Grenfell Tower Inquiry

Day 115

March 30, 2021

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(10.00 am)

SIR MARTIN MOORE-BICK: Good morning, everyone. Welcome to today's hearing. Today we're going to hear opening statements from three further core participants, beginning with Ms Anne Studd Queen's Counsel on behalf of the Mayor of London. So my first task is to check whether Ms Studd is there and can see and hear me clearly.

Good morning, Ms Studd.

MS STUDD: I can see you and I can hear you, Mr Chairman.

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

Well, you're the first off to make a statement on behalf of your client, and I think, if you're ready, we're ready when you are.

Opening statement on behalf of the Mayor of London

by MS STUDD

MS STUDD: Thank you.

Mr Chairman and panel members, the Mayor of London wants to make clear that he regards the dismissive treatment of the tenants of Grenfell Tower when they were making justifiable and, as it turned out, prophetic complaints, to be a disgrace.

The Kensington and Chelsea Tenant Management Organisation was everything a Tenant Management

Organisation should not be. It was not community based, it was not co-operatively run, it was not representative, and it was not responsive to residents' needs or feedback.

The Royal Borough of Kensington and Chelsea had a responsibility to ensure that the TMO was fit for purpose. The evidence overwhelmingly suggests that RBKC failed in its duties to the people it was supposed to serve.

The inadequacies and failures of the TMO had been considered by Maria Memoli in her report dated 10 April 2009, and yet in spite of her recommendations, the tenants in 2012 to 2017 were coming up against the same issues that she had identified as requiring remedy during the programme of works undertaken at Grenfell Tower.

Years after the publication of that report, when recommendations concerning the need for a single complaints procedure, proper use of progress reports to keep the complainant informed, swift remedial action, and improved response times, had apparently all been implemented, the residents of Grenfell Tower were facing strikingly similar problems.

Within a few days of the tragedy, Helen MacNamara, then director general for housing and planning in the

Department for Communities and Local Government, emailed Jeremy Heywood, the then Cabinet Secretary, with some initial thoughts on wider questions following the fire. She posed the question of whether the fire was a tragic incident or a sign of wider system failure. She then referred to issues such as catastrophic building failure -- which you, Mr Chairman, confirmed in your Phase 1 report -- tenants' complaints being left unanswered, and issues with social housing regulation, such as whether the regulator knew the TMO was failing, and the effectiveness of the Housing Ombudsman.

These were issues so obvious to Ms MacNamara in the immediate aftermath of the fire, and yet, in the months before the fire, RBKC had been unable or unwilling to acknowledge that the TMO was failing and unfit for purpose.

As late as March 2017, RBKC were responding to a complaint, saying that "the TMO is judged to have a robust management complaints system, which ultimately ends with the judgement of the Ombudsman". That assessment could not have been more wrong.

That the bereaved, survivors and residents were being treated appallingly in multiple different ways does not now seem to be in issue, but why and how this was allowed to continue by RBKC needs to be fearlessly

explored.

The conduct of the TMO towards the residents of Grenfell Tower demonstrates a total failure in ensuring that Grenfell Tower was a safe place to live. In fact, to the contrary, the TMO's seeming inability to consider the welfare of those living in the tower as a priority demonstrates a wholesale failure of any tenant management, and left people feeling that they were looked down upon, disrespected and ignored.

Those that persevered with trying to get their complaints recognised, resolved or even taken seriously, were branded as troublemakers. Where it should have provided a bridge between the tenants and their landlords, the TMO's failures to engage with the tenants in any appropriate and constructive way led to deep distrust.

The Mayor refers to just a few examples. The TMO was dismissive in relation to a disabled resident when she raised concerns about her safety in a fire, and the lack of adaptation to her flat. They were slow and rude when responding to complaints, and yet swift to place a padlock on a garage when a tenant was a few days late paying for the space.

There is consistent and voluminous evidence of the TMO's unacceptable attitude towards residents. This

includes references such as:

"They made us feel a nuisance." {IWS00001539}

"She [the complaints officer at the TMO] was very abrupt and short with me. It was like she was angry with me that I was making a complaint. I felt like they thought I was a troublemaker." {IWS00001775}

And:

"My impression of the TMO's attitude towards the Tower was that it was social housing and that we, its residents, would get what we were given, and be grateful for it." {IWS00001661}

Another example is:

"I feel that the way these concerns were handled is a good reflection of the culture within the TMO and the attitude it had towards Grenfell Tower residents at the time. Ultimately we were people who wanted to feel safe in our homes, and this should not have been perceived by the TMO as something which was annoying or bothersome. I also believe that as residents in so called 'social housing block', we were treated as sub citizens or sub class." {IWS00001619/8}

Does the treatment of residents at Grenfell Tower demonstrate an institutional indifference based upon a perception that social housing tenants should indeed be "grateful" for what was being provided for them "for

free"? Certainly there is an evidential basis for reaching that conclusion.

The Inquiry must look closely at issues related to social housing tenants and their treatment by the authorities, including the possibility of institutional discrimination, racial or otherwise. Although many residents spoke English as a second language, there is a consistent theme that important information was not made available in languages other than English, and that residents felt that having English as a second language was a barrier to them being able to make complaints on their own behalf.

In addition to the grossly substandard service being provided to the residents, the TMO also manipulated the complaints system. Residents became aware that, contrary to published policy, telephone complaints were not recorded and therefore not acted upon, as all knowledge of them was denied. Not only was this contrary to published policy, but it also discriminated against those who were unable confidently to register a written complaint in English.

A second method of manipulation of the complaints system was to ensure that a "complaint" was downgraded to an "enquiry".

In 2015, GTLA complained about the failure to

replace the smoke ventilation and the extraction system was converted to a member's enquiry and not recorded as a complaint. This robbed the GTLA of the opportunity to use the three-stage procedure for the complaints process and to refer the matter to the Housing Ombudsman.

This highlights Ms MacNamara's issue in her email in relation to the effectiveness of the Housing Ombudsman. Clearly in the case of the Grenfell Tower residents, the Housing Ombudsman system is ineffective, but the lack of effectiveness was contributed to by the lack of a clear, unassailable complaints system.

It appears that some of those that did complain soon found out that the TMO and RBKC complaints system was not fit for purpose, and so simply decided that complaining was pointless. This is a position that has to change nationally. Confidence in the complaints system is as important as the robustness of the system itself.

The tragedy at Grenfell has uncovered institutional indifference towards those living in social housing on an alarming scale and with catastrophic results. Residents' safety should be and always should have been of the utmost priority. Residents' voices must be at the heart of decision-making by councils and housing associations. After all, they alone know what it is

like to live in the building, and they literally have to live with the consequences of others' actions or inaction. Residents must have a stronger voice to challenge their landlords to improve performance, and there is an urgent need for better representation of social housing residents at national level.

Social housing must be placed at the heart of Government plans to increase housing delivery. It must not be treated as a secondary tenure.

As part of the equality, diversity and inclusion funding conditions in the new Affordable Homes programme for 2021 to 2026, the Mayor will champion a stronger voice for Londoners, especially those who are underrepresented or face significant housing-related inequalities.

The Mayor calls for a commission for social housing residents who would give strength to those underrepresented voices. The commissioner should be a person who resides in social housing, and their role would be to champion the views and interests of social housing residents and make recommendations to inform future Government policy.

The role of the Housing Ombudsman is obviously crucial. To be effective, the Housing Ombudsman has to be widely publicised, easily accessible and represent

the final arbiter at the end of a streamlined and efficient process.

The Mayor welcomes the Government's plans to simplify access to the Housing Ombudsman as proposed in the Building Safety Bill. He regrets the delays to the publication of the Government's social housing White Paper, which was due to be published on the third anniversary of the fire, but in fact was not published until November 2020.

The Mayor considers it is vital that the social housing regulator adopts the more proactive role proposed in the White Paper as soon as possible in order to properly monitor and drive compliance with the enhanced consumer standard and with the additional enforcement powers as set out in the White Paper.

A key concern is the overlapping remits of the Housing Ombudsman, the social housing regulator and the new building safety regulator. Clarity and collaboration around these roles are essential, as is proper resourcing to enable them to carry out their roles effectively.

At the heart of this module are the bereaved, survivors and residents, who tell you that they live with the consequences of the fact that, in spite of their best efforts, they were unable to prevent this

tragedy occurring. It is a terrible indictment of this obviously broken system that they should have to live with the feeling of responsibility, having tried so hard to make the authorities listen.

Topic 2 will consider the obligations of the TMO and RBKC under the Regulatory Reform (Fire Safety) Order 2005 and their compliance with those obligations.

For reasons that are to be established in the course of this module, the fire risk assessments were unable to identify the very real risks that were presented by this tower. The fire at Lakanal House and the investigations and recommendations that followed were meant to change the approach of social landlords to fire safety forever. The fire at Grenfell Tower shows this was obviously an unfulfilled objective.

But this is an opportunity to fulfil that remit, and ensure a robust system whereby fire risk assessments are made available to residents and, most of all, they are fit for the purpose for which they were designed.

The bereaved, survivors and residents' evidence to you about their concerns about safety will extend to cover issues in relation to the lifts, the self-closing mechanisms on fire doors, and the smoke control systems. You have already heard from them in respect of some of their concerns in earlier modules of this Inquiry.

The Lakanal fire Rule 43 letter dated 28 March 2013 from the Coroner to Eric Pickles, the then Secretary of State of the DCLG, recommended encouraging providers of housing in high-rise residential buildings containing multiple domestic premises to consider the retrofitting of sprinkler systems. The Mayor is clear in his view that automatic fire suppressant systems have a proven record of saving lives, protecting residents, and reducing property damage by controlling the spread of fire and allowing firefighters more time to facilitate evacuation and/or rescue residents. He invites you, sir, to consider again whether the retrofitting of sprinklers should be mandated and centrally funded by the Government in order to avoid future catastrophic loss of life.

Londoners can be assured that the Mayor has ensured that all future buildings on GLA land commissioned under the London Development Panel will include sprinklers or other fire suppressant measures in all purpose-built blocks of flats, regardless of height, all schools and all housing for vulnerable residents. This requirement has also been introduced into the Mayor's new Affordable Homes programme.

This module of the Inquiry is directly focused upon what action the authorities could or should have taken

to avoid the catastrophic events of 14 June 2017. It must provide the answers as to why residents' complaints, enquiries and questions were not appropriately answered or resolved, and why no one took responsibility for this building being so dangerous in the event of fire, when the residents themselves, without any expertise, appear to have been able to recognise those risks, and it must make recommendations that ensure this can never happen again.

Thank you very much, Mr Chairman.

SIR MARTIN MOORE-BICK: Thank you very much, Ms Studd.

The next statement is going to be made by Mr Seaward on behalf of the Fire Brigades Union.

Mr Seaward, are you there?

MR SEAWARD: Yes, indeed I am.

SIR MARTIN MOORE-BICK: Good morning, can you see me and hear me all right? I sense you can.

MR SEAWARD: Yes, I can, thank you.

SIR MARTIN MOORE-BICK: Good, thank you very much. Well, then, I'll invite you to make your opening statement on behalf of the FBU.

Opening statement on behalf of the Fire Brigades Union by MR SEAWARD

MR SEAWARD: Thank you.

Good morning, sir, and your colleagues, both on the

panel and the assessors.

The submissions of those representing the families contained in their written and oral opening statements are most welcome and the FBU endorses them.

The FBU has been fighting the austerity cuts, deregulation and privatisation agenda of central government over the last 15 to 20 years. The FBU contends this agenda has decimated public services, including building control and fire and rescue services, weakened the enforcement regime of fire safety rules, allowed ambiguity and confusion to pervade the guidance, and has led to multiple failures in the application and enforcement of fire safety rules and regulations affecting high-rise residential buildings.

Like Shahid Ahmed and Edward Daffarn, to name but two amongst the families named by their counsel yesterday, the FBU persists. It hasn't given up and won't go away.

The FBU and the firefighters and control staff we represent remain humbled by the suffering of the families and committed to a full and open inquiry. Unlike so many witnesses we have seen in Phase 2 so far, the firefighters and control staff were willing to go into the witness box in Phase 1 without consulting lawyers, reframing their evidence in carefully crafted

witness statements or seeking any undertaking from the Attorney General. They did so out of a sense of public duty. They were casualties too, being placed in an impossible position and expected to deal with it without an evacuation plan or any training how to implement one. They now put their trust in this Inquiry to unearth the causes of the tragedy.

In these submissions, I will focus on the lifts in Grenfell Tower. This is not to detract from the importance of the other matters being investigated in all three topics under Module 3, to which I hope to return briefly, time permitting, but to assist the panel to address the question why the lifts didn't work as attended on the night of the fire.

This matters to the firefighters, both because there may have been fatal consequences, and because the expert lift engineer assisting the panel, Mr Howkins, relies on the witness evidence of lift engineers from PDERS and Bureau Veritas to suggest the fire control switch was working shortly before the fire, and that the reason it didn't work on the night may have been due to the firefighters using the wrong size of key. The FBU ask the panel to reject that suggestion for the reasons which are detailed and fully referenced in our written opening submissions. I do not repeat them this morning,

but summarise the main points.

Before I start, a few preliminary points.

These were not firefighter lifts in the tower as they should have been and as Mr Stokes wrongly advised they were. As a result, there was no triangular key which would have lessened the chances of a firefighter having a key with the incorrect dimensions, and these lifts could not be used to evacuate residents from the tower.

It's not known which drop release key was used by firefighters on the night, and there is no criticism of firefighters sourcing their own drop keys.

By at latest 1.40, the lifts and most of the lift lobbies had filled with thick black smoke and were unusable. It follows that the inoperability of the fire control switch is only relevant in the early stages of the emergency response. I refer the panel to the FBU's chronology of lift use for the details substantiating this submission {FBU00000175}.

Structure: I propose to describe the fire control switch and to explain why it was so important, and then to consider the physical evidence of the switch being blocked with builders' debris and how it became so blocked, and then to consider the unsatisfactory nature of the witness evidence from Bureau Veritas and PDERS.

Then, time permitting, I will say a few words on the other important issues raised in Module 3.

The fire control switch was an important firefighting control in the tower. It was high up on the wall between the lifts. It was designed to be operated by an express drop release key inserted through a round hole and turned to operate the switch. When operated, the switch was supposed to cause both lifts to descend to the ground level, the lift car doors to open and thereafter remain under the control of the firefighters and unavailable for anyone else because the call buttons higher up the tower should have been disabled. This is to protect residents from the known dangers of becoming trapped in heat and smoke in a lift car or lobby.

The firefighters tried to operate the fire control switch as soon as they got into the tower and again thereafter. Crew Manager Secrett tried unsuccessfully at 01.01. Crew Manager Gallagher tried the fire control switch again at 01.34. Firefighter Nuttall later removed the drop release key which had been left stuck in the fire control switch.

The inoperable fire control switch may have had fatal consequences. Tragically, three fatalities were recovered in the lift lobby at floor 10. The Chairman

has found that these people may have been in the lift when it left floor 11, and then exited at floor 10 when the car filled with thick, black, acrid smoke. None of the residents would have been in the lift if the fire control switch had worked.

Additionally, the firefighters were deprived of a valuable firefighting tool. Mr McGuirk and Dr Lane are agreed that, under the firefighters' control, these lifts could have been valuable tools for firefighting operations, enabling them to get to upper floors quickly via the lift, carrying themselves and their equipment; to reach higher floors than their standard duration breathing apparatus would otherwise allow; facilitating longer wears by sparing them the long and exhausting climb up the stairs.

Operator, please show the photographs in Mr Howkins' annex at {RH00000004/108}.

While that's being obtained and put up on screen, I ask the question: so why didn't the fire control switch work? The FBU contends this is because it was blocked and jammed with physical debris.

Turn now to the physical evidence. You can see on the screen on the left-hand side the notes made by the WSP inspectors for Operation Northleigh on 18 April 2018. Starting with the note that says:

"The faceplate was removed to determine the reason for failing to operate the switch."

So they couldn't operate the switch.

The next note:

"We discovered that the mechanism was seized and damaged/deformed."

Looking at the photographs now, you will see that the top photograph shows the fire control switch screwed flush to the wall with no parts of its inner mechanism exposed. That's how Dr Lane found it when she photographed it in the autumn of 2017. It was just the same then.

Please now notice the lower photograph. That shows the switch after the WSP inspectors had failed to operate the switch and then unscrewed the faceplate to determine the reason. The exposed inner mechanism was caked with builders' debris. I ask you to remember this image, both when you look at the next photograph, taken after it had been manipulated by hand by inspectors at Deer Park on 15 February 2019, and when considering whether it should have been reconnected in that state, as it must have been, in August 2016.

Andre Horne and others inspected the switch on 15 February 2019 in a workshop at Deer Park to determine why it wasn't working. They reported also the

microswitch was jammed, appeared to be wall plaster used during the works, and they go on to talk about plaster grains on the work bench, and that the build-up of builders' material on the top of the switch was from the original works, not caused by the extraction of the switch, and they noted that the microswitches operated correctly when the jam was cleared.

According to Andre Horne's later report on 15 February 2019, the switch frame arms of the ground floor switch were found to be jammed. There was some debris evident on the frame. It goes on to say that after some gentle manipulation by hand, it moved freely. Then he gave their opinion that forceful manipulation of a fitting key would have moved the switch frame arms. The bent side wards and the switch frame arm did not cause the jam experienced at the start of the examination. So it was only after the switch had been cleaned of the debris that the fire control switch worked.

I was going to ask you all to have a last look at the caked debris on the fire control switch in the lower photograph. I wonder, operator, if you could just put that back {RHO00000004/108}. I don't know if you can enlarge the lower photograph, operator. That's very helpful, thank you. You can see there that it is

indeed, as it comes out of the wall on 18 April 2018, caked with builders' dust and debris.

Now, operator, please put up the photographs taken on 15 February 2019, that's {RHO00000004/234}. Thank you. You can see there, this is the photograph taken after the switch had been manipulated by hand to clear the blockage, and you can see that it's much cleaner after that manipulation by hand than it was when it was found on 18 April 2018. You can actually see in the photograph some shiny bits, where before it was completely covered with debris.

To recap, the fire control switch had not worked when firefighters tried to operate it on the night, when they're likely to have applied reasonable force to turn the key, nor when the WSP inspectors tried to operate it on 18 April 2018. It was then taken to Deer Park, where it was again found to be jammed, and didn't work until, after some gentle manipulation by hand, it moved freely.

The photographs can be taken down now, thank you.

The FBU therefore invites the panel to investigate whether the blockage would have prevented firefighters operating the fire control switch on the night, whichever type of drop key was used. If so, it's irrelevant whether Crew Manager Secrett and Crew Manager Gallagher and/or Firefighter Nuttall used

a key like the one later provided by Firefighter Nuttall or a standard express drop release key. Whichever key they used, the fire control switch was blocked with builders' debris and could not be turned with the application of reasonable force until the plate was removed and the blockage cleared. If this is right, the blockage is the principal reason why firefighters were unable to take control of the lifts, as they repeatedly tried to do.

Accordingly, the FBU invites the Inquiry to reject Mr Howkins' conclusion at his paragraph 597.3:

"... but with forceful manipulation with a fitting key the fire control switch would probably have worked."

How it got into that state the panel may also wish to investigate, how the fire control switch came to be caked with builders' debris. Shahid Ahmed complained of misuse and overuse of the lift during the refurbishment, and Simon Lawrence of Rydon admitted using the lifts daily to get materials up the building, so there was plenty of builders' dust and debris generated by the works in the vicinity of the ground floor switch.

Mr Howkins has concluded that, during the main refurbishment works, the ground floor switch had been disconnected, a temporary fire control switch had been installed at walkway level on floor 2, this temporary

floor 2 switch had been disconnected by August 2016, the ground floor fire control switch had been reconnected from about the same time, August 2016, and the disconnected temporary fire control switch had been left in place on floor 2, whereas it should have been removed. The Inquiry may conclude that the ground floor fire control switch should not have become contaminated with builders' debris if it had been secured or covered during the works, and thus infer, as the FBU contends, that it was probably left vulnerable and thereby exposed to contamination by plaster dust and debris after the temporary fire control switch was installed at walkway level on floor 2. How else could it have become contaminated by builders' debris?

The Inquiry might also conclude that the switch should not have been reconnected in August 2016 caked with builders' dust and debris. Whoever reconnected it should have ordered a new one, or at least cleaned and tested the existing one. Reconnecting it in this state showed a shocking disregard for an essential firefighting feature of the tower, and so also for the safety of residents. It's no surprise that the person who reconnected the switch has not been identified.

Mr Howkins has observed that the witness evidence of engineers from Bureau Veritas and PDERS is that they

tested the fire control switch before the fire and didn't identify any faults, and he has reported that, assuming that PDERS were checking the operation of the fire control switch and associated systems each month, it doesn't appear that any other potential maintenance deficiencies would have affected the operability of the fire control switch.

Mr Howkins acknowledges it's the function of the panel to make findings of fact, and the FBU asks the Inquiry to investigate whether his assumption can properly be made, or whether Dr Lane's approach is to be preferred. This is her Module 3 report, chapter 8, at paragraph 12.2.41 {BLARP20000027/256}:

"I have post-fire information by means of witness statements from a small number of lift maintenance contractors, that this was done [ie inserting the rotating fire control switch] – but just that they never once documented it over a seven year period ...

"As there are years of records demonstrating concern about the various lift contractors employed by KCTMO, it is not appropriate for me to rely on such weak evidence and so I have taken the decision not to rely on it."

The FBU urges that that is the proper course to take.

Dr Lane found no written records to demonstrate that

the switch was ever manually operated in a routine inspection. Mr Howkins likewise found no evidence of any regular or any testing of the fire control switch by other people who were supposed to test it, so the TMO's lift engineers, The Gerald Honey Partnership, Apex or Calfordseaden, even though they were all supposed to do so. There is thus a track record of lift maintenance contractors and engineers not testing the fire control switch, yet Mr Howkins credits Bureau Veritas and PDERS with having done so.

So it all comes down to the witness statements filed on behalf of Bureau Veritas and PDERS. These are all self-serving, because both companies were obliged to inspect the fire control switch under the terms of the 2017 procedure for Bureau Veritas, and under their contract with the TMO for PDERS.

But for the reasons set out in detail in our written submissions, the FBU invites the panel to find these statements, particularly of Mr Fallis-Taylor and Mr Wallis of PDERS, and Mr Lasisi and Mr Arnold of Bureau Veritas, are unreliable insofar as they allege the fire control switch was inspected and tested and found to be working normally before the fire.

After the fire, of course, everything changed. Our reasons can be summarised as follows.

Any competent lift engineer who inspected the lifts and tested their firefighting features in the months leading up to the fire could reasonably be expected to have observed at least three defects:

(1) the fire control switch on the ground floor was stiff and difficult to operate, and then, upon rudimentary inspection, that it was damaged and blocked with debris, and to have reported the need to clean or repair it or replace it.

(2) the fire recall function was disconnected and, upon rudimentary inspection, that the wires had been cut with straight ends, and to report the need to reconnect it.

(3) that the disconnected fire control switch on floor 2 should be removed.

None of them did. The Inquiry may conclude that was because they were not asked or encouraged to do so by their supervisors and did not do so until after the fire. Certainly there was no record made of any pre-fire inspection or testing of the fire control switch.

The Inquiry has just recently decided to dispense with the oral evidence of Mr Fallis-Taylor and instead to read his statement into the record. The FBU asks the GTI team either to reconsider this decision, or at least

to attach no weight to Mr Fallis-Taylor's statement, given the partial and self-serving nature of his contentious assertions, all of which are based on hearsay or speculation, not on what he saw, did or heard.

Have I time for a few words on the other issues raised in Module 3? I think I do, don't I?

SIR MARTIN MOORE-BICK: You have a few minutes, but not too many.

MR SEAWARD: Thank you.

As to topic 1, the FBU welcomes the opportunity afforded the BSRs to explain some of their fire safety concerns before the fire and how they were dealt with by the TMO.

As to topic 2, the obligations of the TMO and RBKC under the Regulatory Reform (Fire Safety) Order and their compliance with those regulations, the FBU notes the divergent opinions of Mr Todd and Dr Lane and, where they differ, invites the panel to prefer the opinion of Dr Lane. It's a great shame that careful analysis of the relevant legislation and guidance given on how to implement it such as Dr Lane has now provided was not commissioned and provided by the DCLG soon after the recommendation of Her Honour Frances Kirkham CBE in 2013. Baron Pickles, then the Right Honourable

Eric Pickles MP, should explain this to this Inquiry, his different conclusion in 2013.

The FBU agrees with Dr Lane's opinion:

That Grenfell Tower was a complex building with a mixture of domestic and non-domestic accommodation, with multiple responsible persons and over 300 residents. This is patently preferable to Mr Todd's contrary opinion.

That Grenfell Tower required a comprehensive fire risk assessment process, carried out by a competent fire risk assessor within a framework of a documented set of fire safety arrangements, including a documented and comprehensive emergency plan.

That Mr Stokes substantially failed to adequately consider the arrangements for the safe evacuation of people identified as being especially at risk, particularly those with vulnerabilities relevant to a fire event.

That there were no documented arrangements made by KCTMO to confirm that their employees would arrange a general evacuation of any high-rise residential building and KCTMO made no such arrangements for Grenfell Tower.

That their fire risk management system for the huge property portfolio of 9,476 properties appears to have

been woefully underfunded. Whereas adequate resources were required to fund RBKC's fire risk management system, fire risk assessments borough-wide cost a mere £1,226 per month for the year ending July 2014, and fire risk assessment works cost just £200,000 in the year 2016 to 2017, just before the fire. Dr Lane could not find a comprehensive and clear budgeting process for all aspects of KCTMO's fire risk management system, nor understand how the TMO communicated to the borough the resources that were required each year for the TMO to adequately implement their fire risk management system and thereby comply with the order.

The FBU agrees that the TMO's and also RBKC's fire safety management system was woefully under-resourced. The health and safety team comprised, top-down, the chief executive, Robert Black, who appointed Anthony Parkes until June 2015, and then Barbara Matthews thereafter, as executive director of financial services and ICT to take day-to-day responsibility, and Janice Wray as health, safety and facilities manager. Dr Lane found no evidence of KCTMO assigning any persons as specific fire safety managers of individual buildings or groups of buildings.

Against this background, it's no surprise that Mr Stokes submitted the lowest bid of all five tenderers

for the role of fire risk assessor, or that the TMO failed in their primary duty to monitor and review their fire risk assessment programme and assure themselves it was producing suitable and sufficient risk assessments for their premises.

There is currently no formal designation equivalent to chartership for fire risk assessors and this is a concern, the FBU agrees.

Dr Lane was unable to find any guidance like the Fire Risk Assessment Competency Council's "Choosing a Competent Fire Risk Assessor" that would have been in place in 2010 when KCTMO first appointed Mr Stokes.

Once again, the FBU makes the point that industries cannot be trusted to regulate themselves. After the Lakanal House fire, recommendations were entrusted to the Fire Sector Federation, whose efforts failed to solve the problem of ensuring adequate training, qualification and competency for fire risk assessors of complex buildings. This was a factor in the Oldham Street fire also, leading to Senior Coroner Meadows recommending that the Secretary of State for the Home Department considers measures to ensure that fire risk assessors are adequately trained and qualified so as to be competent in the role, and the responsible person has the means to verify the

competence of any person holding themselves out to be a fire risk assessor.

Dr Lane has identified that a well structured definition of competence and associated qualifications, training and experience, as well as professionalising the role of fire risk assessor, would, in her opinion, be an appropriate focus for recommendations from Phase 2 of the Inquiry.

The Local Government Association guidance, Dr Lane is of the view that it significantly downplays for blocks of flats the importance of the planning and recording of fire safety arrangements, as well as the need to clearly communicate organisational requirements as part of the duties the responsible person has under the order. If the panel agrees that this is a valid criticism, it may assist in deciding whether to prefer Dr Lane's opinion or Mr Todd's, where they differ, in respect of complex buildings such as Grenfell Tower was.

Finally, moving on to topic 3, the FBU agrees with Mr Hancox's report of 1 October 2019 about the installation of a new gas riser in the stairwell. The FBU hopes the Inquiry will investigate how and why the possibility of running the new gas riser in the same place as the old riser was discounted in discussions between tRIIO and the TMO. That's his paragraph 317.

It bears the appearance of a shameful disregard for the safety of residents -- I should say another shameful disregard of the safety of residents -- to take the easy option of running it up some means of escape, thereby further reducing the already minimal and confined space and introducing combustible material, timber and gas, to a protected area.

Mr Hancox's conclusion is that Cadent should have refused to replace the gas riser and offered compensation to the residents instead. The FBU hopes the Inquiry will investigate the question of whether the decision to place the gas riser in a single means of escape was justifiable on any ground other than keeping down costs.

Thank you, sir, those are my oral submissions.

SIR MARTIN MOORE-BICK: Well, thank you very much, Mr Seaward.

Now, the last opening statement which we are going to hear is to be made by Mr Walsh Queen's Counsel on behalf of the London Fire Commissioner.

So, Mr Walsh, good morning. Are you there? Can you see and hear me well?

MR WALSH: I can see and hear you very well, Chair, I hope you can see me.

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

good morning, and if you're ready to make your statement, off you go.

Opening statement on behalf of the London Fire Commissioner by MR WALSH

MR WALSH: I am, indeed.

Well, good morning, sir, and good morning, Ms Istephan and Mr Akbor.

Sir, having heard the submissions made this morning, just briefly, on behalf of the London Fire Commissioner, we would echo the calls by the Mayor of London, through Ms Studd, for the introduction of sprinklers in all high-rise residential buildings. That is something which the LFB has promoted for many years and campaigned for.

Mr Seaward's submissions on behalf of the FBU in respect of the lifts at Grenfell Tower, which you have only just heard, are well made and we broadly agree with them. I can't strengthen those arguments by repetition, so I won't try.

Instead, on behalf of the London Fire Commissioner, I would like to begin these relatively short submissions by recognising the exhaustive work which the Inquiry has carried out in Modules 1 and 2, which has exposed the way in which the maintenance and refurbishment of Grenfell Tower were carried out so as not only to render

what should have been multiple essential fire safety measures ineffective, but also to create a situation which caused and actively contributed to the devastating fire on 14 June 2017.

The evidence has exposed a truly shocking picture, as so many of the core participants have said over the last day or so, and obviously the existence or repetition of such a state of affairs is utterly unacceptable.

There is an absolute necessity in the public interest to ensure that the construction, maintenance and refurbishment of premises by and on behalf of building owners includes and results in necessary lawful and effective active and passive fire safety measures.

Sir, as you know, those fire safety measures are in turn crucial to fire and rescue services when carrying out their essential core functions, and the extent to which the LFB, or any fire and rescue service, can or should be expected to anticipate, plan for and resource the possibility of catastrophic failures of fire safety measures in the built environment remains of fundamental importance to the sector and, we submit, to this Inquiry.

The expectations that can be properly placed by fire and rescue services on its personnel is a critical

aspect of that question. The fundamental failure of basic fire safety measures in buildings such as Grenfell Tower present an obvious serious risk, not only to residents, who are clearly the primary concern, but also to firefighters, who depend on the existence of such measures when carrying out their duties at great personal risk.

The importance of protecting the safety of firefighters in the complex process of developing fire and rescue procedures for catastrophically failing buildings is often ignored, or at least given lower priority than it should be by some commentators.

But to fire and rescue services, it is of the highest importance, not only because they owe a duty to their employees, but also because the risks to firefighters who are deployed into buildings in the most dangerous of circumstances, which may result in significant injury or worse, has a direct impact on the safety of the public, the people who they are trying to protect or rescue at an incident.

Now the Inquiry's focus turns, through Module 3, to consider how, if at all, the hazards presented by the tower as refurbished were or should have been identified and, once identified, how they could or should have been responded to. A key element of that work revolves

around the adequacy or otherwise of the fire risk assessment carried out by or on behalf of the responsible person under the Regulatory Reform (Fire Safety) Order 2005, the RRO.

The Inquiry has the benefit of a wide range of factual evidence and expertise to absorb and assist in reaching its conclusion, including in particular the evidence of Colin Todd and Dr Barbara Lane, who are both eminent experts in their specialist fields.

In relation to Dr Lane's analysis, one aspect of chapter 10 of her report requires some observation, in our opening submissions to you. That is the LFB's position as to whether or not the external envelope of a building was caught by the terms of the RRO.

What is not in doubt is the desirability of its inclusion, and by that we mean a clear legislative requirement, whether it's found in the RRO or in some other relevant legislation. But the lack of clarity within the RRO itself, as it was originally and is currently drafted, is commensurately undesirable.

Whatever the merits of the very different views expressed by Dr Lane and Mr Todd in their expert reports, which are variously deployed by core participants in their opening statements, the inescapable fact is that it has been and is now

necessary to change the terms of the legislation to resolve the problem.

It is of note that the current Fire Safety Bill amends the RRO so as to expressly apply it to the building's structure and external walls and common parts, including the front doors of residential flats.

Now, whether these amendments can properly be understood as clarification or extension of the scope of the RRO, they have in reality been received as changes, welcomed by the public and industry bodies alike, and expected by Government to increase the burdens on persons responsible for multi-occupancy residential buildings and "provide for increased enforcement action in these areas, particularly where remediation of ACM cladding is not taking place".

In other words, the change in the terms of the legislation was, is, necessary to allow enforcement action to be taken with certainty, as the Government anticipates.

But, sir, notwithstanding the lack of clarity in the terms of the RRO, the benefits and desirability of including the structure and external envelope of buildings within its scope lay behind Assistant Commissioner Steve Turek's letter to London boroughs and social housing landlords of 23 March 2009, and in our

written submissions we provide references to that document as to where it can be found, and indeed to other documents which we will refer to in a moment.

But those considerations also informed the exerpted content in chapter 10 of Dr Lane's report of the notice of fire safety deficiencies issued to the TMO in respect of Trellick Tower on 19 September 2012.

However, at those times, during those times of enforcement, the lack of clarity in relation to external envelopes of buildings remained a considerable problem for enforcement bodies and for a broad range of other stakeholders. The Lakanal House fire and the investigations that followed underlined the continuing lack of clarity so that clear advice had to be sought, and was sought, by the LFB from the responsible Government department.

In response, in letters to the LFB in February and again in December of 2013, the Government response was effectively that the requirements and powers set out in the RRO were not, in its view, applicable to the external structures and surfaces of residential buildings. The reasoning given in those letters was that the RRO does not apply to domestic premises, as is unquestionably the case, saving in the most limited of circumstances, and it would be artificial, so goes the

reasoning, to exclude the exterior walls from the domestic premises which they surround. It was also pointed out in the letters that other legislative mechanisms were available to secure fire safety standards, in particular the Building Regulations 2010, as they then were, and the Housing Act 2004.

But nonetheless, following the receipt of that view from the Government department, the LFB continued to consider what means were at its disposal to raise awareness with building owners of risks imposed by external envelopes of buildings, even if the formal enforcement tools set out in the RRO were not available.

The letter of Assistant Commissioner Dan Daly of 6 April 2017 sent to local authorities, including RBKC, did not assert expressly that an assessment of the external envelope itself fell within the scope of the RRO, but it was carefully and deliberately crafted by Assistant Commissioner Daly to set out the strength of the LFB's concerns and its expectations in light of the fire at Shepherds Court, including the provision of "all relevant information about any replacement window and façade schemes to fire risk assessors", so as to ensure that the fire and other safety risk assessments were carried out in full understanding of the relevant built environment.

And, sir, the LFB remains of the view that this is and was a proper expectation of a building owner and a responsible person. Of course the fire risk assessment process does not and cannot function as an audit of the built and constructed environment, but a fire risk assessor instructed by a responsible person is dependent on the adequacy and accuracy of the information which is supplied.

So, Assistant Commissioner Daly's letter to RBKC in April 2017, and to other London boroughs, illustrates the LFB's commitment to building pragmatic partnerships with local authorities by sharing known fire safety risks with building owners and promoting public safety. That commitment is also apparent in the LFB's engagement with both the TMO and RBKC, which I know will be explored further in Module 3.

But apart from the need for clarity in the terms of the RRO, there are obviously broader issues which fall to be considered in Module 3, and in later modules. High on the list of those issues, as is made clear in the submissions on behalf of the bereaved, survivors and residents, is the overriding need to ensure that residents' vulnerabilities are accommodated to ensure their safety in case of fire. That is particularly so in the social housing context, and it must, we say,

include the allocation of suitable properties in suitable locations in high-rise premises where the use of stairs may be the primary or only means of escape during a significant fire.

Just as an aside, here we would point out that the presence of a working firefighter lift, while extremely valuable for a variety of reasons, is by no means a complete answer to that question.

Now, this is one of a number of issues which have national significance for fire and rescue services and building residents alike, and the LFC strongly believes that the Inquiry would benefit from the views of the National Fire Chiefs Council on a range of those issues.

Sir, the LFB continues to look to the future in developing its response strategies to fire risk in high-rise residential premises. It has not only conducted an extensive review of policies and procedures for information-gathering, assessment of risk and operational firefighting, but has also commissioned a significant number of research projects to inform ongoing learning.

Among those projects, and here we give a couple of small but important examples of a much bigger piece, in partnership with the University of Bath, research has been conducted into the physiological effects on

firefighters who are deployed into high-rise buildings in which active and passive fire measures may have fundamentally failed. One of the purposes of that research is to determine the extent to which firefighters can be deployed in a way which does not place them at unacceptable risk to their own safety and, as a consequence, to that of the people who they are required to assist.

It is expected that the results of that research will be of national and international significance, because as far as we're aware, no similar research has been undertaken anywhere worldwide.

Another research project, this time in the field of communications, has informed the imminent introduction by the LFB of a system by which fire survival guidance information can be viewed in real time, at the same time, in the control room and on the fire ground using devices provided to incident commanders and at the bridgehead inside the building. It's expected that the introduction of that new system will positively influence the development of operational procedures by fire and rescue services nationwide.

Finally, sir, the evidence which the Inquiry has examined in Modules 1 and 2 has been highly informative to the LFB in its ongoing review and learning process.

Module 3, insofar as it relates to the vital requirement for building owners to conduct suitable and sufficient assessments of fire risks in their premises, will provide an opportunity to underline a principle which is of great importance to fire and rescue services.

The safety of occupants of high-rise residential buildings, and the ability of fire and rescue services to carry out their work effectively in case of fire is wholly dependent upon a robust system of risk assessment, and the rigorous amelioration of the identified risks by building owners and other responsible persons.

Well, sir, those are the opening submissions on behalf of the London Fire Commissioner, unless I can help you further.

SIR MARTIN MOORE-BICK: Well, Mr Walsh, thank you very much indeed. Those are very helpful remarks. Thank you.

Well, that brings to an end the oral opening statements. There are other written opening statements which will be available for people to read, but that concludes the oral opening statements.

The next step in the Inquiry is to begin taking evidence from witnesses. We shall begin to do that on 19 April, and we hope, and indeed expect, to be able to resume limited access hearings at the Inquiry's premises

at Bishop's Bridge Road.

In those circumstances, it only remains for me to close the hearing for the time being, and to reiterate that we shall resume at 10 o'clock on 19 April, when we shall begin taking evidence.

Thank you very much.

(11.00 am)

(The hearing adjourned until 10 am on Monday, 19 April 2021)

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