew what he was in for if he stayed put. Not only did he know, he had very clearly signposted what was wrong with the block. So in a sense he's an expert, and the families are experts in terms of what they knew.

We have it in the building sector, the construction sector, whereby companies knew full well, some of them, that they were providing combustible materials but they went ahead. Why? Profit. And in this area, we have a very similar situation. The similar situation here is where they are being told -- that is the authority -- what is wrong and what is going to happen, but they do nothing. That is why we say it's a chronic culture all the way through, whether it's a lavatory or anything else. This is where essentially there's discrimination of a class of people, and I'll come back to that as well.

Just pausing again on that particular chronicle, if I may put it that way, so that it can be seen in another context, he, that is Shah Ahmed, lived in flat 156,

which is why I've mentioned all the other flats he went to, on the 18th floor. Between -- and this is in your Phase 1 report -- 1.20, so we're dealing with a situation obviously in the middle of the night, and 1.30, that's ten minutes, the fire had enveloped -- and anyone -- I'm not asking for scenes to be shown, but that's why it's so important to keep going back to what happened here. The fire enveloped all the 6s, by which I mean all the flats ending in 6 who were one above another in the tower, between floors 10 and 23, and in fact his telephone call to the operator was at 1.27.56, and he exited with his wife at 1.31. So he got out just in time, but without, again, going through, and it would take too long and it would take the number of days it did at the start and in Phase 1, you then have the picture of what happened to everybody else. Some survived, and a large number didn't.

But what were they facing, the ones who were not able to get out in the way that he did? They were facing, as you will recall, a situation in which the stairwell was filled with increasing amounts of black, acrid smoke, with the difficulty of walking down the stairs in the night, badly lit, badly signed. In fact, refurbishment, what had they done? Nothing, absolutely nothing to the means of escape. It was still in the

same condition. And this again tells you how bad the neglect had been. And there are those who are making phone calls, who are being told to stay put, and others, the operator says, "Well, just open the door, you've got to go, you've got to go", and they're talked down. Others can't do it, others are left to die. That's the chronic situation that has been created on the night, and those doors that he tapped on, two of them are significant, because they tie in with what we say is a dereliction of duty here, now well before you.

In flat 154, where the door opened, there was in fact just one man living. He died. He had a mobility problem that was known. He was disabled. He didn't die in his flat, he managed to go up, and you will recall a number did do that in the hope that there might be a rescue from above. So he unfortunately —— mainly because, of course, no one had thought about: how's he going to get out, then? Too much trouble to think about that?

One has to pause for a minute. What are we saying, it's necessary to have protocols and regulations before you begin to think about who's living in the block you own? If that's what it takes, that's what it takes. But the problem here is whether the caring society has, as it were, left certain people at the door, including

the authorities. But he died.

In fact, six occupants on this floor died, five of them —— he was one of them —— went to floor 23 above. Flat 151, where he tapped, two sisters, they were —— I'm not going to name them all the time —— one with the frame. Those two sisters, they went up as well to floor 23, and they died.

Just reflecting here on the total situation for a moment, out of the 120 flats, how many flats contained people who were disabled in various definitions, dealing with age, either old or young, or mental difficulties, physical difficulties, reading difficulties, hearing difficulties, seeing difficulties: 52 out of the 120 flats. I won't, obviously either on screen or off at the moment, deal with —— there is a schedule that you have, we I think submitted it with our written opening, which indicates the number of individuals who had an impairment.

This you would think is common sense: you would want, as a caring authority, to ensure that you look after and provide safety. Why do we have to write it out? Well, apparently we do. But there is —— and it hasn't been mentioned extensively, but I just want to mention it, it's in our written submissions so I don't develop it —— there's an obligation upon the Inquiry

itself under Article 2 and Article 14 in relation to human rights, the protection of life and the prevention of discrimination, and that you make enquiries and you investigate the extent to which, besides the protected characteristics here, whether there is a racial characteristic which enters this arena, because you have to ask why for so long a whole diverse community have been ignored, basically. That is a question that has to be asked.

They have a duty, again under the statutory duty, 2010, the Equality Act, a public sector equality duty, and that must not be shirked. It can't be delegated. It's not negotiable. And we say they must have known about that, but were not —— 2010, it's an interesting year, happens to coincide with some occurrences I'm going to come to in a moment, 2010.

So that's a very important —— one of many statutes. We've put them all in our written submissions, but that perhaps rises to the surface. And we give other examples of the disabled who died because there was no provision.

I'm citing, I think to move on in one moment to the experiences of Shah Ahmed, but before I do, it was part of his experience as well, I'm going to go back from the night itself, in other words we're moving back from the

14th through the 13th.

There is an irony here that you might have reflected upon at some point. On 10 June —— it's only four days before —— there were a series of visits, home fire safety visits, four firemen from the North Kensington White Watch visited a number of flats. Not all of them, but a number. 25 altogether they visited.

Now, the object usually of a home fire safety visit, two prime ones, it's obviously to make sure the alarms are working, and also if there are people who have particular vulnerabilities of the kind I've already described, they should be getting advice.

Now, of the 25 flats visited, 15 of those flats gave rise to 32 people dying on the night, and 20 of those 32 were vulnerable in the various categories. One of the flats that they did go to —— interestingly, they didn't go to the two I've mentioned next to Shah Ahmed, that's 154 and 151, they didn't go there, but they did go to his. What's important about the visit to him —— and you may remember that there was a witness in Phase 1 who remembered Shah Ahmed, and it's interesting, because Shah Ahmed's name is not well known, in fact, and I want to come to him in a moment as an individual representing essentially so many people in the block. But the point

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the boxing—in started.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Why? Because of course there isn't one.

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

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

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

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

Then there comes the paragraph just below:

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

And so on.

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

a little bit to the heading, "Proposed School", just above that:

"The residents of Grenfell Tower have been treated as sub-human and your handling of the incident has been unacceptable."

That letter has everything in it. That letter is warning, seven years before, the same chief executive officer, the same TMO, that there will be an inferno. It is exactly what was said in the Daffarn blog, which you heard in Phase 1.

I appreciate the time, and I'm going to, as it were, concertina my final remarks into a few seconds rather than minutes.

The question is: why has this been allowed to happen? I'm going to encapsulate it in very short form. It's been allowed to happen because of a climate, a political climate, and the political climate in 2010 and 2013 was one in which -- and we use the analogy with the Florentine 15th century burning bonfires, Bonfire of the Vanities -- yes, well, what David Cameron actually said was to get rid of the safety culture. Why? It gets in the way of profit. Those were the words that he was using, and one can't baulk at this at all, because if you're going to change a culture, you have to look at where the culture is coming from.

But he wasn't standing alone, and I opened Phase 1 with that comment about a meeting on the very day of the fire about deregulation. That's what it was all about then, and one has to remember that all these events were happening, and of course, who was the Mayor of London at the time? The now Prime Minister. What was he doing in 2013, just as all this was taking off? Austerity cuts to Fire Brigade, fire engines, work and jobs, and even the training facilities, of which there still isn't in London a training facility allowing for high-rise. When he was taxed about this by Andrew Dismore in 2013 -- again, it's all part of an attitude of mind -- Boris Johnson's response: "Get stuffed".

We're living, we were living and hopefully we might come out of that "Get stuffed" when it comes to safety. And of course you link it to something else that Boris has recently said, as a motivating force. He may regret he said it. He may want to retract it. We will see. Greed. Greed as a motivating force. Not in relation to this issue, another issue altogether.

So we say until you roll back the avarice, until you roll back the culture of neglect, the culture of discrimination that has gone on here, then there will be no real change, and no real hope for those who have had so much faith in this Inquiry, including Shah Ahmed.

Thank you.

I'm sorry, I think I have run over by a bit.

SIR MARTIN MOORE-BICK: Well, only a fraction, if you have at all, Mr Mansfield, so thank you very much for your opening statement.

I'm now going to invite Mr Williamson Queen's Counsel to make a supplementary opening statement on behalf of the same core participants. So I'll just check that you can see me and hear me, Mr Williamson.

MR WILLIAMSON: I can, sir.

SIR MARTIN MOORE-BICK: Good, thank you very much.

Can I just mention this: on the programme that I've got, you are down to have half an hour before lunch at 1 o'clock and quarter of an hour at 2 o'clock. I don't know quite how your statement is going to work out -- perhaps you don't either, I don't know -- but if at 1 o'clock you think you could finish within a reasonable time, by which I mean, let's say, ten minutes or so, I think we would all be perfectly happy to let you do that. On the other hand, that's not to put pressure on you. If you would rather break at 1 o'clock or at a convenient point around then and finish after lunch, that's equally acceptable.

MR WILLIAMSON: Yes, thank you, sir. I have a carefully

worked out timing and I will take a view as to where we are when we get to that stage.

SIR MARTIN MOORE-BICK: Exactly, take that course.

Opening statement on behalf of BSRs Team 2 by MR WILLIAMSON

MR WILLIAMSON: Thank you very much.

Mr Chairman, Ms Istephan, Mr Akbor, I shall deal first with topic 2, and the core issue for this topic is for the Inquiry to ask itself how the tower, itself home to many vulnerable residents, came to be a building that was so defenceless when it came to the risk of fire. It was of course unprotected in the face of what we now know was a massive risk, namely a situation in which, as the Phase 1 report made clear, the external walls of the building actively promoted the spread of fire.

Standing back from the detail, there is a stark and simple question: if the tower had been the subject of adequate fire risk assessment in the years leading up to 2017, how was it that 72 people died in a catastrophic fire? This was a fire safety failure on a monumental scale.

At the heart of this failure was the TMO. Its personnel lacked the relevant skills to provide a safety strategy to protect the tower against fire, and they took no adequate steps to ensure that other suitably skilled persons were engaged to carry out fire safety

work. There was in fact at all relevant times no fire safety strategy in place. Without such a strategy, the basis of an integrated approach could not exist.

Exova failed to provide a strategy, a failing which was not recognised by them, the TMO, RBKC, or Rydon. Indeed, from at least 2010 onwards, Grenfell's fire safety was in a perilous state. The TMO then reached an agreement with the Fire Brigade that any remedial works identified in fire risk assessments would be made fully compliant within five years.

This was an extraordinarily lax and leisurely timetable showing how complacent at best the TMO were about fire safety. This approach was entirely contrary to the interests of the residents and demonstrated also a reluctance on the part of the LFB to utilise their enforcement powers. In fact, as Dr Lane states in her report, over the next five years the risk level rose from medium to intolerable, meaning that the premises should not have been occupied at all until the risk was reduced. Over these years, the TMO essentially entrusted all fire risk matters to Carl Stokes as the fire risk assessor. He was not a chartered fire engineer and he lacked the necessary skills to carry out the work.

As regards his qualifications, we emphatically do

not agree with the view expressed by Mr Todd, one of the Inquiry's experts, that "little if any special competence is required in relation to the principles of fire safety to enable a competent fire risk assessor to carry out a type 1 FRA for a high−rise block of flats such as Grenfell Tower".

Indeed, I should make it clear at this stage that we do not agree with Mr Todd's general approach and do not accept that he is an appropriate expert to guide the Inquiry. We echo the criticisms made in relation to his evidence this morning by Ms Barwise and Mr Friedman.

In relation to all relevant matters, the Inquiry should therefore take its cue from Dr Barbara Lane. In any event, the TMO's faith in Stokes was not universally held by others. In a meeting between the TMO and the LFB in January 2016, Rebecca Burton of the Fire Brigade "raised her concern that our fire risk assessor sometimes makes statements which are not justified or supported and that the FRA reports need to include justification for statements made".

The TMO, however, relied on Stokes to give advice on the refurbishment works that would have been more appropriate if he had been a consulting engineer, rather than an unregulated fire assessor with no formal engineering qualifications.

As Dr Lane puts it, the TMO appears to have instructed Mr Stokes:

"... to undertake ad hoc inspections of the works. Mr Stokes recorded these inspections in letters to KCTMO. I have seen no evidence as to how Ms Wray or the TMO addressed issues raised by Mr Stokes in these letters, which do not appear to have been part of any of KCTMO's formal processes or procedures."

Crucially, and compounding this error, the TMO excluded the building's façade from Stokes' scope of work. He did not take exception to this, despite the fact that his brief asked him to consider the compartmentation of the building and any possible shortcomings with it. Compartmentation simply cannot be considered when a wall is excluded from scope.

On any view, the exclusion of the façade from the assessment was an extraordinary omission. Clearly the façade was of critical importance and urgency. In August 2016 a fire had occurred on the 18th floor of Shepherds Court, an 18−storey tower block in Shepherd's Bush. Cladding on the outside of that building compromised polystyrene and plywood insulation panels. Tests concluded they were the likely cause of the fire spreading up the outside. The similarities to Grenfell were striking. Flames began pouring from the

open window of a 7th floor kitchen, quickly spreading up the side of the building. At the time, the publication Inside Housing described the fire as a "stark warning for social landlords".

Eight months later, in April 2017, the LFB wrote to Laura Johnson of RBKC to say that testing showed that the combustibility of the panels at Shepherds Court did not meet the levels expected to comply with Building Regulations. This letter caused Wray to ask Stokes whether the cladding recently installed at Grenfell complied with Building Regulation requirements. He replied in an email sent from his mobile phone that:

"Grenfell was clad but the cladding complied with the requirements of the Building Regulations. Lots of questions asked of Rydons and answers received back from them."

In an internal email the next day, Wray reported that she had:

"... checked with Carl Stokes who had investigated the details of the installation with Rydon when the works were on site and he confirmed that the installation complied with the current requirement of the Building Regulations".

In fact, Wray had misrepresented Stokes' two−line email, which had not addressed the nature of the

cladding at all.

The last FRA completed before the fire, shortly after the completion of the refurbishment, noted that the tower appeared to have appropriate fire separation and compartmentation and, from a visual inspection of the structure, no areas appeared to raise concerns. Stokes felt it appropriate to make these unqualified comments, but he did not, firstly, assess the materials used in the construction of the cladding; secondly, complete or recommend any invasive assessment of the materials; thirdly, seek the input of a chartered fire engineer; fourthly, consider material classification or material safety datasheets for the cladding; or, fifthly, make any enquiry of the basis upon which building control had passed the cladding.

Both Williams and Wray of the TMO now rely heavily on the words in Stokes' FRA assessment that the building appeared to have appropriate fire separation and compartmentation. This reliance is clearly misplaced, given they were both aware that Stokes had not been instructed to consider the external façade of the tower.

As to all this, Dr Lane concludes, not surprisingly, that neither Mr Stokes nor Ms Wray, nor her superiors in the TMO, demonstrated competent understanding of the hazards posed by the works at the time, and they did not

make a suitable and sufficient assessment of the risks to relevant persons.

Moreover, in relation to this building, clad as it was in combustible cladding, and in respect of which Stokes had never been asked to consider the external façade, evacuation planning had never been made part of the TMO's procedures for tower residents.

Indeed, in her witness statement, Wray takes a dismissive view of any requirement for evacuation plans, saying {TMO00000890/38}:

"It was also not our role to capture where disabled and vulnerable people might be living in the Tower. This type of information, where available, was kept by the Neighbourhood Management Teams, which were part of the Operations department."

That approach is clearly contrary to the non-delegable, strict duty the TMO were under to ensure, so far as reasonably practicable, that residents were safe from harm. It also ignored the relevant guidance on the topic.

As the responsible person safety officer under the 2005 FSO, Wray should have ensured that the TMO discharged its evacuation planning safety duties. The TMO did not engage with this at all. It did not take residents' safety in the event of fire seriously.

For example, Councillor Blakeman, to whom Mr Mansfield has already referred, whose area included the tower, notes in her witness statement {MET00045751/7} that following the refurbishment:

"... residents received no advice about fire safety and only after several representations were instructions as to what to do in the event of a fire installed on the walls of the communal hallways ... It was left to the residents themselves to be proactive in order to obtain this advice."

Indeed, the statements which have been given across the entire group of the bereaved, survivors and residents suggest that the TMO's practice in relation to the provision of fire safety information was grossly deficient. Many residents reported they were not given fire safety advice or information about what to do in the event of fire.

The FRAs suggest that Stokes did in fact understand that evacuation planning was essential in the event of fire. However, he appears to have thought that evacuation planning could be effected ad hoc by either the fire service or residents themselves, which is contrary to Government guidance and represents a flagrant disregard for residents' safety.

There is no reference in any FRA of a documented

emergency plan, neither did the TMO produce any document on the subject. This was a serious breach of their legal duties to the BSRs.

Furthermore, as Ms Barwise has explained, there were no TMO drafted PEEPs, ie individual plans for means of escape from fire, in place in the tower for any of the residents. This was despite the existence of well known and long-established guidance on vulnerability. Some 20 or so tower residents were vulnerable in one way or another.

Stokes did not prepare any PEEPs at Grenfell. He apparently understood that Wray's team were drafting them. As with so many of those involved with the tower, he relied upon an unjustified assumption.

The TMO's non-delegable duty to keep the residents safe was not in any way diluted by any resident's mental health issues or physical vulnerability. On the contrary, it placed a burden on the TMO to ensure that any such vulnerabilities were accommodated. The TMO should therefore have ensured that there were in place adequate PEEPs for disabled and vulnerable residents. It failed to do so.

Furthermore, Stokes advised the TMO in 2014 that the lifts were firefighter lifts, even though this was not the case. On the night of the fire, this caused

an avoidable loss of life. Others with limited mobility and mental health vulnerabilities may have lost their lives because they did not feel able to utilise the lifts to evacuate.

I will return to the issue of the lifts in a moment.

The evidence on topic 2 will show, therefore, the following things: (1) there was at all relevant times no fire safety strategy, ie no overarching basis of fire safety engineering in place; (2) Stokes was not qualified academically, vocationally or by experience to carry out the complex FRAs that Grenfell required; (3) the FRAs were wholly inadequate, in particular in that they did not deal with the façade and external envelope of the building; (4) there was no, or no adequate, evacuation plan and no emergency plan; (5) no proper consideration was given to vulnerable residents; and (6) no PEEPs were prepared.

I turn now to topic 3.

Topic 3 deals with a diverse range of issues concerned with the operation and maintenance of the tower. Although these issues are various, they have a unifying theme: the failure of the TMO to ensure that the tower was properly and safely operated and maintained. The TMO then carried out works, as we have seen in Modules 1 and 2, which involved fixing to the

tower highly flammable cladding products, turning the tower into a death trap.

The building was, in view of the series of failings I'm about to consider, singularly ill-equipped to respond to or withstand a catastrophic fire.

Dealing first with the doors.

The TMO and a company called Manse entered into contracts for flat entrance door replacements in 2011. This was an ideal opportunity to ensure that all the doors were fire safe. It was not taken. Indeed, instead, the contracts failed to specify the doors' performance requirements.

The TMO was well aware that it was necessary to ensure that all the doors in their estate were fire safe. Indeed, in January 2010, Wray had informed a meeting of the TMO's health and safety subcommittee that:

"The main issues being raised were in relation to:

"1. Inspection and if necessary replacement of flat entrance doors in enclosed blocks to ensure they present a sufficient level of fire resistance, are self-closing and fitted with intumescent strips and cold smoke seals."

And, as another point:

"Where flat entrance doors are demised to lessees,

can they be persuaded to replace them with the appropriate fire rated door? Can we enforce this in respect of leaseholders? If not it is the fire assessor's view that we would need to adopt an 'evacuation strategy' within our blocks and not 'defend in place' and this has significant implications for the installation of automatic detection ..."

In the event, the leaseholders' doors were not subsequently replaced, and neither was an evacuation plan put in place. It is likely that many of the leaseholders would not have been able to afford new doors. Given the relatively low number of leaseholders, the TMO should surely have included them in the replacement programme. No doubt they did not do so because of concerns over cost.

By February 2013, by which time the door replacement programme for the tenants was substantially complete, the TMO reported to the GTLA, the Grenfell Tower Leaseholders' Association that:

"We have recently had a fire risk assessment for Grenfell Tower reviewed and the assessor advises that none of the properties at Grenfell Tower are highlighted as having potentially non-compliant entrance doors. It seems, therefore, that the doors currently installed provide sufficient fire resistance."

This was dangerously complacent advice. It also ignored or forgot the concerns expressed in 2010.

Furthermore, various non-compliances were noted in Stokes' June 2016 significant findings and action plan, including non-compliant entrance doors and newly fitted doors which did not have cold smoke seals. Some of the doors had had their intumescent strips painted over, some staircase doors did not fully close, and the 16th floor door was damaged. There were, therefore, multiple examples of fire safety breaches.

Indeed, on 17 November 2016, the London Fire and Emergency Planning Authority sent a notification of fire safety deficiencies in respect of Grenfell Tower to Wray in her capacity as the health and safety manager of RBKC. This set out numerous alleged breaches of the FSO.

These failures highlight a systemic failure on the TMO's part to take action. Indeed, this was not just at Grenfell, but also in other blocks. In December 2016, a TMO safety board update was issued following deficiency notices issued against four TMO properties, including the tower. This referred to several notices queried with the LFB and expressed surprise at having received the notices.

On 16 March 2017, just three months before the fire,

the TMO's health and safety committee met to review the fire strategy and provide an update on self-closers. The minutes record -- and could we have up CST00000065/5.

(Pause)

SIR MARTIN MOORE-BICK: Mr Williamson, we have it on our screens.

MR WILLIAMSON: We do, but that's not the right document. I'll just move on because time is short.

I was referring to the minutes of March 2017, which in summary recorded that there had been a discussion with RBKC in March of 2017 in relation to the issue of self-closing devices, and it had been agreed that there was no need to deal with them, and if the LFB were to make that a priority, then the TMO "would take legal advice and make representations to the GLA in advance of instigating any inspection programme".

What is so striking is that the TMO were determined to do nothing if they could possibly do so, and to spend money if they had to on lawyers rather than on improving fire safety.

LFB's senior fire safety officer, Mr Finn, subsequently visited the tower and produced a report. This is dated 18 June 2017, but was clearly prepared before the fire. He noted that a significant number of

the self-closing devices on the composite fire doors to dwellings above the third floor had either had the self-closing device removed or this device was broken and still in place but ineffective.

It is unclear what action was taken by the TMO to rectify the many outstanding fire door failures prior to the fire. However, in view of the history of non-compliance, it is likely that either no action or insufficient action was taken.

On a related issue, in April 2018, the Government Legal Department, on behalf of the MHCLG, wrote to this Inquiry setting out the results they had obtained, having tested Manse doors in various London boroughs to ascertain their fire resistance. Of 14 doors tested, only one survived longer than 30 minutes. The only compliant door was manufactured in 2009, indicating that Manse's manufacturing after 2009 had a direct effect on door quality.

Manse's technical manager, Mr Duncan, is noted by other witnesses to have instructed changes to manufacturing that affected the doors' integrity, and the company's production team leader, Mr Whitton, confirms in his witness statement the impetus behind the drop in manufacturing standards was to save money.

The experience of those we represent underlines all

these failures. They speak of replacement doors where door-closers broke shortly after being installed and were never fixed, and the doors never functioned properly. They speak of lobby fire doors that would not close.

In short, there was a long and sorry history of defective and inadequate fire doors at Grenfell Tower. The TMO never addressed this satisfactorily or at all. The LFB attempted to do so, but ineffectually. The doors' poor quality had a significant impact on the spread of smoke and flames throughout the building.

Returning then to the lifts.

The lifts at Grenfell Tower should have been firefighting lifts, but they were not. In 2004, Apex Lifts were appointed by Butler & Young Lift Consultants to refurbish all three tower lifts to the latter's specification. However, this refurbishment did not specify firefighting lifts, even though the concept of a firefighting lift had been in force for some years prior to this first lift project. The TMO, Butler & Young and Apex do not seem to have considered compliance with the objectives of firefighting lift requirements. All of them should have been keenly aware of the requirement for the lifts at Grenfell to have such a capability.

The failure to upgrade the lifts in 2004 and the lack of consideration in the intervening years was a grievous safety breach, the ramifications of which had grave consequences in 2017.

What is particularly poignant is that this upgrade could have been achieved for a cost of about £20,000, or 3% of the total contract price. 3% is a small price to pay, particularly given the importance of these firefighting lift features.

The Inquiry's lift expert, Mr Howkins, has observed that he would have expected a reasonably competent lift consultant to have considered modernising the lifts to the firefighting standard, and we agree.

There was then a further lift project in 2014/2015. This too did not address the issue of an upgrade to modernise the lifts to the firefighting standard. It should have done so.

In May 2015, the TMO produced an internal document called "The KCTMO fire safety policy and strategy". Section 18 of that document dealt very briefly with fire safety and lifts. However, it did not reference a single standard. Having regard to the standards that should have been considered, the combined effect which give definition to the concept of a firefighting lift, the TMO document is clearly inadequate. The TMO

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

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

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

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

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

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

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

MR WILLIAMSON: So I turn then to maintenance.

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

She said this:

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

responsibility to spearhead the TMO in its improvement plan."

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

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

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

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

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

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

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

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

plant and equipment. This involved regular, sometimes daily, physical checks of the equipment and the display panels to see if anything was out of the ordinary. I formed the impression that the TMO would get these checks done by their on-site caretaker rather than by their external maintenance contractor ..."

This complacency was not justified by events. Moreover, there was a lack of clarity as to which company was obliged to carry out regular maintenance.

This lack of clarity extended to the maintenance of the lifts as well. Mr Wallis of PDERS, the company responsible for lift maintenance who inspected the lifts in April and May 2017, has confirmed in his witness statement that he did not see a copy of any operational maintenance manual when he began working on the lifts at Grenfell Tower.

In conclusion as to maintenance, what is noticeable, as with so many other aspects of the TMO's performance, is its inability to get to grips with maintenance problems. The tower needed a systematic plan, the planned preventative maintenance and reactive maintenance put in place by the TMO. The TMO then needed to follow up assiduously to ensure that what was planned and agreed was put into practice. None of this happened. At best, various organisations responded

ad hoc as problems arose. Often this response consisted of little more than the assertion that some other body needed to deal with the issue. All of this contributed to the poor state of the building on the night of 14 June 2017.

Indeed, a post-fire audit report on TMO's Repairs Direct organisation is an indictment of just how poor the TMO's own in-house repairs and maintenance organisation was, concluding:

"It is a reasonable statement that the service (1) isn't good quality; (2) performs poorly; (3) is expensive."

Dealing finally with gas, on the night of the fire the time taken to isolate the gas supply was woefully prolonged. As Mr Mansfield mentioned, as soon as the gas was isolated, the fire went out like a light.

The background is that, due to a failure in the existing gas supply line, a new line had to be installed by tRIIO. These works were carried out in a chaotic fashion. In the early part of 2017, residents raised concerns about the newly installed exposed gas pipework in communal areas and stairwells. It seemed to take emails from the residents for either the TMO or the contractor, Cadent, to do anything about the gas pipe works. The TMO were, as ever, purely reactive.

As Dr Lane observes in her recent report, it therefore appears that the residents' complaint prompted the TMO's top management into pursuing Cadent and tRIIO to expedite the commencement of the fire protection works to the gas replacement riser. However, KCTMO top management failed to seek assurance that the risk to relevant persons pending completion of those works was being adequately controlled.

Moreover, a riser survey undertaken by Cadent at the end of September 2016 did not locate any isolation or service valves on either of the two gas supplies entering the tower. A subsequent hazard and operability study specified the investigation of the reported absence of those valves. It seems, however, that nothing was done about it. This was a clear breach of regulation 13 of the Pipeline Safety Regulations of 1996, ie a failure to maintain the gas supply in good order.

The replacement service installed in 2017 suffered a similar fate. No trace was found of a valve surface box at the expected location of the pressure isolation valve, either by Mr Hancox, the police or CORGI Technical Services. This is an extremely basic safety provision. It is highly unlikely isolation valves were not installed. The failure to locate the valves on both

occasions was likely to have been due to contractors building over areas where the valves were installed. The evidence shows in fact a complete lack of information that would have assisted Cadent or the LFB in locating the isolation valves.

The effect of this litany of failures is that the tower's gas supply took much longer to isolate than should otherwise have been taken. Our clients consider this a very important point. The fact that this supply could not be isolated for many hours was as a direct result of incompetent design decisions and inadequate construction management decisions taken many months before the fire.

So, to conclude on topic 3, we say that the evidence shows that the TMO and its advisers never got to grips with a range of key issues, in particular: (1) the fire doors were defective and dangerous in numerous respects, and as the LFB reported at the time of the fire, they likely provided no protection; (2) due to a pre-considered decision not to plan escape routes, there was no evacuation plan; (3) none of the lifts were firefighting or evacuation lifts; (4) a litany of failures meant the tower's gas supply took much longer to isolate than it should have done; and (5) the tower was not adequately maintained.

Much has gone wrong, and this will no doubt be investigated at length in the weeks to come. However, this Inquiry needs to think about the future as well as the past to ensure that failings of this kind do not happen in the future. Its recommendations should, we suggest, include the following matters.

First of all, the obligations on local authorities and other social landlords to consult and inform residents and residents' organisations on fire and other safety matters need to be strengthened.

Secondly, those who conduct FRAs should be required to have specified appropriate qualifications and should be subject to a professional code of conduct.

Thirdly, in high-rise blocks there should be clear requirements for the fire safety of all doors, whether those of social tenants, leaseholders or in communal areas.

Fourthly, lifts in such blocks should be firefighting lifts.

With those observations, that concludes my oral opening submissions.

Thank you very much, sir, and thank you very much to the panel for listening to us.

SIR MARTIN MOORE-BICK: Well, thank you very much indeed, Mr Williamson, and you have done very well, you finished

within the time that you suggested you were aiming for.

Well, that's a convenient point for us to break for some lunch. We will resume at 2.15, and the next speaker, who is going to be Mr Maxwell-Scott, is expecting to start at 2.15, so that will suit everyone very well.

So 2.15, then, please. Thank you very much.

(1.15 pm)

(The short adjournment)

(2.15 pm)

SIR MARTIN MOORE-BICK: Good afternoon, everyone. Welcome back. We are now going to hear further opening statements from other core participants.

The next person I'm going to invite to address us is Mr Maxwell-Scott QC, and I'm just going to check -- I think I can see him there -- that he can see me and hear me.

Good afternoon, Mr Maxwell-Scott.

MR MAXWELL-SCOTT: Yes, I can indeed. Good afternoon.

SIR MARTIN MOORE-BICK: Good, thank you very much.

I think there is nothing more to be said, other than to invite you to make the opening statement on behalf of the council.

Opening statement on behalf of the Royal Borough of Kensington and Chelsea by MR MAXWELL-SCOTT

MR MAXWELL-SCOTT: Mr Chairman, panel members, I, together with Katie Sage and Bethany Condron, represent the Royal Borough of Kensington and Chelsea, instructed by DWF Solicitors. As you know, we have submitted a 50-page written opening, which I anticipate the Inquiry will make public later today. We also, last week, provided the Inquiry with a document identifying some key changes made within the council since the fire that are relevant to Module 3 issues.

I do not intend in this oral statement to repeat all of the points made in our written opening; rather, I wish to identify some themes which are likely to be important during Module 3.

Before doing so, may I take this opportunity to say that the council is truly sorry for the suffering and tragic loss of life caused by the Grenfell Tower fire. As the leader of the council has previously stated, the council could have and should have done more to stop it happening. The council has adopted the Charter for Families Bereaved through Public Tragedy. It is committed to candour in its approach to this Inquiry.

There are six topics which I will address you on in this opening. The first is the council's role in relation to Module 3 issues and the council's monitoring of the TMO. About half of this opening will focus on

this topic. The other topics will be: expert evidence and guidance documents; the role of professional fire risk assessors in the years before the Grenfell fire; residents with vulnerabilities; flat entrance doors and self-closers; and, finally, complaints.

In our Phase 1 opening statement, we identified ten principal ways in which the council was involved with Grenfell Tower and its residents, both before and after the fire. In this module, we are concerned with four of them, which I can summarise in this way: the council was the owner of Grenfell Tower, the residents were its tenants and leaseholders. The council was their landlord. Both before and after the refurbishment, the council worked closely with and monitored the TMO's performance.

In Module 1, some of the council's involvement was in areas in which the TMO had no involvement. Planning was an example of that. But the most important example was building control. You will recall that the council identified and apologised for a number of failings in the way the council's building control service processed and considered the application for building control approval.

In this module, we have identified a number of specific failings in the council's monitoring of the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The TMO was an independent organisation, owned by its members and accountable to its board. Residents elected to the board at all times made up a majority of the board members.

From 2002 onwards, the TMO was an arm's length management organisation. When the TMO was set up in 1996, approximately 250 employees transferred from the council to the TMO. In 2017, the TMO employed over 200 people, including many in managerial positions. Those TMO managers were themselves monitoring the TMO's performance and reporting it to the TMO board. The council officers involved in monitoring the TMO were conscious that it was an independent organisation. Their work was not intended to duplicate the work of the TMO managers and board.

The agreement between the council and the TMO did contain provisions that could be used to exert greater control over the TMO if it was underperforming, and the council had shown a willingness to use them where necessary. In 2008, the TMO agreed a deed of variation which temporarily varied the TMO's obligations under the MMA and an improvement plan was put in place. This temporary process ended in 2010. After that, there were a number of indications that, overall, the TMO had healthy governance arrangements and that its performance

was improving. In 2013, the TMO management agreement full systems audit and a five-year review report both reached positive conclusions about the TMO.

There was required to be a test of opinion of the residents every five years. The last one before the fire was in 2013. It was run by an external organisation, and the results were reported to the TMO board. They were informed that the number of residents who participated was the highest ever. 86% of those who voted, voted for the TMO to continue managing their homes, and the results were better than those of neighbouring boroughs and had also improved.

One of the TMO's aims was to increase its membership. In the period 2012 to 2016, it did so by almost 500 members per year. At the TMO's last annual general meeting before the fire, over 95% of those who voted were in favour of the TMO continuing to manage their homes.

I'm moving now to my second topic: expert evidence and guidance documents.

In this module, you have the benefit of expert evidence from two distinguished experts on fire risk assessment, Colin Todd and Barbara Lane. Mr Todd has been probably the country's most well known expert on fire risk assessment for many years. His advice has

been sought by a range of governmental and non-governmental organisations, including the British Standards Institution, the Local Government Association, the Institution of Fire Engineers, the Fire Industry Association and the Fire Service College. Dr Lane is the global fire safety engineering technical lead at one of the world's leading engineering practices. She has proved herself to be a highly competent expert in the course of this Inquiry.

One of the themes running through this module will be the fact that Mr Todd and Dr Lane do not agree on all points. Similarly, the guidance documents that existed before the fire did not all give identical advice.

Where there is disagreement between the experts, the panel will need to decide how best to resolve it. But there is a second aspect to this: prior to the fire, there was one guidance document specifically designed for those managing purpose-built blocks of flats for local authorities. This guidance was published by the Local Government Association in 2011, following an extensive consultation exercise and input from the Department for Communities and Local Government and the Chief Fire Officers Association. It described itself as the "more appropriate guide to use for purpose-built blocks of flats". In 2013 it was re-endorsed by DCLG

after the inquest into the Lakanal House fire, and was never revised or withdrawn before the Grenfell Tower fire.

With the assistance of its assessors, with social housing and local government expertise, the panel will need to consider the extent to which it would have been reasonable for those involved in the management of Grenfell Tower to focus on the LGA guide in preference to other guidance documents. Industry practice is likely to be a relevant consideration when analysing this issue.

Industry practice is likely also to be relevant to your consideration of the fire risk assessments carried out on Grenfell Tower. In an ideal world, fire risk assessments would always be carried out by someone of the calibre of Mr Todd or Dr Lane. But this is not an ideal world, and it was never intended that the task of carrying out fire risk assessments be reserved to qualified fire safety engineers. For it to have been, the Government would have needed to pass legislation regulating the sector. In fact, the sector was and remains completely unregulated. No qualifications are required by law. No training is required by law. There was and is no bar whatsoever to anyone seeking to go into business as a fire risk assessor.

When one combines this absence of regulatory framework with what was going on in the sector at the time, one can see why Mr Todd says the following about Carl Stokes, who carried out all the fire risk assessments on Grenfell Tower:

"His FRAs are amongst the most detailed of the many thousands of FRAs I have studied. Within the FRAs, there are many 'tell-tale' indications that Mr Stokes is competent to carry out a suitable and sufficient FRA in general, and, more specifically, FRAs of high-rise blocks of flats such as Grenfell Tower.

"In conclusion, in my opinion, Carl Stokes was competent to carry out FRAs for Grenfell Tower, taking into account his training, skills and qualifications in the practice of fire safety and the FRAs that he documented."

There can be no doubt that, at the time, the TMO genuinely believed that Mr Stokes was a competent fire risk assessor providing it with a professional service, and that presumably explains why the TMO sought his advice on such a wide range of issues. Because Mr Stokes didn't just do fire risk assessments for the TMO, he also advised on issues that applied generally to the properties managed by the TMO and on issues specific to Grenfell Tower.

Mr Stokes' fire risk assessments and advice to the TMO will be central to many of the issues to be considered in this module. The panel will need to consider whether he was a competent fire risk assessor, and whether his fire risk assessments for Grenfell Tower were suitable and sufficient. But it will also need to consider whether anyone at the time had reason to doubt his competence or the adequacy of his fire risk assessments, and if so, who.

I now turn to the topic of residents with vulnerabilities in the event of fire. This is not a phrase used in the Fire Safety Order, but it is a helpful phrase used by Dr Lane to cover adults with cognitive impairment, adults with sensory impairment, adults with mobility impairment, and children. This is an important issue, because the evidence suggests that a higher proportion of adult residents with such vulnerabilities died in the fire.

Here, the different approaches recommended in the different guidance documents is particularly stark. Most of the guidance documents advised that specific measures be taken to protect, for example, disabled residents. But in contrast, the guidance in the LGA guide, which was current at the time of the fire, stated that:

"... it is reasonable to expect that the occupants of a 'general needs' block of flats will reflect the diverse range of physical and mental capabilities of the general population as a whole ...

"It should be determined as to whether the number of disabled people is likely to be different from a typical general needs block of flats ...

"It is usually unrealistic to expect landlords and other responsible persons to have in place special arrangements, such as 'personal emergency evacuation plans'."

The position at Grenfell Tower was that no resident had a personal emergency evacuation plan, and none of the fire safety advice from the TMO to residents contained advice tailored to the needs of persons who would be vulnerable in the event of fire.

Here again, with the assistance of its assessors, the panel will need to consider the extent to which it would have been reasonable for those involved in the management of Grenfell Tower to focus on the advice in the LGA guide in preference to that given in other guidance documents. They will also be able to assist you with whether the occupancy profile of Grenfell Tower was different from other general-needs blocks of flats.

I now turn to the topic of flat entrance doors and

self-closers.

Phase 1 established that a major route for the spread of toxic smoke within Grenfell Tower was from individual flats through flat entrance doors into communal areas. At the time of the fire, there were 120 flats in the tower located on floors 4 to 23. The flat entrance doors to 106 of those flats had been replaced in 2011. There are three main reasons why those comparatively new doors did not prevent the spread of smoke.

The first reason is that some of them were open rather than shut on the night of the fire because they did not have a working self-closing device. All of them had been fitted with self-closers when installed, but for various reasons some of them were no longer working or no longer present some six years later.

Not all of the council's tower blocks were fitted with self-closers in 2011. One of those that was not was Adair Tower, where fire broke out in October 2015. After that fire, self-closers were installed in Adair and consideration was given to introducing a self-closer programme through all of the properties managed by the TMO.

The council acknowledges that there should have been such a programme in place before the Grenfell Tower

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

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

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

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

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

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

My final topic is complaints.

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

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

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

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

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

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

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

Thank you, that concludes my opening statement.

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

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

MR AGEROS: I'm here, sir.

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

MR AGEROS: Yes, good afternoon.

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

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

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

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

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

MR AGEROS: I can see you all.
SIR MARTIN MOORE-BICK: Good. It just remains, therefore, for me to invite you to make your statement.

Opening statement on behalf of the Tenant Management Organisation by MR AGEROS

MR AGEROS: So, Mr Chairman, panel members, we too have submitted a near 50-page written opening statement. These oral submissions represent an abbreviated version of that statement, and they develop themes which are set out there, and so we invite the Inquiry to refer to those written submissions when considering the detail of any oral submissions made here.

Sir, may I say at the outset that the TMO and all that worked for it acknowledge the immense tragedy of the Grenfell Tower fire, and nothing in these submissions is intended to diminish or detract from that tragedy. All those who give evidence on behalf of TMO, and there will be many of them in Module 3, sir, continue to express their profound sympathies and condolences to the bereaved, survivors and residents.

Sir, topic 1 of Module 3 is primarily concerned with the TMO's systems for communication with residents; consultation concerning the refurbishment; residents' complaints regarding fire safety risks; doors and the quality of workmanship during the refurbishment; and the

response and degree of engagement, I think as you put it, of the TMO and RBKC to those complaints.

Sir, you will hear first from former residents of Grenfell Tower and then from witnesses from the TMO and RBKC at varying levels of seniority regarding the systems, policies and procedures each body had implemented to deal with residents' complaints and their response to those complaints as well as the management of the building.

Sir, you're also going to hear evidence about the governance arrangements between RBKC and the TMO and, in particular, how they worked during the refurbishment. To that end, you will hear from senior representatives from TMO and RBKC.

Sir, we acknowledge that, when considering the issue of complaints and concerns, the Inquiry's primary focus will be on matters causally connected with the fire, but the Inquiry will also consider the way in which complaints more broadly were managed. Sir, this being the case, the TMO intends to briefly address some of the wider issues touching on that topic here.

At the outset -- and it's right that we say this, sir -- the TMO acknowledges that the relationship with some residents was sometimes strained and difficult, both before and during the refurbishment, and we have no

doubt that you will scrutinise the reasons for this. However, sir, this is not to say that all residents were always at odds with the TMO, and the Inquiry may wish to consider whether views expressed by some more vociferous residents were truly representative of the views of a majority of residents.

Sir, can we say in a nutshell that the TMO doesn't accept that it ever adopted a dismissive attitude towards residents or indeed to their complaints and concerns.

Sir, we suggest that when you look at the nature of the relationship between TMO and the residents during the relevant period, the Inquiry should have particular regard to the following three factors.

Sir, first, there had been vehement opposition from some residents at Grenfell Tower to the KALC project -- and forgive the abbreviation, but it's for the sake of time -- from its very inception, and strong criticism of RBKC in particular, and much of this criticism was voiced in the Grenfell Action Group blog, which I'm going to refer to as the GAG blog, sir, going on. The Inquiry may consider whether this soured the relationship between some tenants and the TMO and RBKC, but also, indeed, whether this strong opposition was representative of the Lancaster West community as

a whole, given that the KALC project was to build a much needed school and leisure facilities for children in the borough.

Second, the TMO finally took over in 2014 from the Estate Management Board, referred to as the EMB, for the Lancaster West estate. The EMB was a tenant-led organisation separate to and pre-dating the TMO which was first registered in 1993.

There came a point when the EMB was not functioning well, and there was a strongly held view that its members were unaware of what was expected of them. Although it's right to say that residents voted at one point to retain the EMB, concerns remained about its performance and RBKC worked on an improvement plan, a step which was prescribed by the MMA. This failed to result in progress and RBKC eventually terminated the contractual relationship with EMB in 2014.

Despite a widespread perception of mismanagement -- and, sir, there are various emails which relate to this -- some residents thought it had been shut down, and this is a quote, "in an underhand and duplicitous manner by RBKC". Sir, of course, it's a matter for the Inquiry, but we would submit that this probably created a breakdown in trust between the TMO, RBKC and some residents, and impaired TMO achieving a good

relationship with some tenants going forward.

Sir, third, when considering the nature and volume of complaints made by residents during the refurbishment, it should be kept in mind that, for residents, continuing to live in situ when major works were occurring both inside and outside their flats can only have been extremely difficult. The construction work was intrusive and noisy, and one lift was often unavailable to residents because it was being used by builders. Sir, against this background, it's possibly unsurprising that there was an increased number of complaints and expressions of dissatisfaction from residents.

Indeed, consideration was given to the possibility of rehousing residents during the refurbishment, but this was not thought practicable or desirable. Indeed, some residents had concerns that if they left the area they would be rehoused in an unfamiliar location and would not be able to return. Whilst such concerns were certainly baseless, they are indicative of the level of mistrust that existed between some residents and the TMO/RBKC.

Sir, we have an eye to the evidence that you will be hearing in this module, and one of the parts of the evidence in relation to fire-related complaints will be

the contents of the Grenfell Action Group blog dated 20 November 2016. Just to say a couple of the things about the blog. In fact, the language often used in the blog was indicative of the levels of mistrust that had built up in the minds of some residents towards the TMO.

What we on behalf of the TMO submit is that the Inquiry should be cautious about the contents of the GAG blog because it contained a highly personalised narrative, including a number of personal attacks on TMO and RBKC employees, and because indeed the authors never identified themselves, the blog often uses the word "we" in connection with the residents of Grenfell Tower and, so far as the TMO is concerned, it appeared to be the work of at most a handful of authors.

Sir, we summarise one part of the blog, and the November blog said -- and this is a quote, and we've abbreviated the quote, and I hope not unfairly so -- that the TMO was:

"... an [irresponsible] mini-mafia ... [and] only an incident that results in serious loss of life to KCTMO residents will allow the external scrutiny to occur that will shine a light on the practices that characterise the malign governance of this non-functioning organisation."

Sir, what we say about that is this: despite the

appearance of prophecy, and we acknowledge that, the writers were certainly not predicting a cladding fire of the type that occurred on 14 June 2017. So far as the TMO is aware, no witness or organisation connected with this Inquiry predicted such a fire at Grenfell Tower, despite the fact that similar cladding fires had apparently occurred abroad and about which you have heard evidence in Phase 1.

Sir, ultimately it's a matter for you, but we would submit that the evidence that you have heard in previous modules bears out that the fire was not caused by "the malign governance of a non-functioning organisation", ie referable to the TMO; rather, it arose from the widespread and deep-rooted blindness within the private and public sector to the inherent dangers of materials regularly used in the building industry, or, even worse, by deception for commercial gain on the part of those companies that marketed and supplied cladding and insulation.

Sir, the evidence the Inquiry's heard in Module 2 thus far was, it is submitted, truly shocking, and shows that even those with responsibility for safety certification did not uncover the combustible nature of the products used in the refurbishment.

Sir, a measure of the extent of the blindness, as

I've referred to it, is the fact that some 2,000 buildings across the UK had been clad in and insulated with similarly combustible materials. Although the fire happened at Grenfell Tower, it could as easily have happened at another building clad in combustible materials. Sir, it's no doubt for this reason, among others, that fire marshals maintain vigils at numerous buildings even to this day.

Sir, the debate about how to solve this systemic and far-reaching problem continues even now between the Government, the construction industry and building managers and their tenants, including who will bear the cost for removal and replacement of cladding.

Sir, when considering the role of the TMO, we invite the Inquiry and you, the panel members, to bear this in mind: the TMO was an organisation staffed by non-construction professionals with a background in social housing. This was a design and build contract, and the TMO relied on various specialists and industry professionals throughout the refurbishment project, and its reliance on professional advisers represented the norm for contract procurement and capital works within the public sector.

Sir, while, if I may say rightly, as you have put it -- and I hope I quote you correctly -- the TMO was

an educated client, it operated only with the reasonable foresight of a social housing manager, and in not foreseeing such a terrible tragedy, it was no different to hundreds of other organisations across the UK. The question must be whether the TMO is to be judged differently to organisations in a similar position.

Sir, Dr Lane particularly criticises the TMO for not uncovering the risk the refurbishment posed following warnings arising from two fires, the Lakanal House fire in 2009 and the Shepherds Court fire in 2016, and the warning letter from LFEPA as a result of the Shepherds Court fire in April 2017.

Sir, the TMO invites the Inquiry to consider whether it alone should have been expected to see through the deceptions practised by the manufacturers of the cladding and insulation, especially when certifying bodies such as the BRE and BBA approved their suitability for use in construction and/or provided misleading certificates which inspired trust in materials used on the tower.

Sir, hundreds of other building owners or managing organisations did not untangle this subterfuge, even when, like the TMO, they were advised by teams of professionals.

Sir, I'm going to deal now with the issue of

resident engagement. May we say this: the TMO put considerable effort and resources into resident engagement, which we define as the drive to ensure residents were involved in decisions surrounding the management of their homes.

The TMO was and was designed to be a resident-led organisation, and its constitution made it a requirement that the board consisted of a majority of residents, including the Chair. From the time that Robert Black was appointed chief executive in 2009, the TMO sought to stimulate meaningful resident engagement, recognising that had fallen to a low level, especially following the demise of the EMB in 2014.

Initially, a door-knocking exercise was carried out across all properties in the TMO estate to understand what residents' main issues and concerns were. Following this, the TMO sought to increase resident membership in a number of ways, for example by holding roadshows, annual conferences, the senior citizens' annual party, the youth engagement project and the TMO live "Up Your Game" projects. It also promoted the creation of residents' associations, which numbered something like 53 across the borough, with ten alone set up in 2015/2016. All of this work was done by a dedicated resident engagement team, which included

a resident engagement manager.

Sir, we appreciate that reference to figures that demonstrate levels of resident engagement may not be helpful without context, which we're not going to provide fully here, it's in the written submissions, but the drive to increase resident engagement was certainly successful. An example is the increase in turnout for the TMO board member elections, as well as increased participation in the AGM. At the 2016 AGM, 96% of the over 1,200 people who voted were in favour of TMO continuing to manage their properties.

Possibly the most telling measure of resident engagement, and indeed of resident approval, was the test of opinion which was carried out every five years, where TMO members were asked if they wanted the TMO to continue to manage their homes. The most recent test of opinion before the fire involved an increase in participation of 122%, and there was an overwhelming vote in favour of the TMO continuing in its management role. Sir, in very real terms, if it had been the residents' wish, the TMO could almost literally have been voted out of existence or other management arrangements put in place.

Sir, resident engagement was monitored by RBKC, and it received a substantial assurance result in the

minutes of the HRA performance meeting in February 2017.

Turning now to the question of resident consultation for the refurbishment, sir, we anticipate you will hear that the TMO sought actively to consult with residents concerning the refurbishment from the earliest stages. This included giving residents a choice about how they would like to be consulted.

Consultation on design proposals for the refurbishment took place in 2012 and 2013 in particular, in many different ways, including -- we list these here, sir, they're listed in the submissions -- through meetings in both the daytime and the evening to accommodate as many residents as possible, newsletters which invited residents to roadshows and consultations, and questionnaires where residents were asked about a number of matters, including their priorities for windows, ie whether they should be self-cleaning and options for the operation of the windows, ie pivot, reversible, sliding or tilt-and-turn; whether Grenfell Tower would benefit from thermal insulation cladding, and, sir, there was a high "yes" vote for this, but no clear opinion was expressed about the colour or type of cladding; whether homes would benefit from new individual boilers which could be controlled by each flat individually, and again there was a high "yes"

vote for this.

Residents were also kept up to date via newsletters. For example, there were three in 2013 which advised of any changes to the plans submitted and reported on the results of surveys, et cetera. Sir, we've referred to those in detail in the written submissions.

In addition to the above, Rydon, the principal contractor, hosted coffee mornings and arranged home visits from their resident liaison officer, Lynda Prentice.

Sir, throughout its consultation process, the TMO sought to obtain as many resident views as possible on the refurbishment. Moreover, as an example of how the TMO listened to resident views, it did adapt the project after listening to residents. For example, it changed the design of the windows when it became apparent that the initial proposals would result in more intrusive work being done internally to flats; it recognised and engaged with a new residents' compact when it was suggested that residents' concerns were not being heard properly by the existing Lancaster West Residents' Association; and it eventually moved the HIU after residents challenged TMO about its revised position, and we will go into that in a little bit more detail later.

Sir, dealing now with complaints and service

enquiries.

The TMO certainly had in place systems for dealing with residents' concerns and complaints, including those concerned with the refurbishment. However —— and we acknowledge this, sir —— the content of many of the statements from resident witnesses and the TMO evidence may be difficult for the Inquiry always to reconcile. The picture painted in those statements is sometimes very different. Of course, that will be a matter for the Inquiry to consider carefully in Module 3.

However, complaints handling was always a priority for the TMO, and its performance was monitored both internally and externally, internally by the operations team, the senior management team, the executive team and the board, and externally by RBKC.

The TMO's complaints policy required it to apply the Housing Ombudsman principles for effective complaint handling. The portfolio was overseen on a day—to—day basis by the TMO's policy and improvement manager and there was a dedicated complaints manager and two complaints officers.

The complaints team had monthly meetings where all issues were discussed and a quarterly report on complaints was prepared containing KPIs and statistics.

The complaints policy distinguished between

a complaint and an enquiry. An enquiry was to find out —— and I hope the quote is accurate —— a first time request for information, advice or for an action to be undertaken, eg estate cleaning not undertaken, estate lighting not working or a repair request.

On a practical level, an enquiry would be passed on by the staff member receiving it to either the customer service centre or directly to the relevant team for action. The intention of the TMO was always to resolve enquiries as soon as possible without them escalating into formal complaints. Sir, of course, we've seen some of the submissions made by the BSRs, but we would say this: this wasn't in an attempt to bypass or avoid formal complaints, but because informal resolution was always preferable.

By contrast, a complaint was defined as an expression of dissatisfaction about a KCTMO service, or a service provided by a KCTMO contractor, not resolved immediately to the customer's satisfaction about the level, quality or nature of a service which the customer feels should have been provided. The TMO publicised the complaints procedure widely to residents on its website, at roadshows, in the Link magazine and through leaflets and posters in the housing offices.

Against this background, sir, we invite the Inquiry

to consider whether some of the BSRs' contention, ie that the complaints policy was not widely known or understood, is correct.

Residents with concerns or complaints could contact the TMO by a number of means, including emailing a dedicated complaints email address, calling the customer service centre or visiting the local housing office. Complaints and enquiries were logged and progressed through the W2 system initially and, from 2016, through the CRM system.

The complaint would first be assigned to the complaints team and then re—assigned to the relevant TMO team, for example Repairs Direct, but the complaints team would always monitor outstanding complaints to ensure compliance, including time limits, et cetera, and would use an interactive complaints dashboard to monitor this.

The complaints policy set out a three—stage process. Stage 1 involved an investigation by the manager of the relevant service area, and if a resident was not happy with the outcome of the investigation, they could escalate their complaint to stage 2. Stage 2 involved an investigation by the head of service. Residents who were still dissatisfied at stage 2 could request a stage 3 review, which was the final stage of the

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

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

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

Claire Williams, from whom you have heard and from

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

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

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

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

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

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

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

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

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

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

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

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

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

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

have been extremely difficult and nobody is doubting that.

Following receipt of the petition, the TMO undertook a door-knocking exercise and spoke to 77 of the 120 households in Grenfell Tower. By contrast to the petition, the door-knocking exercise disclosed a high level of satisfaction concerning the refurbishment and no resident raised any issues relating to bullying or harassment.

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

The group recognised that there were significant

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

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

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

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

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

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

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

Mr Collins stated after the fire, ie in his

statement, that:

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

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

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

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

period expired on 4 July 2017, ie after the fire.

Sir, of course it's a matter for the Inquiry, and we acknowledge the strength of the evidence from the BSRs, but the TMO submits that, in overall terms, complaints and concerns were dealt with and responded to in an appropriate and generally timely manner. In addition to the complaints process, there was scrutiny by a panel of board members and oversight by RBKC. The fact that some complaints which were formally escalated up were eventually upheld illustrates the point that this was a process and a system in place which was transparent and effective to a degree at least.

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

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

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

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

would be convenient to have a break at this point. If we came back at 3.35, that would still mean we'd finish roughly within the time.

MR AGEROS: Thank you very much, sir.

SIR MARTIN MOORE-BICK: Thank you very much. We will break now and resume at 3.35, please.

MR AGEROS: Thank you.

SIR MARTIN MOORE-BICK: Thank you.

(3.18 pm)

(A short break)

(3.35 pm)

SIR MARTIN MOORE-BICK: Welcome back, everyone. I'm going to invite Mr Ageros to continue his opening statement.

MR AGEROS: Thank you very much, sir.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

there is strong evidence to confirm this was the case. For example, Colin Todd says of his FRAs:

"The level of detail is, in my experience, well in excess of that normally included in ... FRAs ... The documented FRAs are amongst the most detailed of the many thousands of FRAs I have studied; in my opinion, the level of detail goes well beyond that necessary for the FRA to be regarded as suitable and sufficient."

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

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

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

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

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

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

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

practical training beyond his operational firefighting role.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 minutes and limiting the leakage of smoke to a prescribed extent.

Carl Stokes himself was involved in a programme to fit new doors, and he later confirmed to the TMO that, so far as he was concerned, the new fire doors met the requirements of the Building Regulations in terms of fire protection.

Sir, the TMO notes the evidence suggesting that, almost immediately after the doors were installed, it was observed that some self-closing devices were insecure. There is evidence, in fact, that the problem was brought to the attention of Manse Masterdor, who returned to remediate the problem, although it is noted that there does not appear to be any clear evidence to say what steps Manse Masterdor took and how many door-closers were inoperative. Again, sir, we accept that the Inquiry will look at this particular issue closely.

Sir, there is also the evidence of Seamus Dunlea, who was an ESA, an estate services assistant who is now sadly deceased, the evidence being to the effect that he disconnected a number of door-closers at residents' request. Sir, this is plainly concerning, but it's noted the issue was raised in correspondence between Janice Wray and Siobhan Rumble, both of whom you will

hear from in topic 2 of Module 3, and it's understood that Seamus Dunlea was told to desist.

Sir, when in late 2015 the TMO received a notice in respect of Adair Tower, which included recommendations in relation to fire doors, it sought to introduce a borough-wide replacement programme. It also responded to the matters concerning flat doors in the notice of deficiency issued for Grenfell in November 2016.

The TMO did not have money in its existing budget to replace the fire doors and it was necessary to revert therefore to RBKC for additional funding. While it's absolutely right that RBKC agreed to funding, it's said that the period within which the door-closers would be retrofitted would be five years, not the three years the TMO wanted.

The TMO also applied for funding to instigate a programme of periodic inspection and repair after the replacement programme, but this was not agreed to by RBKC.

Sir, tests conducted after the fire showed there were serious discrepancies between the fire performance of the doors and the evidence submitted to the testing body. In the simplest terms, they didn't have the 30 minutes' fire resistance represented by Manse Masterdor, and, sir, it's difficult to overstate

the seriousness of this misrepresentation.

With this in mind, the TMO queries the Inquiry's recent decision not to hear oral evidence from witnesses from Manse Masterdor. The TMO would submit there is a strong argument for saying that these witnesses should be called to explain the situation and their conduct, just as witnesses from Celotex, Arconic and Kingspan were asked to explain their own products, particularly, sir, as after the fire evidence has emerged of more widespread failures in the performance of fire doors, which led the then Communities Secretary, James Brokenshire, to conclude that there is evidence of a broader issue across the fire door market.

Sir, turning now to the provisions the TMO made for dealing with vulnerable residents.

The TMO fully accepts it was necessary to make provisions for the protection of vulnerable persons in a fire scenario through its fire risk management system. It notes the criticisms made in the opening statements by the BSRs and accepts that the Inquiry will subject the arrangements it did make and the basis on which they were made to great scrutiny in this module.

The TMO invites the Inquiry to consider the provisions it did make for vulnerable residents against the background of the stay-put policy and its adherence

to the LGA guide. These affected and largely determined its policy, including its approach towards personal emergency evacuation plans, or PEEPs.

In her report, Dr Lane assesses and compares the wider guidance documents regarding vulnerable persons and fire risk, opining that the TMO and/or Carl Stokes should, as a minimum, have been required to consider the body of guidance, as she puts it, available and not focus on the LGA guide. She recognises that the LGA guide provides substantially different advice to other guidance and, by applying it, a duty holder would take a different approach towards safeguarding of vulnerable persons.

The Inquiry will note that the guidance was produced by the LGA or at least developed by the LGA following the fire at Lakanal House in July 2009, and published after wide consultation, including with DCLG and the Chief Fire Officers Association. The LGA guide was substantially written, indeed, by the Inquiry's own expert, Colin Todd.

Apropos of its adherence to the guide, the TMO was a statutory body whose lawful obligation would be to follow guidance produced by DCLG and LGA. Sir, further, the LGA guidance postdates all of the other guidance that Dr Lane refers to having been produced in 2011.

You heard these quotes, I believe, from Mr Maxwell-Scott just before my oral submissions, sir, but can I repeat them here. The LGA guide states that while there may be vulnerable persons in blocks of flats:

"It is usually unrealistic to expect landlords and other responsible persons to plan for this or to have in place special arrangements, such as [PEEPs]. Such plans rely on the presence of staff or others available to assist the person to escape in a fire."

Paragraph 19 of the guide says the alternative to a stay-put strategy is one that involves simultaneous evacuation, and notes that this requires a means of alerting residents of the need to leave the building. It observes that purpose-built blocks of flats such as Grenfell Tower are not normally provided with general fire detection and alarm systems, because experience has shown that most residents do not need to leave their flats when there is a fire elsewhere in the building. Indeed, it says, in some circumstances they may place themselves at greater risk if they were to do so.

The guide also suggests that the risk inherent in the absence of a fire detection alarm system in high-rise blocks is acceptable because it's very rare for there to be an extensive failure of

compartmentation, and this is consistent with the absence in Approved Document B of the requirements for high-rise residential buildings to be fitted with a means of communicating with all occupants simultaneously in order to facilitate a total evacuation.

Indeed, the stay-put policy had been in place for many years at Grenfell Tower and was extensively communicated to the residents of the tower. It was well known to LFB and LFEPA and it was never suggested by either that the TMO should implement a full evacuation policy either in place or in addition to a stay-put policy. The stay-put policy remains to date one approved for similar high-rise blocks by the National Fire Chiefs Council.

Sir, in her report, Dr Lane sets out three scenarios in which vulnerable residents may be affected where a fire occurs in a block with a stay-put strategy. These are where the fire occurs in a resident's flat, where it occurs in a neighbouring flat or where the fire has spread to the common parts. She says that the duty holder should make provision for three corresponding scenarios: the occupants of the flat of fire origin make their escape, occupants in any adjacent flats make their escape, and all other occupants in the

building leave should a simultaneous evacuation strategy become necessary.

Sir, the TMO accepts that you will no doubt assess whether, in the light of the stay-put policy and adherence to the LGA guide, the TMO should have prepared for all of these scenarios, but it's respectfully submitted that when making provisions for vulnerable residents, the TMO was entitled, if indeed not bound, to work on the basis that compartmentation would not fail and all residents would stay put save for those in the flat of fire origin.

Sir, may I deal now lastly with lifts and, in particular, the inability of LFB to take control of the lifts.

Sir, in your Phase 1 report you said:

"When the firefighters attended the fire at Grenfell Tower, they were unable to operate the mechanism which should have allowed them to take control of the lifts. Why that was so is not yet known, but it meant that they were unable to make use of the lifts in carrying out firefighting and search and rescue operations. It also meant that occupants of the tower were able to make use of the lifts in trying to escape, in some cases with fatal consequences. The ability of fire and rescue services take control of firefighting or

fire lifts in a high-rise building is often key to successful operations."

Sir, may we echo your intention to examine this serious issue with the greatest intensity.

Sir, following the Phase 1 report, you, the Inquiry, obtained evidence from various parties associated with the replacement of the lifts at Grenfell Tower in 2002 to 2005 and the maintenance of them following the refurbishment, including the maintenance of the fire control switch.

As the Inquiry is aware, between 2003 and 2006, the lifts at Grenfell Tower were replaced by Apex Lift and Escalator Engineers Limited pursuant to a specification by Butler & Young Consultants Limited. Butler & Young did not specify that the replacement lifts should be firefighting lifts, something the Inquiry's lift expert, Roger Howkins, criticises. In the event, fully compliant firefighting lifts were not installed.

At a later stage, Carl Stokes represented in his FRAs that the lifts were firefighting lifts, which was not correct. In fact, Janice Wray and Robin Cahalarn were both aware that they were not firefighting lifts, despite Carl Stokes' representations, and so they in particular were not in fact misled. Janice Wray always understood that the lifts would not be used to evacuate

residents in the event of a fire as the strategy for Grenfell Tower was stay put.

Turning to the maintenance of the lifts, Roger Howkins states that although there were some failures overall, the lifts appear to have been maintained to an appropriate standard and were generally in compliance with the relevant standards and industry practice. He did not think it likely that a maintenance failure caused the problems with the fire control switch.

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

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

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

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

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

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

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

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

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

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

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

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

Good, thank you all very much.

MR AGEROS: Thank you, sir.

(4.11 pm)

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

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