GRENFELL TOWER INQUIRY RT

Day 295

June 27, 2022

Opus 2 - Official Court Reporters

Phone: 020 4515 2252
Email: transcripts@opus2.com
Website: https://www.opus2.com

Monday, 27 June 2022

(10.00 am)

SIR MARTIN MOORE-BICK: Good morning, everyone. Welcome to today's hearing. Today we're going to hear closing statements relating to Module 4, and the first of those is going to be made by Ms Allison Munroe Queen's Counsel on behalf of those of the bereaved, survivors and residents whom she represents.

So, Ms Munroe, would you like to take your place at the lectern and we're ready to hear you as soon as you're ready.

Module 4 closing submissions on behalf of BSR Team 2
by MS MUNROE

MS MUNROE: Thank you.

Good morning, Chair. Good morning, Ms Istephan. Good morning, Mr Akbor. These are the submissions in closing to Module 4 on behalf of the bereaved, survivors and residents represented by the T2 group of lawyers.

Can I start by taking you back, as it were, back to the opening submissions in this module made by Professor Thomas Queen's Counsel. You may recall that, during those opening submissions, he took us to the headlines that were at the time circulating in the media, which spoke of the chaos, the lack of leadership, the despair of the survivors, residents and bereaved

families. RBKC was failing in their responsibilities to the community, and they were failing spectacularly. There was frustration. There were tears. This abject failure, we say, by RBKC added to the trauma that people were already experiencing, and, for once, the headlines were not exaggerations or hyperbole; if anything, they understated the reality.

In the course of this module, we have gone behind those headlines to the lived experiences of the survivors, the residents and the bereaved families who were so appallingly let down by their local council and by central government.

The council leader, Nick Paget-Brown, speaking on BBC Radio 4's the World at One at the time, sought to defend himself and officials against criticisms. He said staff had been on the ground since soon after the fire started, and added:

"All I'm keen to say is there is an effective, co-ordinated relief effort on the ground, and I'm sorry if people have not seen that."

Those comments were patently untrue and, quite frankly, errant nonsense. The painful accounts of what people had to endure in the immediate aftermath of the disaster should make us all ashamed. RBKC failed to provide a planned, effective emergency response. This

was a council whose response was chaotic and seemed to be gripped with paralysis and inertia. There was a leadership vacuum. People who were at the very nadir of their suffering were left without proper direction. They required relief, shelter, warmth, sustenance and psychological support. This council's invisibility and failure to communicate with the survivors and people who wanted to help exacerbated the trauma.

In our written submissions, we quoted the words of Karim Mussilhy, whom the Inquiry heard at the beginning of this module. I would like to revisit those words again. They are well worth repeating, as Karim so eloquently articulated the thoughts and experiences of many. He said this:

"I thought we lived in a country where the people we vote for and the people that are put in place to look after its people, its most vulnerable people, would help, would come swooping in, and it never happened. The sad part about that ... is that they never planned to. They don't care about us. They care more about themselves, their pockets, and I won't go into detail, because you questioned these crooks, you sat here and spoke to these criminals who acted so fraudulently and with this constant detachment. I mean, how many more politicians, ministers and lords are going to insult our

dead families before something is done about what happened to us? And it's sad.

"I've almost completely lost faith in humanity. I've almost completely lost faith in the world, because it's always the same thing everywhere. We suffer, and they prosper. And I've said this before: the system isn't broken; it was built this way specifically to benefit them.

"Our families died in the most public and horrific way possible, and here we are, five years later, with no arrests, no accountability, but yet the ones who were put in charge or the ones who were involved have been able to prosper since the fire, and how can we allow this to happen?

"I feel like as time goes on, the general public have forgotten about us, or every time they hear about us, they're fed up, and this is the problem. People need to see themselves in us. People need to understand that what's happened to us and what's happening to us is also happening to them.

"Putting aside these corporates that behave the way they behave, because it's in their nature, it's what they do, but the government, the government's duty is to protect us, to look after its people. But yet only last week, a lord was sitting here, calling our families

nameless, getting the numbers mixed with Hillsborough, and couldn't even say Grenfell, said "Grenbell", and these are the people put in place ... to look after us."

Those words, "They don't care about us", have reverberated throughout this entire Inquiry, at every point and intersection between the BSRs, local and central governments and the corporate CPs. Our clients have said and continue to say: the local and central government did not care about us when the tower was being refurbished, they did not care about us when we were raising issues and warning of the consequences of inaction long before the fire, they did not care about us when these warnings came to pass, so are we surprised that they did not care when people were at their very lowest in the wake of the devastation? They did not care, they never have.

The response by both local and central government to this disaster was unacceptable. It was inept. It was inhumane. There was a lack of respect for the residents and engagement with the community.

With the embers of the tower still glowing hot, the spin and deflection began. David Kerry make the following comment in his witness statement:

"General community feeling is of hurt and anger. This is being stoked by a small number of known local

instigators who continue to fabricate stories in order to further their aims."

When questioned about that, he said that he thought:

"... a suspicion that in amongst a great deal of completely genuine and justified criticism, it was within the scope of a handful of people, who were all the time, well before the fire, extremely antagonistic to the council, to make matters even worse."

We ask: why would a responsible authority even seek to raise matters such as this at a time when people were in such physical and emotional pain? The community's heart was literally broken, and yet some were being characterised as the villains of the piece. But was David Kerry not articulating the deeply held belief within RBKC that positioned themselves in opposition to the residents?

There were no instigators, there were no agent provocateurs sewing the seeds of discontent and fabricating stories; these were baseless and deeply offensive slurs. Yet there were armed police in place at the Westway Centre. RBKC staff were not wearing identification. Some people were threatened with arrest and made to feel like criminals at the Westway Centre. This focus on public order detracted resources and focus away from the relief effort. That RBKC felt emboldened

and entitled enough to do this is illustrative of their own agenda and motivation at the time. This we find extraordinary, inexcusable and unforgivable.

This attitude was exemplified in the most egregious way at the Westway Centre. There was the insensitivity of the police cordon, which again illustrates a hostile approach by RBKC, seeing residents and survivors as the enemy. It was aptly described by Rupinder Hardy as being like a crime scene. Residents and survivors described the interviews at the Westway as robotic and little more than tick-box exercises. This was corroborated by Mark Simms of RPT. The lack of co-ordination meant that people had to repeat and therefore relive their story and their trauma to myriad individuals and agencies, causing further distress. It was, in the words of Mark Simms, inhumane and cruel.

They did not care about us.

Professor Thomas Queen's Counsel also mentioned in his opening to this module the elephant in the room, that being race, ethnicity and discrimination in all its forms. Now, during the course of this module, people have tried to move around the elephant, under the elephant, squeeze past the elephant; but he very much is still there and is not going away. Racism and discrimination, we say, played a very real part in the

response to this tragedy. The playing field was not level. It never has been.

One of the measures by which we look at whether we as a society are functioning properly is how we treat our most vulnerable members. Do we treat them with care, respect and equality? Do we make the necessary adjustments?

Now, we have set out in detail in our written submissions the legal framework of the Equality Act, the public sector equality duty and, in regards to the CCA, issues involving vulnerable people and discrimination, so I mention now only the highlights and headlines of those Acts.

RBKC, as a local authority, had obligations under section 149 of the Equality Act, specifically to have due regard to the aims of the general equality duty when making decisions and setting policies. With respect to the PSED, this meant having due regard to the need to: (a) eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the 2010 Act; (b) to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and (c) to foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The CCA, chapter 5, "Emergency planning", specifically states that plans:

"... should have regard to the vulnerable (i.e. those with mobility difficulties, those with mental health difficulties or who are dependent, such as children) and survivors and others affected (those directly affected by the emergency or the anxiety of not knowing what has happened)."

Chapter 7 of the Act, "Communicating with the public", stipulates that:

"[Category] 1 responders need both to plan their communications and to regularly test their communications arrangements to ensure they are effective. The message must be right for the targeted audience and this must be coordinated with other Cat 1 responders and engaging Cat 2 responders and the voluntary sector."

Now, these pieces of legislation are not there just for show or to look good. They are not mere window-dressing. These are overarching pieces of legislation, and they must be embedded within public bodies and inform all aspects of public bodies, their planning, their training, their delivery of services, their practices. This is even more pressing when one examines Kensington and Chelsea's demographics.

We said in our opening to this Inquiry almost five years ago, the very first set of openings, that in examining this disaster, one must put it in its socioeconomic context. The Royal Borough of Kensington and Chelsea is the richest borough in London. London is the richest city in the UK. The UK is the fifth richest G20 nation based upon GDP per capita. This happened in a very wealthy borough.

But there's more to it, because when one looks at the RBKC borough risk register, which is an important document for emergency planners to assist them to make informed decisions -- and it was overseen by none other than David Kerry -- the profile for RBKC's population showed that the borough had an estimated 178,600 -- this is from the 2011 census -- and is "a borough of extremes with some of the wealthiest neighbourhoods in the country as well as some of the most deprived".

Grenfell Tower was in North Kensington where: (a) the population varied in age, sex and religion; (b) more than a fifth of all households have a first language that is not English; (c) less than half of the residents, 48%, were born in the UK; (d) 28% of residents had arrived in the UK between 2001 and 2011; and (e), as a borough, RBKC had the second highest proportion of Arab residents, 4%, after Westminster.

RBKC's civil contingency manager, David Kerry, had a duty to ensure that the borough's civil contingency plans and policy reflected its target group. It did not. Module 4 has laid bare the inadequacy and simple disregard that existed in the borough, by the RBKC, TMO, and indeed central government, for equality legislation. It was not embedded in their thinking; indeed, we say it formed no part of their thinking.

The contingency plans and arrangements and RBKC's response to the fire failed to take into account those in the community with protected characteristics. Mr Hurd, the former MP and former minister, would not accept that prejudiced or institutional difference towards the BSRs played a part in the response. We do not propose to take the panel through our detailed written submissions in which we set out the experiences of many, many of our clients, because we know that you have read that. But we say this, and we say it loudly and clearly: that their evidence, the admissions made on behalf of RBKC, and when one looks critically at the evidence of Mr Kerry and Mr Holgate, show that discrimination did indeed play a part in this response. It is disappointing to see the former minister, Mr Hurd, fail to acknowledge this. With, we say, classic political spin he said this:

"What I do absolutely accept is that the response in the immediate aftermath of the fire was wholly inadequate and might have led some people to believe there was institutional indifference."

People did not misconceive it. They did not imagine it. Those who felt it knew it. Nicholas Hurd, so-called Minister for Grenfell Victims, can pretend not to see it, but the institutional indifference was there, the discrimination was there and it was very real.

Mr Kerry and RBKC failed to take appropriate steps, having due regard to the needs to advance equality and opportunity, in particular with regards to the need to remove or minimise disadvantage suffered by persons who share a relevant protected characteristic that are connected to that characteristic, and (b) to take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it.

Town clerk Nick Holgate perhaps epitomises indifference and casual disregard with his lack of awareness as to RBKC's ability -- or inability, rather -- to identify vulnerable persons out of hours. Mr Kerry flagged this problem in emails in March of 2017, so a few months before the fire, and it was discussed during humanitarian assistance board meetings.

Mr Holgate admitted he should have been aware of this issue.

They did not care about us.

Race, ethnicity and religion.

It was an obvious and basic need that communication would need to be targeted to non-English speakers in order to provide them with accessible emergency advice and information. This was not done. This is discriminatory.

There was a delay or failure to provide counsellors who spoke the language of the bereaved, survivors and residents. This was not done. This was discriminatory.

There was limited or lack of flexibility in accommodation offered to make allowances for Muslim mealtimes during Ramadan or attendance at prayers and meetings, and food provided was not culturally appropriate in some instances, and in other instances Halal food was not provided at all. This was discriminatory.

The panel will have recalled Nabil Choucair's evidence during this module inviting the panel to examine the issue of institutional discrimination and its role in the disaster. In his words, "We need to have institutional discrimination looked at as part of the terms of reference".

Members of the panel, questions of race are, we say, inextricably linked with Grenfell. We need to look no further than the MPS's categorising of risk and threats in the aftermath. The MPS Grenfell community impact assessment created by RBKC police branch to record the actions taken by the police and its partner agencies in the aftermath of the fire attributed imminent threats of an outbreak of crime and disorder to the Muslim background of the victims. The entry of 18 June read:

"Imminent: Local, national or international events, taken alone or in combination, expected to lead to outbreaks of crime and/or disorder within hours ...

"Rationale: There is an expectation that the final death toll from the fire could rise substantially and with the cause still unknown, any subsequent disclosure could have an impact on community tensions. Especially when the majority off those affected are believed to come from a Muslim cultural background, combined with the incident occurring during the [holy] month of Ramadan."

Members of the panel, this is Islamophobia, it is racism, the elephant staring back at us in the room.

Disability.

Disabilities were known to RBKC and to the TMO. They were known to adult services, they were known to

RBKC disability services. Yet still they too were treated with indignity and disregard.

We had, in the aftermath, people who were frightened, they were grieving for friends, relatives, for neighbours, they were bereft of all their worldly possessions. These residents were placed nonetheless in hotels on high floors, in rooms that were not adapted for their most basic needs. There was no consideration of mobility issues or non-visible disabilities. To use the phrase that Mr Simms has used already, it was inhumane and cruel.

Pregnant women.

A number of expectant mothers who survived the fire, traumatised enough by that, found themselves in hotels or shelters which were not equipped to meet their medical needs and requirements. They were living and sleeping in entirely inappropriate accommodation. This impacted upon their physical and mental wellbeing.

Children.

Children are a particularly important group here, and we spent some time, both in the opening and in the closing written submissions, addressing the issue as to children, and the disproportionate number of children that not only died in the fire, but those who suffered as a result in the aftermath. The Equality and Human

Rights Commission report entitled "Following Grenfell" was based on interviews with family, and they found that many children who lost a friend or family member or their home in the fire struggled to access help.

David Isaac, the commission chair, said this:

"'There are so many children going to the same school and still affected,' one respondent said. 'They just don't know where to turn because there aren't the services available.'

"'Supporting families who lost friends and loved ones that night should have been a primary concern, but especially the children involved ... While authorities sought to respond to the disaster, children received disjointed mental health and educational support. Their needs and rights have slipped through the cracks.'"

Families found themselves in hotel rooms with no facilities to sterilise bottles and cots if they had small children, babies and infants. School-age children, some of whom had exams to sit that week, had no uniforms to go to school in, they had no room to study. Often whole families were sharing one hotel room, so teenagers had no privacy and no space.

At the other end of the spectrum are the elderly, and although Module 4 focused on the seven days after the fire, the response to the fire is long-lasting and

far-reaching, with greater impact on vulnerable people such as the elderly, and this has been clear from the evidence heard and the news reports that we alluded to in our opening and I've alluded to at the beginning of these submissions.

One of our clients, Elzbieta Konarzewska, was 80 years of age, and on the night of the fire she was evacuated from her home in Grenfell Walk, where she had lived for the past 35 years. She, like Michael John, of whom the Inquiry has heard in the opening, was one of the forgotten people by RBKC in this aftermath. She received no subsistence or housing support until many months later. She was belatedly offered temporary housing, and was put through further trauma when later rehoused in a property which had multiple fire safety issues resulting in the decanting of residents. The failure to rehouse Elzbieta in settled accommodation after the fire had a detrimental effect on her health, and sadly she died in January of this year at the age of 85, four and a half years after the fire, awaiting still placement in sheltered accommodation.

Mental health.

We have set out in our written submissions the mental health impact of this disaster. The aftermath of this fire created a mental health crisis that cannot be

understated or underestimated, and it's probably still being under-reported.

In August of 2017, so only a few months after the fire, BBC Newsnight reported that 600 people had so far received counselling, including 100 children. That was the tip of the iceberg. By October 2017, The Guardian was reporting that the mental health response following the fire was the biggest operation of its kind in Europe, according to one doctor, with the number of people affected likely to exceed 11,000. As with the other provisions of services for the BSRs, psychological and mental health support in the immediate aftermath was woefully inadequate.

Rest centres.

The alacrity with which the voluntary sector filled that leadership vacuum created by the inertia of RBKC and TMO was matched only by the speed with which RBKC began to spin malign the names of certain residents and their intentions. Whilst those in positions of authority at the council dithered and prevaricated, arriving on scene many hours after finding out about the fire, Mark Simms of Rugby Portobello Trust, RPT, sprang into action some 120 miles away in Nottingham, and immediately set about providing aid and support to the BSRs once here in London. He summed it up perfectly:

"... the North Kensington community, was looking after its own people in the absence of anything coming from anywhere else ... it's a sad indictment, really, that people were getting out of bed to help their fellow neighbours when other people weren't getting out of their offices to help our citizens."

Pausing there for a moment, it's worth perhaps mentioning the MPS again, because very little has been said about them in this Inquiry. In their closing statement, they focus on the Casualty Bureau and family and friends reception centre, conceding that it needs to give consideration as to how the role of the Casualty Bureau should be better communicated in the future, it needs to consider how its operation could be improved and how it might fit into wider systems of disseminating information about those who are missing as part of an improved humanitarian response. All we would say to that is: well, an adherence to the Equality Act, the PSED, would be a very good start.

The TMO.

Whilst brevity in lawyers is always to be commended, it is noted, in its very short written closing submissions, that the TMO has continued to emphasise that it was not a category 1 responder. It says that its emergency plan had no effect on the fire or the

aftermath. We find that statement extraordinary, but there's more. It goes on to say that the TMO staff were present in the rest centres, and if they did not seem visible to BSRs, that might have been down to how busy it was. No. That explanation is an affront and insult to the intelligence of our clients. It is not an acceptable or credible explanation and we reject it wholeheartedly, and we invite the Chair and the panel to do likewise.

The TMO's position has consistently been that it was obvious from the scale of the fire that their emergency plan was not relevant and that RBKC's emergency plan would prevail. Its role, it says, therefore, was to support and assist once decisions had been made, rather than to make decisions itself, and to respond to requests made of it by RBKC and other agencies where appropriate. Mr Black went further by saying that that is how it was planned and operated.

There was quite clearly a lack of co-ordination between RBKC and the TMO, and it is acknowledged by RBKC in its written closing document. They say:

"[RBKC] admits that it and the TMO never formally agreed what the role of the TMO would be in the event of an emergency ... [and it] acknowledges that it would have been better if the role of the TMO in the event of

an emergency had been set out in writing before the fire. This might have enabled better use to be made of TMO's willingness to assist."

Firstly, we say this shows a fundamental failure on the part of both RBKC and the TMO to appreciate what the TMO's role could and should have been in the event of a large-scale emergency. Planning, training and preparation are key to emergency response, and the role of the TMO staff should have been firmly embedded in RBKC's emergency planning.

We know from the evidence that RBKC simply did not have enough staff who were suitably trained in emergency planning and response. This is a gap which could and should have been filled by TMO staff. This is because the TMO is not just a TMO; it is also an arm's length management organisation, ALMO, with a responsibility for the management of the entirety of RBKC's housing stock. It therefore needed to perform the functions of a local authority internal housing department. An authority's housing department is, of course, part of the authority itself and, therefore, part of a category 1 responder. As such, it is fully integrated within the authority's emergency plan and provides staff trained to act as part of a co-ordinated response with other local authority departments.

Secondly, RBKC and the TMO should have realised this was an obvious point. It should never have been the case that the TMO had "no formal role except to provide resource and support on an ad hoc basis". The TMO should have been fully integrated within RBKC's emergency response team. The failure to ensure this was the case vastly reduced RBKC's capacity to respond effectively to the fire.

RBKC seeks to shift the blame for its failure to agree with the TMO as to their role by relying on the fact that their respective roles were defined by the modular management agreement, MMA, which is issued by government and which fails to address an ALMO's role in an emergency. Central government, therefore, also bears some responsibility for the lack of co-ordination between RBKC and the TMO in the response to the fire, but that cannot serve to excuse the inadequate planning of both RBKC and the TMO.

Both RBKC and the TMO also conveniently ignore the evidence of the TMO's own emergency plan, which recorded that it was intended to work within the framework of RBKC's emergency response. To quote from the plan:

"The plan is primarily for managing local KCTMO emergencies on, within, or surrounding our properties and estates, one which can be managed within the

resources available to KCTMO. However, this plan can also be used for large scale major events which would overwhelm the KCTMO's ability to manage on its own, and which would involve the RBKC council resources. The difference being the scale of the emergency and the number of people affected by it."

When this was drawn to Mr Black's attention in his oral evidence, this part of the emergency plan, he accepted that he had misunderstood the TMO's role and that there was no reason why parts of the TMO's emergency plan could not have been activated alongside RBKC's response. This is important because, as Mr Black accepted, the TMO's role as stated in the emergency plan envisaged that TMO staff would be available to undertake roles including setting up rest centres. RBKC has admitted that it did not have enough trained rest centre managers before the fire and that initially it did not deploy enough council officers of sufficient seniority to rest centres. This, we say, is a crucial failing on the part of both the TMO and RBKC. The TMO should have been able to provide staff trained to establish and run rest centres, and RBKC should have known that this was a resource that, if needed, they could call upon.

Ms Brown confirmed in oral evidence that her staff had no training working at rest centres or collating

data in an emergency. While at the TMO, Mr Black received no training in emergency planning and response, nor had he attended any joint training with RBKC about how its plans would work in practice. Likewise, Ms Brown had no emergency training whilst at the TMO. She gave evidence that employees on the out-of-hours rota had received training; however, significantly, this was not corroborated by one of her own employees, Kiran Singh, who says in his witness statement that he attended no training or exercises in the emergency plan. This is a crucial and critical admission, as it was Mr Singh who was primarily tasked with collating details of residents on the night of the fire, including the safe/missing list. That proved to be something of a disaster.

The Inquiry took Ms Brown through that spreadsheet of the safe/missing list in its various versions at length and demonstrated how terrible mistakes were made, so that residents were recorded as being both safe and missing at the same time. That led to relatives being told that their loved ones had survived, when that was not the case. Such appalling mistakes should have been avoided and could have been avoided had there been proper training and preparation.

The TMO had previous fires from which lessons should

have been learnt. Following the fire at Adair Tower in October 2015, RBKC and the TMO knew that they needed to improve their co-ordination during an emergency. Two years before Grenfell, on 11 November 2015, a meeting of the TMO's executive team concluded that better integration between RBKC and the TMO was necessary. Despite this, on the night of the fire at Grenfell Tower, the TMO still lacked a clearly and formally defined role in the event of RBKC's contingency planning systems being invoked. Such was the lack of co-ordination between the two that Mr Black confirmed RBKC didn't even telephone the TMO's out-of-hours contact number. His role at RBKC's Gold Group was "just to be there and see what you could provide". The total lack of co-ordination is graphically illustrated by Ms Brown's evidence that not only did she never have any contact with Sue Redmond during the emergency, but she did not know that Sue Redmond was the HALO or even what the HALO's role was.

Following the Adair Tower fire, the key role identified for the TMO in an emergency affecting the homes of council tenants was to attend the scene of the emergency with a list of known residents. That was to include identification of residents with any vulnerabilities. As Ms Brown accepted in her evidence,

that was a perfectly good opportunity to update the emergency plan, and the annexed sets of details for each tower block and estate.

In its written closing, the TMO says this:

"It is acknowledged that there were deficiencies in the Emergency Plan, however these did not impact delivery of the TMO services during the Aftermath."

That, I'm afraid, beggars belief. The TMO's emergency plan stated it included information on the numbers of known vulnerable residents to be included on the block details which formed part of this plan. The information specific to Grenfell Tower was completed in 2002 and it had not been updated, despite the emergency plans purporting to be the 2016 version. It therefore took no account of the refurbishment works, and stated there were 120 dwellings, not 129; approximately 330 to 360 residents; and that the likely number of vulnerable residents was between 8 and 12. All those figures, all those stats, are wrong. It contained no further information about the location of these residents, nor the nature of their vulnerability. So far from being of assistance to the emergency services and RBKC in responding to the fire, it was actively misleading and a hindrance.

Although the TMO was the obvious first port of call

for information on residents, RBKC's departments, such as adult social care and children's services, also have records which should and could have recorded the composition of a tenant's household and, more specifically, would have assisted in identifying vulnerable residents. Yet there was no sharing of data held on residents between the TMO and these departments, as both Ms Brown and Ms Redmond confirmed.

It is clearly essential that responders have information about those affected by an emergency which is as accurate as possible and available as soon as possible. It is undoubtedly the case that the quality of the information would have been greatly improved if there had been an existing database which collated all the information available to the TMO and to RBKC's social services department.

So why was there no such database created? Well, it appears from the evidence given by Amanda Johnson in Module 3 that there were concerns about breaching data protection rules. There was, however, no reason why a data sharing agreement could not have been put in place between the TMO and RBKC. Even though sensitive personal data about vulnerable residents could not have been shared without their consent, surely that consent would have been given if it was properly explained that

it would be used in an emergency. We suggest the Inquiry should recommend that such collated databases be kept by all social landlords and local authority social services departments.

But why was the TMO's information so very poor? There is an obvious answer: the distant attitude of the TMO to the residents it was meant to serve. The evidence in Module 3 demonstrated how the petitions, pleas and warnings of residents were ignored. The evidence in Module 4 yet again showed that residents were not given the respect and dignity that they deserved.

How can this be, given that the TMO was a tenant management organisation, emphasis on the tenant? The answer is that it was a TMO, but it was, as the Inquiry is well aware, a unique TMO. Tenant management organisations were envisaged as and usually are locally based community bodies formed by groups of tenants and leaseholders. Imagine how much better the information on residents would have been if the estates had been managed by a TMO set up by and for the residents of the estates, and staffed by housing officers who were properly integrated within the local community. The concept of the TMO is not flawed, but KCTMO was fatally flawed because it was incapable of proper resident

engagement, participation and empowerment.

The TMO says in its written closing that issues of information gathering from residents "appears to be an industry-wide social housing problem". If that is so, the reason is that lack of proper resident engagement and participation is also an industry-wide issue. For far too long, residents in social housing have been treated as second class citizens.

The current proposals to strengthen the powers of the regulator of social housing in the Social Housing Regulation Bill in relation to tenants' empowerment are to be welcomed, and we invite the Inquiry to make strong recommendations reflecting the need to ensure that residents of social housing have greater participation in decision-making and have a greater access to redress.

Housing duties.

In our written closing submissions we set out RBKC's duties to the homeless under the Housing Act 1996. I do not propose to repeat the legal framework today, but emphasise that accommodation secured by a local authority under any of the housing duties must be suitable, and that in deciding whether accommodation is suitable, the PSED requires that authority to focus on effects of an applicant's vulnerability and cultural needs.

In her evidence, Laura Johnson accepted the many failings RBKC have admitted to in their opening. Just a few: some residents were entitled to emergency accommodation but were not provided with it because they were not made aware of their rights. Some were misled as to their entitlements. Others were not provided with transport to get to their hotels and they had to rely on the kindness of strangers. In seeking to match accommodation to families' needs, errors were made in relation to the size of the accommodation. There were many examples that we've given of accommodation being provided which lacked appropriate facilities for disabled residents and young children and families. Many were placed in hotels and then left for days without RBKC contacting them to follow up on their support needs, leaving them feeling abandoned by the council. As many families were reliant on food provided by the hotels, as we said, many Muslim families were unable to get Halal food. Extraordinarily, in the first few days RBKC gave no consideration to the floors on which emergency accommodation would be provided, so some residents, having survived the horrors of a high-rise fire, were then placed in high-rise accommodation. One can only imagine how that played out.

The failings of her department as part of RBKC's broader failure to comply with its duties under the CCA 2004, in particular proper training of staff and adequate planning. Aside from attending one event in 2015, Laura Johnson had no formal training in contingency management planning and played no part in two significant training exercises which took place in 2015 and 2016. Although there was a housing contingency plan dated 2012, Laura Johnson had failed to update it and was "not confident" -- her words -- that her housing team was even aware of it.

RBKC's housing department, therefore, failed to take basic steps which would have prepared them for providing accommodation in a large-scale emergency. As Laura Johnson accepted, having standing arrangements with hotels or hotel groups would have helped to avoid the difficulty encountered in booking rooms because hotels require payment upfront. A small and simple thing to rectify; a problem that became very, very pressing for a large number of people in the aftermath.

I turn then to contingency planning.

As we have stated in our written closing, emergency planning, preparedness and the assessment of risk lies at the heart of civil contingency planning and statutory duties underpinning the Civil Contingencies Act. RBKC's

failing in relation to its statutory duties pursuant to the CCA 2005 were systemic, and we invite the panel to find that these systemic failings contributed to the abysmal response to the fire. There was a systemic lack of internal oversight of the contingency arrangements, which saw the plans being left un-updated. Annexes were left blank or in draft form, they were outdated or they were superseded. Again, simple and basic oversight and proper governance would have addressed those very, very important issues.

Coupled with the systemic lack of oversight, there was a lack of investment in contingency planning, under-resourcing and a culture steeped in, "This is how it's done" and a resistance to change. We are reminded of Rebecca Blackburn's evidence of RBKC's response to her concerns about the lack of training in and testing of contingency plans, and David Kerry's inability to cope with what she raised, Tony Redpath's response being that David could cope:

"He's been doing this job for this amount of years, he's the adviser to the LAP panel ... he's a professional, he'll cope."

The evidence in Module 4 has shown that he did not cope.

The silencing of Rebecca Blackburn, placing her on

secondment following her response to the concerns raised about the CMU, also strikes at the heart of RBKC's poor governance, and, as we have heard, she returned from secondment in 2016 to a deteriorated state of affairs, with management turning a blind eye to the concerns raised.

Given the specialised nature of contingency planning and emergency management, there needs to be greater investment in both. Local authorities, CMUs and that of responder organisations must be staffed with personnel, including managers who are trained in emergency and disaster management. RBKC's lack of contingency preparedness prior to the fire and its tardy response weaves the familiar thread of neglect of which the residents of the tower complained during the life of the building, and which was sadly the experience of many members of the community in the aftermath. The scene was ripe for RBKC's failed emergency response which failed an entire community.

Although apologies were tendered on behalf of RBKC for its failings, its contingency planning and its response to the fire, the mea culpa has been somewhat qualified, buck-passing again and defiance is again obvious. This is borne out particularly in David Kerry and his response to questions asked during the course of

his evidence about RBKC's role in the provision of premises for rest centres as set out in RBKC's CMP.

Although the plan clearly specified that its role in the immediate aftermath included "the provision of premises for Body Holding Centres, Survivor Reception Centres, Friends and Relatives Reception Centres", David Kerry sought, and steadfastly sought, to deflect responsibility on to the Metropolitan Police, as he did when asked about the council's duty to co-ordinate communication, and even when confronted with RBKC's own admissions of its failed communications. Mr Kerry's response to the Inquiry's questions on these very obvious failings is indicative, we say, of RBKC's culture of institutional defensiveness, blaming someone in an effort to escape responsibility.

If lessons are to be learnt from institutional failings and meaningful change implemented, we as a society must cleanse ourselves of the cancerous culture of institutional defensiveness and buck-passing. Candour cannot be lip service. It must constitute the framework of public accountability.

In their written closing submission, RBKC accept that contingency arrangements and managements were indeed failings that were systemic and were enabled by an inadequate or non-existent oversight framework.

LRF's terms of reference place the onus on the organisation to self-report issues of concern and to fulfil their statutory obligations under the CCA 2005. At the time of the Grenfell Tower fire, there was no national or regional oversight body with statutory powers to ensure compliance with the CCA 2005 or standardisation of CMP provisions and arrangements. This remains the case to date. They also accept further failings in relation to the BECC.

Now, it would be churlish not to acknowledge those failings and to welcome them (sic). However, our clients are not going to give RBKC a pat on the back for accepting those failings which we say were blindingly obvious.

The risk of fire in high-rise buildings was foreseeable and should have been identified as a risk on RBKC's risk register. Although this risk was ever present, given the prevalence of tower block fires in London, including the Adair Tower fire which, as I've mentioned, Mr Kerry had personal involvement with as the BECC, the risk of tower block fires was never raised by RBKC of its own initiative, nor with other organisations in the LRF. Mr Kerry's evidence of casual conversations with the LFB at BRF or other events generically about matters to the exclusion of risk of fires in

tower blocks also supports a systemic lack of oversight, risk assessment and management.

We do not propose to take the panel through our detailed written submissions on the London Resilience framework which, again, we're very grateful you have read. The panel has heard, we say, sufficient evidence from which to make findings. For the reasons given and the evidence heard, we would invite the panel to make findings of the inadequacy of the resilience framework and the need for a national, regional quality contingency management resilience compliance and quality assurance organisation or authority, and that needs to have statutory powers.

Turning, then, very briefly, to central government.

We say soundbites and platitudes characterise the response of central government. We were, and the Inquiry, we say, was subjected to a parade of witnesses who simultaneously espoused regrets and apologies whilst failing to properly take ownership of the disastrous manner in which this government dealt with this tragedy.

The Grenfell Tower fire was an exceptional national disaster. It required and it needed an exceptional national response at governmental level. What it got was Nicholas Hurd MP, a man only two days into his own

ministerial appointment as Minister of State for Policing and the Fire Service. In answer to questions as to whether he was adequately briefed for the role, he, not surprisingly, admitted he was not:

"I don't see how I could have been, given that this was day two."

In their written closing submissions, DLUHC says this:

"... the Department recognises that the commitment to re-house all affected individuals in the local area in three weeks was too ambitious and could not be achieved."

This was not only an error, and it wasn't the only error. In its oral opening, the department also acknowledge that it should have been:

"... clearer in the way that the commitment was communicated. It should have emphasised that affected people would be provided with temporary accommodation before being offered permanent accommodation, and that they weren't obliged to accept [this] offer."

Now, it is one thing for someone to decide whether to move into temporary accommodation for six months or a year; a decision about whether to accept a council or housing association tenancy intended to be your permanent accommodation is of a totally different order.

At a time when absolute clarity was necessary, it is truly extraordinary that both central government and local government in the form of RBKC could not (sic) send out such confusing messages. RBKC should have been clear in its own mind that the commitment was to provide temporary accommodation.

An email from Fiona Darby, DCLG's deputy director of homelessness, to Laura Johnson on 17 June summarised what had been promised to RBKC the previous day. The government was, in effect, offering RBKC a blank cheque to cover the whole cost of temporary accommodation in the private sector until permanent accommodation could be provided. RBKC could book everything available, even if it was not used, because the government would bear cost. In light of this email, astonishing, it is clear from Laura Johnson's written and oral evidence that she understood the commitment to be the provision of permanent housing.

The three-week target was not just ambitious, it was totally irresponsible. It should have been obvious to the government that it was impossible to meet the deadline, given the commitment to rehouse locally, the acute shortage of housing and the sensitive decisions that were involved ensuring that accommodation was suitable for each and every family's needs.

RBKC was placed in a situation where it made offers of accommodation to families even when it knew that those offers were unsuitable. As Laura Johnson put it in her written evidence:

"We were making offers we knew survivors would refuse, in order to meet their three-week target, and to make sure everyone had an offer."

Indeed, many residents moved into temporary accommodation which was subsequently found to be unsuitable and then had to move again and again. Many waited months or even years to obtain suitable accommodation, and many still have not achieved that and have not been provided with proper permanent homes.

Insufficient steps were taken to address these concerns, and the lack of leadership was not functioning properly. Despite considering the issue of an intervention during the weekend following the fire, a decision was made against intervention due to the role played by Gold Command having taken over RBKC's leadership and the replacement of the chief executive and leader of RBKC. This raises further issues regarding the pan-London approach, the legislation, the effectiveness of the legislative framework and clear lines of activating the intervention.

In terms of central government, there were clear

failings. There was a failing by central government to act upon known information that RBKC and its leadership were out of their depth and that people were suffering. Nick Hurd had met with volunteers. He knew that they were filling the leadership vacuum in the response. The system of which Mr Hurd was a part itself failed. Data provided did not add up. It was inconsistent. Further, there were inadequate resources in place to monitor or oversee RBKC.

Sir, in conclusion, we say with a large population and complex society that we live in now, the probability of something very unlikely happening is actually very high. In one year alone, there was the Manchester Arena bombing, the London Bridge terrorist attack and the Grenfell Tower fire. Unlikely disasters all of them, but they all happened, and they were all met with very different responses and very different levels of effectiveness.

The response to the aftermath of the Grenfell Tower fire was woeful and laid bare a catalogue of breaches and failings. The BSRs demand and expect those responsible to take full ownership of these failings and to acknowledge these and all statutory breaches. It is only by such acknowledgement that the process of accountability can begin.

No community should have to go through such painful and degrading experiences as our clients did in the aftermath of this fire. When they should have been protected and enveloped in the protective arms of the state, they were treated as a hindrance, second-class citizens, who did not warrant the care, kindness and support that they should have been given immediately and unconditionally.

For the final words, I return again to one of our clients, Hanan Wahabi, a woman whose eloquence and quiet dignity and gravitas embodies this proud, brave and resilient community of people. This is what Hanan said to this Inquiry:

"We were treated like numbers, not humans. This is something that we still feel today.

"In my experience, in the eyes of local and central government, our Grenfell and North Kensington community are second class, the people with needs and problems. I cannot help but feel that had our community lived in a different part of the borough, on the more affluent side, had we been from a different class, had we been less ethnic, the response in the aftermath would have been immediate. It would have been present. It would have been felt.

"We may be different, we may be diverse, but we are

people. Think of the different professions in the tower, of the challenges that so many from the BAME communities had overcome prior to the fire in 2017. Think of the dignity demonstrated by those of us impacted over the last five years. We are human beings. We contribute. We pay tax. We provide leadership in our communities ...

"... This tragedy has pierced wounds in each and every one of us in ways that one cannot imagine. We may now and again put plasters to hide our wounds, but they are still there, and sometimes, many times, those plasters fall off.

"To this day, the support that we are given is only provided after jumping through hoops, whether it's fighting to get house repairs done or get the medical support we need. We are forever asked to prove that we have been impacted, forever having to prove our pain ...

"This duty of care needs to extend beyond us to the rest of the country, to the thousands of families who live in communities like us, like we had at Grenfell, who are still treated as second-class citizens. It needs to extend to the thousands impacted by the building safety crisis up and down the country.

"We are still impacted. We still hurt. We still remember. We haven't forgotten. All the issues we

have, the PTSD, the mental and physical trauma that you see as problems in us, this isn't who we were; this is who some of us are now because of what the government did to us. Because of your absence, because you were not there, because you did not show that you cared, you have sapped all the energy from us. Those that caused this tragedy need to be held accountable. Their duty of care to us now has no limit."

Thank you very much, Chair.

SIR MARTIN MOORE-BICK: Thank you very much.

Well, at this point we're going to take the morning break. We'll rise now, we'll resume, please, at 11.25.

As you will all realise, we are running slightly behind time, and so I would encourage those who are coming next to keep their remarks within the span allotted.

Thank you very much, anyway. 11.25, thank you.

(11.10 am)

(A short break)

(11.25 am)

SIR MARTIN MOORE-BICK: The next statement is going to be made by Mr Friedman Queen's Counsel on behalf of those of the bereaved, survivors and residents whom he represents.

Yes, Mr Friedman.

Module 4 closing submissions on behalf of BSR Team 1

by MR FRIEDMAN

MR FRIEDMAN: Good morning.

Panel, if the subject matter of democratic government is the people, then the Phase 2 evidence demonstrates something profoundly wrong, that people were left so exposed in both the origins and the aftermath of the fire. Whilst this Inquiry must therefore conclude on what is needed to better regulate the built environment and the emergency response to its fragility, the study of the fire's aftermath raises an equally important question of this disaster: how can we make democracy more social?

The Module 4 evidence focuses on that question through five lenses: people, community, borough, city, and state. Through those lenses, we say certain basic features of what might be regarded as a good and just society are missing. They include: respect for human dignity as an overriding societal value; real community engagement as a primary goal of all levels of government; effective emergency organisation for the wellbeing of cities; and genuine human and social concern at the heart of state.

From these missing features flowed the following wrongs in what this module calls aftermath but which can

now be properly viewed as the continuation of the disaster: first, people were resilient, but the acts and omissions of government often made them vulnerable; second, there was a practical and moral collapse of local government for reasons foreshadowed in pre-fire relations; third, whatever its improved contribution to recovery, an improvised London command structure took power on the barest of legal foundations; and, fourth, the modern discourse and practices of civil contingency, and particularly its core features of subsidiarity and resilience, had in this instance profoundly antisocial consequences.

Starting with people.

The BSRs' overriding accusation is that the system did not care about them. Consider again Hanan Wahabi's declaration:

"We may be different, we may be diverse, but we are people ... We are human beings."

Mahmoud Al-Karad urged, "I am a human ... I have feelings".

Mohammed Rasoul learned though those in power "don't care about their constituents [because] they can't relate to them".

Hanan Cherbika and those on the walkways discovered "we did not matter, because we didn't come out of the

Tower and we didn't lose anybody".

Mouna El-Ogbani found "no understanding ... no empathy or sympathy ... no ... culture", and what she wanted for people is "to be taken seriously and treated with dignity and respect".

Karim Mussilhy:

"... the system isn't broken; it was built this way ... People need to see themselves in us. People need to understand that what's happened to us and what's happening to us is also happening to them."

Now, these are criticisms of contemporary bureaucracy and should be taken seriously as systemic problems, and not just the neglect of a rogue borough that RBKC was. One of the key gaps in the copious central and local government emergency planning documents is they do not speak of people. They refer instead to categories of vulnerable persons, of the voluntary community sector, of faith groups and of essential services, but they do not require focus on the qualities and needs of individuals or everyday groups of people. This absence of basic human accounting flows down through the rest of the emergency system.

The regime, we are told, relies on subsidiarity, defined in the documents as:

"... the principle that decisions should be taken at

the lowest appropriate level, with coordination at the highest necessary level."

It may have some logic as regards local knowledge, but based on what this Inquiry has learned across its modules, subsidiarity is another species of unaccountable and unmonitored localism.

A powerful example of this is that, before the fire, central government gave no thought to the fact that, following a disaster, mass displacement would likely have a disproportionate effect on lower income groups. It was not considered in the compilation of the national risk register, or in the lead department planning. Katharine Hammond in the Cabinet Office and Melanie Dawes at DCLG could recognise the point when questioned, but, on grounds of subsidiarity, they declared it something exclusively to be dealt with at the local level. In one swoop of doctrine, the major reality of any disaster, that those with less financial means will suffer most, gets entirely contracted out of central government responsibility, and it does so by design.

Once in the midst of the Grenfell disaster, no one in government considered it an obvious problem that the local authority who owned the building, and was therefore primarily responsible to account for its lack

of fire safety, was to lead on response and recovery for the fire's victims. Subsidiarity turned out to be to civil contingency what stay put is to fire and rescue. It's a policy assumption that was allowed to become imprisoning as an article of faith.

A further problematic concept that runs across the documents is resilience. Dictionary definition refers to the innate capacity in nature, physics or psychology to rebound or spring back. Resilience could therefore serve as a marker of the power and creativity of humans to respond to adversity, especially with public sector support. However, the Cabinet Office definition of resilience refers to the:

"... ability of the Community, services, area or infrastructure to detect, prevent, and, if necessary to withstand, handle and recover from disruptive challenges."

Its relevant levels, including its proper noun, "the Community", do not include individuals, the public, or normal community life. Resilience is essentially reserved for formal organisations, structure and services. What the documents really refer to is resilience of state. Those who cannot be resilient due to poverty or disability are lumped under a catch-all of "the vulnerable". No account is given to how inequality

creates vulnerability. Resilience in civil contingency speak is not about empowering in a human capacity; it is a governing ethos, and, in truth, in the present state of affairs, a suspect term.

What Karim Mussilhy and others witnessed was not state respect of human resilience, but authorities more concerned about an uprising or unrest than they were about looking after families. For Tomassina Hessel, council officers hiding badges and not wearing lanyards illustrated how residents were perceived as a dangerous threat. Police risk assessments, as you've heard, expected community tension, especially when the majority of those affected are believed to come from a Muslim background. For several days, the Westway remained a site of intimidation rather than refuge.

Amidst this, RBKC deliberately and consistently lobbied against local residents as agitators with agendas, and on that, civil unrest became the official explanation for delay in moving from response to recovery. That is the justification that John Hetherington of London Resilience provided to chief executives for delayed handover on 15 June. The same day, Nicholas Holgate told Jo Farrar, without repudiation, that Grenfell residents could "make this worse than it is", and the council is worried that they

might need assistance from the police.

Despite all of the overnight diplomacy to activate London Local Authority Gold, the SCG meeting at 11.00 am on 16 June still formally logged the delayed transition to recovery stage as caused by ongoing community tension. This false narrative should never have been officially endorsed in that way. The delay occurred because RBKC was incompetent, incapable and resistant to external involvement, and regional and central government was unable or unwilling to force the issue. Everyone knew this, but instead of acknowledging it, the community were made to take the blame.

Indeed, from Town Hall to Downing Street, documents show a state of elite panic obsessed with wanting to "get a grip". "Grip" is not a government term of art. Its use reflects a mentality in which real engagement with people as opposed to managing or ordering them has no real prior thought or practice. Gripping is more about power than welfare and, again, not about people. In the post-Brexit electoral storm of June 2017, it also spoke to fears of broader collapse of social control.

When Mark Sedwill, as National Security Adviser, warned colleagues that, without getting a grip, "this could become our New Orleans", he was referring, consciously or otherwise, to a seminal moment of recent

history where structural discrimination revealed itself so obviously interwoven in a country's social fabric. As Hurricane Katrina showed in 2005 America, the Grenfell aftermath showed 2017 Britain to be in denial about the effect of economic and race inequality on people's capacity to withstand disaster. On this, the civil contingency system and its practitioners were at fault because of their indifference to inequality.

First, none of the Cabinet or London documents as of 2017 referred to the Equality Act 2010. When Cabinet Office witnesses assumed that socioeconomic disadvantage would be considered locally given the Equality Act obligations, they overlooked that section 1 of the Equality Act, which would require such consideration, has never been brought into force by the post-2010 governments.

Second, as to other enforced protected characteristics under the Act, including age, sex, disability, race and religion, which often intersect with socioeconomic inequality, central government ought to have known that the public sector equality duty has simply not embedded in local authority culture across the country. Indeed, CCS breached its own duty in failing to press the point, just as London Resilience failed to embed the duty as part of its minimum

standards.

Third, at the local level, detailed knowledge of the equal treatment requirements in the Equality Act and their application to emergency planning was non-existent, despite the powerful indices in the population of North Kensington that ought to have made it a priority.

Panel, without exception, the evidence before the Inquiry in every module in Phase 2 has been that breach of the public sector equality duty is the norm. The default answer to the equal treatment questions put by your counsel throughout the phase has never done more and often less than articulate a general need to think about the vulnerable and otherwise prevent intentional abuse. That is not a way to combat discrimination; it signifies incompetency to prevent it.

Why is it that Hisam and Nabil Choucair both raise discrimination with you? That Karim Mussilhy says "We suffer and they prosper"? That Mohammed Rasoul told you they experienced second-class exclusion, as if refugees in their own country, and that they cannot escape the conclusion offered by Hanan Wahabi that, "had our community lived in a different part of the borough, on the more affluent side, had we been from a different class, had we been less ethnic, the response in the

aftermath would have been immediate. It would have been present. It would have been felt"?

These are not just opinions; they are factual descriptions of a concrete situation. As an overwhelming African, Middle Eastern and Caribbean diaspora population, many with intersecting lower incomes and disabilities, and with the vast majority of Muslim faith heritage, they have suffered because of a failure of human accounting.

That absence of accounting produced an experience for BSR in the first period of the aftermath response that was inhumane. It treated people as numbers, not humans, herding them like cattle, ticking boxes about them, ignoring them as victims, requiring them to repeatedly relive their trauma to access services, containing their anger and pain, and even resenting it. More than anything, the treatment of BSR was felt as abandonment by the state when all aspects of their human geography had been lost, neighbours, family, friends, homes, possessions, and means of access to the rest of life.

While the civil contingency system at each level of government is to blame for these outcomes, there is also a bureaucratic mentality in an era of diminished state connection to society that lacks empathy and human

responsiveness. Everyday moral restraints make it hard for people, especially public servants, to admit to inhumanity or comprehend that inhumanity is not restricted to bad people, and yet it occurs in bureaucracies and businesses, when basic moral restraints become neutralised or otherwise compromised. We say that there are powerful examples of this before the Inquiry that need to be marked out, however uncomfortable for some to acknowledge.

Consider Laura Johnson. She presided over the assignment of residents into hotels, with no regard to their human wellbeing once warehoused in that way. Johnson's account is about the movement of bodies and things, not people, and she did this in a fashion that no one would ever do to their own family or friend or anyone whose lives they knew anything about.

Nicholas Holgate regrets now the type of leader he was then, but when he protests that it was not part of his makeup as a career civil servant to refrain from invoking London Gold for the undisputed reason in the log, "That looks like we can't cope", what he really means is, "I am not the kind of person who would want to be seen as refusing help for those reasons". However, out of arrogance and defensiveness, that is just what he did.

Katharine Hammond sees no failure in the civil contingency system, but only a single unprepared borough in the face of an unprecedented threat. She too has become desensitised to the moral deficits of the regime that she and the secretariat were in charge of at the macro level, and which even in closing submissions you are told responded well.

The lack of human accounting at Grenfell has at least been recognised by some. The British Red Cross, in self-described soul-searching of its own shortcomings, has advocated for a:

"... human-centred response [that] requires all of us to develop new approaches to empower and put people and communities at the heart of emergency response."

Nicholas Hurd's final reflection to this Inquiry was that the state must think differently about the critical distinction of doing things with people rather than things to people. What that should have involved was collaboration with local people and everyday community, respecting their agency and not just their vulnerability, and in a more genuine relationship of equals.

That leads to the subject of real community engagement. Like people, actual communities are also unaccounted for in the system. The framework under the

Civil Contingencies Act limits supportive reach into communities in two main ways that are profoundly outdated. First, communities are not mentioned at all. Second, community interests are indirectly catered for by reference to "the voluntary sector", which section 2(5)(k) of the Act designates as:

"... the activities of bodies (other than public or local authorities) whose activities are not carried on for profit."

However, the Act and regulations only require local authorities to have regard to such activities, no more. The guidance adds only that such organisations must be factored into local civil protection arrangements.

The subsidiarity regime therefore only requires limited consideration of community life. It makes the elitist assumption that organisations like the British Red Cross or the Royal Voluntary Services and places of religious worship will act as the representatives of ordinary people, as if they cannot represent themselves.

The duty to develop community resilience does not exist under the civil contingency regime. Cabinet Office papers described it in 2015 as an "untapped resource", and Michael Adamson puts it in this way: it's essential to "make friends before you

need them". But the law of emergency requires no one to do that. Without a discrete legal duty, the approach of the RBKC management team on this issue was to do nothing.

The so-called minimum standards for London, a misnomer given that these were neither a duty nor in force, only invited councils to seek out local partners and to put a documented strategy in place with a programme of collaborative work. RBKC never had a strategy. David Kerry described such a standard as "aspirational stuff" that "wasn't on our agenda at the time", and unachievable in any pragmatic or sensible way. He could only recall that his team had visited the local Church of England and Catholic diocese, but not the obviously more relevant Al Manaar Cultural Centre in terms of access to the Muslim demographic of Lancaster West. Panel, what community engagement for emergency planning meant for RBKC was tea with the vicar and not with the imam, and nothing more.

What occurred instead on 14 June was therefore self-help, human-to-human community action. In the absence of organised places of refuge and decent information channels in the first days of the disaster, community created them. The key rest centres were not set up by an arm's length voluntary sector, but by

people who congregated in trusted places known to them. When information was routinely taken by the authorities rather than given, BSR began to pool what they knew on social media groups and created their own lists. Volunteer organisations, especially Rugby Portobello and Clement James, willingly hosted, protected and facilitated recovery within their spaces, but they did not do it because RBKC asked them or co-ordinated them with any remote degree of partnership. Parts of the local voluntary community then supported BSR to represent themselves, rather than represent them, and in doing that, they did something more meaningful than the formal and mediating role ineffectively assigned to their sector in the present legal framework.

Once in the crisis of disaster, our opening address pleaded the imperative for outreach to BSR to discover what was needed. The British Red Cross evidence agreed that this absolutely meant to walk the relatively contained grid of streets and make contact with people and places to build links and learn what otherwise wouldn't be known. For the BRC director, what had been overlooked at Grenfell was a lot of social capital in that community, a lot of organisation, a lot of very dynamic people and leaders who already knew each other and actually could have been harnessed more effectively

earlier on in the process. Instead, the various communities came together on their own, but there was profound cost, which BSR have explained to you in their evidence. They have described a traumatic experience for them, their families and, importantly, their children that will never go away. The damage wreaked disproportionate impact on working class people, predominantly of colour, who did not have the money, networks or options others have. It is for that reason that the aftermath and its harm has become a social justice issue for BSR that stands side by side with the causes of the fire.

Turning then to the borough.

RBKC's contribution to the damage done is accepted, but its witnesses have continued to hide from the aggravating features of their wrongs. A fire of this nature would have challenged any council, but RBKC's deep-rooted inadequacies made the situation far worse. It was incapable of leading recovery not just because it was overwhelmed but because it was culpable for the fire, and inhumane because of its long-term disengagement from that estate.

Even with flaws in planning and shortcomings in initial response, a council that enjoyed pre-existing meaningful community engagement would have coped better,

not least by correcting errors in real time based on BSR feedback. But RBKC's relations had degraded over the years. Nicholas Hurd now accepts the very clear impression that was forming quickly on the first day that the council was going to struggle to have the moral authority to lead.

From the beginning, RBKC's leadership understood it would be criticised both for its culpability and its disconnection from Lancaster West. Kerry recalled that sprinklers were quickly on Holgate's mind. Holgate was reluctant for outside PR to be appointed because he thought this would be seen as the act of a guilty party. We have given you the references for when RBKC and TMO deflected blame onto BSRs, central government and the media. Holgate's admissions in evidence of suspicion only, ie prejudice, that BSR instigators were fabricating stories in order to further aims should be seen in its true light, as part of a pattern of bias against BSR amongst senior RBKC and TMO officers.

It is important not to overlook the pre-fire animosity towards Grenfell residents by those with power over them. Laura Johnson had made it clear to the TMO as recently as March 2017 that they would be protected against residents from Grenfell, "the bad tempered place" complaining about "minor matters" with "their own

agenda" who are "not to be taken seriously". In an email on 16 June 2017, she stoked the suggestion that residents would sabotage recovery by assuming without any foundation that Edward Daffarn would lead the Town Hall protests.

Robert Black allowed his TMO staff across the regeneration period to regard Mr Daffarn and Councillor Blakeman as a "negative force", repeatedly warned Blakeman for breaching a purported conflict of interest, and would sack her from the TMO board for her criticisms of it immediately after the fire.

As second in command and the principal adviser to Holgate during the emergency when Kerry was away, Tony Redpath's Inquiry statement is littered with victim blaming. He articulates the view that as the emergency plans were premised on the borough being seen as a positive presence by the affected community, and that turned out not to be the case because people maligned the borough with anger, hatred and blame, then the delivery of effective services in the aftermath was, in his view, not possible.

His fallacious reasoning is exposed by the principal issue. RBKC did not immediately act on nor plan for its own conflict of interest, firstly in being culpable for the fire and, second, in long-term conflict with

residents over low-quality works and fire safety standards. Cumulatively, this combination of defensiveness and prejudice rendered Holgate preoccupied with appearing to retain control of the response, rather than activating the massive London support that was needed. Although he resisted this in evidence to the Inquiry, he was obviously concerned with optics, reputation and blame, and for that reason issued improper reassurances well into the Thursday evening and beyond.

On incompetency, we say that contingency planning in RBKC was a low-priority function, presided over by a traditional Town Hall staffing structure, one which lacked in diversity and showed disinterest in humanitarian issues. Priestley and Redpath line-managed Kerry without expertise in their own right, and no experience to carry out the roles expected of them after the fire. Holgate had neither real experience nor training. Kerry progressed through the ranks of contingency management largely due to serving time in the area, rather than as a result of developing expertise through education, training or experience. He combined long years in post with evident ability to speak the Cabinet Office lexicon, and to navigate the convoluted byways of London Resilience, acquiring the

status of official adviser when his abilities clearly did not merit that role.

By contrast, Rebecca Blackburn, educated, younger, female and less deferential, shone a light on the weakness of the service. She rightly regarded Kerry as overly bureaucratic and organisationally conservative. She had repeatedly pointed out the risks associated with the failure to conduct exercises to test the adequacy of the contingency management plan and the cadre of volunteers, both of which she thought the borough was doing "the very least we had to do". She correctly predicted to superiors that Kerry would not cope in the event of a major incident. Redpath told her to defer to her manager's experience. She understood the role of the team was not just to put the plans in place "and make sure we looked good on paper", but to ensure the organisation was able to respond effectively.

Rather than have these issues addressed, Blackburn was seconded out of the team for 18 months. As of June 2017, she was the outlier in her workplace, and stood out for a relative competence during the crisis. Many of the leading personnel leaned on her capability. Meanwhile, Kerry broke down from exhaustion by the first morning. Thereafter, he left inexperienced colleagues profoundly exposed to operate the day shifts and did

painfully little himself during the nights.

Proper prior monitoring would have shown that local government was chronically unprepared. As a result, RBKC made fundamental mistakes in the first 48 hours following the fire, from which it never recovered. Kerry was embarrassed by his own phrase, "We were what we were, we did what we did", but it revealed the truth. His many years preparing for an emergency could not ready the borough for anything more than a bus crash on the high street or a minor fire.

Finally at the level of borough, for all its self-aggrandising descriptions of being a resident democracy, the TMO's contribution to the emergency response was essentially reduced to providing delayed, incomplete and inaccurate information on residents, and conducting delayed and inconsistent repairs for the walkway blocks. Thus, in the aftermath, any pretence the TMO had in being a representative and functional organisation, and one that was well integrated within its community, simply fell away.

Turning, then, to the view from regional government.

Beneath the complexity, branding and multiple stakeholding of London Resilience lies the void that a major capital city does not have its own emergency agency. Instead, it has a duty rota system of

chief executives available to provide ad hoc advice from a London-wide perspective, with additional bodies with various acronyms able to provide guidance and support, but without power or intent to discharge an emergency recovery function.

The required leadership at Grenfell by a selection of London civil contingency specialists was therefore delayed because RBKC did not ask for it and London Local Authority Gold had no power to impose it. The stages by which the hierarchy of London Resilience delayed even advising Nicholas Holgate that there was a serious problem nevertheless reflects the fundamental shortcomings of the subsidiarity system.

At first they kept their distance because the London Gold function, in Hetherington's words, was limited to scenarios requiring pan-London participation, and on subsidiarity doctrine grounds, the local chief executives were deemed to know better how to use his resources. This led to offers of help without insistence, with RBKC taking none of them up.

Soon, London Resilience became complicit in RBKC's incompetence. By taking the council's assurances at face value, they supported RBKC to continue to lead when it could not. Damage was particularly done by the telephone call between Holgate and the key London

figures at 5.30 pm on 14 June. The discussion extended to facilitating political support for a council that needed, in Holgate's words, to be given a chance to do its job, and in circumstances where public criticism in the febrile post-election political climate was, as Hetherington assessed, starting to swell.

After the call, Hetherington commended Holgate to be "extremely ... logical and sensible [and] going through the right steps". Barradell registered "a relatively positive picture ... that they were within their capability [and] within their capacity". Sawyer held back from what he saw as "a chief exec to chief exec call".

John Barradell accepts now that he should have been far more assertive in testing what he was told. At the time, no one confronted the obvious: RBKC would never succeed alone, and a potentially culpable London landlord should not be leading on recovery.

During the second day, complicity moved to disquiet, not just about events in Grenfell, but about London's role. Across regional and central government it became clear that RBKC could not do the job, but the emails of Thursday night still speak of John Barradell planning to visit RBKC offices the following day on a scoping exercise, with great uncertainty as to what London

Resilience would actually do.

There was never a formal letter sanctioning Barradell taking control. Instead, there was an email sent by Hetherington to London chief executives on behalf of Holgate and Barradell at 13.27 on 16 June that:

"Following a request from RB Kensington and Chelsea for strategic support ... the London Local Authority Gold operations have been activated."

This is the document that RBKC relied on in their opening as making clear that the formal transfer to London Gold had been completed by 13.27 hours on 16 June when Hetherington sent that email.

The email does not say in terms that Barradell has taken over, many people did not realise he had, and Nicholas Paget-Brown was told about it at lunchtime, rather than ordering it. The decision was never put to cabinet or council or formally endorsed by reference to any legal framework.

What in fact happened on the Friday is that Jo Farrar arrived from DCLG in late morning to find Barradell still in a support role. Armed with a mobile phone to call the chief executive of London Councils and then text her Permanent Secretary, Farrar essentially improvised a takeover of RBKC recovery in the corridor

outside Holgate's office.

The press release issued on the Saturday evening condemned the initial response as "simply not good enough" and introduced the new Grenfell Tower response team. This was not London Local Authority Gold; it was a joint creature of regional and central government. Whatever improvements it made in the long run, the power of this improvised construct was founded upon the barest of legal foundations.

The Inquiry needs to reveal the extent of this improvisation so that Londoners and others do not live under the assumption that there is a rigorous, organised regional emergency service that will kick in when needed. Likewise, London Resilience and central government leadership share responsibility for hitherto tolerating the absence of a genuine mechanism that could scale up response when humanitarian predicament made it necessary.

Viewing the disaster through the lens of people and community up through the layers of state truly brings home that the UK does not have a disaster management system. The major flaw of the existing Civil Contingencies Act requires its unjustifiable gamble on a given local authority being sufficiently effective in its preparation, especially in the aftermath of

a place—specific disaster that has led to mass displacement of socially, economic and otherwise disadvantaged populations. Grenfell has shown how subsidiarity provides central government with great discretion even when the system is manifestly failing.

First, government departments are not scheduled responders under the CCA. That leaves them with various powers but not duties. Powers include that government can make orders to require or permit responders, third parties or itself to take action, with such orders subject to affirmative resolution by parliament. However, in a case of urgency, a minister may make a written direction to act in place of orders that remain in force for up to 21 days and which require no prior legislative consent. Before and during the Grenfell aftermath, these powers lay unused, and instead Holgate had a new system pushed upon him in that corridor.

Second, central and regional government had no means of effectively predicting the resilience of the local government response because there was no national inspectorate or oversight function, and there still isn't. It is especially untenable that subsidiarity should prevail without proper independent auditing and inspection. That left RBKC not on the radar of DCLG's

RED team; Barradell, by his own admission, being overly impressed by RBKC's positive posture; and Sawyer being ignorant of the weakness in RBKC's system until he physically attended the Town Hall.

Third, the lack of accountability of contingency planning places ordinary people at risk because they cannot easily complain to courts. Any public law challenge to state failure in response and recovery would face litigation difficulty, in that the executive is legally regarded as enjoying a discretionary area of judgement in the governance of security and emergency.

Sir Martin, with respect, will know as a judge that a 5.30 application for interim relief on that Wednesday afternoon would have got pretty much nowhere. What that means is that if planning does not take place in an effective and accountable way beforehand, then once the emergency begins, people and communities are dramatically exposed to the discretion of the state, particularly when it collapses in its function.

Without its own planning and conduct duties under the CCA, the cabinet secretariat and DCLG were able to play by their own rules and, on that basis, they floundered, because they did not appreciate in time that the system had crashed.

Hammond has convinced herself that a pick—and—mix

approach to the central government concept of operations, ConOps, made no difference. We disagree. ConOps requires a formal assessment of large—scale emergencies to establish whether severity levels require government intervention via COBR and in accordance with a set of policy actions. Those actions include joint operations with local responders and sharing in the provision of information to the public. That is what the civil contingencies secretariat should have co—ordinated and they failed to do so. As Dawes would put it to the Cabinet Secretary, once the event was recognised as "more complex than 7/7", there was "one clear lesson: we should have had a PM—chaired COBR on [Wednesday]". That must be correct, and rather than mere branding, as the Cabinet Office now suggest, the consequences were stark:

First, a minister—led meeting limited the weight of oversight to a junior minister in Nicholas Hurd, two days in office, who had no relevant experience.

Second it sent a key message to local responders that central government oversight vested in junior ministerial monitoring as opposed to senior prime ministerial and cabinet—level intervention.

Third, it stalled the extent of cross—departmental assessment and common understanding of the magnitude of

what was going on.

Fourth, it allowed government to maintain a stance of expecting to be asked for assistance rather than proactively seeking it or imposing it.

Fifth, government was ridiculously hands—off with Holgate on the first day, so much so that no one important even noticed his non—attendance at the first ministerial meeting.

When government intervention finally came, it did so through Jo Farrar in the Town Hall corridor. No official direction or orders were required. Whatever benefits derived from this informal seizure of power, the event cannot be regarded as evidence of the subsidiarity resilience system working well, as has been portrayed to this Inquiry. Neither should the CCS be content with the quality of its co—ordinating oversight and expert advice across the days of the emergency. CCS has been critical of RBKC's lack of grip, but as Melanie Dawes accepted, the failure to grip the situation extended to central government and could have been prevented if it had been clearer in the way that central government systems and decisions operated.

The policies and lexicon of the Cabinet Office and London Resilience involve only a few stakeholders who speak the language of resilience subsidiarity. Like all

specialist languages, it can have implications for separating the speaker from others. But this language risks being particularly disconnecting especially here, where it caused officials in Whitehall and London to view themselves primarily as allies in waiting to the subsidiarity state below them, rather than in humanitarian service to people and community.

This last evidence-gathering module for the Inquiry has followed several years of investigating industry and government. For you to have heard BSR evidence is a profound reminder that the foundation of government, economics and law should be the people. Respect for the inherent dignity of people did not function as an overriding objective in the bureaucracies that dealt with BSR before, during and after the fire. The rationalist professional outlook of modern bureaucracy has taught itself to be distant and disconnected from people and communities, and especially those who may be marginalised on grounds of class, race and disability. The damage done by such discrimination is profound. It is antisocial. What is needed is the discipline and practice of respecting dignity as a fundamental feature of what it means to be in civil, political and social service.

People suffered in the aftermath of Grenfell Tower

because of an inhumane borough, but that suffering was also caused by the design of the civil contingency system and its ambivalence towards equality and human dignity. The fact that this Inquiry is not a commission into social housing or the future of the welfare state should not stop it from reporting on how government became anti-social in its indifference, and how that indifference caused the people who lived, survived or lost loved ones from this fire to pay such a terrible price.

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

The next statement is going to be made by Mr James Maxwell-Scott Queen's Counsel on behalf of the Royal Borough of Kensington and Chelsea.

So, Mr Maxwell-Scott, when you're ready, we shall be pleased to hear from you.

Module 4 closing submissions on behalf of the Royal Borough of Kensington and Chelsea by MR MAXWELL-SCOTT

MR MAXWELL-SCOTT: Mr Chairman, Ms Istephan, Mr Akbor, the council had a central role in this module, not because it was the owner and landlord of Grenfell Tower, but because, as a local authority, it was a category 1 responder under the Civil Contingencies Act. This meant that, in the event of an emergency within the borough, it was expected to take the lead in providing

rest centres, welfare, and other forms of humanitarian assistance. The council was also under a duty to undertake contingency planning.

The Inquiry called six witnesses from the council in this module. Although none of them had read the council's opening statement before it was submitted to the Inquiry, the evidence of each of them was consistent with the admissions made in it. The council's chief executive at the time expressly stated that he accepted all the admissions made by the council in that opening statement. We invite the Inquiry to find that all six witnesses gave their evidence candidly and did their best to assist the Inquiry.

As you know, the council has made a commitment to candour. In the light of it, we have reviewed the entirety of the opening statement. The council's position is (1) that it remains factually accurate and (2) that it stands by all the admissions made in it.

In the course of reviewing the opening statement, and the evidence heard in this module, the council has identified further areas where it fell short, and therefore considers that it should make further admissions.

The admissions which it considers it right to make

are set out in full in its detailed written closing statement. At this stage, I will identify some of the most significant admissions which the council makes in this module:

The borough emergency command centre should have been operational in the Town Hall earlier than it was. It should have been more organised and efficient than it was. There were times on 14 June when it was overwhelmed.

Council officers should have been deployed to premises known to be operating as rest centres earlier than they were.

The council failed to have in place an adequate system for registering the details of individuals.

Nicholas Holgate should have activated the London Gold arrangements earlier than he did.

These are all new admissions; they are made in the light of the evidence heard during this module.

The following admissions from the council's opening statement are worth repeating at this stage:

There should have been more internal reporting up the management chain by the contingency planning team.

There should have been greater oversight by the council of that team, and of the council's emergency response capability.

The council should have had a humanitarian assistance plan.

The arrangements which the council had in place before the fire failed to set out how different parts of the council would co-ordinate their communications.

The council failed to provide the public with clear, consistent communications and, as a result, individual residents missed out on receiving support to which they were entitled.

The council had not trained enough rest centre managers.

The council did not run an adequate number of emergency response training events and exercises. There was insufficient attendance at the training events and exercises that were held.

These failings were not technical or abstract failings of procedures and processes; they were failings that had a real and detrimental impact on individuals. The council fully acknowledges this. This is why we included in our closing statement some examples of the impact on the bereaved, survivors and residents.

The council acknowledges that its failings had a disproportionate impact on people from diverse backgrounds and people with disabilities; for example, people who were fasting because they were observing

Ramadan, people for whom English was not their first language, people with specific accommodation needs. The council apologies unreservedly for its failings.

The council has made changes since the fire. We identified some of them in a document served shortly before the oral opening statements, and I outlined some of them in my opening statement. You will recall that these changes were in a wide range of areas, including oversight of contingency planning, communications, community engagement, training and exercising. The council is committed to making improvements and changes continue to be made. We will update the Inquiry further in the recommendations part of Phase 2 later this year.

Finally in this introduction, I would like, on behalf of the council, to thank a number of people: all the people from the local community and further afield who assisted at a time of great need; all the local community organisations, faith groups and charities who worked with the local community to deliver that assistance; and those councillors and council officers who worked long hours and willingly took on challenging tasks.

There are five topics which I will address you on today. They are: (1) activation of the contingency

management plan; (2) problems experienced by the bereaved, survivors and residents; (2) activation of the London Gold arrangements; (4) the impact of the council's failings; (5) the future of emergency planning in London.

My first topic is the activation of the council's contingency management plan. David Kerry was informed about the fire shortly before 2.30 am. He took on the role of Council Silver and began to activate the council's contingency management plan. As Council Silver, he was responsible for determining the level of the council's initial response. Rather than mobilising all relevant officers in the middle of the night, he opted for a more gradual mobilisation. This was because he wanted to reduce the risk of them being tired later in the day, when he felt they might be needed more. One noticeable feature of Kerry's evidence was that he did not turn on his television or see any visual images of the fire for some hours. Had he done so, he would have taken a different approach and would have initiated the highest possible level of response.

Looking objectively at the issue of the activation of the contingency management plan, the council admits that the borough emergency command centre should have been operational in the Town Hall earlier than it was.

The council also admits that council officers should have been deployed to premises known to be operating as rest centres earlier than they were.

Council witnesses who spent time in the borough emergency command centre were asked about how effectively it operated once it was set up. In the light of their evidence, the council admits that it should have been more organised and efficient than it was. The council also admits that there were times on 14 June when it was overwhelmed.

I turn next to the problems experienced by the bereaved, survivors and residents, starting with what happened at rest centres on 14 June.

Officers did not start arriving at the Rugby Portobello Club or the Clement James Centre in significant numbers until around 10.00 am. By then, both had been up and running for several hours. Many of the bereaved, survivors and residents gave evidence about the situation in those rest centres on the morning of 14 June. The picture that emerged was one of confusion, disorganisation, lack of visibility of council officers, and lack of leadership from the council. The council's admitted failings were a significant cause of these problems.

The council had not trained enough rest centres

(sic) before the fire. On 14 June, it did not deploy enough officers of sufficient seniority to rest centres. It deployed officers to rest centres later than it should have done.

The council's plans placed too much reliance on the British Red Cross. An example of this is the registration of individuals at rest centres and at the Westway. Registering individuals was ultimately the responsibility of the council. The fact that local community organisations and the British Red Cross assisted in attempts to record the details of individuals did not alter that position. The council admits that it failed to have in place an adequate system for registering the details of individuals. The lack of an effective registration system and the council's admitted communications failures were two major underlying causes of problems experienced by some of the bereaved, survivors and residents during the first seven days.

A small number of Grenfell Tower residents were not told, but should have been told, that the council was offering them emergency hotel accommodation on the night of 14/15 June. Some residents were allocated hotel accommodation that was not suitable for their personal circumstances. There was inconsistency in the

information provided by the council to residents. Some residents were not aware of the full extent of the support which the council was offering. As a result, some residents, through no fault of their own, missed out on elements of the support package which they were eligible for and entitled to receive. One example of this is the fact that some residents were not aware of the full range of services they were entitled to receive while they were staying in hotels. Another example is that some residents were not aware how much money they were entitled to and did not receive as much as they should have done.

The council deeply regrets the problems experienced by the bereaved, survivors and residents and apologises to them.

My next topic is the activation of the London Gold arrangements.

In our opening statement, we suggested that the terminology used in relation to mutual aid could give rise to confusion. What became clear during the hearings in this module is that the terminology used to describe the activation of the London Gold arrangements also gives rise to confusion. The reasons for this are simple: a chief executive from one borough taking over the leadership of another borough's emergency response

was something that had never happened before and, under the terms of the Gold resolution, was never intended or expected to happen.

If one puts the confusing terminology to one side, it is possible to identify four key stages in the council's reliance on assistance from other London local authorities.

The first was before 9.00 am on 14 June, when the council began to receive assistance from its tri-borough partner, the London Borough of Hammersmith and Fulham. The evidence suggests that it was supplying the council with rest centre managers by 8.30 that morning.

The second stage was the email sent by the council to the London Local Authority Co-ordination Centre just after 4.30 on the afternoon of 15 June. During the hearings, Hetherington agreed with our analysis that this was the first request by the council to LLACC for mutual aid. As such, it represented activation by the council of the London Gold arrangements.

The third stage was reached about an hour and a half later, following the telephone call between Holgate and Barradell. By that point Holgate had activated the London Gold arrangements to the full extent envisaged by the London Gold resolution.

The fourth stage was what happened at 2.00 pm the next day. Barradell took over leadership of the council's response from Holgate and became the local authority Gold Commander. As I said earlier, nothing like this had ever happened before. According to the arrangements which existed and still exist within London, it is something that was never meant to happen.

Going back to the beginning, the council's position is that Holgate was right to take on the role of Council Gold on 14 June. He was the most senior officer employed by the council and, under its contingency management plan, was expected to be Council Gold. It was clear from his evidence that Holgate believed that it was his duty to lead the council's response to the fire.

Having reflected on the evidence heard in this module, the council's position on the activation of the London Gold arrangements is as follows:

1. Holgate should have activated the London Gold arrangements earlier than he did.

2. With the benefit of hindsight, one can see that Holgate focused too much on operational considerations at the expense of strategic ones. If he had found or made more time to reflect on strategic considerations, it is likely that he would have activated the

London Gold arrangements earlier.

3. Holgate should have done so at some point after the 17.30 meeting on 14 June. We have identified this time rather than an earlier time because of the following factors, each of which would legitimately have discouraged him from activating the London Gold arrangements earlier than that.

First, the fact that activating London Gold had historically happened so rarely.

Secondly, the viewpoint commonly held within London at the time that the London Gold resolution was more pertinent to an emergency which affected several local authorities than one which was geographically limited to a single borough.

Thirdly, the council's contingency management plan encouraged the view that activating London Gold was not a step intended to be taken immediately.

Fourthly, the existence of the tri-borough agreement meant that the council would more easily be able to draw on resources from two neighbouring local authorities.

Fifthly, nobody involved in the conference call with Holgate at 5.30 pm on 14 June advised him that he should activate the London Gold arrangements. The evidence was that activation was not discussed.

Sixthly, Hetherington's evidence was that he

personally did not think that Holgate's decision was wrong. At the time, Hetherington was the deputy head of London Resilience. He has been head of it since 2018. His views, therefore, carry weight.

So that is the council's position and the reasons for it. I end this topic by making it clear that the council stands by the admission made in its opening statement that its leadership was unable to cope in the days after the fire.

My next topic is the impact of the council's failings.

Mr Chairman, as you know, our written closing statement contains a lengthy section entitled "Reflections on the impact of the council's admitted failures". Today I'm not going to repeat the detailed analysis in that section, but I'm going to summarise the key points.

There are two main themes. The first is that, had the council performed to the level that it should have done, the experiences of the bereaved, survivors and residents would overly have been significantly better during the first seven days. The second is that it would be unwise to assume that everything would have been fine if only the council had performed to an adequate level. That sort of thinking breeds

complacency about the robustness of the current national and local system for dealing with emergencies. It also runs the risk of ignoring an excellent opportunity to learn valuable lessons for the future.

Taking the first theme first, the following are important respects in which an adequate level of performance by the council would have significantly improved the experiences of the bereaved, survivors and residents during the first seven days.

First, training.

The council has made substantial admissions in relation to its programme of training and exercises. It fully accepts that its response would have been better if it had conducted training and exercises to an appropriate standard. The following measures which should have been in place would all have assisted in improving the quality and effectiveness of the response: (1) a formal training programme for Council Gold, Council Silver, and officers who worked in the borough emergency command centre; (2) more senior officers trained as Council Gold; (3) more trained BECC officers; (4) more training events; (5) a higher level of attendance at training events; (6) more trained rest centre managers; (7) a training programme which ensured that the contingency management plan was

exercised at all levels at least once a year.

Second, rest centres.

Getting both more people and the right people to rest centres earlier on 14 June would have made a real difference at a crucial time. More trained rest centre managers would have made a difference. In the absence of a trained cohort of such managers within the council, the deployment of senior council officers in greater numbers and at an earlier time would have made a difference. The full deployment of the council's crisis support team would have made a difference. Earlier deployment of the housing officers and social workers who arrived at around 10.00 am would have made a difference.

Third, communications.

Having a communications plan in place which was fit for purpose and had been exercised would unquestionably have improved matters. Had the council's communications function performed at an appropriate level, the number of residents who, through no fault of their own, missed out on elements of the support package would undoubtedly have been reduced.

Fourth, better pre-existing relationships with local community organisations.

It was clear from the evidence heard in this and

other modules that community was very important to the residents of Grenfell Tower, the Lancaster West Estate and North Kensington. Local community organisations played an important part in building that sense of community and supporting its members. Many local community organisations had been providing valuable support to local residents for decades.

The council has previously acknowledged that it did not listen to residents as much as it should have done. The council should have done more before the fire to build effective relationships with local community organisations and residents and to include them within its emergency plans. Had it done so, it would have been better placed to co-ordinate and direct local community organisations. This would have addressed the problem described by many witnesses of local community organisations being willing and able to help but experiencing a lack of overall direction from the council.

I now turn to my second theme: that it would be unwise to assume that everything would have been fine if the council had performed to an adequate level.

There were many respects in which the support provided to the bereaved, survivors and residents could and should have been better. In our submission, it is

appropriate to ask the question whether what went wrong was specific to RBKC, or whether some elements of what went wrong reveal problems with the systems in place across London as a whole at the time. Only by engaging with this question can one ensure that anyone caught up in a disaster on a similar scale in London in the future is better served and supported. Only by engaging with this question can one ensure that all relevant lessons are learned.

In our written closing we have done a detailed analysis of respects in which what went wrong revealed wider problems. What I'm going to do now is to summarise the main points of that analysis of the wider problems. I will summarise points relating to emergency planning before turning to points relating to the response to the fire.

Point 1: how the council's contingency planning team compared to that in other London local authorities. In our submission, the size of the team was fairly normal and all members of the team were suitably qualified and experienced.

Point 2: reporting and oversight. In practice, the council's contingency planning team reported in more detail to London Resilience than it did to the council's senior management. This reporting was done through the

minimum standards for London system. In reality, the phrase "minimum standards for London" was somewhat misleading. The way the minimum standards for London system worked was as follows: each year, every local authority in London would send London Resilience its self-assessment of how it should be scored against the so-called minimum standards. In one year out of two, that self-assessment was peer reviewed by members of the sub-regional resilience forum. Regardless of whether it was peer reviewed or not, the scores were converted into a traffic light format. So, for example, in 2016, each local authority ended up with approximately 35 separate ratings of red, amber or green.

The reason why we say that the phrase "minimum standards for London" was somewhat misleading was that London Resilience expressly stated that "it was never intended or expected that the MSL would be 100% green in all boroughs". So local authorities were not expected to comply with all the minimum standards. But it goes beyond that, because there was no minimum number of minimum standards which an individual local authority was required to meet, and there was no mechanism available to London Resilience or any other pan-London organisation to take action to improve the performance of a local authority which was getting large numbers of

reds and ambers. In 2016, which was a peer review year, RBKC achieved one red, seven ambers and 25 greens. This was far from the worst performance. One local authority achieved three reds, 16 ambers and 16 greens. Yet the evidence heard in this module was that London Resilience had no power whatsoever to enforce the minimum standards.

Point 3: emergency plans. Emergency plans are not procedures or protocols, they are plans. They represent attempts to plan for how best to address unlikely future events of an unpredictable nature. Written protocols and procedures are appropriate for tasks which arise frequently and which benefit from being carried out in the same way on each occasion. Major emergencies are rare, and no two emergencies are alike. An effective response to an emergency requires flexibility and the ability to adapt pre-existing plans to fit the situation being faced.

Point 4: training. Training raises similar issues about the need for flexibility. Training is important. I would go further and say that it is essential. But it would be naive to think that an adequate programme of training and exercises will prevent all problems. However hard one tries to make training exercises realistic, they can never replicate the experience of

a real-life emergency. Training exercises are not a substitute for first-hand experience. But many people working in senior positions in local government will not, through no fault of their own, ever have had to respond to an emergency. It would be highly unusual and resource-intensive to create a scenario for an exercise which was realistic and on the scale of the Grenfell Tower fire. The only exercise we are aware of which fitted both of those criteria was Exercise Unified Response in 2016. That was a London-wide exercise which took two years to plan.

As can be seen from the London risk register, there is a wide range of potential emergency scenarios. Although it did not identify a tower block fire as a risk, it did identify flooding, drought, storms, heatwaves, aviation accidents, public disorder, terrorist incidents and rail strikes, to name just a few. It is quite simply impossible to train for all potential emergency scenarios, and there is no expectation that local authorities will do. The system is premised on the idea that staff who have exercised one scenario will have the flexibility to apply their skills and training to what may be a very different scenario.

Point 5: information about persons who may be

vulnerable following an emergency. This is an area where there is a significant gulf between what people understandably believe the national system should be and the system itself.

In 2017, no local authority was expected to maintain a consolidated master list of every vulnerable person in the borough. The relevant Cabinet Office guidance stated that it would be impossible to maintain a central up-to-date list of vulnerable people. Emergency planning in respect of vulnerable persons has proved to be a long-running challenge across London. Hetherington told the Inquiry that the problem had still not been cured, and that an interagency data-sharing agreement was still being worked on.

Point 6: local community organisations. The council has admitted that it should have done more before the fire to build effective relationships with local community organisations and to include them within its emergency plans. The context to this admission is that very few council officers lived within the borough, whereas local organisations had been embedded within the North Kensington community for decades. These local factors increased the need for the council's emergency plans to include and make use of the capabilities of local community organisations.

This should not disguise the fact that the level of engagement with the voluntary sector required by legislation was low. Regulation 23 of the 2005 regulations states that category 1 responders must have regard to the activities of voluntary organisations. This is a most vaguely phrased obligation which sets the bar extremely low. It was notable but unsurprising that several of the witnesses called from community and voluntary organisations emphasised the need for more legislation to address this issue.

I now turn to points relating to the wider problems in relation to the response to the fire.

I start with what is the logical starting point: the implications of how events unfolded in the first few hours.

People who fled from the tower did so in all directions. They did not have their details recorded systematically inside the cordon. Once outside the cordon, if they were not taken to hospital, they were free to go wherever they wished. Many made their way to local premises that had opened as unofficial rest centres. At least five such unofficial rest centres had opened and provided support to residents by 9.00 am. This turn of events had the following implications:

Implication 1: it would never have been possible for

the council or indeed anyone else to have ensured that there was at all times a single rest centre.

Implication 2: reaching a point where there was a single official rest centre was desirable, but the transition to that point was always going to be difficult.

My next point, my second point, is about communications, which are incredibly important in an emergency. Even with a good plan and a good team, effective communication in an emergency is a challenge. In our submission, whoever was tasked with communicating the message about available humanitarian assistance would have faced the following challenges: the challenge to be heard; the challenge of reaching all residents; the challenge of communicating an accurate and up-to-date message in a situation that was inevitably fast-moving; the challenge of resources being diverted to address questions which were understandably being posed about the causes of the fire; the challenge of resources being diverted to address questions about the effectiveness of the response to the fire; the challenge of dealing with negative sentiment and, in some instances, hostility.

My third point is about individuals, registration of individuals and sharing information about vulnerable

persons. Michael Adamson, the chief executive of the British Red Cross, told the Inquiry that data sharing is always an issue. Creating a comprehensive list of individuals and then making best use of the information in it would always have been a complex task. This is particularly so given that people who fled from the tower did so in all directions: some went to one unofficial rest centre, some went to another, some went to multiple centres, and some went to family or friends and did not go to any centres.

Moving, then, to the related issue of vulnerable persons. The expectation at the time would have been that the council adopted and followed the list of lists approach. The list of lists approach has two inherent limitations. First, it will not produce information instantly. Even in circumstances in which it works as intended, there will be some delay in information being provided. Secondly, it is unlikely that the information provided will be completely accurate and up to date.

My fourth and final point is about the activation of the London Gold arrangements. If one wants to assess how robust the system was, one has to consider how the arrangements were meant to operate, rather than the unprecedented course that events took. If Holgate's activation of the London Gold arrangements had followed

the hypothetical normal case, there would have been no takeover by Barradell. Holgate would have continued to lead the council's response to the fire with support from whichever chief executive happened to be on the on-call rota at the time.

Drawing the threads together, three overarching themes emerge. The first is that there is always a gap between what survivors and residents need and expect and the level of response a local authority can achieve in the first 24 hours. The second is that the solution to addressing those needs and expectations was not found by carefully implementing the existing framework within London; it was found by operating outside of the existing framework, by breaking boundaries and by people, in effect, making up a new framework as they went along. The third is that, in the event of a large-scale emergency in London, even one confined within a single borough, it is highly likely that the local authority will need to rely on assistance from other London local authorities.

This brings me to my final short topic: the future of emergency planning in London.

The evidence heard in this module has revealed serious limitations in the formal arrangements that existed within London for responding to an emergency of

the complexity of the Grenfell Tower fire. In our submission, serious consideration needs to be given to improving the London-wide arrangements for contingency planning.

Because there will be a separate recommendations part to Phase 2 of the Inquiry, I don't want to go into too much detail today about what changes might be desirable. We will make detailed submissions about recommendations in accordance with the Inquiry's request at the relevant stage later this year. However, I can indicate at this stage that, in our view, careful consideration should be given to the following three ideas: having a cohort of persons trained and available to provide urgent humanitarian assistance 24 hours a day across London; greater external oversight and auditing of the emergency planning capabilities in London; improving the training of those on the London Gold on-call rota.

The council is very conscious of the recent anniversary. Although this is the aftermath module, it does not address events that took place after 20 June 2017. The council is fully aware that the aftermath of the fire did not end on that day. The bereaved, survivors and residents continued to experience the impact for many weeks, months and years.

Many of them still experience the impact today.

The council apologises for its failings in pre-planning and in its response to the fire.

I would like to finish with what its leader, Elizabeth Campbell, wrote in her open letter to mark the fifth anniversary. She said:

"I want you to know that I am deeply sorry for the council's failings and the suffering that so many people experienced at Grenfell and in the aftermath."

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

The next statement is going to be made on behalf of the London Fire Commissioner, but that, on the timetable, will be at 2 o'clock. I think, given the time that we've now reached, the right course would be to adjourn at this point, and we'll resume at 2 o'clock, please.

Thank you very much.

(12.52 pm)

(The short adjournment)

(2.00 pm)

SIR MARTIN MOORE-BICK: Now, the next statement is going to be made by Ms Emma Collins on behalf of the London Fire Commissioner.

Ms Collins, if you would like to come up to the

lectern, we'll be pleased to hear you. Thank you.

Module 4 closing submissions on behalf of the London Fire Commissioner by MS COLLINS

MS COLLINS: Thank you.

Good afternoon, sir, Ms Istephan and Mr Akbor.

The London Fire Commissioner is acutely aware of the suffering and distress of the bereaved, survivors and residents in the aftermath of the fire, having heard about their experiences in his meetings with the Grenfell community groups, and again in their powerful evidence in Module 4. Their experience shows that the framework for responding to emergencies in London failed them in the aftermath of the fire.

In these brief closing submissions on behalf of the London Fire Commissioner, we wish to start with a general point about the role of the London Fire Brigade within the resilience framework, before touching upon two issues arising from the evidence as it developed throughout Module 4: first, the role and function of the London Resilience Group; and, secondly, the critical importance of accurate information gathering and sharing.

The London Fire Brigade fulfils two functions within the resilience framework. Firstly, and most obviously, its role as a category 1 responder under the Civil

Contingencies Act, which requires no further explanation or discussion for the purposes of this module.

Secondly, together with the Greater London Authority and London local authorities, the London Fire Commissioner jointly funds and governs the London Resilience Group to act on their behalf to co-ordinate and support resilience in London.

The Fire Brigade acts as the host of the London Resilience Group, which means that it employs London Resilience Group staff and provides them with their office space at London Fire Brigade headquarters, with all of the administrative and human resource support that comes with that. But the cost for that is split between the three organisations who fund the London Resilience Group, as I have explained: the Fire Brigade, the Greater London Authority and London local authorities.

I don't propose to rehearse the foundation and development of these arrangements, which were touched upon in our opening written statement and also that of the Mayor of London, and also dealt with in detail in the witness statement of John Hetherington.

What I do wish to touch upon, which leads to the first issue arising from the evidence, is the remit of the London Resilience Group.

At times in Module 4 there was a tendency by witnesses to conflate or confuse the component parts of London Resilience, the brand, as John Hetherington described it in his evidence to the Inquiry. This in turn risks creating or fostering confusion about the scope of the London Resilience Group's remit.

By way of clarification, and I hope not undue repetition, the broader London Resilience term or brand encompasses three elements: first, the London Resilience Forum, which is, as you know, a local resilience forum within the meaning of the Civil Contingencies Act, which is chaired by the deputy mayor for fire and resilience, and which is responsible for setting the strategy and objectives for resilience in London; secondly, the London Resilience Partnership, which is a term, rather than an entity as such, which groups together all the agencies involve in emergency response and preparedness, including category 1 and 2 responders; and, thirdly, the London Resilience Group, which, as I've already stated, is tasked with supporting and co-ordinating resilience in London. It does this principally by carrying out three related functions: first, it provides business and secretariat support and administrative structure for the London Resilience Forum; secondly, it provides support for the London Local Authority Gold arrangements, which

are governed by the London local authorities panel; and, thirdly, the London Resilience Group provides the secretariat for the strategic co-ordination group, a multi-agency group established when a major incident has been declared.

The London Resilience Group is a team of approximately 20 people, currently headed by John Hetherington, who was one of three deputy heads at the time of the Grenfell Tower fire, all of whom were involved in supporting the response; indeed, the entire staff was involved in supporting the response to the Grenfell Tower fire. He attended the Inquiry to give live evidence during Module 4, in addition to the comprehensive and detailed witness statements and numerous exhibits that he provided. The detailed witness statements of his colleagues, Toby Gould, Matthew Hogan and Hamish Cameron, were also read into the record. Those statements revealed the scale and intensity of the work carried out by London Resilience Group in supporting and co-ordinating the work of those London Resilience partners with emergency obligations in the aftermath of the Grenfell Tower fire.

By its very nature, the work of the London Resilience Group does not involve deployment of personnel on the ground or any active involvement in the

operational response or its overriding strategy. In general terms, the London Resilience Group's work in the aftermath of the fire included, firstly, providing the secretariat for the strategic co-ordination group, which was led by the Metropolitan Police Service, although the initial meeting was chaired by the London Fire Brigade, and that group met multiple times a day in the first week after the fire. It also provided varying degrees of support for the various sub-groups established in support of the strategic co-ordination group, and that included the London Resilience communications group, the humanitarian assistance group, the mass fatalities co-ordination group and the scientific and technical advice cell.

In addition, the London Resilience Group supported the London Local Authority Gold arrangements. Those arrangements and the nature and timing of their invocation in the immediate aftermath of the fire were the subject of extensive questioning in Module 4. It's important to be clear that the London Resilience Group is not responsible for the decision as to when and how the LLAG arrangements are activated, but rather it assists in bringing together and updating the key players, whilst setting up and co-ordinating the London Local Authorities Co-ordination Centre, or LLACC, to

support them. As John Hetherington described in his evidence, in its paradigm form, there was no pseudo-organisation of London Local Authority Gold that had access to any greater resources than were already available to any other borough at a time of incident that they could ask for directly themselves.

When the Inquiry considers the initial views of the London Resilience Group as to the actions of the Royal Borough of Kensington and Chelsea and the need to activate the LLAG arrangements, it may wish to bear in mind the narrow scope of the LLAG arrangements in principle, rather than the more expansive shape they ultimately took.

As John Hetherington described in evidence, the Grenfell Tower fire represented a unique set of circumstances, and he explained that John Barradell's involvement:

"... probably pushed the boundaries both of the LLAG arrangements and what we were asking people to do in terms of come in and support in such a large-scale incident, and almost run the show for Nicholas Holgate in response."

He explained that the words "takeover" and "intervention" were only ever used in conjunction with the Local Authority Gold arrangements in relation to the

Grenfell Tower fire and only afterwards. They were never in the vocabulary of the LLAG arrangements before then.

The evidence of the witnesses from central government, specifically Dr Farrar and Dame Melanie Dawes, as was John Barradell, has revealed in greater detail how that state of affairs came about, and that the London Resilience Group understandably, given its limited remit, was not instrumental in that decision-making process.

Turning then to our second and a separate issue arising from the evidence in Module 4, which relates to the critically important and challenging task of information gathering and sharing in a complex incident involving multiple agencies.

In Phase 1 of the Inquiry, Commissioner Roe, then Assistant Commissioner Roe, was asked by Counsel to the Inquiry what system he put in place as incident commander to record the details of those residents who had managed to leave the building. Commissioner Roe explained the challenging task of recording the details of those residents who had self-evacuated or been assisted from the building, and that he would have expected, as a fallback, that their details would have been picked up at some point within rest centres or

within the system to gather casualties once they had come out of the tower beyond LFB cordons, and the reference to that, sir, is in our written submissions.

The humanitarian assistance framework describes how the information about those affected by an incident can be gathered at various stages of an emergency response. It recognises that information gathering is very challenging, especially at the initial stages of a response, and especially when responders are managing a very fast-moving and uncertain situation.

The police, via the Casualty Bureau and also a survivor reception centre, if established -- which it was not at Grenfell -- and the local authority, through its staffing of reception and rest centres, are the key agencies involved in gathering information about affected people.

Commissioner Roe's decision log and tactical co-ordination meeting minutes show the mixture of information reported to him from agencies such as the London Ambulance Service, the Metropolitan Police Service, as well as the local authority, regarding the numbers of people affected by the fire.

At 7.13 on 14 June 2017, it's recorded that there were six rest centres, with loose estimates given of the numbers, number of people attending them, as well as

a note that "rest centre managers will get up and running soon".

Commissioner Roe is recorded as asking the local authority for numbers and where people in rest centres were coming from, in addition to his request for plans for the tower itself.

The evidence in Module 4 revealed a chaotic situation at the various rest centres in the immediate aftermath and the lack of any effective system for recording and sharing the details of those who had been affected by the fire. The inadequacy of this information is apparent in the meeting minutes for the strategic co-ordination group, which show that there was a lack of clarity as to the numbers and identities of affected people.

The evidence of Colin Brown and Michael Adamson from the British Red Cross paints a stark picture of this failure, revealing an absence on the part of RBKC of any centralised system of recording the details of those affected, which ultimately took close to one week to be coherently organised.

The evidence in Module 4 highlighted the vital importance of accurate data collection and sharing so that all emergency responders and those that support them can fulfil their vital functions in both the

response and recovery phases of an emergency, thereby providing effective assistance to those who need it.

In conclusion, sir, the London Fire Commissioner recognises that the framework for resilience in London can be viewed as complex and not easily understood by those not operating within it. However, this may perhaps be understandable given the complexity of the undertaking in a city such as London, and the need for flexibility or elasticity when responding to emergencies.

In due course, the London Fire Commissioner, drawing on the knowledge and experience of the London Resilience Group team, will make considered submissions regarding recommendations, and will welcome any findings and recommendations that the Inquiry may make so that local communities like Grenfell are not let down again.

Thank you.

SIR MARTIN MOORE-BICK: Thank you very much.

Next we're going to hear a statement made on behalf of the Mayor of London by Ms Anne Studd Queen's Counsel.

So, Ms Studd, when you're ready, thank you.

Module 4 closing submissions on behalf of the Mayor of London by MS STUDD

MS STUDD: Mr Chairman, in his evidence to the Inquiry, the Right Honourable Nick Hurd said:

"I'm ashamed ... of the failure of the system I was part of to provide ... fellow citizens with the most basic support and comfort that they had every reason to feel totally entitled to in arguably their darkest hour."

Each core participant with a commitment to public service must endorse that sentiment. For those directly affected by the tragedy at Grenfell Tower, the damage inflicted by the failures during the aftermath of the fire has caused unimaginable additional and unnecessary distress and pain, which continues to this day.

As you were told powerfully at the beginning of this module by Hanan Wahabi:

"No one from government looked for us. No one helped us. We were left exposed and vulnerable, and when the authorities eventually did come, it felt like a tick-box exercise."

And this from a family who had walked out of that burning building and had to watch as other members of their family died in it.

The bereaved, survivors and residents consider that they were treated as they were because we, as the state, did not care about their community. As Mark Simms from the Rugby Portobello Trust so clearly articulated:

"... but who was really looking after people who had

lost their children in the fire was far from people's minds, because they were left to God and good neighbours, and that can't be right in 2017 in central London."

The issues which the Mayor will focus upon in this closing statement are: first of all, the resilience framework; then the humanitarian response; and, finally, in brief, reforms for the future. An examination of these topics will illustrate why this community was failed so badly in the immediate aftermath of the fire and what this Inquiry can and must do to prevent such a situation being repeated.

I turn to deal with the resilience framework.

It may be easy for this Inquiry, faced as it was with numerous documents, guidance and acronyms, and no experience of the workings of the resilience framework, to reach the simplistic conclusion that the system was overcomplicated, a suggestion put to many of the witnesses in the course of the Module 4 hearings.

Such an approach would be misguided. The Mayor does not doubt that the documentation might be slimmed down, that reviews of the guidance material might be conducted periodically as a single piece of work, and that there might be a need to clarify responsibilities, focus on roles and review some of the arrangements in the light

of the learning from this Inquiry. However, it would be inappropriate to recommend anything that resembles starting again.

The system in place necessarily relies upon category 1 and 2 responders co-operating as partners, working together, each with their own responsibilities as part of the resilience framework. By way of examples, as part of its category 1 duties, the London Ambulance Service will obviously be responsible for providing emergency healthcare on the scene, just as Transport for London will be responsible for handling the impact on its travel network. There is no practical alternative to this. The difficulties arise when responders such as local authorities are required to prepare themselves and resource those preparations for a wide range of major incidents as identified by the national and London risk registers that, fortunately, are unlikely to ever occur in their area, but, if they do, are fundamentally different to their daily activities. That is to be set against the need to also resource the day-to-day business of a local authority, which has considerable impact on its residents, especially the most vulnerable, with the constant backdrop of limited financial resource.

No one gave evidence that the complexity of the

resilience arrangements resulted in the failings by RBKC. Perhaps of most significance, Nicholas Holgate himself knew about the resilience framework, knew about the role of London Local Authority Gold and the support system available to him and his borough by way of mutual aid. His failure to invoke substantial mutual aid quickly enough and the consequences of that failure cannot and should not be laid at the door of the perceived complexities of the system.

Those who knew and worked within the system conceded it was complex to the outsider. As John Hetherington, the current head of London Resilience, told you:

"I would agree that they [the structures and arrangements] are complicated, yes. I think those practitioners in it understand it, but I completely appreciate that, to the layperson, it is a complicated structure ... I think bodies did understand their roles, because they lived and breathed it."

John Barradell identified some issues that were clearly contributory to RBKC's lack of appropriate response. He told you:

"In my view, there are too few people in local government, and some of the other sectors as well, that are trained, ready, but more importantly prepared to step in to assist and to lead, and because we don't have

enough of them, we can end up relying on people who are perhaps less ready, less able, less trained, less capable to do so. That's partly the need ... for why there are so many different forms of document, not simply to provide the framework and accountability, but, frankly, the guidebook to do something that may not be needed if you have experienced training/exercising for those functions."

There is also the wider issue revealed by the National Preparedness Commission's report of March 2022 which comprised an independent review of the Civil Contingencies Act and its supporting arrangements. The review concluded that resilience in the UK has suffered strategic neglect. As John Barradell told you towards the end of his evidence, that conclusion, he said:

"... reflects my experience in terms of the lack of strategic understanding and intent of resilience in the UK, by which I mean I think it's a bit of a Cinderella, actually, for local authorities and for central government."

If the failures demonstrated by the absence of a structured and effective response in the aftermath of the Grenfell Tower fire teaches us anything, it must be in the importance of proper funding, capacity and training for resilience. The current reactive approach

needs to change. The commission's report considered that the United Kingdom needs to prioritise resourcing to mirror the progress made by a wide range of other countries to build their risk and emergency management systems.

The Inquiry also needs to take care not to amalgamate the failures by RBKC, the individual borough, with failings in the system itself. Importantly, the system has been shown to work effectively in other scenarios where it has been utilised, in particular for terrorist attacks, the emergency decant of residents from the Chalcots Estate in Camden in June 2017 and, most recently, in the course of the COVID-19 pandemic.

However, it relies upon partners being equipped to carry out their own legal duties and for the candid exchange of information between partners. Neither was effective in this case, and the shortcomings in the system, such as they may be, should not shift the focus from those fundamental failures by RBKC as demonstrated by the evidence heard in Module 4.

I turn to deal with the humanitarian response.

The aim of the humanitarian assistance framework is to ensure that humanitarian care is delivered in an effective manner that meets the needs of those affected by major emergencies. As John Barradell

explained in his evidence:

"Structures are very important in emergencies, because they provide a framework within which people can request, ask, direct. Without the structures being sensible and robust, the likelihood of a response being, frankly, adequate is diminished significantly."

The failures in the humanitarian response to the Grenfell Tower fire did not arise because individuals did not know about the London Local Authority Gold arrangements or how to invoke them, nor from the complexities of the system, but rather from the lack of structures caused, primarily, by a lack of trained people to ensure that the resilience framework could be and activated. The structures required for delivering humanitarian care were not in place. In the circumstances where the lack of trained staff was a known issue, the failure to invoke mutual aid to deal with a known gap in the resource had devastating consequences for those who so desperately needed help and support.

Unfortunately, the failure of the response to meet the objective lies squarely at the door of RBKC. The failures in the preparedness of RBKC meant that the response was always going to be inadequate in the face of a disaster on the scale of the Grenfell Tower fire.

It was clear from the evidence of David Kerry that RBKC management board failed to bite the bullet before the fire when they were made aware of the significant lack of volunteers for the roles required to properly resource resilience within the borough. In spite of the increasing difficulty of obtaining volunteers for the contingency roles, and the consequential lack of staff available to respond to an emergency if required, highlighted as it was in the 2016 minimum standards for London review, the management board had failed to address this serious issue prior to June 2017. The failure to have sufficient trained staff also compromised the ability to train staff effectively, as did the time limit of two hours imposed on the training by the chief executive.

The result was that staff at RBKC were not adequately trained, due to insufficient time allocated, to deal with the issues that would arise in the event of a major incident in the borough. The only three Council Silvers out of the optimal ten were not trained at all. Preparedness was the responsibility of RBKC, and they failed to meet the minimum standards for London in material respects. As a borough, they were aware of that shortfall and did nothing to remedy it.

Of particular note, there was no trained operational

humanitarian assistance liaison officer in RBKC at the time of the fire. The absence had been highlighted in 2016 by the minimum standards for London review, and had not been capable of remedy because no one in adult social care would step up to volunteer, not assisted, perhaps, by the absence of any additional remuneration or ringfenced preparation time to undertake the role, on top of the doubtless demanding job they already held within RBKC. David Kerry's solution to this was that RBKC would rely upon mutual aid. Such an approach, as well as ignoring that mutual aid should be a reciprocal arrangement, lacked the advantage of local knowledge and contacts within RBKC and pre-existing relationships with the local community and the voluntary sector.

Unfortunately, mutual aid was not immediately invoked. Instead, Sue Redmond was given the role in her "why me" moment. She was notified of the role on 14 June, read the definition for the role that evening, and was formally appointed at 10.00 am on 15 June 2017 at the RBKC Gold Group meeting. Her appointment was made because she was the director of adult social care, and the framework provided that:

"The HALO will be appointed to support Local Authority Gold, and will typically be a director with responsibility for Adult Social Care."

That was her only qualification for the role and, even using her best endeavours, did not equip her in any respect. She was not trained and she only received the definition of the HALO and what the role entailed on 14 June 2017.

The humanitarian assistance framework specified in the critical information section that the first steps should be:

"Appoint the HALO, call the first meeting of the humanitarian assistance steering group, begin assessing the needs of people and identify options for providing support."

On 14 June, there was no HALO, and there could be no meeting. The HALO should have been in post by 4.00 am at the latest on 14 June, a meeting called later that day, probably in the morning. Instead, the first meeting of the humanitarian assistance group was during the afternoon of 15 June 2017, by which time the trust and confidence of the community had been lost, and the ability to ensure that humanitarian care is delivered in an effective manner that meets the needs of those affected by major emergencies had demonstrably failed.

Stuart Priestley and David Kerry, two of the three Silvers for RBKC, were aware early on that the response to the Grenfell Tower fire was going to require

invocation of mutual aid under the London Local Authority Gold procedure, and yet for reasons that may never be entirely clear, Nicholas Holgate, who could and should have invoked that procedure, failed to do so. The Inquiry will have to make findings about why that was, but the evidence revealed that it was clear Nicholas Holgate knew about its availability and what mutual aid and/or London Local Authority Gold could offer, but was reluctant to invoke it until the borough response had been "deemed insufficient".

Perhaps because David Kerry was known to sit on the local authorities panel as practitioner adviser to the chair and was considered to be quite competent as an emergency planning officer, perhaps because there was a perception that RBKC was a well-run borough, perhaps because no one practising in the resilience world would have thought that a borough would fail to ask for help when it was obvious that assistance was required, the strategic co-ordination group, co-ordinating a response involving many important and complex issues, accepted the reports from Nicholas Holgate and other RBKC officials that their response was effective and adequate, and that RBKC was managing without the need for substantial additional resources.

However, the lack of strategic oversight, the

absence of trained staff able to quickly implement the necessary structured approach to fulfil the humanitarian need, together with an operational approach and the continuation of business as usual, meant that the RBKC Gold Group on 15 June did not resemble what Mark Sawyer expected to see. He told the Inquiry:

"I think it was very operational, and I think that was because there wasn't, for want of a better word, consistent understanding of the situation. I think it was too big, and I think there was no -- it was too polite and I'd need to qualify that. It was -- I think it may have been described as a board meeting by other people giving evidence, and it was, for me, very similar to a traditional style of local authority meeting, very polite, very structured. It wasn't dynamic, it wasn't forward-looking, and ... I've probably said enough about that meeting."

The resilience system was logically built on the assumption that if a borough needed help they would ask for it. There was no contingency in place to address the situation of a borough not recognising they needed help, or taking a defensive stance, or regarding the request for help as a sign of not coping, surrender or failure. Those explanations have been ascribed to why it was that RBKC chose not to seek the assistance that

would have been freely and willingly given. Had he chosen to utilise the resources available to him, Nicholas Holgate may have been able to provide a very different experience for the bereaved, survivors and residents in the aftermath of the fire.

The failures by RBKC left a chaotic response exacerbating time and time again the trauma of those who had already suffered, and its effect was calamitous.

In contrast to RBKC's approach of waiting until the response was deemed insufficient, the voluntary and faith sectors were noticeably proactive in driving the humanitarian response. These organisations understood from the start the imperative of a warm, safe space, and recognised the damage being caused to the bereaved, survivors and residents by being asked multiple times by multiple agencies to talk about the fact that they were bereaved or that they had fled fire. It was traumatising people over and over again.

The lack of planning, lack of training, lack of staff and lack of a proactive approach to resilience by RBKC left a vacuum filled as far as possible by the community and the voluntary sector. The basic human needs identified by the humanitarian assistance framework and best provided for by the state should have been provided by RBKC and were not.

The lack of proactive planning or effective mobilisation of any leadership on the ground led to a disorganised and chaotic setup at the Westway Centre, where there was no clear command structure and a complete lack of basic and necessary information from those in authority to those in need.

The bereaved, survivors and residents had been failed by RBKC before the fire, they were failed during the fire, and they were failed after the fire. How could they not feel that there was institutional indifference towards them as a diverse community?

Unable to locate their loved ones, unable to obtain money, a lack of communication from authorities, unsuitable hotel accommodation, abandoned for days without anyone official having a conversation with them, leaving families to figure it out for themselves, resulted in people feeling traumatised, humiliated and demeaned in one of the richest boroughs in London. This is what happens when the tenants of the system are not prioritised by the borough that has a statutory duty to do so.

It is important to remember that this was not a borough that did not know what their Civil Contingencies Act duties were or how to implement them. It is also a borough regarded as having considerable

reserves in comparison to others, and therefore more able to meet an emergency need. This proved not to be the case. It is a borough which seems to have considered that the likelihood of having to respond to a single-borough major emergency was remote and therefore allocating resources, financial and time, to it was a low priority. Consequently, when required to step up, and knowing that its preparedness had been woeful, it was defensive, adopted a siege mentality, and appears to have been more concerned with its own reputation, rather than the welfare of the residents that they had a duty to support and assist. As John Barradell put it:

"The moral compass here should be for those affected, not about any other consideration, and I think the most concerning thing that I was hearing back on that day was that that did not seem to be the case."

Looking to the future, the Inquiry must reflect on these failures by RBKC, but it also has to look forward. Any recommendations have to reflect a solution to prevent individual borough failings and also to look at how the system can be strengthened.

As a category 1 responder in its own right, the GLA has sought to strengthen its capabilities since the fire to respond to emergencies.

In October 2019 the GLA established the London situational awareness team, which sits within the City Operations unit at the GLA, and forms an integral part of the GLA's response to an emergency. It's staffed with ten people who work on a rota basis, and provides 24-hour horizon scanning capability, research and analysis and incident response function for the GLA. LSAT carries out proactive and reactive research into issues that are likely to have an impact on business-as-usual functions in London, identifying emerging threats and ensuring that the GLA has the information it needs to carry out its responsibilities during an emergency. It also acts as a crucial point of liaison between the GLA and the external partners, including the Metropolitan Police, the London Fire Brigade, the London Ambulance Service and others.

To coincide with the establishment of LSAT, the GLA also expanded the number of staff who could act as the duty manager to ensure that there was resilience within the system. The duty manager attends the strategic co-ordination group meetings during an emergency. All duty managers have attended and passed the College of Policing's week-long Multi-Agency Gold Incident Command course. The incident response protocols and capability also remain under regular review.

Returning to the particular failures of RBKC, the evidence demonstrated a series of light-bulb moments when the various category 1 responders and central government became aware that RBKC were not coping and did not have a "grip". In the end, sufficient pressure or soft power had to be brought to bear on RBKC to invoke the London Local Authority Gold arrangements for mutual aid, including for leadership of the overall response. But by then, it was too late and the process took too long.

Clearly there was a need for the strategic co-ordinating group to be more intrusive and for boroughs and other responders to agree that the system should permit the strategic co-ordinating group to be more intrusive, notwithstanding their own statutory responsibilities.

Melanie Dawes said that the DCLG were over-reliant on what was coming up through the SCG via RED, and David Bellamy also referred to the fact "we only really had the assurances that RBKC provided at the SCG meetings". Given that the humanitarian assistance framework requires the first step to appoint the HALO and call a meeting of the humanitarian assistance steering group, it is perhaps somewhat surprising that the SCG did not ask for the identity of the HALO and the

timing of the meeting in the course of the morning of 14 June.

Changes may be required to the strategic co-ordinating protocol to allow for the group to provide more critical questioning of the situation on the ground and how a category 1 responder is actually coping and what its capabilities are in the aftermath of a civil emergency. There cannot be a repeat of the situation where RBKC's blanket assurances that it was coping limited the strategic co-ordinating group's situational awareness of the reality, as happened on the ground at Grenfell.

The local resilience forum must also receive reliable assurance that proper steps are being taken by a borough to ensure adequate preparedness, training and exercising is put in place to enable an adequate response within the borough or adequate assistance to be provided by way of mutual aid if required.

Exercising is a very important element of preparedness. Because of the time resource it requires, there is always the risk that it is not carried out sufficiently.

Enforcement in the face of non-compliance remains an issue. A report to the government or to the Mayor from the local resilience forum, with them on receipt

having the necessary power to require action by a borough, may be an option. David Kerry's view was that the under−preparedness of RBKC would have meant that they would have been unable to provide adequate mutual aid response if requested.

As noted earlier in this submission, the resources required to improve resilience, training and, importantly, exercising must be forthcoming and be ringfenced by central government to ensure that they're not withdrawn as soon as the publicity and concern raised by the response to the Grenfell Tower fire takes a lower profile. In the current climate, there is increasing responsibility and accountability for local resilience forums, particularly so in London, and those increasing obligations must be matched with equivalent, predictable and sustainable funding.

So far as any expansion of the Mayor's role in civil emergencies is concerned, it should not be considered as political. It is to be remembered that there was an early concern raised by Mark Sedwill, the National Security Adviser, on 20 June 2017, that:

"K&C didn't realise they were out of their depth for at least 2−3 days, so it can't be a local decision to pull in regional/national support. We need a 'push' mechanism to 'nationalise' a disaster, and insert

regional/national resources led by a local Gold with a national Gold to lead on wider implications."

The Inquiry heard considerable evidence about John Barradell and others having to use "soft power" to persuade and apply pressure to Nicholas Holgate to invoke the London Local Authority Gold arrangements on the evening of 15 June 2017.

There was and remains considerable concern about leaving the triggering of substantial mutual aid and/or the London Local Authority Gold arrangements at borough level. As may be the case here, the decision may raise conflict issues in relation to the capabilities of the borough chief executive or the borough itself. The question is: who should have responsibility for the decision to step in? It could be allocated to central government; however, given their national focus, they may not be best placed to assess the situation in the borough −− the Inquiry in this case has heard that RBKC was well thought of by government −− or how it put in place the optimum mutual aid.

The decision could be left to the local authority community, for example the unelected chief executive who chairs the local authorities panel, or the chair of London Councils. However, neither has a democratic accountability to the residents of the borough in

question. Therefore, it is suggested that in London the appropriate decision−maker would be the democratically elected holder of the office of the Mayor of London. On receipt of a request or a report from this strategic co−ordinating group, the office of Mayor arguably has the advantage of having regional knowledge, being democratically elected by an electorate that would include the citizens of the relevant borough, and is accountable for the decision−making, both to the London Assembly and, ultimately, to the electorate.

Whatever the procedure, there must be a mechanism to allow a much swifter and more coherent intervention than occurred after the Grenfell Tower fire.

By way of conclusion, of course the experience of the fire itself will have been life changing for those who survived it, but failing to provide proper humanitarian assistance in its aftermath made that trauma intensified.

However, there were chief executives and many others from around London local government who, through a commitment to public service, stepped up and worked hard to provide for the traumatised and to recover the trust and confidence that had been lost in the immediate aftermath of the fire due to RBKC's failings. It should be recognised that the position they inherited was

incredibly challenging and the Mayor remains grateful to them for their willingness to help and what they were able to achieve.

At the start of Module 4, the panel heard from a number of bereaved, survivors and residents in person, giving evidence about how the lack of response made the trauma even more difficult to cope with. Many felt dehumanised, demeaned and humiliated. As Mark Simms from the Rugby Portobello Trust so memorably told you:

"I remain incredulous that this happened in London in 2017 and people were left to their neighbours to provide care, comfort and shelter, in one of the richest boroughs in the country in one of the richest cities in the world. It still shocks me to the core that that is how we treat our citizens in this country."

Where an individual borough fails, London fails. The Mayor too is ashamed by the response of RBKC in failing to provide for the basic needs of the BSRs in the aftermath of the fire. It is essential that, in future, the resilience framework is developed to ensure more intrusive monitoring of the response to an emergency, coupled with an ability to "push" resources into a situation, rather than wait for them to be pulled in by the borough.

There is no better way to conclude this closing

submission than by re-telling what Mohammed Rasoul told you:

"The British public kind of stepped up, and they filled in those gaps in an amazing way. But it shouldn't have been the case. This should have been the responsibility of the people who were in charge of us, the people -- you know, the politicians, the councillors, who are in charge of the local authority ... this is their role. They're meant to be leaders, looking after us and kind of attending to our needs, but they were nowhere to be seen during the whole -- like the majority ... the immediate aftermath and afterwards."

The Inquiry must strive to ensure that, by its recommendations, the experience of Mr Rasoul and the other bereaved, survivors and residents cannot be repeated.

Thank you.

SIR MARTIN MOORE-BICK: Thank you very much.

Well, now, the timetable for the afternoon suggests that we should take a break at this point, but it is rather early. I'm just wondering whether Mr Beer Queen's Counsel would be willing to give us his closing statement before the break.

Thank you, Mr Beer. I'm sorry to pull you on a bit

earlier than expected, but it's very convenient if you can.

MR BEER: Yes, not at all, sir.

SIR MARTIN MOORE-BICK: Thank you.

Module 4 closing submissions on behalf of Department for Levelling Up, Housing and Communities by MR BEER

MR BEER: This closing statement is made on behalf of the Department for Levelling Up, Housing and Communities, which I will refer to as "the department".

As it's done throughout the Inquiry, in this module the department has assisted and supported the Inquiry by providing, by way of disclosure, thousands of documents to the Inquiry; by providing 32 witness statements to the Inquiry from 21 witnesses, ranging from the then Secretary of State, the then Permanent Secretary, and other senior civil servants through to junior civil servants, from which the Inquiry selected three witnesses to give oral evidence: Dame Melanie Dawes, Dr Jo Farrar and Gill McManus; and, finally, by setting out, in its 49-page written opening statement, its position in relation to the issues that arise in Module 4, supplemented by its 28-page written closing statement following consideration of all of the evidence. In doing so, it has addressed directly the qualitative question raised by the Inquiry in

paragraph 13 of its list of issues, namely: was the response adequate and, if not, in what respects was it inadequate? In other words, it has again taken a candid, reflective and self-critical approach.

The Grenfell Tower fire was an appalling tragedy which left a community bereaved, homeless and traumatised. People lived through events no one should ever have to experience and continue to feel the impact to this day. The powerful and moving evidence provided by the bereaved, survivors and residents and others who lived through the days and weeks following the fire makes it clear that they did not receive the level of support that they so desperately needed and deserved. Serious problems in the handling of the response undoubtedly compounded their suffering and that is wholly unacceptable. Where the department in any way contributed to those problems, it apologises unreservedly.

Even though the Grenfell Tower fire posed significant challenges for all organisations involved in the emergency response, and though much good work was done, the department is nonetheless clear that the initial response to the fire, and especially that of RBKC, was inadequate.

The issues which I shall address are accordingly as

follows: firstly, whether the department performed its role before 14 June 2017 appropriately by reference to the legislative and policy system then in place; secondly, whether in the seven days after the fire the department performed its role appropriately by reference to that system; and, lastly, whether the legislative and policy system is the right one.

So the department's role and conduct before the fire.

In its opening statement for this module, the department set out in some detail its role and its conduct before the fire. The department's position, in summary, remains that, through RED, it fulfilled its role in accordance with the statutory scheme and applicable policies, guidance and doctrine. Following the fire, however, the department has taken the opportunity to reflect on its role in the emergency planning system and has made important changes to its internal structure and resourcing, which I shall address in a few moments. It has also developed further its critical friend role, which now includes greater challenge of local partners at the planning stage.

The department's role and conduct in the seven days after the fire.

Having considered all of the oral and written

evidence heard by the Inquiry during Module 4, the department considers as follows. Firstly, it should not have assumed that RBKC would request mutual aid and activate London Gold arrangements, even though it is inexplicable that RBKC did not do these things. RBKC's failure to activate London Gold arrangements was, the department believes, a major cause of the deficiencies in the response. However, on behalf of central government, the department should have challenged RBKC earlier than it did.

Second, the department considers that although it does not routinely deploy senior officials to attend emergency response sites, and there are very good reasons why it would not ordinarily do so, it now believes that, due to the scale and complexity of the incident, it should have sent a senior civil servant with experience of disaster management to observe the humanitarian support arrangements earlier, to be a visible presence, and to gather early indications on the effectiveness of the support offered. However, to suggest that RBKC was given the benefit of the doubt because they were "guys like us" is to mischaracterise the database checking exercise that was in fact undertaken.

Third, when it became clear that RBKC was not

capable of fulfilling its statutory duties, the department acted appropriately by intervening to support the transfer of Gold Command to John Barradell. Whilst it took time for these changes to make a tangible difference on the ground, the changes to the Gold Command structure were fundamental to the improvements later felt. The suggestions that government ought to have exercised its statutory powers of intervention and that the failure to do so is evidence of "the disastrous manner in which government dealt with the tragedy" are unrealistic and do not properly consider the role of national government during a tragedy within a local area.

Fourth, it acted appropriately by making multiple offers of support to RBKC on the day of the fire and in the days following, including at ministerial and Permanent Secretary level, which RBKC refused.

It also acted appropriately by later providing practical assistance in support of the response. This included, for example, deploying departmental staff to RBKC to assist in the co-ordination of the humanitarian relief effort and to help with rehousing and establishing a central government response function at the rest centre to help with access to central government services.

Fifth, the three-week rehousing commitment arose as a result of proper concerns about the lack of impetus and ambition in RBKC's rehousing programme. It was motivated by the best of intentions, but was too ambitious and inadvertently placed pressure on individuals in the aftermath of an extremely traumatic event. It was accompanied, as has been observed in the submissions of some of the BSRs, with what they rightly describe as a blank cheque from central government, which RBKC's senior housing management seemingly failed to appreciate, despite that being spelled out for them clearly in writing.

Sixth, RED did not place excessive focus on Building Regulations issues. Whilst the information emerging in relation to the cause of the fire was clearly relevant to the department and central government more widely, RED's essential focus was on what was happening on the ground and whether support was needed. In this regard, the suggestion that witnesses have used the pre-defined scope of the role of RED to defend what it did in the aftermath of the fire is wrongheaded. A description of doing what it was meant to do is not a defence, it is a description of a body of people carrying out the work that they were meant to do.

Seventh, RED fulfilled its role in sharing

information across central government in the aftermath of the fire, although the department acknowledges and shares the frustrations of other government departments about the lack of timely and accurate information in the aftermath of a major disaster. The department considers that it should have better managed the expectations of other stakeholders as regards the speed with which accurate information could be obtained and disseminated.

The department does not consider that central government taking over the delivery of the response to this fire would have been the correct answer. Departmentals do not have the training, the experience or the expertise in disaster relief, nor have they built the local knowledge and relationships that are necessary to manage a disaster response. The essential problem with the management of the response to the Grenfell Tower fire was not with the principle of a local response to it; rather, it was that RBKC had failed properly to plan and, in the event, failed to draw on all of the support that was available to it. The department continues to believe that the system of locally planned and locally led resilience remains the best model.

As in Module 6, the Inquiry will wish to consider whether the risk that a category 1 responder would fail

to comply with its statutory duties in this way is properly identified and catered for in the legislation and guidance. In other words, does local democratic accountability provide adequate oversight and assurance that the civil contingencies system is working effectively in practice? If it does not, what additional layers of assurance should be built in?

Alongside the Inquiry's work, and in line with the commitment in the 2021 integrated review of security, defence, development and foreign policy, the department will work with other government departments, LRFs and responder organisations to identify ways to strengthen the roles and responsibilities of LRFs, including empowering their leadership and scope to build resilience into wider initiatives. This is in recognition of and builds upon the enhanced role that LRFs have increasingly taken on, especially through the response to the pandemic. As part of this, the department is considering whether a strengthening of assurance and oversight would be appropriate, whilst maintaining the emphasis on subsidiarity and local leadership as key principles.

Lastly, then, current work and recent developments.

The department proposed this Inquiry so that it could independently establish the facts, identify

failures and make recommendations, and the department is fully supportive of the work the Inquiry does, and looks forward to its conclusions and recommendations on the issues covered by Module 4.

At the same time, however, the department believes that critical self-reflection has been necessary throughout this period and, since the fire, it has quite rightly reviewed its own civil contingencies processes and made changes where it has identified improvements could be made. So the department has restructured and strengthened its resilience and emergencies function, bringing it within the new resilience and recovery directorate. The number of permanent staff in RED has doubled, the number of deputy directors in the staffing model has increased from one to four, and the regional teams have increased from four to five, each headed by a head of regional resilience.

The department has made improvements to the way that RED seeks to fulfil its critical friend role in the local emergency planning system. Each LRF now has both a lead resilience adviser and a support resilience adviser to ensure greater continuity of relationships and to build in more time to spend with their designated LRFs. RED is more systematic in its planning for meetings at the local level, including prioritising

attendance at LRF executive meetings and facilitating more meetings at a regional level to help support best practice and sharing between different LRFs.

The department has adopted an LRF level risk model and is continuing to review whether the way in which RED fulfils its role of providing assurance to central government that necessary capabilities are in place at the local level can be strengthened further.

The department has, in conjunction with Solace, the Society of Local Authority Chief Executives and Senior Managers, updated the good practice guidance for local authority chief executives to assure themselves that they are adequately prepared and equipped to respond to emergencies.

The department now expects and trains RED GLOs to identify overstretch and to challenge local arrangements during an emergency, including by questioning local authorities on their plans, and engaging directly wherever offers of support are refused.

The department has updated the RED operating model to provide for direct senior civil servant engagement with the SCG in the event of a serious or large-scale emergency.

The department has created a dedicated situational awareness function within RED equipped to gather,

collate, assess and disseminate information from a range of sources.

The department has agreed a protocol for the departmental response to a fire in a large residential building, enabling more effective management of information and reducing the risk of confusion and duplication.

In April 2022, the government published the post-implementation review of the Civil Contingencies Act 2004, sponsored by the Cabinet Office. To inform the review, the department consulted representatives from LRFs across England in a series of in-depth workshops. Following the review, further improvements to UK resilience arrangements will be implemented. In particular, guidance will be updated and strengthened to reflect the growing co-ordination role that local resilience arrangements are fulfilling, whilst making clear what government can expect from local partnerships.

New provisions will require local responders to report on how they have fulfilled their duties under the 2004 Act, improving accountability, driving up standards and improving consistency across local resilience arrangements, thereby enabling the development of best practice.

Lastly, a national resilience strategy will be published later in 2022 in conjunction with the scheduled 2004 Act review setting out improvements in the government's approach to UK resilience.

In conclusion, this department remains committed to supporting those affected by the Grenfell Tower fire. In total, central government has committed over £160 million to supporting the community since 2017, including £132 million that has already been spent to support rehousing efforts, to deliver bespoke health and wellbeing support, and the refurbishment of the Lancaster West Estate.

The department will continue to reflect and to learn the lessons of the past, and it looks forward to the Inquiry's conclusions and recommendations in Module 4. It will continue to make sure that where change is needed, it is implemented.

Thank you, sir.

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

Well, at that point we shall take the afternoon break. We'll rise, therefore, and resume at 3.20, please. Thank you very much.

(3.06 pm)

(A short break)

(3.20 pm)

SIR MARTIN MOORE-BICK: Now, finally we're going to hear a closing statement by Mr Andrew Warnock Queen's Counsel on behalf of the Metropolitan Police Service.

So, please, Mr Warnock, come to the lectern. Thank you.

Module 4 closing submissions on behalf of the Metropolitan Police Service by MR WARNOCK

MR WARNOCK: Thank you, sir.

Chairman, members of the panel, the Metropolitan Police Service, the MPS, falls outside the Inquiry's terms of reference for this module, which focuses on local and central government. However, the MPS has had a representative in court throughout the Module 4 hearings, and has listened to the evidence. It recognises that, as a category 1 responder, it formed part of the wider response to the aftermath of the tragedy. It took a key role in chairing the strategic co-ordination group for an extended period after 14 June 2017, and it also fulfilled a key role in policing the local area and supporting the local community in the weeks and indeed months thereafter.

These brief closing submissions focus on four areas of evidence which touched upon the involvement of the police. Two are issues very much to be considered within the context of the joint agency response:

rest centres and the return of residents to the walkway properties. Two concern functions that fell to be delivered entirely by the MPS, that is the Casualty Bureau and the allocation and role of family liaison officers to those who were bereaved by the tragedy.

The MPS prepared an electronic presentation on the function and dynamic location of police cordons, both inner and outer. The cordons were initially focused on facilitating the work of the other emergency services, and also preserved the location as a crime scene, which the MPS were responsible for examining forensically not only for the criminal investigation, but also to enable victim identification on behalf of Her Majesty's Coroner.

First, the Casualty Bureau.

The Casualty Bureau telephone line is a police service defined as "an initial point of contact for the assessing and receiving of information relating to persons who have been, or are believed to have been, involved in an emergency". It is the MPS view, having listened to the evidence, that the lived experience of some of those who contacted the Casualty Bureau was not a positive one, and it is accepted that this exacerbated the impact of the tragedy on those people.

The Casualty Bureau fulfilled an important investigatory function to not only trace, identify and reconcile missing people, but to provide timely information to the coroner as part of the MPS's disaster victim identification responsibilities. Mercifully, it is a resource which has not had to be activated often, and indeed it has not required activation by the MPS since the Grenfell Tower tragedy.

That the Casualty Bureau telephone line operated primarily as a means of gathering information was apparent from the evidence of a number of witnesses. It is also clear that, understandably, this was not the expectation of those calling it, who, in the absence of any other phone lines or other effective communication option from other organisations in the early response period, understood it to be a helpline or, at the very least, a line where there would be a two-way flow of information. It is apparent that many found calling the line to be a frustrating and bureaucratic process. The MPS is sorry that this was the experience for some people who were so deeply affected by the tragedy.

In the light of the evidence, particularly from the bereaved, survivors and residents who gave oral evidence, and those whose statements have been read in, the MPS recognises that it needs to give consideration

as to how the role of the Casualty Bureau should be better communicated in the future. It needs to consider how its operation could be improved, and how it might fit into a wider system of disseminating information about those who are missing as part of an improved humanitarian response.

One of the most consistent messages from the witness evidence in this module related to the "information vacuum" that was felt by those impacted and by those working in the voluntary sector. These are matters which the MPS will consider further and address through submissions about Phase 2 recommendations which will be provided in accordance with the Inquiry's timetable.

Next, reception centres.

Under the extant LESLP guidance from 2015, a survivors' reception centre, or SRC, is normally set up following a major incident, and the responsibility for opening one sits with the police, with local authority support. An SRC enables police to collect information relevant to an investigation, and facilitates the provision of immediate shelter and initial care to survivors. However, the guidance also recognised that an SRC might be a dynamic venue, depending on the ongoing demands of the incident. In the early stages of an incident, where those involved

are leaving the scene, it may not be practicable to set one up, because of the more pressing primary responsibilities such as life-saving and clearing the public from danger.

As the panel will be aware from the evidence received in Phase 1, such circumstances prevailed in the early hours of 14 June 2017. The police focus was on getting survivors and residents out of danger, and the police did not open an SRC. Evacuees from the tower needed medical attention and were being assisted by the London Fire Brigade and the London Ambulance Service. The MPS ensured that those agencies continued to have a safe area to work from by maintaining cordons in the area.

Shelter to displaced residents was provided spontaneously by community organisations. SRC functions were discharged by police attendance at the St Clement James Centre and the Rugby Portobello Club prior to the opening of the Westway.

The LESLP guidance did not allocate responsibility for the opening of a friends and family reception centre, but under the draft London Resilience Partnership humanitarian assistance framework, version 5, it was the responsibility of the police to determine the need for an FFRC as part of a wider

disaster victim identification process in consultation with the local authority. The guidance provides that it is likely to be set up within 24 hours of the incident.

The need for an FFRC was determined at a tactical co-ordination group meeting at 10.00 am, and Tom Brady from the Royal Borough of Kensington and Chelsea was tasked with setting up the FFRC, and it opened at the Salvation Army building on Portobello Road at 12.30 on 14 June, moving later to the Westway Centre.

The responsibility for setting up and running rest centres lay with the local authority.

Some witnesses gave evidence that they found the police presence at the Westway to be off-putting. Police had an important role at the centre, which included helping to keep order generally and managing the intrusive presence of the press, both inside and outside the centre. The police officers discharging those functions were uniformed and so were inevitably visible. Visibility provided a reassurance to some, and might be seen as a positive feature as against the reported lack of visibility of personnel from RBKC. The MPS did not deploy firearms officers to police the Westway Centre, and the MPS is unable to account for what Clare Richards, but no other witness of which the MPS is aware, believes she saw in that regard.

Return of residents to the walkways.

The decision on when it was safe for residents to return to the walkways was not a police one. The police responded to the recommendation of the London Fire Brigade to evacuate certain locations as an emergency life-saving measure. Whilst MPS officers may have facilitated limited access to residents of those properties for specified reasons before they were allowed to officially return, the MPS did not have responsibility for deciding when re-occupation was safe and necessary.

Family liaison officers.

The criteria for the allocation of family liaison officers, or FLOs, has been explained in the witness statement of Detective Chief Inspector Kate Kieran dated 17 February 2021. They were allocated to families based upon a decision taken by 8.00 am on 16 June 2017 to allocate to the family of any person missing and believed to be deceased. As set out in the second statement of DCI Kate Kieran, the FLOs voluntarily take on the role in addition to their existing professional responsibilities, and receive specialist training to work with bereaved families. The primary role of the family liaison officer was as an investigator, which included the identification of victims, but they also

facilitated bereaved families' access to a range of other agencies who were able to provide support services.

One additional matter: the possibility of Islamophobia has been raised by Ms Munroe Queen's Counsel in relation to a community risk assessment. This was not a matter explored in the evidence, certainly not as regards the MPS. The writer of the risk assessment has not been called to give evidence. We draw your attention to the fact that, following on from the passage cited by Ms Munroe from that risk assessment, the assessment said:

"Community leaders from local Mosques have been contacted and are working with the police and to support those affected, as are community leaders from other faith groups."

The MPS sought to work in a positive way with all those affected by the tragedy. Whilst it will not have got everything right, it would strongly refute any suggestion that Islamophobia affected its response to the tragedy.

In conclusion, the MPS acknowledges the difficulties faced by the bereaved, the survivors and the residents in the aftermath of this awful tragedy. The touchstone for the success of the joint agency response in the

immediate aftermath can fairly be judged by the lived experience of those impacted by the tragedy. From the outset, the MPS has been concerned to engage with bereaved and survivors as part of its ongoing criminal investigation and enquiries on behalf of Her Majesty's Coroner. The MPS is keen to assist this Inquiry in any way it can in trying to ensure that, should an event occur again, the experience of those affected would be significantly better.

A full submission will be provided to the Inquiry in accordance with the recommendations timetable to inform the Inquiry, as well as core participants, what improvements have already been made since June 2017 and what work is ongoing by those charged with responding to major incidents which result in mass casualties.

That is our statement.

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

Well, that brings to an end the oral closing statements in Module 4. There will be no sitting of the Inquiry tomorrow, but we shall be resuming our hearings on Wednesday morning at 10 o'clock, when we shall begin hearing evidence from Professor Purser, the expert toxicologist instructed by the Inquiry.

So that's it for today. We resume at 10 o'clock, please, on Wednesday morning.

Thank you all very much.

(3.40 pm)

(The hearing adjourned until 10 am Wednesday, 29 June 2022)

INDEX