



GRENFELL TOWER INQUIRY RT

Day 293

June 20, 2022

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(10.00 am)

SIR MARTIN MOORE—BICK: Good morning, everyone. Welcome to today's hearing. Today we're going to begin hearing closing statements in relation to Module 6, and the first statement is going to be made on behalf of some of the bereaved, survivors and residents by Ms Barwise Queen's Counsel.

So, Ms Barwise, if you would like to come up to what is now the counsel's bench.

Before I invite Ms Barwise to start her statement, can I just say this: we have a very tight timetable to get through today, so I'm going to ask all counsel to make sure that they finish their submissions within the time specified in the timetable. I say "within", because I don't think anyone is going to be grateful to those who overrun or try to overrun and, if necessary, I shall intervene to invite you to draw your statements to a close.

With that, Ms Barwise, we should like to hear from you, please. Thank you very much.

Module 6B (Government, Testing and FRA) closing submissions on behalf of BSR Team 1 by MS BARWISE
MS BARWISE: Good morning, sir. Good morning, Ms Istephan. Good morning, Mr Akbor.

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Our submissions fall into five parts: first, an overview; second, the relationship between Building Regulations and ADB, the history of fundamental flaws in ADB and amendments made; third, delays in reviewing ADB following Lakanal and knowledge of risk; fourth, the department's systems failures; and, finally, the role of industry.

Starting with the overview.

The evidence has made plain that the seeds of the Grenfell disaster lie in the concealment, beginning over 20 years ago, of the fact that class 0 cladding was a fire hazard, at a time when 1960s blocks were failing and more energy efficient housing was desperately needed. The realisation of a burgeoning cladding crisis led to continued lack of candour, and the failure to adequately regulate the requirements for the external wall was motivated by a desire to allow the construction industry sufficient latitude to rapidly build housing. All this militated against exposing the dangers of existing cladding upgrades.

Over time, this was exacerbated by an overarching, unyielding, safety—blind deregulatory agenda, which ministers deny, but officials believe allowed no change to or clarification of Building Regulations or ADB.

The evidence has revealed an extraordinary conflict

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which the panel must resolve, in that ministers would have the panel believe officials laboured of their own volition under this fatal misapprehension, but that is not credible and the evidence suggests otherwise.

The other, allied fantasy which the panel must resolve is the portrayal of the department's Mr Martin as a lone wolf, the single point of failure, as Dame Dawes described him, and he, after seven days of evidence, accepted. Given his physical proximity to colleagues and the way the department operated, this is not credible. The truth of the matter is that he was put and kept in that position to execute the department's deregulatory strategy and, indeed, promoted even after Grenfell. Colleagues, despite their loyalty to him in giving evidence, must have been aware of his cavalier attitudes, which are evident in the majority of his emails. His fundamental desire to protect the financial interests of UK Plc, as he called it, secured his primacy in the Building Regulations division.

The department completely ignored all the coroner's recommendations following the fatal Lakanal House fire in 2009. The review of ADB was deliberately deferred until 2016/2017, when it would have been done anyway, and was then rolled up into a wider Building Regulations review. The panel has heard from Mr Ledsome that the

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roll—up of ADB into a wider review was so that savings could be made from ADB in order to introduce the necessary environmental changes into Approved Document L, and that was clear from the documents put to Lord Pickles, who did not deny the intent, but thought the figures merely projections.

The horse trade between parts B and L was, as both ministers and officials knew, to satisfy deregulatory policies, which required the introduction of any new regulation to be compensated for by the omission of existing regulation, so as to result in a net equivalent cost to business. These decisions were taken to subjugate Building Regulations to both the energy efficient housing and deregulatory agendas at the behest of Prime Ministers, initially David Cameron and latterly Theresa May.

The series of warnings concerning modern materials received by the department, often directly to ministers, either by submissions or APPG or the fire sector, in advance of ministers making deregulatory decisions on Building Regulations, makes undeniable that government knew both regulations and ADB were potentially hazardous, and yet forged on with its twin deregulatory and housing and deregulatory agendas.

An accompanying pattern of concealment emerges from

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1 BRE's misleading investigations into fires, from the
2 department's failure to transparently report on them,
3 from allowing ambiguity in 12.7 of ADB from 1992 onwards
4 and failing to review ADB at all from 2006, other than
5 for deregulatory purposes, until well after Grenfell.
6 Indeed, the department made a conscious decision, as
7 Dame Dawes told us, not to clarify clause 12.7 of ADB
8 even after Grenfell. All this despite the 2009 Lakanal
9 fire and inquest goes beyond peradventure.

10 From at latest Spring 2015 onwards, when BRE's seven
11 workstream reports formally reported, the department was
12 aware of ADB's antiquity and of it not having kept pace
13 with modern materials, as made clear by those reports.
14 They were withheld following input from the then
15 Secretary of State Sajid Javid's adviser. The Building
16 Regulations discussion document stalled in
17 Lord Heseltine's office. It is clear both the
18 workstream reports and the discussion document were
19 withheld for political reasons. The discussion document
20 was withheld until February 2019, despite the
21 department's appreciation of its significance, because
22 it would have committed the department to a review of
23 Building Regulations, albeit the scope of the discussion
24 document was purely deregulatory. The workstream
25 reports were withheld because they exposed the extent to

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1 which ADB was undermined by the use of modern insulation
2 and showed the need for a complete overhaul of Building
3 Regulations.

4 The deliberate decision—making is only consistent
5 with a desire to suppress known risks, to avoid
6 interfering with the two driving imperatives: energy
7 efficient housing and deregulation. The panel has heard
8 credible evidence from officials that the deregulatory
9 and housing agendas took precedence over Building
10 Regulations and ADB review, and Lord Barwell also made
11 clear that the housing agenda was predominant.
12 Generally, however, ministers did not admit that the
13 housing and deregulatory agendas took precedence over
14 ADB review despite the life safety risks. In the case
15 of each deferral of ADB post—Lakanal, the relevant
16 minister was aware of the dangers posed by delaying ADB.

17 The evidence has also exposed the tension between
18 functional building requirements, Building Regulations
19 which implicitly require state scrutiny, and ADB, which
20 is prescriptive, exploited by industry and policed by
21 an inadequate building control, in turn too lightly
22 scrutinised by government. This was exacerbated by
23 introducing approved inspectors, who did not compete on
24 a level playing field with local authorities as they
25 lacked powers of enforcement, and would lose fees if

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1 work had to revert to local authorities for enforcement.
2 Those authorities had to be cost neutral and, therefore,
3 were desperate for work.

4 The department considered approved inspectors
5 a regulator, but they are not a public body, have
6 private competing interests and no enforcement powers.
7 As such, they were merely an inspectorate. But this
8 inequality was overlooked. NHBC's behaviour
9 demonstrates its total unsuitability as a putative
10 regulator. Its acceptance of non—compliant K15 drove it
11 to interpret the regulations and ADB perversely, and
12 latterly, in 2016, to publish guidance which approved
13 the use of ACM PE together with combustible insulation
14 without test. NHBC's closing observes that, as insurer
15 of its own book, it is in its own interests not to lower
16 standards. We agree, but, probably to save face, that
17 is nevertheless what it did, although NHBC denies this.

18 Underlying ADB was a testing and certification
19 regime propped up by BRE as test house and BBA and LABC
20 as certifiers, with UKAS presiding above. The dishonest
21 and unrepresentative testing and certification was
22 client—focused and carried out by insufficiently
23 competent staff. UKAS's failure to witness BRE testing
24 for some seven years between 2008 and 2016 shows
25 a disregard only consistent with not wishing to find

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1 problems. UKAS emerges as an ineffectual organisation,
2 too willing to assume competence in the bodies it
3 oversaw, and so focused on pleasing them at the expense
4 of public safety that it will not even report fraud.
5 The frailty of this house of cards was an ideal prop to
6 facilitate industry capture of an inadequately robust
7 regulatory regime.

8 The role of BRE as adviser on ADB revisions and
9 investigator of fires make it complicit in government's
10 actions. BRE protest that it is not a regulator; we
11 have never said it is, but its code of conduct requires
12 it to hold paramount the health and safety of others.
13 In this fundamental purpose, it failed.

14 Whilst BRE was somewhat hamstrung by the department
15 in the way that it was funded and latterly required not
16 to make recommendations, it is up to a competent service
17 provider, especially a safety critical service provider,
18 to inform its employer of any constraints affecting its
19 ability to carry out its work. If the supplier doesn't
20 advertise the difficulty, then it is complicit, as BRE
21 was. This is exemplified by BRE's misleading and
22 therefore dangerous research. It does not avail BRE to
23 assert, as it does, that government received warnings
24 from others. Many of these others might have been, and
25 were, perceived as having their own agendas, whereas BRE

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1 was supposedly independent.
2 BRE's flaccid recommendations to the department were
3 unscientific and did not communicate the sense of
4 urgency or importance of the recommendation. This was
5 particularly true of the cc1924 test report, which
6 recommended only that the fact that a class 0 panel was
7 by far the worst performing of those tested may require
8 further consideration.

9 Whilst BRE was independent from 1997, the
10 relationship between it and the department, with Martin
11 in both camps for nine years, was unhealthily close.
12 BRE did the department's bidding. An important feature
13 of the department's failure to clarify ADB is BRE's
14 protectionism of its own role as custodian of the fire
15 safety mantle, with a BS 8414 testing monopoly which
16 blossomed whilst clarification of ADB was being mooted
17 by industry. Whilst of course, in Module 6, it is right
18 to focus on government and related institutions'
19 responsibility, industry's role in the events which led
20 to Grenfell is ultimately more important, as I will
21 explain. What follows must be understood in that light.

22 I now turn to the relationship between Building
23 Regulations and ADB.

24 Building Regulations are performance-based,
25 requiring the designer to achieve the functional

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1 requirements, and ADB is supposed to postulate routes by
2 which the functional requirements may be achieved. Both
3 the Building Regulations themselves and ADB make clear
4 that following ADB is not a guarantee of compliance and,
5 therefore, the designer must use judgement.

6 There are two relevant respects to Grenfell in which
7 the department failed to adequately address the
8 functional requirements: B4(1), external fire spread,
9 and B1, means of escape.

10 First, external fire spread.

11 As explained, even if using the linear route, and
12 particularly if using the test route, the designer must
13 exercise judgement. Nevertheless, a culture of
14 convenient dependency on ADB has developed, whereby
15 industry has fixated on diagram 40 which, in the
16 versions of ADB in force from 1992 onwards, provided
17 a cladding panel need only achieve class 0 or, from 2002
18 onwards, class B or 0, regardless of its core. This
19 permits ACM panels, even though that is clearly in
20 conflict with the functional requirement.

21 The evidence shows that neither government nor BRE
22 considered how the functional requirement, B4(1), was to
23 be achieved effectively, despite prescribing routes
24 which it now accepts it did not understand and did not
25 know whether they would achieve the functional

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1 requirement.

2 The test route depends on not failing the
3 performance criteria in BR 135 which govern the
4 large-scale BS 8414 tests. The panel has heard evidence
5 from Drs Colwell and Smith that these criteria are
6 completely arbitrary and are only failure criteria, so
7 they tell the designer only what he should not use and
8 do not assist with how to design a safe system.

9 As to the linear route, no one considered whether
10 limited combustibility insulation and class 0 would
11 achieve adequate resistance to flame spread in any type
12 of building, still less a high-rise building.

13 These failures are the primary failures insofar as
14 functional requirement B4(1) is concerned. Delay in
15 withdrawing class 0 and in failure to introduce the
16 Euro classifications in a timely manner are subsidiary
17 to this failure, albeit significant contributors to the
18 problems experienced.

19 Professor Torero considers the ambiguity resulting
20 from the functional requirements, coupled with ADB,
21 places a considerable burden on the designer, but
22 Professors Torero and Bisby, Mr Hyett and Mr Sakula,
23 also consider that a competent designer should have
24 understood what the regulations and ADB required.

25 Second, functional requirement B1, means of escape.

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1 The department failed to produce adequate guidance
2 in relation to means of escape for those with
3 disabilities. ADB was premised on inclusive design,
4 albeit referencing a repealed statute, and, according to
5 Dr Lane, a competent fire engineer should have
6 appreciated additional measures would be required.

7 However, the department had known since 2004 that
8 means of escape for disabled people, in particular the
9 need to evacuate, were inadequate, especially given the
10 defend-in-place strategy underlying ADB. This was why
11 they commissioned BRE workstream report 7. Yet, despite
12 that report confirming the guidance was wholly
13 inadequate, nothing was done.

14 Martin admitted he was aware from his involvement in
15 drafting BS 9991 that a better approach was to cater for
16 the scenario where stay put is withdrawn and evacuation
17 required, which Martin thought flowed from Lakanal. Yet
18 there was no formal consideration, even after Lakanal,
19 of ensuring ADB or the LGA guide which supported the
20 Regulatory Reform (Fire Safety) Order was consistent
21 with BS 9991. The interface was not addressed because
22 Martin and BRAC considered ADB consistent with BS 9991,
23 which they considered simply added more detail.

24 Martin's view and government policy on PEEPs was
25 that disabled people would self-evacuate or, hopefully,

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the Fire Brigade would get to them in time, and that PEEPs were impractical and too expensive. Martin and Upton were not willing to revisit that, despite Elspeth Grant, a disability consultant's letter, pointing out that the guide breached law. No equality analysis was prepared because they regarded the LGA guide as reflecting current practice, even though it did not; neither did the department seek advice, and no effort was made to consult. This inaction was not accidental, but was done deliberately to avoid disproportionate burdens on landlords.

Martin subsequently contradicted himself, saying government simply forgot to consult with vulnerable peoples groups. His take was characteristically offhand: pursuing the issue was futile. "It's a debate that has been going on for years", he said. He admitted to being "fed up with Ms Grant's persistence".

By 2013, Martin was aware BRE and the stakeholder group on workstream report 7 were relying on the concept of extraordinary effort, whereby disabled people would over-exert themselves in emergencies. Martin also knew compliance with the Equality Act was considered doubtful. Yet he did nothing to correct these disastrous assumptions or ensure that compliance with the Equality Act was required.

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The failure to define functional requirement B4(1) in any adequate way and to provide adequate guidance for B1, means of escape, together with the government's failure to create reliable processes for timely review of ADB and procedures to stay abreast of market developments, created an unsafe system of regulation, which pertained from 1992 onwards. Government admits it presided over a system which facilitated disasters such as Grenfell.

The primary fault in relation to B4(1) was the department's failure to address the meaning of the functional requirement and its relationship with the two groups to compliance. Government admits, by its closing, that it has not been able to unearth any justification for why class 0 was used as a classification for external walls. That makes all the more extraordinary the now admitted catalogue of 13 missed opportunities to observe that class 0 was a flawed metric and failure to withdraw it, despite knowledge of the risks.

The catalogue of missed opportunities begins earlier than the department admits with the Knowsley fire. The panel may draw its own conclusions from the department's failure to address the impact of the Knowsley and Garnock fires, or to admit they were also missed

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opportunities.

The necessary context is that overcladding was a means to solve the problem of failing 1960s blocks, and Knowsley was a pilot project. No witness could explain which individuals sent or received the BRE memo recording an instruction from someone in government to play down the Knowsley fire. BRE's failure to identify in subsequent reports that a critical factor in Knowsley was the combustibility of the cladding is an indicator that the subject was taboo.

Knowsley was followed by the unexplained removal of the word "adequately" from both Building Regulations and ADB for an eight-year period, thereby making the functional requirement to resist external flame spread absolute. Burd and Martin explained the reintroduction of the word "adequately" was decided by lawyers purely for consistency, but what is the panel to make of that? That the lawyers failed to notice this inconsistency for eight years? Or is it more likely that removal of "adequately" was in fact a reaction to the severity of the seminal Knowsley fire, which led to the Connolly system test which, in turn, led to the introduction of the large-scale test?

The word "adequately" nevertheless reappeared by amendment to the Building Regulations in December 1999,

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despite the Garnock fire in June 1999. Whilst Knowsley is the fire which eventually led to the development of the large-scale test, Garnock should not be dismissed as simply non-compliance, as Martin and some others would have you believe.

BRE reported on Garnock in August 1999 to North Ayrshire, making multiple references to class 0. The deliberate excision from BRE's subsequent report to the department of any trace of class 0 cannot sensibly be justified by the fact that it was by then known that the cladding was not class 0.

It was highly relevant that the remedial solution proposed in BRE's August 1999 report was to replace what need only have been class 0 cladding with non-combustible cladding, especially given, in August 1999, the word "adequately" had not yet been reintroduced, so the functional requirement for no flame spread was then absolute.

Whilst Professor Bisby considers Garnock did not in a literal sense demonstrate the need for the large-scale testing because the GRP was not even class 0 and hence non-compliant, Garnock and Knowsley together led to the select committee report. Garnock should have prompted a reconsideration of the linear route. Given the purpose of the large-scale test is to eliminate the

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1 worst systems, had it been the sole route to compliance,
2 it would have eliminated Garnock's cladding.

3 Despite Martin and Colwell's continued involvement,
4 and their having witnessed the catastrophic failure of
5 a class 0 ACM PE in cc1924 testing in 2001, no one at
6 the department or BRE ever reviewed the Knowsley or
7 Garnock report in that light. On the contrary,
8 following Lakanal, the department, Martin, actively
9 procured BRE, Crowder, to produce bogus research, which
10 led to two articles which did not identify the cladding
11 as a significant cause of fire spread at Knowsley and
12 Garnock, did not mention Lakanal and continued the
13 misconception that class 0 cladding would limit the rate
14 of fire spread.

15 This is disingenuous and misleading. Crowder
16 accepts the research is flawed and Professor Bisby
17 considers it profoundly inaccurate and unhelpful. Even
18 if one of the original authors of the Garnock report,
19 Penny Morgan, confused class 0 with limited
20 combustibility, those who followed her at BRE suggest
21 there was little confusion. Colwell claimed she never
22 understood a colleague to have been confused about this.
23 Crowder claims he may have been a little confused in his
24 early career prior to Lakanal but not afterwards. These
25 reports should have been the subject of proper analysis

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1 by those subsequent BRE commentators who were not
2 confused. It is, however, a convenient confusion to
3 explain dangerously misleading reports.

4 Professor Bisby expresses amazement that no one
5 realised the cladding or continuous cavity at Knowsley
6 was to blame for fire spread, and instead focused on
7 lack of cavity barriers. That amazement reflects the
8 perversity of selecting an obviously wrong cause of fire
9 spread, but it was, however, a necessary disassembling
10 if one wished to detract from cladding being the cause.
11 This happened again at Lakanal, when the government's
12 Chief Fire and Rescue Adviser focused on
13 compartmentation as the cause, at the expense of
14 downward fire spread, which he now regrets.

15 The department has admitted 13 missed opportunities
16 to withdraw class 0 began with Connolly's work in 1994;
17 the second is the select committee's recommendations in
18 1999; the third, RADAR 2; and the fourth, the
19 catastrophic ACM PE failure in 2001. The remaining
20 admitted missed opportunities to withdraw class 0, which
21 we do not consider to be a comprehensive list, spans the
22 period 2008 to 2016, and includes Lakanal.

23 The department's explanation why these 13
24 opportunities were missed is wholly unsatisfactory.
25 Apart from quoting Lord Barwell, who accepted that

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1 ministers must bear some responsibility for the failures
2 of the department, officials are blamed for the failure
3 to understand their oversight function and their
4 perception that they could not challenge deregulatory
5 policies. We are therefore back to the position in
6 which we started at Module 6, namely the fallacy that
7 officials had misinterpreted ministers' and Prime
8 Ministers' deregulatory agendas, including
9 David Cameron's "bonfire of the Building Regulations",
10 effected through the Red Tape Challenge.

11 Whilst the department admits to having other
12 priorities, it does not admit that it was adherence to
13 those priorities which meant ADB was relegated to the
14 back of the queue and that, realistically, officials had
15 no power to raise its profile. Instead, it blames
16 Mr Harral and the Building Regulations team for becoming
17 totally internalised in their thinking and, therefore,
18 lacking the will to ensure their work was prioritised.
19 That is blaming individuals for failure to resist
20 an overpowering agenda fanatically adopted by ministers.
21 It runs counter to the department's tangible
22 frustration, and Harral's evidence that his 2017
23 exchange with Martin suggesting "gilding lilies" meant
24 finding ways to make the discussion document more
25 attractive to the rest of government and ministers.

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1 The department claims its failure to abandon class 0
2 after the select committee report was not politically
3 motivated, yet Martin's evidence was it was a deliberate
4 decision to retain class 0, taken with understanding of
5 the risks which had been clear since Knowsley in 1991.
6 In the circumstances, it can only have been a political
7 decision. Similarly, as the department admits, the
8 failure to remove class 0 after the RADAR research,
9 despite the clear warnings that programme gave as to the
10 lack of equivalence between national and European
11 classes, was a conscious decision not to distort the
12 market or be a barrier to trade. That decision was one
13 which was patently against the interests of safety and
14 ought to have been recognised as such. It would not
15 have been a barrier to trade to refuse to allow use of
16 the national classes for a reference scenario for which
17 they had not been designed, namely externally as opposed
18 to internally within a compartment.

19 During the 2005/2006 consultation on ADB, the
20 department received a clear warning from Martin, Colwell
21 and Greenwood — all then at BRE, but Martin seconded to
22 the department — that the provisions of section 12 of
23 ADB governing external fire spread were insufficiently
24 clear. The warning flowed from a serious cladding fire
25 at The Edge in 2005, and led Martin to propose a redraft

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of section 12 which required all materials in the external wall to be limited combustibility. Martin's evidence was that the department would not make this amendment as it would prohibit timber frame over 18 metres.

The resulting changed version was a hastily contrived fudge. By the insertion of the word "filler" into 12.7, the department deliberately left ADB 2006 ambiguous. The word "filler" had been mentioned in BRE's report on The Edge, but latterly mentioned in an NHBC consultation response on insulation provisions. The effect of inserting the word "filler" into a clause dealing with insulation in practice led to the confusion that, whatever "filler" meant, it did not mean the core of a cladding panel.

Both Burd and Martin initially said their thinking was focused on insulation as they were addressing The Edge, which involved insulating core panels, but their evidence evolved such that both later said the word was intended to prompt the designer to think more broadly about the use of a combustible core. It is now clear that the department had not itself thought through the implications of the word "filler", nor the products to which it applied.

The department adopted this approach in order to

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allow the use of timber frame and other combustibles in the external wall because, without timber frame, the demand for factory-built, ready-to-assemble housing, which many volume housebuilders use, could not be satisfied. As Mr Burd said, requiring all materials in the external wall to be of limited combustibility was too blunt an instrument, and had the massive knock-on effect of prohibiting timber-frame housing, which Dawes described as "kit housing" and one of government's top 10 to 15 priorities.

At latest from 2013 onwards, Martin and likely others in the Building Regulations team, as well as BRE, were aware of the debate within industry as to the meaning of the external wall guidance. In 2014, an industry body, BCA, produced a guidance note, TGN18, which did what the department had not and suggested 12.7 required all key components to be limited combustibility. TGN18 was a mixed blessing. It tightened the linear route, but suggested a specific concept of desktops for BS 8414 tests not contained in ADB and not previously common practice. As NHBC observes in its closing, desktops were common for fire doors, but at least in those tests the entire doorset is tested, not only part of it. Indeed, BRE's Tony Baker, in 2013, said BRE would generally not carry out

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a BS 8414 desktop unless the system was very similar to that tested.

Whilst Professor Bisby accepts desktops were permitted by the Building Regulations, as the designer may adopt any approach, Bisby does not consider desktops were expressly specified by ADB as a route to compliance, nor were they. Although ADB's introduction mentioned the possibility of a holistic fire engineering assessment, this was for complex projects such as airport terminals and was not a suggestion of desktops specifically for façades.

The whole purpose of ADB was to provide specific routes to comply with the functional requirements. The notion of desktops for BS 8414 tests seems to have created the confusion that BS 8414 equated to a model test, suggesting generic fitness for use. On one view, desktops contradicted the express terms of BR 135, which governs BS 8414, and stipulated the classification report is confined to the precise system tested. Furthermore, it's a test designed to eliminate the worst offenders, and so offers limited data from which a positive assessment can be made.

Desktops opened the door to products prohibited by the linear route. Following TGN18, desktops became the preferred route to compliance, such that BRE was

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overwhelmed with the number of requests. TGN18 was therefore causative of industry behaviour.

The impact of TGN18 was exacerbated by the June 2015 edition, which expanded the category of those who might make the assessment to "any suitably qualified fire specialist", which was an offensively broad definition and, in real terms, meant anyone claiming to be a fire specialist could carry out desktops, even if devoid of relevant qualifications.

Industry continued to issue warnings as to the lack of clarity regarding the external wall from 2013 onwards and, in 2016, revealed the legacy of ACM PE as a ticking timebomb. Yet these, coupled with a spate of international cladding fires, did not provoke clarification of ADB.

As the department admits and was clear from Martin's evidence, from at latest 2014, he appreciated ACM posed a threat, given the rules permitted it, yet claimed to have underestimated the scale of the hazard. The department nevertheless took no position on it, nor did it change ADB to prohibit ACM PE.

I now turn to delays in reviewing ADB post-Lakanal and knowledge of risk being ignored due to the overarching housing and deregulatory agendas.

The department's closing fails to analyse extensive

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evidence put to Minister Stephen Williams and Lords Wharton and Barwell of their own individual knowledge of safety risks involved in deferring ADB review. APPG repeatedly warned Williams that the timeframe for ADB review was too slow and posed a life safety risk, but he simply toed the party line, petulant at being "slagged off", as he said, by APPG on account of his dismissive responses to their justifiable concerns. Despite claiming to be aware of such issues, he considered himself unable to flick the dial on them and, as he said, was more focused on zero carbon homes. He admitted that during the Sophie Rosser debate in spring 2015, which addressed the fire safety issues such as doors, he said the Building Regulations review was on track, not because he believed it, but because officials told him to.

Williams' motivation may derive from the many conversations he admitted to having with Oliver Letwin, then cabinet minister for government policy, whom Lord Barwell and Dame Dawes described as the minister pushing the deregulatory agenda and leading on the Red Tape Challenge, which Dawes considered a very important part of the drumbeat of the coalition government.

Following the department's receipt of BRE's seven workstreams, Harral asked Martin for a "worry list".

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Harral claimed the purpose was just to have a cohesive list of things people had expressed concerns about.

The language in itself is telling. Despite describing the seven workstream reports as "overall low risk" in a 2016 email, Harral knew that the seven workstream reports did give cause for worry, hence his telling the panel that they were "desperate" to release them. As he understood, the first report warned of increased temperatures in fire caused by part L insulation requirements, and the seventh was "entirely damning", as he said, of the guidance on means of escape for disabled people.

The worry list was followed by the May 2015 "war book" produced for Wharton to brief him on concerns. A forwards-look produced at his request in late May 2015 introduced the concept of the discussion document, specifically to address the commitments to the Lakanal coroner.

As the panel heard, by summer 2015, review of ADB was rolled into a wider review of Building Regulations. Pausing here, an orderly review of either ADB or the Building Regulations would have required the publication of the seven workstream reports and, thereafter, a discussion document directed by those reports, as opposed to directed by the deregulatory agenda, as was

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the eventual draft discussion document. The reports showed the premise of ADB was undermined by increased temperatures due to insulation, and report 6 expressly highlighted that it didn't include the effect of fire spread on the external wall.

As from May 2015, Lord Wharton was on notice by the war book of ongoing concerns about the impact of modern materials, particularly combustible foam insulation and wood-based products. The decision to roll ADB into a wider review so that the department could maximise deregulation was a conscious decision taken by the department at the highest level, not only at director general and director level, as Dame Dawes claimed, but also by Lord Wharton, who was aware of the extent of delay caused by the deferral, this despite being warned of the risk and urgency of ADB review by APPG's letter received the following day.

They told Wharton the failure to review ADB had significant life safety implications, yet Wharton met with housing director, Peter Schofield, and director for Building Regulations, Sally Randall, to discuss the submission in October 2015. Following a further patently deregulatory submission copied to the then Secretary of State, Greg Clark, which made clear the extent of delay to the discussion document and Building

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Regulations review, Wharton approved it. His evidence was he believed earlier review of ADB alone sub-optimal.

That he understood the purpose of roll-up was deregulatory is clear from his telling APPG that the review's principal objective was simplification and red tape reduction.

Lord Wharton became aware, if he was not already, of the catastrophic Old Tannery fire, which happened on 4 July 2015, and about which he was interviewed a year later. The note of interview recorded:

"We had a lucky escape with Tannery last summer and the Minister fully understood this."

The failure at Old Tannery was extensive failure to install cavity barriers at the outset, as was the Kennett Drive fire in June 2014, which led to the timber-frame housing debate in December 2014, and of which both Brandon Lewis and Stephen Williams were also aware. Both fires caused total destruction of many homes but, miraculously, without loss of life.

The significance of the timber frame and cavity barrier issue is not that it was causative at Grenfell, but rather it demonstrates government's continued disregard for fire safety in housing, in circumstances where Martin said he knew that, from 2014, a major fire might occur due to lack of cavity barriers. Despite

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1 this, nothing was done to ensure compliance or to
2 reconsider the use of timber in façades.
3 During Lord Barwell's time as housing minister, the
4 limited process of review which was underway ground to
5 a halt. His time in office began in July 2016 and
6 lasted until shortly before the Grenfell fire.
7 Lord Barwell, unlike his predecessor, had responsibility
8 both for housing and Building Regulations and, on his
9 watch, both the publication of the seven workstream
10 reports and the discussion document stalled. The
11 discussion document would always have required
12 write-round to all departments and the Cabinet Office
13 but, as Barwell told the panel, it was unnecessarily
14 deferred pending publication of the housing white paper.

15 The office of the then Secretary of State,
16 Sajid Javid, proposed to Lord Barwell in September 2016
17 that Javid's dedicated housing policy [adviser],
18 Tim Leunig, with whom Barwell worked closely, should
19 review the discussion document as agent for Javid and
20 shape the review. As Ledsome told the panel, Leunig is
21 the person who could have told Javid he could give the
22 green light to the discussion document.

23 As a result of senior officials' subterfuge
24 in November 2016, forcing two ministers to communicate
25 with each other in a desperate attempt to make progress

29

1 on ADB, Lord Barwell received a significant warning. It
2 put him on notice of the longstanding commitment to
3 review ADB and warned him of the need not to become
4 complacent, and that the fire sector was concerned about
5 matters including vulnerable people and changes in
6 construction technology, in particular increased use of
7 combustible materials. He did not ask officials what
8 those were, claims to have probably assumed the
9 materials were timber, and considered it to be addressed
10 in the review or the discussion document. He accepted,
11 however, that the only review in progress was the purely
12 deregulatory discussion document.

13 In April 2017, Lord Barwell approved the discussion
14 document and gave his steer to his private secretary
15 that parts B and M were "the two areas where I feel
16 politically there's a significant pressure to move
17 rapidly". But Ledsome told the panel that Barwell's
18 email to Leunig in April 2017 suggested Barwell again
19 wanted Leunig's buy-in on the discussion document. It
20 read:

21 "Gavin was content with the recommendations ...
22 particularly interested in the work in parts B and M.
23 Any thought[s] Tim ...?"

24 Leunig evidently had some negative thoughts on the
25 discussion document because Harral never received

30

1 Barwell's approval of it and Ledsome never even saw this
2 email thread prior to giving evidence. Barwell was at
3 a loss to explain, but explained his office and Javid's
4 office had caused five months' delay to the discussion
5 document as a result of taking a collective decision to
6 prioritise the white paper.

7 The decision to withhold the seven workstream
8 reports was at the highest level. Contrary to Harral's
9 evidence that they were politically low risk,
10 Lord Heseltine's private secretary in May 2016 advised
11 Lord Wharton that, "there are some potential issues
12 here — I will come and speak to you both". In context,
13 these can only have been political issues. Lord Barwell
14 characterised the delay in publishing the reports
15 until February 2019 as absurd, and yet latterly the
16 reports got stuck in his office in 2017, albeit some of
17 that time was with Javid's special advisers, or SPADs.
18 SPADs are not technically minded; they advise purely on
19 policy.

20 The only conclusion that can therefore sensibly be
21 drawn from this evidence, taken together with the
22 government's post-Grenfell misinformation campaign that
23 ADB prohibits a PE core — a point it continues to
24 argue — is that government was deliberately withholding
25 the reports. To disclose them would have revealed that

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1 government had known ADB's flaws since, at latest, early
2 2015, and knew overhaul of the Building Regulations and
3 ADB was necessary. Given the warnings which led to
4 Grenfell — some deliberately ignored, such as the
5 select committee and the chorus led by APPG — delay
6 releasing these critical reports is yet further proof
7 the department was enslaved to its deregulatory agenda
8 in disregard of safety.

9 I now turn to the significance of the department's
10 systems failures.

11 The department is keen to present its failures as
12 due to a lack of understanding its oversight role and
13 inability to gather intelligence. The department was
14 supposed to obtain information from industry to ensure
15 policy reflected current technology. This was known as
16 the "intelligent client function". Future developments
17 were to be anticipated by a process known as "horizon
18 scanning". Both were an abject failure.

19 As the panel heard from Mr Harral, the department
20 was a behind-the-curve function and inherently
21 unresponsive. As a result, Building Regulations did not
22 keep pace with modern materials. The department not
23 only failed to horizon scan, but to notice, still less
24 defuse, the ticking timebomb on which it stood.

25 That said, department officials were aware of

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combustible insulation potentially being in hundreds of homes, and although Harral and Ledsome denied being aware contemporaneously of the "filler" debate, Martin claims to have discussed this with them in the four years preceding the fire. Harral and Ledsome also considered warning ministers of flammable tower cladding in 2016 but, in fact, failed to do so.

The process failures, significant as they are, and resulting as they did in an unsafe system of regulation which failed to protect life, are really the product of the overarching and unyielding deregulatory agenda, coupled with the extreme financial constraints following the 2008 crash which, as Harral said, halted the regular review of Building Regulations.

It is therefore fundamentally misleading to characterise the parlous state of the Building Regulations and associated guidance as an unfortunate by-product of a prolonged lapse in concentration by the department's officials, tinged with some unspecified ministerial responsibility and a degree of austerity. It is more than that. The evidence points to wilful blindness and complacency towards safety, which was subjugated to the more pressing and politically appealing housing and deregulatory agendas.

That this is so is evidenced by the department's

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knowledge of risks to life, coupled with deliberate concealment dating back to the instruction to play down the Knowsley fire, which concealment continued through Garnock, through the catastrophic 1924 tests, which were never published and not disclosed to the Inquiry until leaked to the press. Latterly, the way in which the department approached the Lakanal inquest and its failure to implement the coroner's recommendations makes clear its disregard for safety in the face of proven risks.

Finally, I turn to the role played by industry. It is ultimately responsible for the events which led to the Grenfell disaster. The Inquiry's experts consider the external fire spread guidance in ADB, even as it stood, was intelligible to competent designers and, therefore, if Grenfell's designers had been competent, they would have understood it. Those who rely on the ambiguity of "filler" are not fit to design façades if they fail to realise the core should not equate to diesel or lighter fluid, as ACM PE does, and if they fail to appreciate the risks of using combustible materials.

The Inquiry will of course also need to consider the impact of Arconic's testing of its rivet product to obtain a class B, and its use of that test to obtain

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a BBA certificate extending to both the rivet and cassette product. That, together with Arconic's reliance on a class 0 classification for the PE/FR product, despite the PE never having achieved a class 0, led to a highly misleading BBA certificate.

Although Arconic's Mr Schmidt accepted Mr Wehrle knew or suspected the class B was not honestly achieved, and although it was superseded by a later test for rivet resulting in a C, which was subsequently downgraded by Arconic to an E, Arconic's closing perversely maintains its continued reliance on class B was legitimate.

Although industry could not be expected to appreciate Arconic's misrepresentations to the BBA, industry's knowledge of the implications of using ACM PE is clear from its characterisation of the situation as a ticking timebomb. It is therefore not certain that if government had clarified the word "filler", or even required A2 in external walls over 18 metres, as it now has, the façade at Grenfell would not have supported lethal fire spread. This is because Grenfell's designers did not claim to be confused by the regulations, principally because most were not familiar with them, and neither was RBKC building control competent to detect the patent non-compliance in relation to both the insulation and cavity barriers,

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despite the requirement for those two elements being entirely clear.

Similarly, in relation to the other critically relevant consideration for the Inquiry, namely means of escape for those with disabilities, Dr Lane considers ADB is premised on inclusive design and did make clear to the reasonably competent engineer that additional measures were required, and that legislation protecting those with disabilities must be complied with. Competent designers were aware of BS 9991 and the different approach to evacuation and stay put.

To conclude that the failure to clarify or amend ADB led to the lethal fire spread at Grenfell is to overlook the role of the construction sector in deliberate non-compliance, even in areas where ADB left no room for debate, such as insulation and cavity barriers. The relatively small contribution of any insulation, combustible or otherwise, to the Grenfell fire, which Professor Bisby puts between 2 to 10%, does not detract from the significance of the prevalent culture of non-compliance and lack of competence.

Industry's capacity for both good and bad behaviour is nowhere more starkly personified than in Nick Jenkins, on the one hand advocating greater clarity in section 12.7 of ADB in 2016 and drafting guidance

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1 accordingly, but, following Grenfell, assisting Kingspan
2 in manipulating the outcome of a Building Safety
3 Programme test, the "NJ joggle", as he called it.

4 Furthermore, just after industry recognised the
5 ticking timebomb posed by ACM PE, NHBC produced its
6 irresponsible July 2016 "Acceptability of common wall
7 constructions" note. Whilst NHBC accepts by its closing
8 this note was deficient, it was worse than that. It
9 permitted the use of the very products used at Grenfell
10 without the need for test or even a desktop. Whilst the
11 note itself was not causative of Grenfell, being
12 published after the completion of the refurbishment, it
13 evidences the degree to which industry sought to
14 manipulate and circumvent the regulation. NHBC has
15 notably not, in its closing, addressed how the
16 volte face which led to it issuing this note occurred.

17 It appeared from the Module 2 evidence that Kingspan
18 may have lobbied NHBC for the production of that note.
19 They certainly had lobbied for the widening of the
20 desktop provision of BCA's TGN18.

21 Kingspan's closing suggests we argued Kingspan was
22 seminally causative of fire spread at Grenfell. We did
23 not, but said, and still say now, that Kingspan created
24 a false impression from 2005 onwards of the suitability
25 of combustible materials at height. It did so by being

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1 the first insulation to seemingly pass a BS 8414 test,
2 and by misleading marketing, coupled with Kingspan's
3 express desire to "educate the market" in matters of
4 combustibility and its insignificance in terms of
5 individual product performance.

6 In that sense, it was seminally causative of the UK
7 market's willingness to use combustible materials at
8 height. The fact that at Grenfell neither Kingspan nor
9 Celotex's insulation was causative of the fire spread
10 beyond the 2 to 10% that any insulation would have
11 contributed does not mean these insulations could not be
12 causative in other constructions. Professor Bisby has
13 been at pains to stress that such insulation,
14 particularly K15, could be significantly causative if
15 used in a different form of construction.

16 To conclude, whilst it is beyond doubt that the
17 department never addressed functional requirement B1 or
18 B4 adequately, with the result that it has allowed
19 an unsafe framework of regulation to exist for over
20 30 years, those designing façades and fire engineers
21 designing fire safety strategies must be competent. Had
22 they been, they would have understood the functional
23 requirements and taken responsibility for interpreting
24 them correctly. Whilst Arconic's, Kingspan's and
25 Celotex's products were potentially dangerous, the

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1 designers should have appreciated their unsuitability
2 for use in a high-rise building with a stay-put policy.

3 Whilst, of course, regulation must be sufficiently
4 clear, building regulation alone cannot prevent
5 disasters. The sectors themselves must engender
6 competence. That alone, however, is not sufficient,
7 given the competence crisis that we have. As a minimum,
8 the title "fire engineer", we say, should be legally
9 protected.

10 Those are my submissions, sir. Thank you.

11 SIR MARTIN MOORE-BICK: Thank you very much indeed.

12 Well, we're going to take our morning break rather
13 earlier than usual, and we'll take it at this point.
14 After the break, we're going to hear a closing statement
15 on behalf of other bereaved, survivors and residents by
16 Mr Stein Queen's Counsel and Mr Mansfield
17 Queen's Counsel. That we'll do at 11.15.

18 At the moment, therefore, we shall rise for our
19 morning break.

20 Thank you very much.

21 (10.59 am)

22 (A short break)

23 (11.16 am)

24 SIR MARTIN MOORE-BICK: We're now going to hear a closing
25 statement partly by Mr Stein Queen's Counsel and partly

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1 by Mr Mansfield Queen's Counsel on behalf of the other
2 bereaved, survivors and residents.

3 Good morning, Mr Stein.

4 MR STEIN: Good morning, sir.

5 SIR MARTIN MOORE-BICK: We are ready to hear you as soon as
6 you are ready. Thank you.

7 Module 6B (Government, Testing and FRA) closing submissions
8 on behalf of BSR Team 2 by MR STEIN

9 MR STEIN: Thank you, sir.

10 As you have already outlined, I will be addressing,
11 first of all, matters on behalf of Team 2 insofar as
12 they concern testing and certification. I will also be
13 dealing with disability issues, and then Mr Mansfield
14 will then come forward and then take on the question of
15 central government.

16 Sir, we say this: it is a disgrace that the cladding
17 and insulation manufacturers, Arconic, Celotex and
18 Kingspan, knew that their lethally combustible and toxic
19 materials were being sold on to residential buildings,
20 and that they continue thereafter to profit
21 substantially in the aftermath of the Grenfell Tower
22 fire. But it is also a national disgrace that the
23 testers, certifiers and government all knew of the
24 dangers of these materials as well. It is a disgrace
25 that, despite this knowledge, nothing was done to

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1 protect the only people who did not know: the people
 2 living in tower blocks and, in particular, those living
 3 in the Grenfell Tower up until the night of
 4 14 June 2017.
 5 Heaped upon this disgrace is the fact that around
 6 650,000 families, children and disabled people still
 7 live in buildings covered in combustible cladding,
 8 five years and six days after the fire at
 9 Grenfell Tower. That's five years and six days after 72
 10 innocent men, women and children, and one unborn child,
 11 lost their lives due to crime, compound negligence and
 12 neglect across this industry.
 13 Sir, this is why we have called within our written
 14 submissions for accountability. What we mean is that,
 15 at the very least, those who knew and had responsibility
 16 should be sacked. Dr Colwell should go from her
 17 position at the BRE and Brian Martin should be removed
 18 from any future work that might have a detrimental
 19 effect on people's lives. We don't make this call
 20 lightly or frivolously. It is made in the light of the
 21 evidence that you have heard during this module. Both
 22 individuals, through indolence or professional
 23 ineptitude, missed clear opportunities to change the
 24 system of regulation which would have prevented the
 25 tragedy at the Grenfell Tower.

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1 The fact that a building industry—wide ban on
 2 Grenfell—style aluminium composite materials with an
 3 unmodified polyethylene core is only coming into force
 4 this year is yet another disgrace. Multitudes of flats
 5 are still covered in this stuff.
 6 In November 2018, the government introduced
 7 regulations intended to ban the use of combustible
 8 materials on high-rise residential buildings over
 9 18 metres. Only material achieving the two highest
 10 reactions to fire classification, class A2 and A1, could
 11 be applied. But, notwithstanding the presence of
 12 similar fire safety risks to those in other residential
 13 buildings, such as hotels, hostels and boardinghouses,
 14 they were excluded from the scope of the restrictions
 15 introduced under the 2018 regulations. It has taken
 16 further public outcry and another consultation.
 17 The government has finally decided to extend the
 18 2018 regulation restrictions in the 2022 regulations.
 19 This means that this year there will be a complete ban
 20 on the use of the type of metal composite material used
 21 on the Grenfell Tower, those with an unmodified
 22 polyethylene core, to ensure it does not become part of
 23 an external wall or specified attachment of any new
 24 building and buildings undergoing building works,
 25 irrelevant of height or use, and, finally, hotels,

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1 hostels and boardinghouses will also and finally be
 2 brought within the ban's scope.
 3 The 2022 regulations should come into force on
 4 1 December 2022, and apply unless an initial notice,
 5 building notice or full plans have been deposited
 6 beforehand and work has started or starts within
 7 six months of that date. But why allow this? The
 8 industry has fair warning in the form of the tragedy at
 9 the Grenfell Tower: don't use these materials. They are
 10 dangerous and they are going to be banned. Does it make
 11 sense to let an unscrupulous company buy up the no doubt
 12 ever cheapening stocks of this material to shove on
 13 hospitals just in time to limbo under the ban? Can we
 14 please stop putting corporate profits over safety to
 15 life?
 16 The real question posed by the Module 6 evidence is
 17 how it was that so many buildings, including the
 18 Grenfell Tower, were made dangerous by the combustible
 19 cladding placed on them. We suggest that the witnesses
 20 called within Module 6 have done their best to try to
 21 hoodwink you, the panel. Witnesses have presented their
 22 evidence to imply that there were some suggestions of
 23 problems with combustible cladding and insulation, and
 24 little more than that. The truth is much worse.
 25 Grenfell Tower was built not long after the

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1 Ronan Point disaster, where an entire corner of a tower
 2 block fell away due to poor construction. Ronan Point
 3 was a 22-storey tower block in Canning Town, Newham,
 4 East London, that partly collapsed in May 1968, only
 5 two months after opening. At Ronan Point, four people
 6 died and 17 were injured. Because of Ronan Point,
 7 Grenfell Tower was built to last, until the corrupt,
 8 incompetent manufacturers and builders, and the erosion
 9 of the regime of inspection and building regulation,
 10 fatally undermined its safety.
 11 We need, first of all, in the line of documents that
 12 we're going to be examining shortly, to weigh up the
 13 understanding of the relevant guides from the BRE,
 14 starting in 1988.
 15 The first edition of BR 135, the 1988 guide, warned
 16 of risk posed by overcladding materials. We will see
 17 that, by 1988, concerns regarding cladding systems were
 18 already well understood. Concerns of class 0 were also
 19 clear.
 20 I take you first of all, please, to the document
 21 BR 135 1988. That is {BRE00005553/6}. Thank you very
 22 much.
 23 Under "Regulatory Aspects" you will see, bottom
 24 right corner:
 25 "Control over the external surface of walls of

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buildings, particularly those of multi-storey flats, to avoid ignition and flame spread which might endanger the lives of residents above by breaking down effective 'compartmentation' is currently controlled by reference to tests specified in BS 476: Parts 6 and 7. However, these tests only provide information on surface fire behaviour. The overall fire performance of a ventilated cladding system or insulated assembly, incorporating independently-supported weathering finishes and complicated reveal details, can only be investigated under actual fire conditions on a full-scale building facade. To identify the design principles on which constructional recommendations might confidently be based demanded research. This would be to determine both the risk of flame spread over the surface of the building and the risk of progressive spread via a cavity within the cladding system or through a layer of combustible insulant to areas remote from the original fire."

Further down on page 7 {BRE00005553/7}, the document refers to "Investigation of the problem". You will see there:

"Current concern has involved the likely performance in fire of large areas of external wall insulated in these ways when a flame plume emitted from a window on

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one storey impinges on the facade above.

"In high rise buildings it was felt that a life risk might be caused by the penetration of fire or smoke through walls or upper windows resulting from ..."

I will read the second of the two bullet points:

"Fire spread through continuous cavities or combustible insulants contained between the solid wall and the external finish of the system."

What does this mean?

From 1988, cladding fires — which may destroy reliance upon compartmentation and meant that stay put as an answer to a fire in at least some tower blocks could not be sustained — this means that from 1988, cladding fires were a known risk, a risk that could kill. A killing risk.

The test programme is described in the first edition of BR 135 at {BRE00005553/7}, bottom left-hand corner. That is a timber crib that at point (a) was designed to provide, "Flames typical of a fully-developed building fire impinging on the facade". Page 7 shows the results carried out. Figure 3 shows the rig before the test. It is worthwhile noting that in relation to figure 3, if we look at — and, in fact, at figure 4 {BRE00005553/8} we can see the same — some consideration was given to windows being included in the test rig.

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If we go back to page 7 {BRE00005553/7}, bottom right-hand corner, "Experimental fires":

"Typical experimental fires are illustrated involving:

"(a) a system with insulation sandwiched between rendering and wall ...

"(b) an aluminium-faced cladding system incorporating expanded polystyrene, the extent of the ventilated cavity being limited by fire barriers ..."

Then at the top of page 10 {BRE00005553/10}, please, these are the test results, which revealed, at the top of the schedule, under the "Performance" column, that:

"Cladding melted allowing active EPS fire in cavity and dropping from base of cladding. Process slowly self-sustaining."

Just three years after the 1988 BRE guidance was shared with industry, a fire tore through a flagship government-funded project at Knowsley Heights. The guidance in 1988 had foretold the fire's behaviour. The panels there, GRP, glass-reinforced polyester, were class 0, and the cavity acted as a chimney, and smaller window frames created gaps filled with combustible materials. This may sound familiar.

As a further premonition of the Grenfell Tower fire, flame re-entry occurred throughout the build. Mr Martin

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was asked in his evidence in relation to the Knowsley Heights fire why small-scale fire tests, including a class 0 classification, were an inadequate basis for trying to predict and control a fire in the external cladding. His answer: well, he couldn't recall discussing it, and asked rhetorically: where does a surface start and finish? Class 0 remained in place, allowing a clear threat to life safety to go unchecked.

The resulting 1991 Building Regulations called for cavity barriers in an external cladding system, which of course proved ineffectual at Grenfell. The functional requirement, B4, "The external walls of the building shall resist the spread of fire over the walls". Jumping ahead in the chronology, it was following the next major cladding fire in 1999 at Garnock Court that B4 was diluted to read, "The external walls of the building shall adequately resist the spread of fire". Suddenly, therefore, in one stroke, fire risk became a subjective exercise, although Anthony Burd of the DCLG claimed his insertion made no difference at all, agreeing, as he put it, it was a "lawyers' thing".

Now, the BRE had been privatised in 1997. The BRE's ability to advise on policy and carry out crucial research was now severely limited by the new client relationship with government, a relationship

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1 demonstrative of government's willingness to limit their
2 own knowledge of risk in favour of cost-saving. Beyond
3 this, client confidentiality on manufacturers' failed
4 tests protected the results from wider dissemination.

5 In the future, it is essential and in the public
6 interest for data on failed fire performance tests to be
7 made publicly available. We must ensure decisions made
8 on compliance are able to take account of all known
9 facts, not just those that are proffered by
10 manufacturers in pursuit of a route to market instead of
11 a route to safety.

12 Even though privatised, the oversight body that
13 could have stopped the BRE from running wild was
14 ineffective. Despite identifying multiple failings at
15 the BRE, UKAS failed to enforce throughout the decades.
16 Assessment of the BRE generally was lacking, and the BRE
17 were permitted to act in the interests of industry over
18 public safety. They relied on corporate contract terms
19 to protect them from the obvious need to protect life.

20 On 11 June 1999, there was the fire at
21 Garnock Court, a 14-storey block of flats in Irvine,
22 North Ayrshire, Scotland. It led to the death of a man
23 who used a wheelchair. Five others were injured.
24 Cladding was a significant factor in the fire spread.
25 The fire spread via the external cladding, reaching the

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1 12th floor within ten minutes of outbreak, destroying
2 flats on nine floors.

3 At Westminster, the environment, transport and
4 regional affairs select committee conducted
5 an investigation.

6 I am going to turn, please, to the FBU's memorandum,
7 which is {FBU00000127/6}.

8 The FBU's memorandum outlined the risks from
9 cladding and concluded starkly. It's under the heading
10 "Whether a Risk is Posed by Such Cladding":

11 "2.1. There are a number of risks that may be posed
12 by the use of combustible, or badly installed, external
13 cladding systems. Having said that it should be
14 understood that cladding systems themselves are unlikely
15 to be the first item that is ignited. They are far more
16 likely to become involved in fire as a result of a fire
17 in a room that has vented through the room window(s) and
18 which is travelling up the building face. This is
19 a common occurrence and is predicted by the laws of
20 physics (ie, heat rises therefore fire travels upwards).

21 "2.2. The primary risk therefore of a cladding
22 system is that of providing a vehicle for assisting
23 uncontrolled fire spread up the outer face of the
24 building, with the strong possibility of the fire
25 re-entering the building at higher levels via windows or

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1 other unprotected areas in the face of the building.
2 This in turn poses a threat to the life safety of the
3 residents above the fire floor.

4 "2.3. A secondary problem of fire spread through
5 external cladding may be caused by the method of fixing
6 the panels to the exterior facade of the building. If
7 lightweight fixings (aluminium or metal alloys, etc) or
8 resin bonded systems are used to attach the panels.
9 There is a risk of the panels becoming detached when
10 exposed to fire and failing from the face of the
11 building posing the associated missile risk to
12 firefighters and members of the public in the vicinity
13 of the building."

14 Following the Garnock Court fire, and as a result of
15 a request from the subcommittee to review standards, the
16 BRE cc1924 contract was born. This was meant to be
17 a programme of work to review the guidance given in
18 BR 135, the fire performance of thermal insulation for
19 walls of multi-storey buildings. A major part of this
20 involved large-scale experiments in 2001, one of which
21 included ACM PE as cladding. Dr Colwell recalled this
22 experiment's results as shocking after the rig erupted
23 into 20-metre flames. Mr Martin, however, could only
24 recall it as an "interesting outcome", stating that
25 Dr Colwell — she described the mechanism by which it

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1 reacted with the fire, ie the aluminium burnt away,
2 exposed the polyethylene, and then the polyethylene
3 began to burn. Mr Martin put it this way, "I think she
4 said that it failed the test". Yet again, this clear
5 risk was not acted on.

6 The ACM PE had been included as a result of
7 an industry survey on materials in cladding systems. It
8 is a further total disgrace that this obvious screaming
9 risk to life was simply left, hidden from the public eye
10 until this Inquiry's investigation.

11 A final part of the cc1924 work was the production
12 of the second edition of BR 135, dated 2003, written by
13 Sarah Colwell and Brian Martin. I take you, please, to
14 the document, which is {BRE00005554/3}.

15 Both at that time were working at the BRE. It was
16 written from the perspective of the BRE's FRS, the Fire
17 Research Station, as part of the contract cc1924,
18 placed, as you can see, by the Office of the Deputy
19 Prime Minister.

20 I'm now going to turn you to another image, but
21 before I do so, it would be best if I give an image
22 warning. The image potentially is upsetting as it may
23 call back memories of the tower fire. I will therefore
24 pause just for one moment for people to react if they
25 wish.

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1 (Pause)
 2 Therefore, please turn to {BRE00005554/2}. You can
 3 see that there could be no doubt that the severity of
 4 a cladding fire was understood. As we can see, a test
 5 rig completely under fire on the front page.
 6 Now turn in the same document to page 9
 7 {BRE00005554/9}, showing the schematic that we are all
 8 familiar with.
 9 BR 135, the second edition, shows the mechanism of
 10 fire spread. A reminder of dates: we've had 1988,
 11 strong warnings, compartmentation at risk. By the time
 12 we get to 2003, there is absolutely no doubt at all from
 13 this schematic of the nature of the risk and how it can
 14 be demonstrated on paper. We can see that this diagram
 15 shows graphically a cladding system contributing to fire
 16 spread. It can result in a risk of multiple
 17 simultaneous secondary fires.
 18 The left-hand side of the block of flats schematic,
 19 just below the floor second from the top, the schematic
 20 states:
 21 "If the external cladding contributes to the flame
 22 spread there is a risk of secondary fire spread to all
 23 levels."
 24 Page 10 {BRE00005554/9}, under paragraph 2, "Fire
 25 break out":

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1 "Following the initiation of a fire inside the
 2 building, if no intervention occurs, the fire may
 3 develop to flashover and break out from the room of
 4 origin through a window opening or doorway. Flames
 5 breaking out of a building from a post-flashover fire
 6 will typically extend 2 m above the top of the opening
 7 irrespective of the material used to construct the outer
 8 face of the building envelope ..."
 9 We can see there figure 3.
 10 The severity of the danger is then emphasised under
 11 paragraph 4, just further down the page, "Fire
 12 re-entry":
 13 "Window openings or other unprotected areas within
 14 the flame envelope provide a potential route for fire
 15 spread back into the building. This creates the
 16 potential for fire to bypass any compartment floors that
 17 may be present, leading to a secondary fire on the floor
 18 above. If secondary fires are allowed to develop
 19 without intervention before flashover occurs, then
 20 flames may break out again thus extending the flame
 21 envelope and threatening other openings further up the
 22 building, irrespective of the materials used on the
 23 building envelope."
 24 Finally, at paragraph 5, there is a reference to the
 25 impact on firefighting. I'll skip the first sentence.

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1 "However, where the external cladding system is
 2 contributing to the fire propagation rate, the potential
 3 exists for the fire to affect multiple storeys
 4 simultaneously, thus making firefighting more
 5 difficult."
 6 Perhaps a considerable understatement.
 7 This means that, from 1988 and confirmed in 2003,
 8 Dr Colwell, Brian Martin, the BRE, government and the
 9 building industry are all aware that cladding and
 10 insulation can provide a route for fire and be a fire
 11 risk itself. If cladding and insulation are involved in
 12 a fire, this may leap up a building. If cladding and
 13 insulation are involved in a fire, compartmentation may
 14 well fail. If cladding and insulation are involved in
 15 a fire, firefighting will be made more difficult.
 16 Despite the clear warnings in the 1988 edition about
 17 the risk of re-entry via window or otherwise, in the
 18 2003 second edition, any attempt to include windows or
 19 apertures in test rigs had also now gone, as we can see
 20 at the same document, second edition, which is
 21 {BRE00005554/20}, figure A1.
 22 Sir, you will recall recently the questioning by
 23 Counsel to the Inquiry of Professor Bisby, insofar as it
 24 touched upon the question of windows/apertures not being
 25 included in the test rig. So at 1988 there was some

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1 attempt to include. By the time we get to 2003, no
 2 windows, no attempt to provide apertures within the test
 3 rig.
 4 The next revision of BR 135 is in 2013, the third
 5 edition. I will take you briefly to {BRE00005555/2}.
 6 Then moving on, please, to {BRE00005555/13}, we see our
 7 familiar schematic. The third edition of BR 135 repeats
 8 the same embedded warnings of fire spread up a building
 9 and increased difficulty with fire service intervention,
 10 as shown in the second edition.
 11 It is worthwhile pausing just to remember what's
 12 going on now at the Grenfell Tower itself.
 13 By 2013, the refurbishment plans at the
 14 Grenfell Tower were well underway. As an example,
 15 in November 2012, there was the design team meeting
 16 involving the TMO, Studio E, Curtins Consulting,
 17 Max Fordham and Appleyards. The discussion point there
 18 regarding cladding was colour and ratio of zinc for the
 19 façade, and nothing else.
 20 I will take you back, please, to the BR 135 third
 21 edition to {BRE00005555/23}.
 22 In addition to previous warnings noting the dangers
 23 of combustible cladding and insulation, with this third
 24 edition, there is consideration of combustible panels at
 25 underscore page 23, second paragraph to the bottom

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right—hand side. You will see there the "Combustible panels" reference:

"Combustible panels are typically based on vinyl or glass—reinforced plastic, although various new products are being developed in this area, some of which also contain insulation materials. These products generally have good surface spread of flame characteristics to prevent rapid fire spread across the surface of the system, but once the panels become involved in the fire, they have the potential to generate falling debris, add to the overall fire load, and provide a route for fire to propagate up the outside of the building."

This paragraph dismally confirms that, whilst the outside shell of a product may resist fire spread, it can also be dangerously combustible, making clear the threat posed by its use when involved in a fire. This provides no excuse for the unremitting danger to life from these materials being used on buildings.

The trend, therefore, from 1988 to 2003 to 2013 has made it clear to all and sundry — government, BRE, all of industry — what is the nature of this risk, what is the extent and seriousness of this danger. But, of course, we have the evidence that relates to other fires. It has already been mentioned by Ms Barwise Queen's Counsel: the fire at Manchester's The Edge

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development. That building was clad — this is 2005 — in sandwich panels that contributed to rapid fire spread up 17 floors in just ten minutes. Dr Colwell's subsequent report on the fire suggested the government revisit the relevant section of Approved Document B guidance around external wall construction to remove confusion about what materials were compliant.

Following that work, Mr Martin rewrote this section as part of a new draft version of Approved Document B, including a new section stating that "insulation or any other material" used in external wall construction in a building over 18 metres tall should be of limited combustibility. However, despite this being included in the draft, the final version of Approved Document B omitted that amendment, instead stating that any "insulation product or filler material" should be of limited combustibility. That phrasing never went out to consultation and Mr Martin admitted the thinking was so that they could come back and slip in something unconsulted—on later.

You have also heard the evidence that relates to the group meeting at the CWCT, the Centre for Window and Cladding Technology, which effectively tasked the BRE's Dr Sarah Colwell in July of 2014 to draft an FAQ. According to the meeting minutes, the dangers of ACM

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cladding with a polyethylene core were raised, with attendees pointing to major fires in the Middle East and France.

Pausing again, 2014. By that stage you've had the Water Club Tower, Atlantic City; you've had Wooshin Golden Suites fire in South Korea; Mermoz Tower, Roubaix, France; the Saif Belhasa building fire in Tecom, Dubai; and the Tamweel Tower Dubai fire. These are all fires involving exterior panel façades.

So at that meeting, Dr Colwell was directed to the fact of the other fires in other parts of the world. Dr Colwell apparently tried to explain that Approved Document B was intended to prohibit ACM use in buildings over 18 metres tall, but was told the current wording was insufficient as it only referred to prohibiting combustible insulation products, with cladding panels apparently subject to the lower fire classification, class 0, a standard many ACM products claimed to obtain.

Dr Colwell appeared to take responsibility for a clarifying FAQ and raised it with Mr Martin, the civil servant responsible for the guidance. Mr Martin, as you will recall, had attended the meeting but left before this discussion. Dr Colwell never completed the FAQ, later claiming she believed the issue would be dealt with in a forthcoming revision of Approved Document B.

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She said:

"... it was assumed that ... it would be taken up with that, so I didn't pursue that conversation with Brian, which, with hindsight, is something I should have done."

Therefore, Approved Document B was never revised and remained in place until after the Grenfell Tower fire.

Dr Colwell indicated that, by September, she had decided not to draft an FAQ, but failed to inform the CWCT group. She said:

"On reflection ... it is something that I should have followed up directly with [the group] ... I fully acknowledge that that was a lapse on my part ... not keeping them [fully] informed [with regard to the whole process] ..."

It was also, as you will recall, revealed in her evidence that Dr Colwell failed to reveal those details in her witness statement.

The Inquiry has heard that she told an attendee at the March 2015 meeting that she had completed a draft of the FAQ. However, when an attendee chased for an update, she ignored multiple emails and voicemails until that individual gave up.

It should be remembered that the CWCT 2004 meeting came at a potentially critical moment when the final

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decisions to clad Grenfell Tower in highly combustible polyethylene—cored panels were being considered.

Despite a clear golden thread of knowledge of risk posed by the cladding, industry—produced guidance flew in the face of public safety. The BCA, the Building Control Alliance, Technical Guidance Note 18 legitimatised desktop studies, which operated in a space of entirely insufficient knowledge of performance of materials, and Professor Bisby has recently described the six desktop studies he reviewed as "missing basic information", "pretty inadequate" and "not evidence—based". Mr Martin was aware of incompetent studies in use but entirely failed to act or warn his own department, even speaking at the launch of the later 2016 note permitting the Grenfell cladding and insulation combination.

It is against the background that we have set out of known danger to life that the evidence of all Module 6 witnesses must be judged. It is not just that in the past these witnesses didn't take the risk seriously, but, importantly, they didn't take account of the seriousness of the risk.

In addition, we urge the Inquiry to give careful consideration to the abject performance of organisations such as the NHBC and LABC who have, through a process of

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evolution, taken on regulatory functions under the guise of profit—making businesses. From 2009 to 2015, the LABC certified Kingspan's K15 and Celotex's RS5000 based upon missing, false or misleading data, and NHBC ultimately green—lit the use of ACM, RS5000 and K15 in their 2016 guidance.

Now, we all recall the evidence from Professor Bisby describing what he was describing as the limited contribution to the fire of those materials, but we need to remember at all times the toxicity of those materials and the gases that they gave off and, therefore, the contribution cannot just be limited to how much flame they produced.

Both the LABC and NHBC, private companies, gave false reassurances as to public safety. This was against the background of industry having the clearest of warnings surrounding the use of these products from BR 135 editions 1 to 3. As with the certifiers in Module 2, there is a clear tension between the public service obligation of ensuring public safety and commercial pressures where private businesses conduct regulatory or quasi—regulatory functions. It should not need to be said, but public safety must be the driving and principal concern in any and all circumstances. The evidence you have heard demonstrates that, instead,

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profit—making has been given an equal and sometimes overriding emphasis over public safety.

As of this moment, the evidence from Inquiry experts, Professors Bisby and Torero, stands to say that much must be done to test cladding systems and materials used within such systems, and much must be done to test such systems before we can get a standard for such construction. What does that mean? Well, it means this: that until the science is settled, our ability to measure the safety of existing exterior cladding systems is also seriously suspect.

Our clients say: with responsibility comes accountability. As stated by Professor Bisby on Day 291 of the Inquiry:

"... if it's your job to write building regulations, then you need to make sure that what you are doing is representative of what is happening in the world, and if you don't, then you're not doing your job."

He mentioned the fact that this jurisdiction stands on an international stage. Our systems are not just our own, but emulated by other countries. That means that we cannot imagine that our disgrace from a failure to act on the consistent knowledge of risk, dating back over four decades, affects just us.

This cannot be allowed to continue. The system must

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be reformed so that the discharge of regulatory functions concerning public safety is put back into the hands of entities that are protected from and not subject to any competing forces such as the desire to make money.

Further, attention should be paid to the market dominance of organisations such as the NHBC which, because of their market share, hold an inordinate amount of power in shaping safety standards.

Our submission is that a new safety standard must be set within the building industry, a Grenfell standard. This must be not only what is thought to be safe but, additionally, a wide margin on top to account for industry crime, builders' and designers' ignorance and incompetence and expert error. The Grenfell standard should mean that, in practice, a door that is rated potentially to withstand 30 minutes subject to a fire, judged to be sufficient to allow for the arrival of firefighters, add 30 minutes to make sure, to make safe. The Grenfell standard could become a mark of safety across the building industry and be a very small part of remembering those who died in the fire.

I now turn to disability issues.

The bare minimum we should accept is that a block is only safe if it is safe for all residents, not just for

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1 all residents except disabled people. The future litmus
2 test for fire safety should be to regard people with
3 disabilities, those who need the law's protection most,
4 as mentioned by Mr Thomas Queen's Counsel early on in
5 the Inquiry, and their ability to survive as the minimum
6 standard by which we should judge risk to life from
7 fire.

8 We have heard shocking evidence about government
9 attitudes towards disabled residents and their safety
10 from fire in the years between Lakanal and Grenfell, but
11 the government has even managed to trump this. On the
12 eve of the fifth anniversary of the fire, two and a half
13 years after the Prime Minister committed to implementing
14 the recommendations, the government reneged on that
15 commitment by openly rejecting the recommendations most
16 focused on protecting disabled people.

17 What could have led to that mindset? We have seen
18 how little the government wish to do to improve things
19 after the Lakanal coroner's recommendations. For
20 disabled people, it was worse. Post-Lakanal, the
21 government chose to actually make them less safe.
22 According to the DCLG's Louise Upton, Lakanal House was
23 totemic, and for the housing sector, guidance was the
24 thing that was most wanted after the fire.

25 Brian Martin admitted that, before 2011, all

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1 statutory guidance on means of escape for disabled
2 people recognised that disabled people had a right to
3 a plan for their evacuation in case of a fire. To the
4 government, that was a big problem.

5 Within two days of his office being selected to
6 write the LGA guidance, Colin Todd recorded that
7 disabled evacuation had been identified as one of the
8 showstoppers to address, as he put it, evacuation or
9 not. What resulted was the 2011 LGA guide.

10 By 2013, without independent analysis, the official
11 statutory guidance was born and endorsed by Lord Pickles
12 in his response to the Lakanal Rule 43 letter. The LGA
13 guidance stated, without precedent, that responsible
14 persons need not have any plan for how disabled people
15 would evacuate a building in case of imminent danger.
16 In getting there, the government dismissed concerns that
17 it was discriminating against disabled people contrary
18 to the Equality Act. We suggest this: the government's
19 guidance on landlords' evacuation duties to disabled
20 residents was unsafe and unlawful, ignoring the public
21 sector equality duty.

22 We now know that this arose out of a culture of
23 complete disregard for the views of disabled people.
24 Neither Mr Todd or the government consulted disabled
25 people or disability organisations or specialists at all

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1 before deciding it was unrealistic to expect landlords
2 to have an evacuation plan for disabled residents. Why
3 didn't they ask disabled people?

4 There were two strands to government-led officials'
5 evidence on fire safety and Building Regulations. On
6 the one hand, they forgot about disabled people. But
7 the more illuminating and deadly strand was that they
8 didn't think disabled people had anything useful to add
9 to their own safety from fire, and landlords' views
10 would suffice. As a result, the only stakeholders whose
11 views counted were Mr Todd's office and his clients,
12 landlords, not residents. This is how the government
13 operated. So current practice became best practice.

14 Now, the government had hardly allowed the ink to
15 dry on the transcripts of this evidence before they
16 revealed their stance on this Inquiry's PEEPs
17 recommendations. At the Building Safety Bill's third
18 reading in May of this year, building safety minister,
19 Lord Stephen Greenhalgh, stated:

20 "Fifteen of the 37 disabled residents living in
21 Grenfell Tower died in the fire. That is more than 40%
22 of the disabled residents. The Government are committed
23 to supporting the fire safety of disabled and vulnerable
24 residents."

25 In the next breath, his tone changed:

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1 "The Government ran a consultation on the issue of
2 personal emergency evacuation plans — PEEPs —
3 in July 2021. The consultation has made clear the
4 substantial difficulties of mandating PEEPs in high-rise
5 residential buildings around practicality,
6 proportionality and safety."

7 Except it didn't. The PEEPs recommendations were
8 massively backed up by the public consultation,
9 including by disabled people and organisations. 80 to
10 90% supported PEEPs.

11 That mantra, "practically, proportionality and
12 safety", was not new. We've heard those words before.
13 This is a haunting echo of the government witnesses'
14 evidence to this Inquiry about why it attempted to
15 relieve landlords of their vital duties to disabled
16 people.

17 These three obstacles to implementing the 23
18 recommendations purportedly revealed by the July 2021
19 consultation were, in reality, taken from the same
20 playbook employed a decade ago and defended in
21 Mr Martin's evidence. First, Lord Greenhalgh said:

22 "On practicality, how can you evacuate
23 a mobility-impaired person from a tall building before
24 the professionals from the fire and rescue service
25 arrive?"

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1 Disabled people and organisations had told the
 2 government how PEEPs could work with the assistance of
 3 staff or others, the phrase used in the guide itself .
 4 But the government regurgitated the same stance
 5 Mr Martin used in his dismissal of the contemptuously
 6 named "benevolent neighbour".
 7 Secondly, Lord Greenhalgh stated:
 8 "On proportionality, how much is it reasonable to
 9 spend to do this at the same time as we are seeking to
 10 protect residents and taxpayers from excessive costs?"
 11 A decade previously, the government dismissed
 12 discrimination concerns due to an anxiety to avoid
 13 imposing disproportionate burdens on landlords, and
 14 Ms Upton agreed that this should have been disclosed in
 15 a spirit of candour.
 16 That purported concern for residents and taxpayers
 17 resulted from closed-door meetings with landlords. That
 18 disabled people should be trapped to die in fire to
 19 avoid excessive cost was one of Brian Martin's dark
 20 facts. Brian Martin was asked:
 21 "So people die in their flats because they're
 22 bedbound, because it's too expensive to have a system to
 23 get them out?"
 24 His answer:
 25 "I suppose so."

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1 Lord Greenhalgh's third point was:
 2 "On safety, how can you ensure that an evacuation of
 3 mobility-impaired people is carried out in a way that
 4 does not hinder others in evacuating or the fire service
 5 in fighting the fire?"
 6 Lord Greenhalgh's attempts to justify why disabled
 7 people would continue to be left in their flats in
 8 a high-rise fire because they might slow down
 9 non-disabled people exercising their rights to evacuate.
 10 It was that mindset that led to 40% dying in the
 11 Grenfell Tower.
 12 It was the view, he went on to say at the time, that
 13 "hopefully the Fire Brigade would get to them in time",
 14 but if not, "that's one of the reasons why there are
 15 a large number of people that — with disabilities that
 16 die in fires, is because they can't get themselves away
 17 from an incident."
 18 This was the government's decision: rejection of
 19 your Inquiry, this Inquiry's recommendations on PEEPs
 20 and sharing information with the FRS for nearly all
 21 high-rise blocks. For the very small fraction of
 22 high-rise blocks with simultaneous evacuation policy,
 23 the very highest risk, there is a person-centred fire
 24 risk assessment, a PCFRA. Typical suggested outcomes
 25 include fire retardant bedding and fire safe ashtrays.

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1 Well, they're fine in themselves, I suppose, but they're
 2 not an evacuation.
 3 It was the minister who said 40% died in Grenfell.
 4 This was not because they had a cigarette in bed. What
 5 this is instead is a sad reminder of the evidence before
 6 this Inquiry that, apparently, disabled people are
 7 a risk to themselves and to others.
 8 Has time already softened the tragedy's impact?
 9 Have the government's failures and their consequences
 10 already been forgotten? It's the purpose of this
 11 Inquiry that this should not happen and that this
 12 tragedy should never be repeated. We suggest that the
 13 government's rejection of this Inquiry's recommendations
 14 to safeguard the most vulnerable who are at risk of
 15 death strikes at the heart of that purpose.
 16 One final point: when I came into this Inquiry,
 17 I had to make myself familiar with the system of
 18 regulation that in theory existed, and I paid close
 19 attention to Dame Judith Hackitt's reports, which
 20 predicted much of the concerns and considerations that
 21 you have considered within this Inquiry. Heaven knows
 22 what Dame Judith would now say, after hearing this
 23 evidence. She said that the regulatory structure was
 24 not fit for purpose. What words would she use now?
 25 One thing that we all expected was that there would

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1 be a system of some type, a system with checks and
 2 balances, risk assessments, impact assessments, the very
 3 stuff of regulation. We've seen nothing of that. On
 4 all of the issues that I've been speaking about this
 5 morning, including disability issues, if there had been
 6 any type of system at all, impact assessment, risk
 7 assessment and their type, consideration by committees,
 8 by meetings, by those people that actually are paying
 9 attention to these details, then this tragedy may have
 10 been avoided.
 11 So we're looking ahead now to a system in the
 12 future, but it needs to be one that has a system of
 13 checks and balances, risk assessment and impact
 14 assessment, that looks carefully at these matters into
 15 the future.
 16 My final point: that is never going to be cheap. It
 17 has to be paid for and it has to be funded.
 18 Sir, those are our submissions.
 19 I now turn and cede my place to Mr Mansfield.
 20 SIR MARTIN MOORE-BICK: Thank you very much, Mr Stein.
 21 Yes. Well, now, Mr Mansfield, you're going to add
 22 to that statement on behalf of your clients, so
 23 would you like to come up.
 24 (Pause)
 25 Yes, Mr Mansfield, when you're ready.

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1 Module 6B (Government, Testing and FRA) closing submissions
 2 on behalf of BSR Team 2 by MR MANSFIELD
 3 MR MANSFIELD: Good morning, Chair, Thouria Istephan and
 4 Ali Akbor as well this morning.

5 You have had — in a sense, the public will realise,
 6 because it is publicly available — from the families —
 7 that's split into Team 1 and 2 — extensive, detailed
 8 written submissions on this part of — well, the whole
 9 of Module 6, but the part I am dealing with is included
 10 in that.

11 Now, in addition, you've had detailed submissions
 12 this morning, so I hope that it might be acceptable if
 13 I were to — and would be of assistance to you if I were
 14 to — in my case I'm sitting back, but stand back
 15 a little, and try and sort of distil some principles for
 16 the future out of this module, because as you listen,
 17 perhaps the most startling fact is that the simple
 18 solution that might have obviated the need for any of us
 19 to be here was present for many years, was neglected by
 20 successive governments, but obviously particularly one
 21 I shall come to in a moment between 2010 and 2015,
 22 namely David Cameron's. There was one staring them in
 23 the face.

24 This can't be explained by the fact that they didn't
 25 know, because they did know. It can't be explained by

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1 oversight, forgetting, falling between the gaps. It's
 2 much more serious than that. And one has to say, as the
 3 select committee did, the fire service did before that:
 4 just how many deaths do there have to be before changes
 5 are made, a refrain that you will have come across many
 6 times.

7 It's not limited, interestingly, to Building
 8 Regulations or other forms of social interplay. It's
 9 a kind of lethargy which says, well — and, in fact,
 10 Martin said this at one point. I think he wasn't so
 11 keen to adopt the strength of the words, but it's the
 12 "Let the bodies build up, where are the bodies?"
 13 attitude before pedestrian crossing, whatever it happens
 14 to be, a safety issue, is put in place.

15 So it's no accident that this has happened, and of
 16 course the measure that can be focused on very simply,
 17 and was spelt out in the select committee, as you've
 18 seen, in 1999 — not entirely it was encompassed, but it
 19 was there, the seeds were there, and have remained
 20 there, namely a ban on combustibles.

21 It's what the families whom I represent and
 22 everybody else who you have heard represents — these
 23 are the questions: why did it take so long for this to
 24 happen? In fact, it's only really happened about a week
 25 ago. Interesting. Just before this part of this

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1 module, that finally we get the complete picture. It
 2 isn't even complete yet. Why has it taken a decade,
 3 essentially a decade, to get to this position?

4 Now, that question — because you will recall that
 5 Counsel to the Inquiry — very helpfully, we put them in
 6 our submissions — set out four questions for this
 7 module:

8 What were the risks from fire, and were they in
 9 high-rise properties understood by government before the
 10 blaze? First question. I'll come back to that.

11 Had lessons been learned from previous incidents in
 12 the United Kingdom and overseas?

13 Third question: what steps had or had not been taken
 14 by government to address these risks from fire?

15 Final question, perhaps of all the most important,
 16 because it links to what I'm saying at the moment about
 17 why, namely: what motivated government in its approach
 18 to fires before the 2017 disaster? That, we say, is the
 19 key to answering why it took so long.

20 It is in fact, of course, a motivation that is
 21 discernible, and I'll come to exactly — and you've
 22 heard it before, but it's worth just going over it
 23 a little, to indicate the strength of that motivation,
 24 because the length of time waiting is excessive and
 25 extraordinary and can't be explained by anything other

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1 than a determined policy not to do it; in other words,
 2 not to have the ban.

3 The second allied question to that, you may think,
 4 that it is necessary for this Inquiry to think about,
 5 because of the length and duration of dilatory behaviour
 6 by government, not just the one in 2010, and what has to
 7 be remedied for the future, appreciating the Inquiry
 8 itself may not be able to encompass all of this, but it
 9 is essential to think: how did such a motivating force
 10 over such a long period survive and, to a terrible
 11 extent, succeed — because it killed 72? There was no
 12 ban. I appreciate there are other factors, but the ban
 13 is pretty central.

14 Part of the answer to that part of the "why"
 15 question is, of course, the nature of the governance
 16 under which we all live.

17 I want, if I may, just to address that, because it
 18 is a situation in which, when a centralised government
 19 is motivated in the way successive governments obviously
 20 right up to the last were motivated, we do not appear to
 21 have the means any longer. It is — like Grenfell Tower
 22 itself, the fault line in government are severe. It's
 23 when you begin to address those two questions related to
 24 the — I'm calling it the "why", but the motivation
 25 question as set by counsel, that one begins to say: why

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1 did that happen?

2 Could I just bring it up to date, just with things
3 that have happened. We say the legacy is still there,
4 the legacy of the why it happened over ten years, to
5 even get to the stage we're at.

6 Sir, you may remember, because you were there when
7 I first opened the case in Phase 1 for the families, and
8 I used a quite astonishing occurrence, and I want to
9 just refer to it again because there's a risk that it's
10 all going to be repeated, and I appreciate that none of
11 you as the panel want to look back and feel that the
12 work that everybody has done and put into this Inquiry,
13 resources into this Inquiry, are going to be at the
14 behest and whim of whoever happens to be in power at
15 that point.

16 But the example I gave at the beginning was — and
17 now might be perhaps even more potent because of the
18 evidence you've heard — that on 14 June, the day of the
19 fire itself, there was a meeting set up. A meeting was
20 convened in the name of the Red Tape Challenge, RTC,
21 which has this — it's like an éminence grise in this
22 case, it hangs behind, set up in April 2011, essentially
23 by David Cameron, but chaired by Oliver Letwin.

24 Now, the terrible irony of this, as it were,
25 motivational factor, the "why" question, is that on that

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1 day, what were they due to discuss? They were due to —
2 so it certainly wasn't off the agenda, as Lord Pickles
3 seemed to think, and I have to come back to him
4 obviously. They were considering whether it would be
5 possible to liberate a little more cladding on to the
6 market in the absence of European standards to enable
7 industry to, as it were, exercise their rights in the
8 marketplace.

9 Of course, as it is understood, the meeting didn't
10 happen. However, that's a telling example of what is
11 possible here.

12 I raise it because, not only does it illustrate what
13 was going on in that period particularly, but there is
14 a risk that a similar situation could occur again. It
15 may not have come to everybody's notice but, on 14 June
16 this year, recently gone with the memorial week that
17 there has been, there was a meeting in parliament of —
18 and it's the first one that has happened, apparently —
19 the National Insulation Association held its first
20 parliamentary meeting. There were members of government
21 there, and a member of the House of Lords who was
22 a minister as well, all there. In principle, of course,
23 that's part of the process of our government. But what
24 is interesting is not just that this was publicised on
25 the 14th — the actual meeting was just before, a week

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1 or so before — it was publicised on the 14th, and what
2 was extraordinary was — and it shows that there is
3 a legacy unless we're careful — there was no mention of
4 Grenfell.

5 One doesn't obviously want to fall overboard, but
6 one is somewhat surprised, in the publicity that they
7 gave to this on the 14th, the meeting happening a few
8 days before, not a single mention of Grenfell. A lot of
9 mention of the role of the insulation industry in
10 relation to green energy. That's a perfectly valid
11 point. However, one might have thought that the lessons
12 of Grenfell had percolated industry to such an extent
13 that on that week before the memorials, they might at
14 least have remembered, they might at least — because
15 you've heard this morning from the previous speakers
16 about the role — and you've heard in evidence as
17 well — of insulation in this particular case.

18 What it tends to demonstrate — I don't overegg
19 it — what it tends to demonstrate here is the
20 relationship between those in government, ministers in
21 particular, industry, and safety is still at risk if
22 it's not respected, if it's not given the place that
23 it's due in our society.

24 The second point has been touched on by Mr Stein
25 only minutes ago, so I don't go back through it. But

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1 what is interesting is in the debate over building
2 safety, fire safety guidance, which is being put out at
3 this moment, is in fact the terms — he's been through
4 the terms on which it's, for the moment, been rejected
5 so far as the recommendations for those who are less
6 able, those who are vulnerable. In a way that is, as
7 the word has been used, the litmus test. The phrase has
8 been coined on many occasions that the measure of
9 a society lies within how it treats those who are most
10 vulnerable, attributed originally to Mahatma Gandhi but
11 it may have been others. It's had different phraseology
12 at different times. But the point is a very simple and
13 extremely good one: namely you do at the end of the
14 day — whatever else you do or don't do, that's the one.

15 To suggest that it's going to cost too much — it's
16 going to cost too much if you don't, as we now see.
17 It's the wrong economic analysis, which should not be
18 applied. But that's the worst aspect of what was said
19 in the House of Lords over these measures, sent back for
20 consultation for another, as it were, kick into the long
21 grass, is that in the same way that fire safety became
22 an impediment to government policy in 2010, 2011 and
23 2012, we now find that the disabled, those less able,
24 they have become the impediment, because they might get
25 in the way of the able-bodied making a quick exit. One

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only has to put that in its, as it were, true light to recognise the risks that still pertain in terms of making progress on all of these matters.

So before I just distil a couple of principles, I would, if you would forgive me, want to just read — I am not sure, obviously, of the extent to which you may have already read the written submissions, but there are just a few initial paragraphs in the one we submitted on behalf of Team 2 for government, because it does summarise our position, but also it leads into the principles I just want to develop in the time we have today.

The paragraphs, so that you have them in case you need to refer to them again, come under the heading of "Central government", and they're the preamble. It's a few paragraphs, 81, 82, 83, 84, 85. That's it. But this is how it's phrased, and I just would like to read this part of it:

"81. The nature and substance of the evidence in the Inquiry in this part of the module beggars belief — belief in a system that failed to protect the right to life. There is one overarching conclusion: that the edifice of government was, and remains, as much at risk as Grenfell Tower itself was in 2017.

"82. The Inquiry has exposed the fundamental fault

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lines in both, the former significantly contributing to the latter. An unresponsive system of parliamentary democracy, wherein the concentration of power is vested in a cabal of short-term Ministers, bereft of any technical expertise to enable challenge, enquiry, robust oversight and transparency; this was, and is, a recipe for disaster. The core accelerant fanning the flames was a deep rooted, remorseless, aggressive political dogma disguised as freedom, freedom to facilitate the interests of industry and private enterprise.

"83. This combination of forces nurtured a hostile environment where health and fire safety, human rights, and equality within social housing were systematically portrayed as impediments to the free market. This provided licence and momentum for behaviours ranging from incompetent to grossly negligent and corrupt.

"84. The testimony in the government part of this module, which has singularly marked those in positions of authority and responsibility, is characterised by arrogance, ignorance, indifference and, in some instances, deceit. Witnesses have regularly shown a remarkable lack of awareness, effectively, 'the higher you go the less you know' as if this is a quality to be proud of. It has often been born from 'not wanting to know' as it did not fit the political purpose of

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government. It has become increasingly clear that few, if any, of the Nolan 'seven principles of public life' have been upheld by the majority of senior politicians and civil servants."

We list those principles. I do it quickly without the description that follows. These were published in 1995, and it's easy to overlook and brush them aside but these principles are:

"... Selflessness; Integrity; Objectivity; Accountability; Openness; Honesty; Leadership."

I pause on that before finishing the last paragraph, because, again, a reflective moment: is it possible to look back on this module and say that really any of those have been satisfied by the witnesses, particularly the ones in prime position, particularly Brian Martin, particularly Lord Pickles? I'm going to add David Cameron, for reasons I'll come to at the end. The answer I think would be: no, they have not been upheld and, in fact, worse, seriously undermined.

These weren't contrived, these principles, just for academic discussion; they were contrived because it was necessary to imbue public life with a sense of morality, if nothing else, and in a sense that's what the families are looking for here.

The last paragraph of this preamble reads as

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follows:

"The apotheosis of this race to the bottom came in the module's final stages with Lord Pickles. His demeanour, excuses and ill-informed attempt at empathy do not bear repetition. Even his apology is couched in terms of an involuntary act of 'misspeak' for which he is not really responsible."

Well, we say here you have another fine example of why these principles are extremely important, because one has to re-examine, as part of the Inquiry's robust approach to the evidence, is — to the "why" question again, why it went on for so long, because actually at the end of the day, those concepts that are contained in those principles, combined with the concept of ministerial responsibility — where is it?

Mr Millett put very carefully to Lord Pickles, which he accepted, in the end, responsibility — but it was like, if you remember, a brush-off, "Yes, yes, yes, of course I'm responsible". It doesn't mean anything because, within minutes, of course, were the errors that he was making.

The ministerial responsibility in our system at the moment, which is important in terms of not only those principles but the question of accountability — it's not just me or Mr Stein or Stephanie Barwise asking

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these questions; the families — as you attended, the memorials last week, more than one, but particularly the one at the tower, what is it that the families and those who speak on their behalf are wanting? It's easy, it trips off the tongue: justice. It can be a meaningless concept, but not in this one. This time it's very meaningful, because justice for those who are truly responsible — and, of course, I'm already putting fingers very carefully on those who are responsible — they are expecting that those who have and should have, if ministerial responsibility is going to mean anything, then there has to be a follow-up, there has to be justice for the families in terms of the accountability.

There's two forms of accountability: there's the one you have here, in which witnesses come and they're asked questions, perfectly properly. But the families are not — and it isn't — and obviously not wishing to obviously indicate what the Inquiry's function is, as you know well, it's not expected that you will deliver accountability; you will identify where responsibility lies in this particular instance. That has been done through the evidence, and it is hoped that those who are watching, those who are listening, those who are receiving this evidence will understand that this is only half the exercise, long though it's taken to do,

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but necessarily do in careful detail. So that process has not yet finished.

So accountability, part of the Nolan principles, is absolutely vital if this Inquiry at the end of the day, besides making changes in government thinking — and one hopes that the government will rethink their rejection of the less able or vulnerable.

So accountability we say is a key point here but, actually, at the end of the day, it's combined with another proposition, and that is the one that is likely still to be pushed to the back, and that is a respect not just for those who are less mobile, but a respect generally for public health and safety. We say that hasn't been present. It's one of the reasons for the gap. The length of time is because the deregulatory agenda, which existed long before, many years before the advent of the coalition government in 2010, so it had existed for many years before, that deregulatory approach, safety was not taken seriously. It wasn't on everybody's lips. It wasn't something that was a pressing need. But, of course, that's stage 1. It's not given the respect it's due. Once it isn't given the respect, and it's something that's an also-ran, something that can be traded off so that industry can get on with its business, and so it becomes obviously

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later one in, two out, three out and so on, the honed regulatory agenda, which is the key one here.

So it has not been regarded with respect, but it gets worse than that. Again, that's the key factor here because, obviously, deregulation goes back through a number of governments and, as I shall be saying at the end, there is some character in this whole scenario that you haven't heard from, but he is, we say, responsible for the deregulation agenda, deregulatory agenda, being honed specifically not just to disregard fire safety or — and safety, but actually to ditch it, actually to target it, actually to kill it off. And then one wonders why it's taken ten years or more. Because the critical years in the lead-up to refurbishment at Grenfell Tower and all the rest, we have, as it were, the tentacle reaching out and essentially corrupting the system. And the problem was there wasn't a way of dealing with this for those who felt, as many — and I would submit the majority of the population would want there to be not a risk-averse society, as was held, not a cowardly society, as it was described by those in the Red Tape Challenge, but a courageous society that puts the priorities — even though they may cost in the initial stages money, but save in the longer run.

In this context, therefore, with these principles in

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mind, there are just one or two documents that it's worth reminding oneself of.

I wonder — we have given notice. I'll make sure I get the right reference: {HOM00018307/2}. Yes, here we are. That's it, thank you.

I called up this document because it's had some exposure, you will recall. This is the letter that Lord Pickles says is a fancy letter, it's the sort of letter CEOs send out from time to time to get their ... I'm sorry, this is exactly the mentality of those who obviously don't regard safety as a top priority. But this letter, which was dated, as the first page shows, in April 2011 on the 8th(sic) — I'm not going to read it all. Can we go back to the second page, please. We've got the date: April 2011. This marks the demarcation between the deregulatory policies before the coalition and then how the coalition, as it were, lifted all of that, as it were, work that had gone before and then honed it and focused it on safety, which they did.

I'm not going to repeat the Maidenhead speech which in fact came a year later in 2012, because the theme of targeting fire safety and safety generally as an albatross had been going on all around. So this is what ministers are getting. The last page of the letter — I don't ask for it to come up — indicates

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1 that this is a letter that went to all government
2 ministers, it went to the Cabinet Office and to the
3 Permanent Secretaries of the civil service throughout.
4 There's no mealy-mouthed about this, there's no ambiguity
5 about this, about new regulations. The top paragraph:
6 " ... I want us to be the first government in modern
7 history to leave office having reduced the overall
8 burden of regulation, rather than increasing it."

9 Next paragraph:

10 " ... bold ambition ... if we try a new approach."

11 Then he's talking about scrapping this, that and so
12 forth. I don't read all of it:

13 "In the past, when government has tried to
14 deregulate, Ministers were asked to make the case for
15 abolition. In other words, the assumption was that
16 regulations should stay, unless there was a good case
17 for getting rid of them. We are changing that
18 presumption; we are changing the default setting.

19 "Our starting point is that a regulation should go
20 (or its aim achieved in a different, non-government way
21 [industry]), unless there is a dear and good
22 justification for government being involved. And even
23 where there is a good case for this, we must sweep away
24 unnecessary bureaucracy and complexity, end gold-plating
25 of EU directives, and challenge overzealous

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1 administration and enforcement.

2 "This marks a change from the old ways of doing
3 things ..."

4 You see quite clearly — I don't trouble you with
5 the terms of the rest of it. It's all in the same vein.

6 This isn't a fancy letter just to get the troops
7 a bit worked up. This is the Prime Minister making very
8 clear that his government is going to do things quite
9 differently even to the pre-regulatory regime that went
10 before. That is why this letter is extremely important,
11 and it's this letter combined with what the Prime
12 Minister was saying in the Maidenhead speech and
13 elsewhere about fire safety that meant you had
14 a combination — an aggressive approach to this policy.
15 Safety is no longer given respect. It's kicked down the
16 road because it's seen as the albatross or the
17 hindrance.

18 This explains clearly — because this is 2011; the
19 speech in Maidenhead, 2012; the coroner's letter, 2013.
20 So the coroner's letter is coming into central
21 government, Lord Pickles in particular, but others, at
22 a time when actually nobody is taking it seriously, any
23 more than the letter, carefully crafted, was taken
24 seriously.

25 You will remember — astonishing — the head of

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1 civil service within the department, Dame Melanie, I'm
2 calling, if I may, her "Lakanal moment". How could she
3 be in this department, head of the civil service? She
4 did not know about Lakanal, she did not know about the
5 Rule 43 letter, until the morning of the fire, when the
6 Red Tape Challenge were meeting just down the road. She
7 didn't know anything about it. But she wasn't alone.
8 She hadn't been briefed. Why? Because it wasn't of
9 concern.

10 You saw some of the — well, you saw the results of
11 the slideshows that some ministers were given. The
12 briefings were usually very brief, very informal and not
13 adequate at all, which is why Lakanal was on the
14 back-burner. But the slideshows themselves didn't deal
15 with external fire spread, didn't deal with ADB, because
16 they weren't — despite the Building Regulations, 70%
17 are really concerned with safety, and yet it was
18 relegated. It was relegated because of this kind of
19 agenda. And it's serious because if you — there's
20 another document I would like to also refer you to, and
21 that is the ... sorry, just one moment while I get the
22 reference to it.

23 I don't seem to have it readily available, but you
24 will remember it is the Amess — the statement that he
25 made to the House of Commons. I read it out in opening

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1 this module, and you will recall how serious that was
2 for him. We put it in our main submissions, but it is
3 something that needs to be reflected on, because he, now
4 the late Sir David — and in a way he summarises the
5 attitude of anybody who tried to challenge — that's why
6 the system is at stake here, and this is what Sir David
7 was trying to say. This was a speech in 2019:

8 "The world was horrified when we saw a tower block
9 ablaze in the fourth or fifth wealthiest country in the
10 world, and it should never, never, have happened. Over
11 the past six years, the all-party group has met
12 resistance when seeking improvements to fire safety,
13 despite compelling evidence that such measures should be
14 introduced. In the 13 years since the regulations were
15 last reviewed, nothing has happened. It is perhaps
16 rather easier for a Conservative Member to make those
17 points than it would be for other Members, because we
18 should never have got to the position of the
19 Grenfell Tower fire tragedy, especially after the
20 warnings and the recommendations from the coroner after
21 the Lakanal House fire and the 2013 inquest, the rule 43
22 letter to the Secretary of State ... the large number of
23 letters exchanged between me and numerous ministers [21,
24 I think, all together] and meetings with successive
25 Ministers.

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1 "It brings no comfort to the victims of Grenfell ...
 2 It is the fault of the Conservative Government ... the
 3 Labour Government ... of every Member of Parliament that
 4 our voice was not heard and the recommendations were not
 5 listened to."
 6 Now, in a sense, that is a tribute to a man who
 7 fought hard, who was really rebuffed, who was seen as
 8 an irritant, they didn't encourage anybody to go and
 9 meet him — what's the problem with this? The problem
 10 is twofold. The system is not allowing this to
 11 penetrate the cabal-led cabinet, not allowing a position
 12 in which — and this was the APPG, 10 or 11 members as
 13 it was then, with Ronnie King, you will recall,
 14 Ronnie King of great experience lending his services to
 15 the committee. This is how Ronnie King was dismissed by
 16 Brian Martin, which led to the cross-examination by
 17 Mr Millett. Basically he, Brian Martin, wasn't going to
 18 allow anybody who knew what they were talking about to
 19 get anywhere near ADB, to be allowed to make
 20 a constructive contribution. Why not? Oh, because —
 21 and this goes back to what's being said in the
 22 House of Lords recently — because, "Oh, we'll go
 23 bankrupt, we'll starve to death". It's this approach
 24 that where you have safety in mind, it's getting in the
 25 way of, what? Profit? Getting in the way of — it's

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1 such obvious equations that are being used, that are
 2 remiss.
 3 I want to pause, if I may, just on this because we
 4 have —
 5 SIR MARTIN MOORE-BICK: Mr Mansfield, I hope you'll forgive
 6 me just for reminding you that we were going to break
 7 for lunch about now.
 8 MR MANSFIELD: Ah, I misread. I thought I was going to go
 9 to 1.00. I'm quite happy to do that.
 10 SIR MARTIN MOORE-BICK: Are you sure?
 11 MR MANSFIELD: Yes, yes, yes.
 12 SIR MARTIN MOORE-BICK: When I mean break for lunch, I mean
 13 you've run out of your time.
 14 MR MANSFIELD: Well, I think I started at 12.05, but
 15 I can — if you can give me an extra five minutes, I can
 16 do it now.
 17 SIR MARTIN MOORE-BICK: Shall we say 12.50, would that be
 18 all right?
 19 MR MANSFIELD: Yes, yes, yes. Sorry.
 20 The point — there are a number of other points
 21 within this, in terms of recommendations. Could I just
 22 pause to make the recommendation here. Besides a system
 23 of government, perhaps it's time to suggest that APPGs
 24 are given a statutory basis. There are a number of
 25 them, because there, within their basis — and to be

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1 given powers, because at the moment they're informal,
 2 they don't have statutory powers, and on the whole, if
 3 government wants to ignore them, that is precisely what
 4 they do. So I would ask for that to be considered as
 5 a possible recommendation for the future.

6 The two other points I want to make, one is that
 7 an example of how the Rule 43 letter was ignored and
 8 an example of why things are still the same — may
 9 I just — it's not a regulation, it's a different point,
 10 but it is within the ambit of what's been talked about
 11 today.

12 You will recall Hanan Wahabi gave evidence in
 13 Module 4 right here, and she describes what it's been
 14 like walking away from the fire. Her family were
 15 divided, in the sense that half her family survived
 16 because her half, they got out; the other half didn't
 17 because they were on a higher floor and they stayed put.
 18 Stay put. The question being asked by the families this
 19 week, BBC asked the question, right this week: if I live
 20 in a high-rise block, what am I supposed to do? Do we
 21 know? No, we don't.

22 Looking at the government website on this issue,
 23 we're nowhere near getting answers. London
 24 Fire Brigade, yes. Government, no. The government has
 25 four stages. It's barely finished stage 1, which is

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1 only looking at the past evidence. Another three stages
 2 to go. Are we going to wait for people to die again?
 3 It's the same lethargy. There needs to be an urgency
 4 about these issues that we've been over, and we would
 5 impress you to, as it were, persist in the way that you
 6 have to date.

7 Now, the final point in the last two minutes is
 8 this. We put it in the opening, and on behalf of Team 2
 9 I request consideration by the panel again. The key
 10 figure in the 2010 coalition, the key figure, the
 11 architect of the policy that targeted safety was
 12 David Cameron. This is Hamlet without the prince. Why
 13 is he not being called? We have requested — it has
 14 been said, twice, in reply that it would be
 15 disproportionate, it would be unnecessary. Well, may
 16 I say, we're not asking for every Prime Minister who has
 17 been, as it were, overseeing deregulation, just the one
 18 that turned, as it were, the focus towards fire safety.
 19 There are obviously necessary questions that the public
 20 and the families deserve an answer to, and that is when
 21 he did say the things that he did, both in the letter
 22 and the Maidenhead speech and elsewhere, did he
 23 recognise what he was doing, creating the hostile
 24 environment in which these errors, these gaps, these
 25 mistakes, worse, occurred, because he'd created the

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1 conditions of causation? And we say, once again, it
2 needs answers from him rather than assumptions. And
3 although we appreciate the pressure of time, we would be
4 obliged for further consideration of that matter.

5 And I'm sorry, I misjudged the time.

6 SIR MARTIN MOORE—BICK: That's quite all right.

7 All right. Thank you very much for your statement,
8 your remarks. We will break there. We will resume,
9 please, at 1.45, and we shall be back on track then.

10 Thank you very much. 1.45, please.

11 (12.52 pm)

12 (The short adjournment)

13 (1.45 pm)

14 SIR MARTIN MOORE—BICK: Now, the next set of closing
15 statements is going to be made by Mr Martin Seaward on
16 behalf of the Fire Brigades Union.

17 So, Mr Seaward, if you would like to come up to the
18 desk, you may begin your remarks.

19 Module 6B (Government, Testing and FRA) closing submissions
20 on behalf of the Fire Brigades Union by MR SEAWARD

21 MR SEAWARD: Thank you, sir, members of the panel.

22 These oral submissions are evidence—based. The
23 references are given in the FBU's written closing
24 statement, or most of them anyway, for this part and are
25 not repeated here.

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1 I start with the true causes of the Grenfell Tower
2 disaster.

3 The evidence received in Module 6 shows that the
4 fundamental underlying causes of the terrible loss of
5 life at Grenfell Tower were political decisions made by
6 central government from 1979 onwards in the service of
7 a social and economic system driven by profit and greed.
8 In particular, the disaster was a product of the
9 neo-liberal agenda over the last 40 years of
10 deregulation, privatisation and marketisation, with the
11 introduction of competition into the public sector in
12 areas previously governed through direct public control.
13 Regulation and oversight by the state of fire safety and
14 fire and rescue services at national and local level was
15 deregulated and replaced by looser regulation,
16 self-regulation and guidance. The dominant mantra was
17 that the private sector knows best, with the public
18 sector being opened up to ever greater private
19 provision, and the public sector being increasingly run
20 down and marginalised, especially after the regime of
21 austerity.

22 Corporate interests were prioritised over and above
23 the needs and rights of citizens, particularly those
24 living in social housing, including as to life, fire
25 safety and equal treatment. The deregulatory agenda has

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1 been accompanied by a tolerance of cronyism and
2 corruption, and a war on health and safety regulation.

3 We start by looking at the government, which led the
4 race to the bottom.

5 The election in 1979 of Margaret Thatcher's
6 government heralded a significant ideological change,
7 whereby the market and the private sector were to be set
8 free as far as possible. In 1979, Michael Heseltine
9 fired the starting gun for the deliberate policy of
10 deregulation in the construction industry. He advocated
11 the part—privatisation of Local Authority Building
12 Control, and reducing the Building Regulations to
13 overarching functional requirements as set out in the
14 consultations, including the Future of Building Control
15 in 1981.

16 Professor Bisby described in his Phase 2 report how
17 the changes first introduced by Heseltine in 1984
18 provided the construction industry with the flexibility
19 it had been seeking with the creation of private
20 building control, so that designers and contractors were
21 no longer necessary limited by constraints applied by
22 a local authority building control. He said it
23 unleashed a race to the bottom. We agree. The civil
24 servants and DCLG agree.

25 Mr Burd, head of technical policy in the DCLG until

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1 2013, told the Inquiry the clear pre-1985 rules which
2 had told builders they couldn't use a class 0 panel with
3 a polyethylene core on a high-rise were deliberately
4 replaced by a far more innovative functional approach.
5 Mr Harral, who replaced Mr Burd, said that the
6 Building Act 1984 was intended to deliver a system with
7 the minimal possible government intervention to deliver
8 compliance in the marketplace. Mr Martin gave similar
9 evidence, adding that market forces made building
10 control bodies more willing to let third parties tell
11 them something was acceptable, and that the government
12 approach was to let the sector resolve its own problems.

13 Mr Burd's view that the new functional approach
14 should have been sufficient was at best naive. The
15 commercial marketplace is not some kind of
16 consensus—seeking academic forum, but is driven by the
17 commercial imperative to maximise profits, cut costs and
18 undercut competitors. Ambiguities in the guidance for
19 the Building Regulation regime caused confusion and
20 provided a means to cut costs and corners and, for some,
21 to bend and sometimes break the rules.

22 What is worse is that the government was aware of
23 all this, as is now partially admitted by DLUHC at
24 subparagraphs (d) and (h) at paragraph 6 of their
25 closing and paragraphs 124 and 130. It knew that there

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were ambiguities in ADB, that the deregulation regime was failing to prevent the use of unsuitable materials on high-rise, and that markets know no morality. I am quoting here:

"It is government's responsibility to bring a balance."

That is what Mr Heseltine said at the outset. But they failed to bring that balance.

The tragedy at Grenfell Tower could well have been avoided if a stricter regulatory regime of the pre-1985 Building Regulations had been preserved, preventing the use of combustible materials in rainscreen cladding systems on existing high-rise. Introducing the functional requirement approach without adequately resourcing and supporting local authority building control was a recipe for the Grenfell Tower disaster.

In view of Professor Torero's evidence, including his oral testimony on 16 June 2022, it's clear that the competency gap in all sectors should have been filled before deregulation. The free market, driven by the desire to maximise profit, was never going to be the correct mechanism for ensuring safety in the construction industry. As Mr Harral told the panel, the English marketplace failed in terms of safety. The ambiguous guidance in ADB and the failure to clarify it

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made compliance with and enforcement of the functional requirements much more difficult, and gave the construction industry the flexibility we saw exploited in Modules 1 to 3 of Phase 2.

The FBU ask then: why did no one on the GT refurbishment project think fire? The answer is provided in this Module 6-2. The government policy of deregulation, compounded by austerity cuts, allowed fire safety to become a costly burden which could be disregarded with impunity, pending a disaster like Grenfell.

We agree with the written closing submissions for this part of Module 6 of BSR Team 1 at 1.1 and 1.3; of BSR Team 2 at paragraphs 3 and the paragraphs referred to earlier today by Mr Mansfield, 81 to 85, and paragraph 159. We also agree with the Mayor's submission at paragraphs 18, 21 and 33, and note the concessions made by the current Secretary of State for DLUHC in his written closing statement, already cited.

The government knew from 2002 specifically of the dangers posed by ACM cladding with polyethylene core. Mr Burd admitted that by 2002, following the failed BRE test on 18 July 2001, he was aware (a) how ACM cladding with a polyethylene core could behave in a fire and that it should not have been used over 18 metres; (b) of

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Dr Debbie Smith's view that class 0 was at least questionable as a classification for a product to be used as or as part of an external wall over 18 metres; (c) although a product such as ACM cladding could achieve a class 0 reaction to fire classification, nevertheless it presented a clear external fire spread hazard; and (d) that a PE-cored aluminium rainscreen cladding product was likely to perform dangerously with respect to external fire spread hazards.

However, the government not only failed to act but, when ADB was modified again in 2006, the routes to apparent compliance were actually extended, by keeping the class 0 classification while introducing the option of desktop studies. These significantly weakened the already lax fire safety regime. They were brought in despite the knowledge the government possessed about the failures of ACM cladding systems in the full-scale tests of July 2001. Far from tightening up fire safety protection, the revised ADB maintained and created a regime which could be exploited by the greedy and the unprincipled. As you are aware, even when the all-party parliamentary group on fire safety and rescue repeatedly raised concerns about ADB between 2014 and 2017, including with ministers, their concerns were given short shrift. There can be little doubt that

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deregulation and the failure to clarify ADB were significant factors which directly contributed to the Grenfell Tower fire.

Deregulation impeded the work of civil servants in DCLG. Civil servants have consistently testified that deregulation stifled attempts within DCLG to address concerns about the ambiguities in ADB and the use of dangerous materials for cladding over 18 metres, even after the coroner's recommendations following the Lakanal fire inquest.

Mr Burd told the panel that the deregulatory agenda of the government after 2010 had throttled the possibility of new regulation, and went on to explain the savings that had to be made before any regulatory provision could be introduced. He also said the plan to review ADB triennially was overtaken by the coalition government's policy on deregulation, that regulation was seen as a last resort, that his shrinking team spent an inordinate amount of time looking at how they could deregulate and undertaking other activities supporting deregulation at the expense of other work.

Mr Ledsome told the panel that DCLG was a deregulating department. Deregulation was an important government policy and they were addressing the spirit of what the government wanted to achieve as

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well as the letter. The job of officials, he said, was to provide ministers with the widest range of deregulatory options. No new regulation could be introduced without a compensating reduction in regulation elsewhere, and there was no exemption for the Building Regulations. There was no process of seeking an exemption, other than applying to Secretary of State. No application for an exemption was made to the Secretary of State because they didn't think they would have got one and it wasn't judged a fight worth having.

Deregulation was the reason why the review of ADB was wrapped up into a broader review. A piecemeal review was ruled out as it would have made it more difficult to offset any changes as required by the one in, one out, one in, two out and one in, three out rules. This approach was agreed by the director general. The coroner's recommendations following Lakanal did not result in ADB being exempt from the deregulatory regimes of one in, one out, et cetera.

Mr Harral testified that from 2015 there was a far more vigorous and aggressive approach to deregulation. He explained there was a general sense that regulation was bad, and even when there were proposals to do something that was regulatory, in terms of introducing something that was attractive to ministers or something

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they might want to do, when they recognised it was regulation, they would pull back from that generally, because that was not the way they preferred to drive change.

The DCLG was frustrated by the depth and challenge of regulatory policy. Further, the policy was intended to make it difficult to introduce new regulation.

Anything that involved amendment or change to an approved document triggered a regulatory impact assessment. Deregulatory policy applied to matters of life safety.

This is all what Mr Harral told us.

The review of ADB had to be packaged with a wider review of the Building Regulations to avoid having to find the necessary savings within part B.

At the end of 2016, Mr Harral was told by an official from the better regulation unit not to consider proposing regulation because the department was struggling with its regulatory budgets. The better regulation agenda, he said, prevented the government acting on the improper use of materials and had an impact on people's willingness to comply with the regulations.

Likewise, Ms Dawes gave evidence that the deregulatory imperative cast a shadow over teams in the

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department, and without rolling up the review of ADB into a wider review of the regulations which could be seen as deregulatory, it would have been difficult to progress.

Between 2014 and 2017, the government adopted a far more rigorous approach to deregulation, with increased scrutiny of regulatory proposals. There needed to be very good reasons, she said, for any new regulation or the kind of regulatory oversight put in place from 2017. It would not have been very well received in 2015.

Better regulation would not have happened without the Grenfell fire, she said, and she went on to explain that she found it horrific to think that it took a fire:

"... but I honestly am not sure that it would have happened otherwise."

The Red Tape Challenge, the undervaluing of regulation, the localism agenda which removed oversight and the demise of the audit commission all contributed to Brian Martin becoming what's been dubbed the single point of failure.

Mr Martin told the GTI that after the 2015 general election, there was an even greater ambition towards deregulation, and any document that came out from the department required political approval. Policy change and raising standards was incredibly difficult under

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this regime, Mr Martin told the panel. Government policy progressively hardened. The Prime Minister described people like him as an enemy of enterprise. The approach of successive governments to regulation affected resources and the mindset of the team and contributed to Mr Martin becoming a single point of failure.

All this evidence fully supports our contention that its obsession with the deregulated free market was the cause of the government's failure to do anything about ambiguities in ADB and the use of dangerous materials for cladding and high-rise. Based on this, we submit the panel should find deregulation was a significant cause of the Grenfell Tower fire.

We turn now, sir, to the evidence of Lord Pickles.

Lord Pickles stated in his evidence that the failure to review ADB was the fault of the civil service, who misunderstood government policy, and not a consequence of the drive for deregulation by him and the rest of the government. He claimed that all fire safety regulations, including the Building Regulations and ADB, were exempt from the Red Tape Challenge and deregulation.

We submit the panel should prefer the evidence of the civil servants, which clearly shows the Building

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1 Regulations and ADB were not exempt from the Red Tape
2 Challenge and deregulation, and reject Lord Pickles'
3 evidence on this matter as self-serving and untrue.

4 Mr Burd said that ADB and the Building Regulations
5 were not exempt from deregulation policy. Mr Ledsome
6 said the deregulation policy applied to ADB as well as
7 the Building Regs, even though it was non-mandatory
8 guidance. Mr Harral said that one in, one out,
9 et cetera, all applied to Building Regulations and
10 guidance. Further, the better regulation framework
11 manual applied to both the Building Regulations and the
12 guidance.

13 Lord Pickles did partly but not fully exempt the
14 Regulatory Reform (Fire Safety) Order from the Red Tape
15 Challenge and the drive for deregulation, but this was
16 not because he wished to ensure regulations relating to
17 life and, in particular, fire safety were exempt.
18 Instead, as he himself stated towards the start of his
19 evidence, the Fire Safety Order was not included as it
20 was itself a product of the deregulatory agenda. This
21 evidence was confirmed by Mr Ledsome, who added that
22 a lot of the fire safety legislation was repealed when
23 the Fire Safety Order was introduced, and from
24 Dr Crowder, who recalled the Fire Futures review
25 of December 2010, which was about decentralising fire

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1 safety, government having less of a presence in fire
2 safety, and encouraging industry to take the lead in
3 this belief that it had that industry would lead the way
4 and do what it needed to do.

5 However, the Building Regulations were not even
6 partly exempted from deregulation, and there was nothing
7 in place to ensure the life safety provisions were
8 exempt.

9 Lord Pickles was asked by Counsel to the Inquiry:

10 "Question: Were there any policies in place to
11 ensure that departments such as yours observed their
12 obligations to safeguard life, including under Article 2
13 ... and were properly prioritised?

14 "Answer: I can't think of anything that springs to
15 mind, but I would hope that that would be the case."

16 Hope is not good enough for someone who is the
17 Secretary of State responsible for both fire safety and
18 the policy of deregulation in his department. We submit
19 that he knew full well that there was no such exemption,
20 and Lord Pickles was not being honest in his evidence.

21 Ms Dawes, the Permanent Secretary, would surely have
22 known if there were any specific exemptions to this
23 central government policy. However, her evidence was
24 that she was unaware of any checks and balances to
25 ensure the policy of deregulation didn't go too far in

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1 areas impacting life safety. Nor was she aware of any
2 policies or guidance in place concerning the DCLG's
3 obligations to safeguard life. There were none.

4 Indeed, a letter from Lord Pickles dated
5 December 2011 expressly included the Building Regs and
6 ADB as part of a programme of, I quote,
7 "barrier busting" deregulation, which was expected to
8 produce £63.6 million by regulatory cuts.

9 Lord Pickles claimed this was a mistake due to
10 naivety on his part, but he accepted he had authorised
11 a deregulatory review of the Building Regulations, which
12 came to be known as the "quick wins" proposal, in 2010.

13 On the second day of his evidence, when trying to
14 show he had exempted the Building Regulations and ADB
15 from the deregulatory agenda, Lord Pickles referred to
16 several documents which he claimed supported him. They
17 do no such thing and the panel is asked to reject his
18 evidence about them.

19 Firstly, the letter exchange between
20 Mr Stephen Aldridge and Will Cavendish of the Cabinet
21 Office from November 2011. It wasn't even seen by
22 Lord Pickles at the time but, in any event, it made no
23 mention of Building Regulations or the ADB. His claim
24 that it was deliberately vague is not supported by any
25 other evidence, and the fact is that neither Building

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1 Regulations nor ADB were reviewed, despite the
2 recommendation of the Lakanal House coroner.

3 Secondly, a policy development document from
4 Ms Upton in January 2012 relied on by Lord Pickles was
5 also not seen by him at the time, but it too made no
6 reference to the Building Regulations or ADB. It was
7 unambiguously addressing the Fire Safety Order and the
8 King's Cross fire regulations. Lord Pickles' reference
9 to it, to its constructive ambiguity, is self-serving
10 and unhelpful to the Inquiry.

11 The submission containing the response to the
12 Cabinet Office on the Red Tape Challenge at annex B to
13 the submission sent to Lord Pickles' private secretary,
14 made it clear that the Building Regulations were not
15 exempt. I quote:

16 "Maintenance and improvement of the Building
17 Regulations into the future will continue to be done in
18 accordance with the Government's approach to regulation
19 — not least the one-in, one-out approach to regulation
20 and the Spending Review commitment to reduce the burden
21 on housebuilders by 2015."

22 Lord Pickles tried to explain this by saying that
23 there was an exemption for ADB. His assertion is both
24 unfounded and illogical. ADB was guidance on how to
25 comply with part B and therefore could not be subject to

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1 a separate standalone exemption.

2 Other documents demonstrate beyond any reasonable
3 doubt that the Building Regulations and ADB were very
4 clearly subject to the policy of deregulation, see eg
5 the email dated 24 June from Jane Houghton, a government
6 press officer, described by Lord Pickles as highly
7 competent, which included a section "Cutting Down Red
8 Tape Regulation for the Construction Industry". It went
9 on to state:

10 "... building regulations have placed more burdens
11 on industry than any other DCLG policy area ... We are
12 conducting a 2013 Building Regulations Review ... to
13 ensure they are fit for purpose and to identify
14 opportunities to deregulate where possible."

15 Lord Pickles unconvincingly claimed this was not
16 policy but "puff" to get more coverage in the press.
17 When pressed on this email, he became prickly, saying:

18 "I respectfully remind you that you did promise that
19 we would be away this morning, and I have changed my
20 schedules to fit this in. I do have an extremely busy
21 day meeting people, but this is more important than
22 anything. But I would urge you to use your time
23 wisely."

24 The fact that deregulation was a core policy of the
25 government from 2010 is evident from a letter from Prime

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1 Minister David Cameron in April 2011, which Mr Mansfield
2 has already referred to. I will just cite one sentence
3 in that letter which he didn't cite, which was
4 David Cameron saying:

5 "Dear colleagues,
6 "[Et cetera, et cetera] ... Be in no doubt: all
7 those unnecessary rules that place ridiculous burdens on
8 our businesses and on society — they must go, once and
9 for all."

10 I just want to emphasise the description of "all
11 those ridiculous burdens on our businesses". That's
12 fire safety, it's ridiculous.

13 Lord Pickles unconvincingly tried to claim the
14 letter was not directed specifically at him, which of
15 course is true; it was addressed to all cabinet members.
16 He said it wasn't particularly serious as it was
17 addressed to "Dear colleagues", yet it was not only
18 copied to all ministers, but also Permanent Secretaries,
19 who were instructed to prioritise tackling unnecessary
20 regulation. He said it had to be seen against the
21 background of private discussions with Mr Cameron. He
22 seemed to be claiming that the Prime Minister had
23 written a letter saying one thing when his intention was
24 the opposite.

25 The panel is asked to reject Lord Pickles'

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1 explanations concerning this letter. It clearly
2 reflected a very important policy for the Cameron
3 government. That deregulation was a key government
4 policy with no exemption for life, including fire
5 safety, was supported by evidence from some of the
6 politicians as follows:

7 Lord Wharton told the GTI that he considered the
8 work of the Building Regulations division in the DCLG to
9 be deregulatory. He reportedly told the APPG that there
10 was a political policy of not increasing the burden of
11 regulation, and the introduction of one measure would
12 need to be offset against the removal of two others,
13 although he couldn't actually recall having said that.
14 He couldn't recall any specific policies to provide
15 checks and balances to make sure that life safety issues
16 were not compromised by the deregulatory agenda. There
17 were none.

18 Steve Williams agreed there was a more rigorous
19 approach to deregulation under the coalition government.
20 He also said Lord Pickles was sceptical about regulation
21 and agreed there was no exemption to deregulation for
22 health and safety.

23 Gavin Barwell gave evidence that the Cameron
24 government had driven hard on deregulation. The Red
25 Tape Challenge and the one in, two out rule remained

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1 manifesto commitments in the Conservative party
2 manifesto and, in 2016, became the one in, three out
3 rule. However, at no stage did they take steps to allow
4 life safety regulation by way of exemption or otherwise.

5 David Cameron's now famous speech in January 2012
6 showed the Conservative government gave deregulation
7 precedence over safety when he said:

8 "This coalition has a clear new year's resolution:
9 to kill off the health and safety culture for good."

10 It's simply not credible for Lord Pickles to claim
11 that deregulation did not apply to the Building
12 Regulations and ADB. Lord Pickles also claimed that
13 no one ever discussed cladding with him in the
14 five years he was Secretary of State. We ask the panel
15 not to accept that evidence, particularly given the
16 letter from the Lakanal House coroner. It's
17 inconceivable that no one discussed cladding with him or
18 that he did not raise the issue himself, given his
19 assurances to the coroner.

20 Lord Pickles told the GTI:

21 "I asked my private office and the larger
22 conglomerate of director generals that I really only had
23 two things I wanted from them, I always gave the same
24 speech, which was loyalty and tell me when things are
25 going wrong. And I promised that I would not seek to

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1 blame them; if things were going wrong, I would try and
2 sort it out. And I think I can say that I succeeded in
3 doing that. I had taken over from people who shouted at
4 officers, who threw things about. I can safely say
5 I never raised my voice to a single officer in the whole
6 of those five years."

7 Yet now, sir, in the face of this disaster, he is
8 doing precisely what he said he wouldn't do: blaming his
9 civil servants for something that went appallingly wrong
10 and which was clearly his responsibility.

11 So moving on to the Fire Safety Order.

12 Lord Pickles' evidence in relation to the Fire
13 Safety Order was simply not accurate. Although the Fire
14 Safety Order was not included in the Red Tape Challenge,
15 it was not exempt from the impact of deregulation. The
16 deregulation policy prevented any effective review of
17 the Fire Safety Order, despite significant concerns over
18 the competence of privately employed fire safety
19 assessors and what was meant by "common parts", which
20 were both the subject of the Rule 43 letter to
21 Lord Pickles of the Lakanal House coroner. These issues
22 were not addressed, again, because of the policy of
23 deregulation.

24 When it was introduced, the Fire Safety Order
25 brought in a far looser self-compliance regime than the

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1 certification procedure it replaced. Louise Upton, head
2 of DCLG fire safety policy team, agreed that the
3 government were aware that the Fire Safety Order would
4 allow a mixed bag of unqualified fire risk assessors.
5 This was a deliberate policy of government designed to
6 spare landlords the expense of having to consult experts
7 in fire safety. A paradigm example of a deregulatory
8 agenda.

9 Ms Upton testified that whilst businesses in the
10 fire safety area wanted more regulation — we can think
11 of the Fire Sector Federation, for example — the wider
12 business and policy environment was for less regulation.
13 They were in a very deregulatory environment. The
14 government did not support the sector's efforts over the
15 fire risk assessor competency because the policy was
16 "hands-off". Ministers didn't want to review the Fire
17 Safety Order because of the deregulatory agenda. That's
18 what she said. The general thrust of deregulatory
19 policy, she further said, led to 43 fire and rescue
20 authorities all enforcing the Fire Safety Order in
21 different ways.

22 It wasn't just civil servants who took this view;
23 Dennis Davis of the Fire Sector Federation said that
24 mandatory competence requirements for fire risk
25 assessors was opposed by a deregulating government.

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1 Brandon Lewis effectively accepted that, despite
2 evidence that the sector was failing, the government
3 failed to address the issue of the fire risk assessor
4 competence, both because of the ideological presumption
5 against regulation, and because government did not
6 consider the cumulative evidence. He expressly
7 recognised a political predisposition against further
8 regulation in the field of fire safety.

9 There is a direct causal link to the Grenfell Tower
10 disaster here. Deregulatory policy resulted in the
11 appointment of Mr Carl Stokes, who was insufficiently
12 qualified and not competent to risk-assess the fire
13 safety of such a complex building. Mr Stokes is by no
14 means unique, as was reported by Her Honour
15 Judge Frances Kirkham after the Lakanal House inquest
16 and by Senior Coroner Nigel Meadows after the inquest
17 into the death of Firefighter Stephen Hunt in
18 Paul's Hair World in Oldham Street, Manchester.

19 The civil servants were clear that commercial
20 interest took precedence over life safety. Selecting
21 just a small sample of the evidence, Ms Upton said that
22 the government was more interested in the wheels of the
23 Fire Safety Order running smoothly for business than in
24 legislating for competent accredited fire risk
25 assessors, and that the government had a business-led

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1 agenda that lost proportion on cutting regulation and
2 lost sight of important matters.

3 Mr Ledsome said that any change, even to the
4 guidance, was seen as disruptive and costly to the
5 construction industry. He explained the wrapping up of
6 the review of ADB into a broader review was due to the
7 cost/benefit to business criteria, and said there was no
8 principle that balanced life safety against cost.

9 Mr Harral explained that even just looking at
10 a document was seen as creating a cost for industry. He
11 agreed that there was a clear level of commitment in
12 government to deregulation, irrespective of life safety.

13 Mr Martin said lower standards of fire safety were
14 accepted by the government for economic reasons. The
15 government didn't want to impose the cost of large-scale
16 fire testing on business. The retention of class 0 was
17 for market distortion, not fire safety reasons, and was
18 politically motivated. He said a review of ADB would
19 have had a disruptive effect on the construction
20 industry at a time that the government was very focused
21 on avoiding anything that might impact the economy in
22 a negative way. He said that every review had to
23 consider transitional costs, and the regulatory policy
24 committee would have rejected anything that did not
25 recognise that people would have to familiarise

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1 themselves with the new guidance document.

2 There was a competition between government
3 departments as to which could save industry the most
4 money through deregulation. This was dismissed as
5 sibling rivalry by Lord Pickles, but it can be seen
6 clearly in a document published by the Department for
7 Business, Innovation and Skills in December 2014.
8 A table headed, "Table 2: Departmental regulation and
9 deregulation from ... 2011 to July 2015", showed the
10 DCLG made a net saving to business over the parliament
11 of £201 million.

12 Please screen page 2 of Professor Bisby's report
13 {LBYP20000001/2}. It's the first document on the list.
14 You can see his paragraph 6.

15 "... by the time of the Grenfell Tower fire there
16 had been numerous opportunities where the statutory
17 guidance and regulatory compliance testing regime could
18 have been made simpler or less permissive. However, in
19 each case there appears to have been powerful commercial
20 and ideological incentives to increase complexity,
21 whilst also increasing flexibility for industry."

22 In our opening for Module 6, we submitted that the
23 drive for deregulation and the war on health and safety
24 created a culture of complacency, with an increasingly
25 prevailing attitude that safety did not matter.

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1 Following the oral evidence in Module 6, we would now go
2 further and say that the government showed a callous
3 disregard for health and safety. It was simply not
4 an issue for them. All that mattered were commercial
5 interests. It can come as no surprise that, given this
6 culture, private sector companies involved in the
7 refurbishment of Grenfell Tower behaved as they did.
8 Safety considerations were not an issue for the
9 government, so why should they be for anyone else?

10 Government ministers and officials ignored and
11 suppressed inconvenient reports and evidence that might
12 have prompted measures that could have prevented the
13 fire at Grenfell Tower. An example is the government's
14 failure to publish the report of the failed BRE tests on
15 18 July 2001 on ACM cladding with a polyethylene core.

16 Mr Burd accepted that even though the government
17 were around that very time consulting on revisions to
18 ADB, these reports and data had not been put into the
19 public domain, that they should have been published and
20 that the BRE would not normally publish reports of this
21 sort by themselves without the consent of government.
22 That's Mr Burd acknowledging that they should have been
23 and were not published.

24 Mr Burd denied there was a cover-up, but he had no
25 explanation for the failure to publish this crucial

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1 evidence, and we submit it was not simply an oversight;
2 the government chose to put profit ahead of fire safety.
3 As reported by Professor Bisby:

4 "Rather than eliminating the use of Class 0 for
5 external cladding products, or alternatively more
6 tightly restricting its application to products where
7 the testing methods underpinning a Class 0
8 classification were more technically credible, the
9 Government chose to simply add a new — and potentially
10 lucrative to the recently privatised BRE — alternative
11 route to demonstrating compliance with the
12 recommendations of the Approved Document B; i.e. large
13 scale fire testing to BS 8414."

14 The DCLG did not want to know about fire safety
15 problems and deliberately buried its departmental head
16 in the sand. The instruction to "play down the issue of
17 the fire" in the aftermath of the Knowsley Heights fire
18 and recorded in a handwritten note in file AT 66/398,
19 uncovered by Professor Bisby, indicates government
20 thinking at the time: "Don't tell me; I don't want to
21 know".

22 From October 2012, ministers required the BRE not to
23 make any policy recommendations or propose revisions of
24 ADB as part of deregulation. That's requiring the BRE
25 not to make any policy recommendations or propose any

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1 revisions of ADB. Another clear example of burying head
2 in the sand. This was reinforced by an instruction from
3 Debbie Smith at the BRE to fire safety staff not to
4 raise issues directly with the DCLG. Likewise, the
5 BRE's government contract to investigate and report on
6 real fires was changed to prohibit on-site
7 investigations, save with the specific agreement of
8 department.

9 Ministers woefully failed to interrogate such
10 reports as they did receive. What are they getting paid
11 for? In his comprehensive Phase 2 report,
12 Professor Bisby set out a detailed analysis of the
13 investigations following various major fires since 1991.
14 He notes in each instance the flaws in the investigation
15 and the failure of government to learn any lessons from
16 them.

17 The following should all have been interrogated, by
18 which I mean read intelligently, understood and
19 questions asked. They were not and the only credible
20 explanation is that the government didn't care.

21 So after the investigation into Knowsley Heights
22 in April 1991, which found that the cladding complied
23 with class 0, no concerns were raised as to whether this
24 provision was adequate, nor to what extent the GRP
25 rainscreen product may have contributed to the fire.

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1 After Garnock Court in 1999, where the fire rapidly
2 spread via the external cladding, there was little or no
3 investigation of the contribution of the cladding to the
4 fire. The cladding did not satisfy class 0, which
5 should have raised concerns about non-compliance and
6 enforcement. None were raised. No questions were
7 asked.

8 After The Edge fire in Salford in 2005, another
9 rapidly spreading cladding fire, Professor Bisby says
10 the BRE investigation failed to achieve any of its
11 objectives, but no questions were asked.

12 After Lakanal House in 2009, no questions were asked
13 nor any action taken, despite the coroner's Rule 43
14 letter.

15 Professor Bisby concludes that following the
16 Lakanal House fire at the latest, class 0 should have
17 been withdrawn. Had this step been taken, the disaster
18 might never have happened.

19 Again, to cite Professor Bisby:

20 "The consequence of the choice to retain Class 0 in
21 2002 would manifest in many subsequent fires over the
22 following 15 years. However, none of these events were
23 apparently sufficient to motivate the government to
24 withdraw Class 0. It would take the deaths of 72 people
25 at Grenfell Tower to motivate government into

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1 withdrawing Class 0, and into disrupting industry's
2 status quo. Only then did government see fit to act on
3 Class 0 and to discontinue its use."

4 There was a readily available alternative to the
5 testing regime in the European Union, which the UK was
6 still part of at that time. The harmonisation of
7 methods of fire testing and reaction to fire and fire
8 resistance, based on EU standards, could have had a huge
9 impact on safety. However, it would also affect the
10 profits of manufacturers and their ability to sell their
11 current products on the UK market. The government was
12 aware of this and exploited their ability to delay the
13 transition period and to determine the equivalence
14 between the testing regimes to the full.

15 Consequently, even though they were aware of the
16 inadequacies of class 0 compared to the EU standards,
17 and that by maintaining class 0 the UK market would be
18 open to cladding products of inferior reaction to fire
19 performance — I'm citing from Mr Burd — they continued
20 to allow it to be used purely for commercial reasons —
21 that's what Dr Crowder said — with devastating
22 consequences at Grenfell Tower.

23 As identified by those representing the BSRs, the
24 consistent pattern of inadequate investigation and
25 suppression of reports from Knowsley to Garnock through

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1 to Edge and Lakanal goes beyond mere accident; it
2 involves government collusion and reflects a corrupt
3 culture.

4 The government regarded fires as something to be
5 covered up or trivialised, such that the public might be
6 reassured and avoid criticisms of underlying
7 regulations, thereby continuing to allow industry the
8 latitude it wanted.

9 We pointed out in our opening to Module 6 that, as
10 well as a lack of competence, the involvement of the
11 private sector brought with it a culture of deceit,
12 cronyism and corruption. We illustrated this with
13 a number of evidential examples.

14 Kingspan were clearly pleased with the government
15 policy, including the delay of introducing EU testing
16 standards. Its technical bulletin in May 2003 stated of
17 the new European fire classification system:

18 "Existing nationality fire standards are not set to
19 be withdrawn for five to ten years ... HM government has
20 stated it will not implement the new Euroclass system
21 until the industry is ready to adopt it."

22 In fact, the delay went well beyond five to
23 ten years. By 2017, class 0 was still in use and EU
24 standards were not in place.

25 The Grenfell Tower Inquiry has not investigated in

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1 any depth the extent of collusion, including lobbying of
2 ministers and other politicians or officials behind the
3 scenes by companies such as Kingspan. Whether or not
4 there was more active collusion or corruption, we submit
5 government policy was driven by commercial
6 considerations to the detriment of fire safety, and this
7 ultimately led to the disaster at Grenfell Tower.

8 Sir, I'm about halfway through. How are we doing?
9 Still on time?

10 SIR MARTIN MOORE-BICK: Yes, you're doing reasonably well.

11 MR SEAWARD: Reasonably well. I'll certainly live with
12 that.

13 Sir, moving on to the next big topic, which is the
14 Building Research Establishment.

15 The BRE was first threatened with privatisation in
16 1981. It was turned into a more commercial organisation
17 during the 1980s, and became an executive agency in
18 1990. By that time, it had lost half its staff and was
19 operating under market imperatives. BRE's privatisation
20 in 1997 brought commercial pressures and conflicts of
21 interest into the heart of the fire safety regime and
22 limited the work the BRE could do in the public
23 interest.

24 Professor Bisby cites the following passage from the
25 BRE's deputy director then, Peter Field, and his

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1 evidence to the parliamentary inquiry in 1999:
 2 "We are a private sector organisation; we are not
 3 part of government. Clearly, in days gone by, when we
 4 were part of [government] then this work would have been
 5 done in the public interest without the need for formal
 6 contract. One regrets there are now commercial
 7 pressures that require clients to place formal contracts
 8 with us before we can undertake work."

9 Since its privatisation in 1997, the BRE has failed
 10 the wider public interest and been too ready to accept
 11 the restrictions imposed upon it by central government
 12 and too willing to collaborate with manufacturers.

13 A correction is needed to our written closing
 14 statement, {FBU000000191/32}, paragraph 86. I accept
 15 Sam Leek QC's submission at paragraph 4.4 of her closing
 16 statement that the BRE was not a regulator. So where
 17 I wrote that the BRE was more collaborator than
 18 regulator, I correct that to more collaborator than
 19 independent contractor. However, we consider that the
 20 parameters of BRE's work and obligations went further
 21 than was permitted or required under its individual
 22 contracts and the regulatory requirements affecting such
 23 work, as she submits.

24 Please screen page 4 of the BRE's written closing
 25 statement {BRE00047683/4}, paragraph 13. If you could

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1 enlarge paragraph 13 so it's legible. Thank you very
 2 much.

3 Ms Leek submits there that the BRE was a charity,
 4 "with a mission to support research into the built
 5 environment for the public benefit". Those are the
 6 important words I want to draw to the panel's attention:
 7 "a charity ... with a mission to support research into
 8 the built environment for the public benefit".

9 You could probably go to paragraph 15
 10 {BRE00047683/5}. She submits:

11 "The trust and charity structures were deliberately
 12 put in place to retain the authority and independence
 13 that BRE had developed while publicly funded, and to
 14 avoid the BRE being driven in any one direction by
 15 commercial pressures."

16 We submit this charitable mission should have
 17 permeated everything the BRE did, including negotiating
 18 its contracts and discharging its contractual duties.
 19 The BRE should, we say, have remained in the public
 20 sector and it should now be taken back into the public
 21 sector. But as things were, as a charity, at the least
 22 it should have carried out its charitable mission.

23 Please now screen page 3 of the BRE's code of
 24 conduct and ethics policy {BRE00035257/3}. So under the
 25 higher heading, "Respect for Life, Law and the Public

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1 Good", this says:

2 "We give due weight to ... the wider public
 3 interest ..."

4 It goes on:

5 "■ [We will] minimise and justify any adverse effect
 6 on society ..."

7 "■ hold paramount the health and safety of others."

8 Under the next heading "Expertise, Science and
 9 Research", it says:

10 "... we hold a privileged and trusted position in
 11 society, and thus expect to demonstrate that we are
 12 seeking to serve wider society and to be sensitive to
 13 public concerns;

14 "■ demonstrate that we are aware of the issues that
 15 science and technology raise for society ..."

16 Those are fine words, but the evidence from
 17 Module 6—2 shows that, post—privatisation, the BRE took
 18 the benefit of being seen to be authoritative,
 19 independent and serving the public interest, without
 20 bearing the burden of carrying out its contractual work
 21 in a manner consistent with its charitable objectives
 22 and its code of conduct. This it failed to do. So when
 23 investigating fires for the government or other
 24 customers, it did not conduct research into the built
 25 environment for the public benefit but for the benefit

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1 of its customer, the government. When discharging
 2 contractual duties for commercial clients, it readily
 3 agreed to keep fire data confidential to its customer,
 4 without any exception in the public interest.
 5 Accordingly, it did not hold paramount the health and
 6 safety of others or give due weight to the wider public
 7 interest, or minimise and justify any adverse effect on
 8 society. Nor did it seek to serve wider society and to
 9 be sensitive to public concerns, or to demonstrate that
 10 it was aware of the issues that fire science and
 11 technology raise for society.

12 From being a publicly—funded safety body, the BRE
 13 became a tool for use by government to limit its
 14 research and suppress fire data, and for use by
 15 manufacturers to market their products, whether they
 16 were safe or not.

17 Sadly, the BRE has now lost the authority and
 18 independence that it had developed while it was publicly
 19 funded. How did this happen? It happened because the
 20 BRE could not overcome the challenges to its
 21 independence introduced by privatisation in the toxic
 22 culture created by the government's war on health and
 23 safety. Instead, financial dependency on manufacturers
 24 and on a government increasingly disinterested in fire
 25 safety led to unresolved conflicts of interest, the loss

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1 of independence and reduced health and safety research.
 2 Dealing with conflicts of interest first, the BRE
 3 largely depended on contracts with government, but also
 4 looked to industry for sponsorship and sold fire tests
 5 to commercial clients for revenue. All of these
 6 activities were obviously loaded with potential
 7 conflicts of interest post-privatisation, particularly
 8 with a government disinterested in fire safety.

9 For example, Dr Crowder gave evidence, albeit
 10 hearsay, of the lobbying pressure from industry on
 11 government to preserve reliance on class 0, despite him
 12 wanting to dispense with it, and Brian Martin asserting
 13 a desire to discontinue it at some point. Dr Smith,
 14 a senior director of BRE, was unaware of any discussions
 15 within the BRE or with government about whether it was
 16 in the public interest that private businesses should
 17 sell fire safety tests for revenue, and made no effort
 18 to find out or consider possible safeguards of the
 19 government interest.

20 She agreed with Counsel to the Inquiry that her
 21 emails about the CWCT guidance on ACM cladding might be
 22 read as indicating that her sole concern was to protect
 23 the BRE's revenue streams and that she was not
 24 interested in matters of public fire safety. She said
 25 commercial bodies were never willing to fund fundamental

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1 research or experiments for the benefit of a better
 2 understanding of fire safety in the public interest.
 3 Dr Colwell also told the panel the potential
 4 conflict of interest between life safety and commercial
 5 gain was never discussed, and so it seems, members of
 6 the panel, that the BRE seems never to have challenged
 7 their clients' demand for confidentiality, not
 8 negotiating a public interest exception to the
 9 confidentiality clauses in its contract.

10 There is no evidence that Drs Smith or Colwell or
 11 anyone else at the BRE attempted to negotiate
 12 a variation of the contractual negotiation where it
 13 conflicted with the wider public interest or otherwise
 14 put the case for publication to alert other interested
 15 parties of fire safety risks.

16 The BRE cites a British Standard in their closing
 17 statement as requiring it to preserve clients'
 18 confidentiality, but paragraph 4.2.1 of that British
 19 Standard provided, and I quote:

20 "The laboratory shall inform the customer in
 21 advance, of the information it intends to place in the
 22 public domain."

23 So why didn't the BRE do this? We invite the panel
 24 to conclude that commercial and government interests
 25 prevented the BRE from notifying its clients that it

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1 would put information into the public domain, or at
 2 least share with other testing houses and regulatory
 3 bodies, information about failed tests or policy
 4 recommendations that arose from its work.

5 The BRE could and should have insisted upon
 6 incorporating a public interest exception to the
 7 confidentiality clause in its contracts, both with
 8 commercial clients and the government. The BRE could
 9 then have published failed test results and made public
 10 its concerns about fire safety, but it didn't.

11 Moving on to policy implication reports. Even
 12 without a public interest exemption, it could have
 13 issued a policy implications report to the government
 14 when appropriate, but it didn't. Our search of
 15 Relativity found no policy implication reports for DCLG
 16 on amending the guidance in ADB or otherwise on the
 17 risks associated with the use of ACM panels on high-rise
 18 buildings before the Grenfell Tower fire.

19 Not publishing failed test results. Dr Smith agreed
 20 when asked by Counsel to the Inquiry that it would have
 21 been beneficial for public safety in relation to the
 22 BRE's work in the service of wider society, quoting from
 23 the code of conduct, to insist that failed tests be put
 24 into the public domain, but it didn't. Instead, the
 25 commercial imperative after privatisation disposed the

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1 BRE to favour the commercial interests of its clients
 2 over the wider public interest.

3 Not pursuing concerns about fire safety. Mr Baker
 4 of the BRE agreed that Kingspan's product literature of
 5 2013 was misleading — that was on Day 100, it wasn't in
 6 this last module — but he could not recall the BRE
 7 taking any action to address these concerns. He said
 8 the BRE was not a regulatory body and didn't have the
 9 power to do anything, but the BRE could and should have
 10 insisted upon incorporating a public interest exception
 11 to the confidentiality clause in its contract. BRE
 12 could then have published failed test results and made
 13 public its concerns, but it didn't.

14 Not advising government properly of the risks.
 15 BRE's review of what is better known as contract
 16 cc1924 — I'm sure that's how you'll remember it — back
 17 in 2000/2001, produced very clear evidence that the
 18 aluminium rainscreen product used in the rainscreen
 19 system 5 test — that's one of the tests conducted —
 20 was obviously unsuitable for external cladding
 21 applications and ought to have raised an alarm. It
 22 seems likely that this was an ACM PE rainscreen cladding
 23 product of the same type as that which was later used
 24 for the rainscreen cladding at Grenfell Tower.

25 Dr Smith testified that she was not in any doubt

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1 after the rainscreen system 5 test that ACM panels with
2 a polyethylene core should never ever be used above
3 18 metres, but she did not include clear advice to this
4 effect in the report to government. She said the BRE's
5 role was to present the technical evidence and data and
6 signal what they think needs to be considered, then it
7 is for government to consider and decide what to do. It
8 appears, however, that she didn't even signal to
9 government that this critical public safety issue needed
10 to be considered. No policy implications report or
11 other similar document was given to government.

12 Also, not advising other interested parties or the
13 public. Dr Smith says she couldn't advise other parties
14 of the dangers of ACM panels with a polyethylene core
15 because of the contractual obligation to keep reports
16 confidential since privatisation. She said it was
17 a matter for the department, not for the BRE. We
18 disagree for the reasons I've already outlined.

19 Not sharing fire data with others in the fire safety
20 regime. Of the BRE's refusal to respond to CWCT's
21 concerns about cladding, Dr Smith told the panel,
22 tellingly :

23 " ... CWCT are a competitor. I mean, how much time
24 do you devote in terms of our effort and resources in
25 producing documents for others?"

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1 Where, we ask, was the wider public interest? The
2 wider public interest was subverted to the commercial
3 imperative of suppressing competitors in the
4 marketplace.

5 Not guarding against cheating. Dr Smith realised it
6 was always possible that manufacturers might attempt to
7 game any aspect of the testing system, including by
8 wilfully cheating, yet neither she nor anyone else in
9 BRE took adequate steps to minimise the risk of it
10 happening. She appears not to have considered steps
11 that could have been taken, such as taking a full suite
12 of photographs of the test rig or insisting that BRE
13 employees set up the test rig according to the
14 customer's design specification.

15 Sometimes, even actively assisting manufacturers to
16 game the tests. It's obviously a matter for the panel
17 to determine on the evidence, but Mr Roome of Celotex
18 and Mr Meredith of Kingspan both testified that
19 Stephen Howard and they said either Dr Sarah Colwell or
20 Phil Clark of the BRE helped them devise tests that
21 stood a better chance of passing and to better market
22 their products.

23 Insufficient funds for health and safety research.
24 Apart from modest funding available for research from
25 the BRE Trust, for which staff could bid every now and

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1 again, the BRE had to fund itself completely after
2 2002 — there was a sort of subsidy until then — and
3 generate an income for each workstream carried out. So
4 post—privatisation, the BRE did not have the resources
5 to support all the health and safety work that it needed
6 to do, like attending standards committees, to do the
7 testing it wanted to do. So, for example, in contract
8 cc1924, testing of the external wall build—up with and
9 without fire barriers was not undertaken.

10 Drs Colwell, Crowder and Smith all confirmed that
11 less work in support of fire safety research was carried
12 out across the board post—privatisation, and that BRE
13 investigate fewer fires as a result. Dr Smith also said
14 less work in support of ADB was carried out
15 post—privatisation. She told the panel:

16 "So you have to sit down and take decisions about
17 which activities you can afford to support, and that's
18 really the environment which we've had to exist in since
19 privatisation. There is nobody there that is funding
20 those attendances."

21 Dr Crowder said his information about the
22 Sudbury House and Taplow House fires, two separate
23 fires, was gleaned from press reports, not from a BRE
24 investigation. He said the resources were not available
25 to capture data and identify trends. Research had to

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1 stop at the limits imposed by clients and their budgets,
2 meaning fundamentals were not understood.

3 There was a reduced independence from government
4 control of fire safety research after privatisation.
5 The BRE could only do the research that the government
6 procured. If the intended research wasn't aligned with
7 particular government policy objectives, then it
8 probably wouldn't get funded. After privatisation, the
9 BRE lacked sufficient independence to carry out the
10 necessary research in face of a government increasingly
11 disinterested in fire safety.

12 On to the inadequate and misleading investigations.
13 After and we say largely due to privatisation, the BRE
14 carried out a series of inadequate and dangerously
15 misleading fire investigations and research projects,
16 and I've already mentioned Knowsley Heights through to
17 Lakanal House and right up to the Grenfell fire. The
18 common thread in these investigations is that they
19 failed to report, let alone to highlight, the
20 contribution to any of these fires made by or the
21 combustibility of class 0 rainscreen products used.
22 This is set out in Professor Bisby's report, which
23 raises many questions, particularly about the conduct of
24 the BRE.

25 We've highlighted several of these failed

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1 investigations in our closing statement and do not
2 repeat them here. On each occasion, the privatised BRE
3 was prevented from performing its proper function, due,
4 we submit, to deregulation and the commercial
5 considerations which were given precedence over public
6 safety.

7 So, to summarise, after privatisation, the BRE's
8 financial dependence on a government increasingly
9 disinterested in fire safety and on commercial clients
10 with their own agenda led the BRE to fail the fire
11 safety regime by not negotiating a public interest
12 exception to the confidentiality clause, not issuing
13 policy implication reports, not publishing failed test
14 results, not pursuing concerns about fire safety, not
15 advising government properly, not investigating fires
16 properly, not advising other interested parties or the
17 public, not publishing fire safety research findings,
18 not sharing fire data with others in the fire safety
19 regime, not guarding against the known risk of cheating
20 in the fire tests, sometimes even possibly actively
21 assisting manufacturers to game the tests.

22 Sir, that concludes our submissions on the BRE.

23 We've already referred at length in our submissions
24 to the BBA and the NHBC and UKAS and don't repeat those
25 here. But if time permits, a few words on the LABC.

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1 The Local Authority Building Control is a clear
2 example of regulatory capture. Privatisation and the
3 introduction of competition had a disastrous effect on
4 building control. Shockingly, it ultimately led to the
5 LABC falsely certifying products as being of limited
6 combustibility because of commercial interests.

7 Before I go on any further, sir, I don't want to
8 fall into the same trap. How much time have I got left?

9 SIR MARTIN MOORE-BICK: Well, how much time do you need?

10 MR SEAWARD: Well, I should think I probably need about
11 five minutes, maybe ten.

12 SIR MARTIN MOORE-BICK: Oh, you're fine at that.

13 MR SEAWARD: I'm fine at that, okay.

14 SIR MARTIN MOORE-BICK: Yes.

15 MR SEAWARD: Okay, thank you, that's fine.

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

17 MR SEAWARD: That was very well negotiated, sir, you didn't
18 actually give me a time.

19 SIR MARTIN MOORE-BICK: Well, I didn't wish either to cramp
20 your style or to extend it too far, but you're doing all
21 right. I'll indicate if I think you're running out of
22 time.

23 MR SEAWARD: Okay, thank you very much.

24 So Barry Turner was a senior technical adviser at
25 Local Authority Building Control, LABC, and that was

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1 an influential membership organisation which advised,
2 supported and promoted local authority building control
3 bodies, who had difficulty competing with business with
4 private building controllers. He said, "enforcement is
5 difficult to sell ... developers don't want you looking
6 over their shoulder".

7 LABC was not publicly funded and, like the local
8 authority building control bodies that it supported, it
9 needed to generate income in a competitive market. This
10 provided ample scope for regulatory capture and the LABC
11 was well and truly captured by Kingspan.

12 For a price, it issued type approval certificates
13 and, after 2010, registered details for building
14 products, which Mr Turner understood would be relied
15 upon to fast-track building control approval on
16 developments specifying those products. For example,
17 LABC issued a type approval certificate for Kingspan's
18 K15 insulation product in May 2009 which falsely stated
19 it could be considered a material of limited
20 combustibility. Mr Turner now accepts that this was
21 inaccurate and misleading, but he could not explain how
22 it came to be issued, despite concerns raised by members
23 of the technical working group, which concerns were
24 overlooked.

25 LABC also collaborated with Kingspan on a number of

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1 projects and accepted sponsorship by Kingspan.

2 Mr Turner accepted that this relationship probably
3 affected the way LABC responded to concerns raised about
4 Kingspan's fire performance statements.

5 For example, from September 2009, Mr Cody of
6 Rockwool complained to Mr Turner about Kingspan's claims
7 that K15 was of limited combustibility. Mr Turner could
8 not explain why he neither invoked LABC's complaints
9 procedure, nor replied substantively to Mr Cody, nor why
10 he did not consult the BRE until June 2015. Incredibly,
11 he turned instead to Kingspan's head of marketing before
12 responding, at which stage, again incredibly, he
13 defended the certificate. He neither reviewed nor
14 withdrew the certificate. He said he would have dealt
15 with it differently if he had appreciated the risk to
16 public safety.

17 He was a chartered building control surveyor,
18 a member of the Royal Institute of Chartered Surveyors
19 with over 53 years' experience. We submit Mr Turner
20 must have realised the risk to public safety of wrongly
21 certifying K15 a product of limited combustibility. His
22 false assertion that it was of limited combustibility
23 revealed the truth: that the LABC was serving the
24 manufacturers', not the public's interest. Once again,
25 commercial interests took precedence over public safety.

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1 David Ewing also now accepts it was a pretty major
2 error to certify that K15 could be considered a material
3 of limited combustibility, there being absolutely no
4 test evidence in support. Likewise, he now acknowledges
5 the claim made in the LABC registered details
6 certificate of August 2013 that K15 was suitable for use
7 above 18 metres was not substantiated by the technical
8 data provided by Kingspan.

9 David Ewing was LABC's technical sales director, in
10 charge of the registered details scheme. In July 2014,
11 he was made aware of Brian Martin's concerns about the
12 use of combustible insulation above 18 metres in his
13 email exchange with Steve Evans of the NHBC, but he did
14 not act in the public interest by, for example, alerting
15 LABC's members to the issue or checking all certificates
16 issued for K15.

17 The only credible explanation is LABC's financial
18 dependency on Kingspan.

19 Mr Lewis says that issuing the K15 registered
20 details certificate in August 2014, based on the 2008
21 BBA certificate and despite Brian Martin's concerns, was
22 an oversight. He denied feeling any pressure, eg from
23 Phil Hammond, the LABC managing director, to increase
24 the number of registered details registrations, or of
25 knowing this contributed to Martin Taylor's decision to

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1 leave LABC. He further says he trusted Kingspan that
2 they would not be providing inaccurate information. But
3 any such trust could not have survived the warning from
4 Steve Evans in August 2014 that Kingspan were not going
5 to be able to prove that K15 was acceptable above
6 18 metres. His oral evidence on these points is, we
7 submit, unbelievable. He did not act in the public
8 interest and check Kingspan's assertion because it was
9 not in LABC's commercial interests to do so.

10 Mr Ewing and the LABC were likewise played by
11 Celotex in August 2014, when they failed to obtain any
12 classification report before issuing a registered
13 details certificate to Celotex in respect of its FR5000
14 product, stating falsely it was suitable for use above
15 18 metres.

16 The part—privatisation of building control, coupled
17 with the absence of public funds or any proper
18 governmental oversight, led to LABC's predictable yet
19 shameful dependency on its fees earned from
20 manufacturers. The LABC's certificates facilitated the
21 successful marketing of combustible insulation for use
22 above 18 metres over an extended period from August 2009
23 up and down the country, including at Grenfell Tower.
24 The LABC's failures were themselves the consequence of
25 a failed regulatory system that was not fit for purpose.

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1 Moving on to the response to the coroner's letter
2 following Lakanal House inquest. Just briefly a few
3 points.

4 As the GTI is aware, the Rule 43 letter to
5 Lord Pickles included a number of recommendations that
6 he review the content of the Building Regulations and,
7 in particular, ADB to provide clearer and simpler
8 guidance in relation to matters such as the spread of
9 fire over the exterior of a building. By the time of
10 the Grenfell Tower fire, some four years later, no such
11 review had been undertaken. In fact, Lord Pickles
12 failed to take any effective steps to respond to the
13 coroner's Rule 43 letter.

14 Following the oral evidence in Module 6, we submit
15 that the simple explanation for the failure of the DCLG
16 in relation to the coroner's letter is that it did not
17 fit in with the drive to deregulate and to prioritise
18 commercial interests. Consequently, it was ignored.

19 We submit there is an urgent need for a national
20 oversight body to consider Rule 43 letters and other
21 recommendations from inquiries to ensure they are
22 properly reviewed and implemented.

23 Failings in government.

24 The evidence in Module 6 has shown that there were
25 significant failings in DCLG, including by Brian Martin,

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1 who has been called the single point of failure.
2 However, we submit it would be wholly wrong to try and
3 lay the blame for the Grenfell disaster on
4 a middle—ranking civil servant. To the extent that
5 senior government ministers have sought to do this, we
6 submit that represents a shameful abdication of their
7 responsibility. Mr Martin has admitted his failings and
8 expressed remorse at their consequences. This is in
9 stark contrast to the evidence of the politicians, who
10 either couldn't remember or, as in the case of
11 Lord Pickles, sought to blame others, including
12 Mr Martin. We also note that he wasn't separately
13 represented.

14 It's wrong and reprehensible that senior politicians
15 who were responsible for the DCLG should seek to blame
16 Mr Martin. We do not accept that any single point of
17 failure by a civil servant caused the Grenfell Tower
18 disaster. The fire at Grenfell Tower was the
19 consequence of decades of policies promoting commercial
20 interests at the expense of everything else, including
21 fire safety. It happened due to the war on regulation
22 as an albatross around the neck of business. Mr Martin
23 was a product of this environment, not its cause.

24 In our opening in Module 6, we contended that side
25 by side with ever more zealous promotion by central

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government of deregulation and the commercial interests of the private sector was the degrading and undermining of the public sector. Further, over recent years, that process has accelerated as a consequence of austerity and cuts in public expenditure. We submit that the oral evidence in Module 6 has further supported those contentions.

There were cuts in civil service staff. The reduction in staff in the civil service, including in the DCLG, was clearly an issue, and the falling headcount reduced effectiveness. Mr Burd told the panel that the headcount in his section of the DCLG had gone down by 40% in the time he was there. This, we have to remember, is at a time when Professor Torero has explained the building environment was becoming ever more increasingly complex. He said declining resources, both in terms of research monies and in terms of headcount, coupled with the undertaking of and being cognisant of the various deregulatory measures, meant they had less and less time to focus on the Building Regulations.

Mr Harral also referred to the reduction in resources, including headcount. In 2006, he said, there were 14 construction professionals in a division with a much smaller scope of work. There were three grade 6s

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supporting the deputy director. By 2015, this had reduced to five technical specialists with one grade 6, Mr Martin. He went on to describe those resource pressures as tectonic.

Ms Dawes also gave similar evidence about the lack of resources, and I won't take up time with those.

We submit that the performance of civil servants in the DCLG has to be evaluated against this background of significant cuts in staff. These policies are not just about numbers; they have real—life consequences, beyond people losing their jobs.

Ms Dawes was asked to comment on an email sent to her on 20 June asking how the DCLG might have incentivised RBKC's choice of the contractor Rydon, who made the lowest bid. She answered — she's talking about the cuts to local council funding — "the budgets for housing were very tight indeed".

Grenfell Tower, along with much of social housing, has suffered decades of neglect and lack of investment. This, too, was a consequence of central government policy. RBKC's housing stock was no different from that in the rest of the country. Although RBKC is a well—off local authority, the council were unable to invest any of their general funds in social housing because central government policy had restricted the available monies to

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those which were generated by rent in the housing revenue account.

Ms Dawes went on to explain how matters deteriorated in 2015:

"But we were also very concerned just about general funding for any form of social housing investment, which had been stopped in the first year of the government following 2015, although it was reinstated later when Gavin Barwell and Sajid Javid did their housing work ... but we were worried about that as well, because that was just simply to keep house—building going in the social sector."

This evidence shows how central government policies forced poor choices on local housing authorities, including the use of inexperienced and inadequate contractors using poor and dangerous materials. Shoddy workmanship was common, as we highlighted in our opening submissions, and this issue too was addressed in Ms Dawes' evidence:

"Question: ... were you aware of this 'open secret' ... being the inconsistent standards and tolerance for shoddy work? Were you aware of that?"

"Answer: Yes, I think I was ..."

"Question: Were you aware of inconsistent standards and tolerance of shoddy work by building control

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authorities before the Grenfell Tower fire?"

"Answer: Well, I can't remember ..."

The impact of austerity and cuts as a contributing cause to the Grenfell Tower fire cannot be overlooked and, of course, there's the ongoing impact of austerity. Louise Upton, during her evidence, said there was little value in PEEPs without someone being there to implement them, and that to recommend that those who manage high—rise maintain information on vulnerable or disabled occupants would place a significant burden on them.

Counsel put to her:

"Question: Now, you can take it from me that this response ... didn't tell Elspeth Grant that the underlying rationale for the LGA guide's position on PEEPs was an anxiety to avoid imposing disproportionate burdens on landlords. Do you know why that rationale was not explained to Elspeth Grant?"

"Answer: No."

"Question: Would you accept it should have been, in a spirit of candour?"

"Answer: Yes."

The advice of a disability expert wasn't sought by the Home Office or anyone else. Ms Upton had no knowledge of disability law. It is clear that commercial interests of landlords are still the

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1 priority , even today, over the lives of disabled people.
 2 Finally , the lack of caretakers or concierge is
 3 itself the direct result of cuts in resources for social
 4 housing stretching back decades. Austerity and
 5 commercial interests continue to prevent issues in
 6 high—rise being effectively addressed today. We've just
 7 seen the latest recommendation on the government website
 8 not to implement your recommendation regarding PEEPs, as
 9 Mr Mansfield explained earlier .

10 As to the fire and rescue service , the Home Office
 11 portrays the white paper as progressive and positive .
 12 The proposals set out in the white paper, it says, seek
 13 to strengthen fire as a profession , enabling fire and
 14 rescue professionals to improve their skills and fully
 15 serve the community, as well as unlocking and nurturing
 16 talent . The proposal seeks to support a positive
 17 culture and to improve diversity and inclusion. In
 18 addition to this , the government intends to commission
 19 an independent review into the current pay negotiation
 20 process and consider whether it's fit for a modern
 21 emergency service .

22 The FBU knows, from bitter experience, that this
 23 heralds an attack on collective bargaining, which has
 24 nothing to do with the Grenfell Tower disaster, or the
 25 steps which the government should be taking to prevent

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1 a recurrence .

2 In conclusion, the central state has a fundamental
 3 responsibility for the safety of its citizens in
 4 a modern society. We submit that central government has
 5 failed woefully in this task. They failed to regulate
 6 high—rise in particular by avoiding the foreseeable
 7 hazards of insulating them against the cold and rain
 8 through installing safe rainscreen cladding systems.
 9 They've cut back regulations and allowed businesses to
 10 ignore safety rules as part of a war on health and
 11 safety culture, and to prioritise profit over safety .
 12 They've abdicated the duty to research emerging fire
 13 risks and develop protection measures .

14 Whereas for half a century central government had
 15 an authoritative statutory fire and rescue advisory body
 16 that strategically assessed the risks and provided
 17 ministers with reliable expertise, that body was
 18 abolished as part of deregulation at a time when the
 19 built environment was increasing in complexity. The
 20 philosophy of deregulation has blighted efforts to
 21 improve and has actually worsened the living conditions
 22 of millions of people .

23 Grenfell Tower was the combination of more than
 24 four decades' worth of these policies . Those who lost
 25 their lives were also the victims of big business and an

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1 economic and social system that values the generation of
 2 wealth over the protection of those without the wealth
 3 to protect themselves .

4 In the scramble for profits , those people were
 5 collateral damage. Central government and the economic
 6 system which they nurture bear ultimate responsibility
 7 for the Grenfell Tower fire .

8 Thank you for your patience .

9 SIR MARTIN MOORE—BICK: Thank you very much, Mr Seaward .

10 Well, it's a little earlier than usual for a break,
 11 but we did start earlier after lunch, so I think
 12 probably this is a good time to take the afternoon
 13 break .

14 We'll stop there and we'll resume, please, at 3.15,
 15 when we'll hear a closing statement on behalf of the
 16 London Fire Commissioner .

17 Thank you very much. 3.15, please .

18 (3.00 pm)

19 (A short break)

20 (3.16 pm)

21 SIR MARTIN MOORE—BICK: The next statement is going to be
 22 made by Mr Stephen Walsh on behalf of the London Fire
 23 Commissioner .

24 Yes, Mr Walsh, when you're ready .

25

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1 Module 6B (Government, Testing and FRA) closing submissions
 2 on behalf of the London Fire Commissioner by MR WALSH
 3 MR WALSH: Good afternoon, sir, Ms Istephan, Mr Akbor .

4 Sir , in this month of June, five years on from the
 5 tragedy in 2017, may I begin these relatively brief
 6 observations on the issues which arose in Module 6B, as
 7 I will call it , by again assuring you that the constant
 8 and ongoing work which the Brigade is engaged in to meet
 9 your recommendations in the Phase 1 report remains
 10 a priority for the London Fire Commissioner. As you
 11 know, there is much to do across a range of the
 12 Brigade's operations, and while a great deal has already
 13 been achieved, some of the improvements and the changes
 14 are complex and will take time to progress .
 15 Nevertheless, 26 of the 29 recommendations which related
 16 to the LFB have been completed, and a further two are to
 17 be completed by the end of the year. It just seemed
 18 an appropriate time, in June, to update you on that and
 19 those who are listening .

20 SIR MARTIN MOORE—BICK: Thank you, yes .

21 MR WALSH: So I know that the panel will have read our
 22 closing statement for Module 6B, and it's publicly
 23 available , so, as usual, I have no intention of
 24 repeating it all here, although I may well — probably
 25 will — repeat one or two of the points which have been

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made by others during the course of the day. Forgive me for that, but those are points which actually do bear repetition.

I do, though, want to say something about the importance of context. The phrase "context is everything" might be — probably is — overused, and sometimes it's misunderstood, but it is a particularly felicitous phrase when applied to the Grenfell Tower tragedy, at least insofar as the operational response of the fire service is concerned. Whether it is the sheer scale and rapidity of the fire and the impact on operational resources that had and in the control room, or the chain of events which led to the building being shrouded in highly flammable materials, or the impact which the political atmosphere of deregulation had upon the efficacy of the Building Regulations — just to give three examples of so many other matters of context — a full understanding of the wider context is essential to a proper and fair assessment of the emergency response of the fire service on the night of 14 June 2017.

But, more importantly, it's also essential for the purposes of learning from the events of the past so that really effective and meaningful changes can be made. The reason why that's relevant to the submissions that

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I make today is that module by module in Phase 2, the evidence has provided a very substantial body of essential context, from multiple witnesses on a wide range of issues, which were explored, as you know, with the LFB almost solely in Phase 1. The evidence in Module 6B has been of vital importance to a proper understanding of the extent to which aluminium composite material panels with a polyethylene core, ACM PE, were generally known to be in use on residential high-rise buildings and the effectiveness of the Building Regulations in preventing such use. When I refer to the Building Regulations, I include Approved Document B, although of course I recognise that one provides the functional requirements and one provides the suggested route to compliance.

We highlight ACM PE here, rather than dealing with modern materials generally and what was known about them, because, obviously, the evidence is very clear that it was that product and the system within which it was designed and installed which was the principal cause of the manner in which the Grenfell Tower fire behaved and the devastating speed of its extensive spread. As Professor Bisby reminded us only last week, it was the polyethylene core which was responsible not only for the velocity of the horizontal spread, but also, crucially,

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for its downward and lateral spread, which was so unusual, by reason of the extensive pooling of the molten product at the top of the building in the architectural crown.

Now, the London Fire Commissioner's position, as you know, and that of fire and rescue services nationally, as far as we are aware, is that, historically, a very high degree of reliance had been placed on the provisions of the Building Regulations as a bulwark against catastrophic, all-consuming fires in residential buildings of the kind which occurred at Grenfell Tower. It was those regulations which existed to prohibit the use of dangerous materials such as ACM PE from being used.

Now, in light of the evidence given in Module 6B, it is clear that, in the years leading up to the Grenfell Tower fire, with actually very few exceptions, the limited extent of the Brigade's knowledge of the risks of ACM PE materials and its reliance on the effectiveness of the Building Regulations was, it would seem, broadly shared across the fire sector and by government itself.

In our written submissions, we have set out some key evidence in Module 6B of witnesses for the responsible government department, DCLG at the time, and from the

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BRE, formerly the British Research Establishment, most of whom, most of those witnesses, were highly experienced technical advisers in relation to the built environment. Now, in setting out that evidence, though, we do not seek to criticise individuals or point the finger of blame. Those are obviously matters entirely for you, for the panel, when you consider the context in which they had to perform their functions in the at least perceived climate of deregulation at key moments.

But, for present purposes, we just want to highlight, if we may, two important points which emerge from that evidence in Module 6B.

First, notwithstanding the failed test of an ACM panel by the BRE in 2001, which was reported to the government department in 2002 but not published until after the Grenfell Tower fire, none of those particular witnesses, those who gave evidence on behalf of the government department or the BRE, none of them, was aware of the use of ACM PE panels on high-rise residential buildings in the UK, save for Dr Colwell and Mr Martin from about 2014. To the extent that there was a growing awareness of the risks, there was obviously a failure to appreciate the extent of the hazard and, again crucially, communicate it more widely to the

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1 industry and the fire sector.
 2 Secondly, although there was an awareness of
 3 international fires involving ACM, there was a firm
 4 belief that those fires would not occur in the
 5 United Kingdom, partly because ACM was not thought to be
 6 widely in use on tall buildings, but partly, and perhaps
 7 mainly, because the Building Regulations were said to
 8 prohibit such use. Indeed, the department, the
 9 government department, expressed views to that effect
 10 when asked by multiple parties, including fire and
 11 rescue services, in light of fires involving ACM PE
 12 materials abroad.

13 Dr David Crowder — and it must be remembered, he is
 14 and has been for a number of years a very highly
 15 respected expert in the field, in the fire sector, and
 16 someone with a great deal of experience and knowledge —
 17 was of the view, you will recall, when he gave evidence,
 18 that that was an industry-wide belief, that is faith in
 19 the Building Regulations and an absence of knowledge of
 20 the use of ACM materials in high-rise buildings.

21 To take one important example — I am now repeating
 22 things that have been said this morning, but it is worth
 23 it — following The Torch fire in Dubai in February
 24 2015, the government's Chief Fire and Rescue Adviser was
 25 informed by the government department later that month

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1 that the dangers posed by ACM PE materials, cladding,
 2 should not be a problem in the UK because "there are
 3 provisions in the Building Regulations to prevent this
 4 kind of problem". The same broad view was expressed by
 5 the department, for example, in response to queries
 6 about The Address Hotel fire, also in Dubai, in
 7 late January 2016. That may be one reason why there was
 8 no system in government by which requests for
 9 information from foreign governments about foreign fires
 10 were routinely made.

11 No warnings by government were disseminated more
 12 widely of concerns expressed, for example — and this is
 13 where there was an acknowledgement of the use of ACM,
 14 but no warnings were given or information disseminated
 15 about concerns expressed, for example, at the CWCT
 16 meeting in July 2014, that ACM may be in common use, or
 17 the expressions of concerns from Nick Jenkins, if you
 18 remember, of Booth Muir in February 2016, that
 19 confusion over the interpretation of Approved Document B
 20 to the Building Regulations raised a risk of a fire in
 21 the UK like those in Dubai. It seems that those
 22 concerns were not escalated to senior officials in the
 23 department, again failing to appreciate the extent of
 24 the hazard.

25 Now, the London Fire Commissioner acknowledges and

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1 has said — you know this from the evidence — that the
 2 Brigade wrote to central government and to housing
 3 providers on a number of occasions from at least 2009,
 4 raising general concerns about materials used in the
 5 construction and refurbishment of residential buildings
 6 and about levels of compliance with the Building
 7 Regulations. Now, while those concerns did not relate
 8 to ACM PE materials, because they were not known to be
 9 widely used, the commissioner accepts, on reflection,
 10 that more could have been done to highlight with
 11 government a growing awareness of the possibility that
 12 the regulations were not always being adhered to or were
 13 being interpreted in a way which impacted on fire
 14 safety.

15 It is in that context that part of the reason why
 16 the Brigade wrote to government seeking greater clarity
 17 in the terms of the Building Regulations, as did the
 18 Lakanal coroner in the Rule 43 recommendations, was that
 19 there was an important link to issues of enforcement of
 20 the Regulatory Reform (Fire Safety) Order, for which
 21 fire and rescue services are responsible. There's
 22 a direct link between the two.

23 Now, that hasn't been the focus of a lot of
 24 attention during the course of the Inquiry, but it is
 25 important that I make the point because, in a great many

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1 cases, proof of a breach of one or more of the duties
 2 held by responsible persons under the Fire Safety Order,
 3 or indeed where such persons want to argue that they did
 4 all that was reasonably practicable to meet their duty,
 5 defending their position, where those arguments occur,
 6 they are dependent, very often, on an analysis of the
 7 requirements of the Building Regulations and
 8 British Standards, and those two are really inextricably
 9 linked.

10 The evidence in Module 6B, as we know, has
 11 highlighted a number of areas within the regulations
 12 where interpretations, especially in relation to ADB,
 13 vary to a significant extent. We also heard — I know
 14 it's Module 7, but it's relevant to this — that the
 15 combined effect just, for example, of regulations 8 and
 16 11 of the Building Regulations is that more or less
 17 a complete discretion is given to depart from the
 18 express requirements — this is for building control
 19 departments — so long as "reasonable standards of
 20 health and safety for persons in and about buildings are
 21 demonstrated".

22 Now, the point about making that submission to
 23 you — it's not in our written submissions — is that as
 24 long as there is uncertainty of interpretation of the
 25 regulations and the statutory guidance, combined with

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the wide discretion which is vested in local authority building control departments to depart from those express requirements, there will continue to be real challenges in the enforcement of the Fire Safety Order against building owners and responsible persons for fire and rescue services around the country.

But what is and always has been certain — this is my final point — about the Building Regulations, as Mr Martin accepted during his evidence, is that they did not — do not — allow for the contingency that stay put, as a safety strategy, might have to be revoked, they just don't provide for it at all, and that a full-scale emergency evacuation ensue. Such an eventuality is just not contemplated — I know I've said it before, but it's particularly pertinent to 6B — and, as a consequence, these kind of buildings were not designed to facilitate evacuation, as you know.

Now, following the fire, the tragedy in June 2017, for buildings in London, they have been inspected by the LFB and others. Just over 1,000 out of a total actually of 29,000—odd, both high-rise and low-rise residential blocks, have been identified to have potentially dangerous cladding. For those buildings, evacuation plans — temporary fire alarms and so on, waking watches, that sort of thing — have been put in place by

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building owners and responsible persons, following the National Fire Chief Council's interim guidelines. That's the position in those buildings. And, of course, the Brigade has new processes to assist in effecting those strategies.

But, in general terms, if stay put as a principle of building design is to be abandoned, as Professor Torero suggests, as you know, it would obviously be necessary, as he says, to fundamentally change the regulatory approach — you can't just change it overnight — including ADB, and to establish multiple redundancies within the safety system to enable mandated phased evacuation, and that would include sprinklers, as we know, smart alarm systems and many other fire suppression measures, levels of redundancy.

The LFB has campaigned for the provision of sprinklers for many years, and currently campaigns for additional protected escape stairways. So if and when such changes are implemented by government — there needs to be political will, of course, as we know — the LFB will purposefully engage in making it work.

All reasonable efforts, of course, need to be made to ensure that residents, including those with disabilities, have an opportunity to evacuate or to be supported in doing so in the event of fire. That is

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about the way in which buildings are designed and refurbished and built. That shouldn't be done by seeking convenient interpretations or loopholes in the statutory guidance about which we have heard so much, or, to echo the words of Stephanie Barwise Queen's Counsel this morning, deliberate manipulation and deliberate non-compliance.

That is all I have to say on behalf of the commissioner.

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

MR WALSH: Thank you.

SIR MARTIN MOORE-BICK: Well, now, the last statement due to be made today is going to be made by Mr Glasson Queen's Counsel on behalf of UKAS, and Mr Glasson is going to make his statement by Zoom.

We're rather earlier than we thought we would be at this stage, due to the expedition of other counsel, but, Mr Glasson, I can see you there waiting to speak to us. Is that right?

MR GLASSON: That's right. I hope you can see me and hear me as well.

SIR MARTIN MOORE-BICK: Thank you very much. I take it you can see us, and you don't need to hear us particularly, but we certainly need to hear you.

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I'm sorry we have come to you rather earlier than you probably expected, but that might be a good thing in any event.

MR GLASSON: Absolutely. I'm sure on a day like this, everyone would like to be able to finish early.

SIR MARTIN MOORE-BICK: Well, we are ready to hear you, so if you are ready to address us, please start whenever you are ready. Thank you.

Module 6B (Government, Testing and FRA) closing submissions on behalf of the United Kingdom Accreditation Service by MR GLASSON

MR GLASSON: Good afternoon, Chairman, Ms Istephan and Mr Akbor.

The United Kingdom Accreditation Service, UKAS, has, as you know, filed a written closing statement and, in these oral submissions, I'm going to expand on some of the points that we have made in writing, picking up on occasion on some of the observations made in the written statements by the other core participants.

At the outset, I would like to repeat UKAS's expression of sympathy to all the bereaved, survivors and residents of the Grenfell Tower fire.

I also want to emphasise on behalf of UKAS two central points.

First, UKAS recognises the strength of feeling

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expressed in written statements from the bereaved, survivors and residents groups. UKAS recognises that the strength of feeling is justifiable, as UKAS acknowledges that some of the evidence relating to the BRE and the BBA demonstrates that improvements are needed on the part of UKAS.

Secondly and relatedly, UKAS is committed to learning all that it can from the Grenfell Tower tragedy, and UKAS is acting now on those lessons. It is that second aspect that I would like to focus on this afternoon, particularly as it will serve to foreshadow the evidence that UKAS intends to serve in October in response to the Inquiry's request for statements from core participants who have implemented or who are implementing relevant reform since the fire.

UKAS sought to respond to the fire swiftly. For example, UKAS conducted a number of additional visits to the conformity assessment bodies, CABs, in 2017. UKAS contributed to the Independent Review of Building Regulations and Fire Safety by Dame Judith Hackitt, which was published in May 2018, and has contributed to the ongoing Independent Review of the Construction Products Testing Regime conducted by Mr Paul Morrell, Ms Anneliese Day Queen's Counsel. Both reviews posed specific questions as part of the consultation, and UKAS

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has responded to those with detailed submissions providing information, identification of gaps and shortcomings of the existing regime and suggesting recommendations.

As we explain in the written statement, UKAS has identified a number of key areas to focus on in response to the tragedy. Those areas are in addition to the work that UKAS has undertaken specifically in relation to the BBA and the BRE that I'll come to at the end.

The first key area of work relates to product certification activities. All existing accredited product certification schemes are being reviewed to ensure that they remain fit for purpose, are meeting end-user expectations and are adequately described in the scopes of accreditation. There are literally hundreds of those schemes.

In the past 12 months, UKAS has commenced a programme to review construction product certification schemes. UKAS has identified over 70 schemes which are being reviewed. That is involving an in-depth evaluation of the scheme criteria against the requirement of accreditation standards. Generally, the reviews are taking place alongside annual assessments to CABs, but specific attention is being given to those schemes that do not utilise national or international

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standards or criteria set by regulations. For schemes that utilise criteria set by the CAB or by another scheme owner, this review is likely to be completed by the end of 2022. Further information on the review will be provided by UKAS in its statement to the Inquiry later this year.

The second key area relates to UKAS's assessment processes. Aspects of the assessment practice are being reviewed to see whether there are sufficient checks that ensure that the scope of accreditation is adequately covered having regard to the risks associated with that particular scheme over a four-year assessment cycle. That has involved a number of different strands of work, developing further processes to evaluate risk in the planning and conduct of assessments. To that end, UKAS established a product in 2020 aimed at developing an evaluation tool to be used for the assessment of each CAB. Criteria are being developed that take into account the scope and operating model of the CAB as well as the sectors in which it operates. The tool has been piloted in two sectors and plans are being established to fully embed the process within UKAS.

UKAS is establishing a new assessment portal in its IT system. As part of that, a new reporting format has been piloted. That will provide improved data to enable

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trends in CAB performance to be monitored and to ensure that a root cause analysis can be conducted.

It has also increased monitoring of the effectiveness of corrective actions carried out by CABs, which is being established through additional training and ensuring that sufficient time is allocated to review corrective actions on assessments.

UKAS is also developing further guidance on the appointment of assessors to ensure any threats to impartiality are mitigated. As part of that, UKAS intends to introduce additional monitoring and audits to review how those threats are being mitigated.

The third area relates to technical expertise. A full review of the operation of technical advisory committees is underway. The committees will in future be managed by a central secretariat, which will enable harmonisation of best practice and increased oversight and enhanced management. There is ongoing work to ensure that there is a sufficient pool of technically competent resources and additional mentoring, which will be made available for new staff and for assessors. That additional mentoring will strengthen the technical expertise available to UKAS.

The fourth area relates to improving mechanisms for handling any significant non-conforming work that occurs

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in CABs, and that will include a more detailed and structured technical review. UKAS has emphasised to CABs and to UKAS's own staff that there is a duty of candour on the CABs to report concerns regarding performance of CABs that UKAS accredits. UKAS has long had a learning culture and the importance of learning from adverse incidents will continue to be reiterated in training and all aspects of UKAS's operations.

The final key area of work that I would like to draw attention to is in relation to the proposed amendments to the customer agreement. In the course of Lorraine Turner's evidence, you pointed out, sir, that a number of the difficulties that have arisen in relation to UKAS's role could be addressed by amending the customer agreement. UKAS respectfully agrees. It has undertaken a review of the customer agreement with CABs and it has instructed external lawyers to advise on revising the customer agreement. Many of the proposed amendments strengthen and, in some cases, clarify existing provisions and powers. Nonetheless, the amended customer agreement will enable UKAS to be confident that it would be able to adopt a more robust role with CABs and that the agreement will address some of the issues that have been raised in this Inquiry.

The proposed amendments will go to a wide range of

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issues, and we've detailed those in section C of the written note. I will just highlight a few points that are of particular relevance.

The first, sir, is in relation to the power to make unscheduled visits. Although this power is already implied in the existing customer agreement, the amended agreement makes that power explicit. The amended agreement specifies that UKAS may, at its sole discretion, carry out additional or unscheduled visits, in particular in order to verify that any notified changes to its requirement for accreditation have been implemented.

The second is in strengthening the obligations owed by the customer, the CAB, to UKAS. The amended agreement will impose more onerous and exacting obligations on the customer. It will provide that the customer must ensure that any information it provides to UKAS, whether as part of an application for accreditation, an assessment or otherwise, is true and accurate in all respects. The customer must notify UKAS as soon as is practicable if the customer becomes aware that information provided to UKAS is false or inaccurate. The customer must take all appropriate steps to correct any statements used by itself, any of its officers, employees or representatives, any of its

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clients or any other person with which it is associated, which could bring accreditation into disrepute or could be misleading, regardless of whether it has been notified of the statement in question by UKAS or from any other source. Finally, the customer must action each mandatory improvement action raised in a UKAS assessment report within the period specified by UKAS.

The third area is in relation to the definition of "significant non-conformity", as well as the notification provisions. The draft amended customer agreement will set out an extensive definition of "significant non-conformity", and will impose an obligation on the customer to notify UKAS as soon as is practicable following identification of any such significant non-conformity.

What the draft amended agreement will do is to reconcile the confidentiality obligations imposed on UKAS with UKAS's wish to ensure that a CAB cannot prevent disclosure of significant non-conformities to regulators or users or other interested parties.

Just in terms of the confidentiality obligations imposed on UKAS itself, you may recall that, in her second witness statement, Lorraine Turner explained that UKAS itself is held to ISO 17011, which imposes confidentiality obligations. Clause 8 of the 2017

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version, which is currently applicable, is the confidentiality clause. It may be helpful just to see that on screen. It's provided at {UKAS0011447/14}. You see at paragraph 44 of the written note we set it out, and the relevant provision to draw attention to is in 8.1.1:

"The accreditation body shall inform the conformity assessment body, in advance, of the information it intends to place in the public domain."

Then critically:

"Except for information that the conformity assessment body makes publicly available, or when agreed between the accreditation body and the conformity assessment body ... all other information obtained during accreditation process is considered proprietary information and shall be regarded as confidential."

I think we can remove that from the screen.

SIR MARTIN MOORE-BICK: Thank you.

MR GLASSON: The draft amended customer agreement will ensure that UKAS can comply with that confidentiality obligation but, at the same time, ensure that it can alert stakeholders, end users and the public to any safety-related information. To that end, the draft agreement will provide that the duty of confidentiality will not apply to "any disclosure made by UKAS in

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circumstances following its apprehension or notification of any Significant Nonconformity or Customer Failure". As I've said, there's an exhaustive definition of what "significant non-conformity" means.

So the changes will make clear beyond doubt that any instance of fraud on the part of the CAB would allow UKAS to depart from its obligation of confidentiality, a point we know which was discussed in oral evidence and which has been commented upon by some of the core participants.

The customer will be under an obligation to notify any significant non-conformity to all interested third parties, including its clients, product manufacturers, regulators or impacted members of the general public. It will be for the CAB to identify any relevant impacted members of the public, and UKAS will ensure that sufficient action is taken. Who will fall within that definition will depend upon the nature of the accredited activity, and in the written note we give the example of a failure by a hospital laboratory, which would mean patients of that laboratory.

Compliance with this obligation will be through assessments of CABs and monitored by the UKAS technical quality and risk team. Then in relation to sanctions available to UKAS, again, you will recall, perhaps, from

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the written evidence that Lorraine Turner explained that a CAB's failure to report significant non-conforming work or, indeed, non-conforming work to UKAS would be sufficient to attract sanctions, although there would be consideration of the relevant circumstances, such as — and I quote from her statement:

"... the reasons why the CAB did not inform UKAS, the associated risk and the actions taken by the CAB to correct the issue and address the root cause of the significant nonconforming work."

There's a range of sanctions available that are detailed in the draft customer agreement, including terminating an application for accreditation or refusing an application; withdrawing, suspending or partially suspending an accreditation; reducing the scope of an accreditation; requiring a further assessment of the customer; and publishing that fact under suspension or withdrawal of the accreditation in any media it considers appropriate.

In terms of publication of sanctions, at the moment UKAS's website confirms which organisations are currently under suspension or have had their accreditation withdrawn. The information identifies where the suspension has been imposed as a sanction. This information is kept up-to-date to reflect the

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current status of the CAB. If a member of the public wishes to find out whether a body has been accredited or subject to a sanction in the past, they are able to request this information from UKAS directly.

UKAS is currently reviewing whether the historical record of sanctions could be retained in the UKAS website, and whether this information is of use, bearing in mind two points: first, that the current status of accreditation is always available via the website; and, secondly, and critically, UKAS will not lift a sanction without confirmation that the issues that led to the sanction have been properly addressed.

Sir, as well as those major areas of work by UKAS in response to the fire, there are some specific areas of work that we mention in the written note that are worth drawing brief attention to, bearing in mind the closing statements that have been made by the other core participants.

First, the construction industry technical advisory committee. UKAS is reviewing whether to include fire performance testing of building products in that committee or whether to establish a standalone committee. That's ongoing work.

Secondly, picking up on some of the observations made by the core participants in their written

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statements about UKAS's relationship with government, UKAS is working with BEIS to conduct a strategic review of accreditation and accredited conformity assessment. This work is expected to be completed over the summer and may result in changes to the BEIS/UKAS memorandum of understanding.

As I indicated at the outset, UKAS is also focused on the accreditation of the BBA and BRE.

First, in relation to the BBA, in his statement for the Inquiry, Mr Randall from UKAS explained at paragraph 15.3 that:

"Following the annual surveillance visit to the BBA in January 2021, UKAS has undertaken a review of the BBA scheme which has highlighted the need to update the references on the BBA schedule to reflect better the scope of their scheme."

Recently, UKAS has concluded the review of the BBA scheme and completed the annual surveillance assessment. That review indicated that a number of changes to the BBA scheme were required to enable UKAS to continue to include the BBA scheme within the scope of BBA's accreditation for product certification under ISO 17065. Alternatively, if the scheme is to continue in its current format, UKAS considers that it could be appropriate to transfer the accreditation to ISO 17020

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as an inspection activity.

UKAS is currently in discussion with DLUHC and with the Office of Product Safety and Standards in its role as the new construction product regulator to work with BBA to determine next steps and the future direction of the scheme, taking into account that the scheme is used in industry to support evidence of compliance with the Building Regulations. We intend to provide further information on the scheme review in the October statement to the Inquiry.

As to the BRE, in April 2022, UKAS staff met with BRE staff to discuss ongoing assessment, to ensure that the requirements of ISO 17025 were met. UKAS emphasised the need for close monitoring of the effectiveness of corrective actions from previous assessments and the need for improved internal audits within the laboratory. The next assessment is taking place this month, where the issues highlighted in the evidence presented to the Inquiry will be covered.

A planning meeting has been held with BRE with respect to the coverage of the fire testing scope. It was noted at that meeting that the level and frequency of witnessing the fire testing activities has been increased. Additional monitoring and review of the assessment and post-assessment activities is being

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implemented.

Drawing to an end, sir, I said at the outset that UKAS accepts that the evidence to the Inquiry, that the Inquiry has heard in relation to the BBA and BRE assessments, indicates that lessons need to be learned. Notwithstanding its acknowledgement that there are lessons to be learned, UKAS does not accept that it is fair to say that the evidence suggests that, as an organisation, it is not fit for purpose. Assessments are necessarily a sampling exercise and it cannot guarantee to find all areas of non-conformity. As acknowledged by some of the core participants, sampling is a valid way of monitoring. The CAB's own system should require ongoing monitoring of compliance with the requirements.

UKAS conducts a huge number of assessments each year. We calculate that over 30,000 assessment days per year are conducted using peer experts. What the Inquiry has seen is of course a very limited snapshot of those. However, what the Inquiry has seen is that UKAS has raised multiple non-conformities. It is not correct to say that UKAS does not wish to find problems.

What the Inquiry has also seen is that UKAS has witnessed tests; for example, in relation to BRE during the period 2012 to 2016, UKAS took a fire testing expert

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each year, typically spending 46 days each year looking at the testing, including resistance to fire and witnessing a number of tests. It is recognised that the full BS 8414 test was witnessed only once in that period. However, the report submitted to the Inquiry demonstrates that multiple fire testing records were examined and staff, equipment and facilities were assessed each year on site in addition to a sample of other fire resistance tests.

It is unfair to say that UKAS does not raise criticisms because it is funded by the CABs. UKAS has in place robust safeguards to ensure that it can retain its impartiality and perform its accreditation function effectively despite its funding model which, as we say in our written note, is one shared with other accreditation bodies internationally. We have sought to explain those safeguards at paragraph 17 to 21 of our written note.

It is also important to bear in mind that UKAS itself is not a regulator. It has no legal or enforcement powers. UKAS itself is subject to a peer evaluation process and, like all recognised accreditation bodies, it submits to a programme of peer evaluation to maintain its European and international mutual recognition agreement signatory status and its

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status as the UK's sole national accreditation body.

The peer evaluation last took place in May 2021 where a team of 13 accreditation specialists from other European accreditation bodies spent a week with UKAS. This evaluation included observation of blind assessments and detailed inspection of case records across all sections of the organisation, to determine the effectiveness of the assessment process and compliance with the international standard.

In addition, the peer evaluation team scrutinised UKAS's impartiality, as well as the effectiveness of the management system and overall technical competence. The review identified areas for further improvements, but concluded that UKAS has robust processes and systems in place that provide confidence in the reliability of the accreditation service that UKAS delivers. No systemic risks were identified with the UKAS system.

All of those points, however, are not made in any way to detract from UKAS's acknowledgement that lessons need to be learned and are being learned. That fact, I hope, has been demonstrated by the detail that is set out in our written statement and which, as I've said, will be developed in our October statement to the Inquiry.

So those are the submissions on behalf of UKAS.

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1 SIR MARTIN MOORE-BICK: Well, Mr Glasson, thank you very
 2 much indeed. You've managed to complete well within the
 3 time that we estimated for you, so thank you very much.
 4 That brings us to an end of the proceedings for
 5 today, but tomorrow we shall have some further closing
 6 statements on behalf of other core participants -- not
 7 tomorrow, no. I'm reminded, tomorrow is a terrible day
 8 for anyone trying to travel anywhere. No, we're going
 9 to sit on Wednesday.
 10 So we shall not sit tomorrow at all; we shall sit on
 11 Wednesday at 10 o'clock, when we shall hear the further
 12 closing statements from other core participants.
 13 So thank you all very much. Wednesday at
 14 10 o'clock, then, please.
 15 (4.05 pm)
 16 (The hearing adjourned until 10 am
 17 on Wednesday, 22 June 2022)
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