



GRENFELL TOWER INQUIRY RT

Day 295

June 27, 2022

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1 Monday, 27 June 2022  
 2 (10.00 am)  
 3 SIR MARTIN MOORE—BICK: Good morning, everyone. Welcome to  
 4 today's hearing. Today we're going to hear closing  
 5 statements relating to Module 4, and the first of those  
 6 is going to be made by Ms Allison Munroe Queen's Counsel  
 7 on behalf of those of the bereaved, survivors and  
 8 residents whom she represents.  
 9 So, Ms Munroe, would you like to take your place at  
 10 the lectern and we're ready to hear you as soon as  
 11 you're ready.  
 12 Module 4 closing submissions on behalf of BSR Team 2  
 13 by MS MUNROE  
 14 MS MUNROE: Thank you.  
 15 Good morning, Chair. Good morning, Ms Istephan.  
 16 Good morning, Mr Akbor. These are the submissions in  
 17 closing to Module 4 on behalf of the bereaved, survivors  
 18 and residents represented by the T2 group of lawyers.  
 19 Can I start by taking you back, as it were, back to  
 20 the opening submissions in this module made by  
 21 Professor Thomas Queen's Counsel. You may recall that,  
 22 during those opening submissions, he took us to the  
 23 headlines that were at the time circulating in the  
 24 media, which spoke of the chaos, the lack of leadership,  
 25 the despair of the survivors, residents and bereaved

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1 families. RBKC was failing in their responsibilities to  
 2 the community, and they were failing spectacularly.  
 3 There was frustration. There were tears. This abject  
 4 failure, we say, by RBKC added to the trauma that people  
 5 were already experiencing, and, for once, the headlines  
 6 were not exaggerations or hyperbole; if anything, they  
 7 understated the reality.  
 8 In the course of this module, we have gone behind  
 9 those headlines to the lived experiences of the  
 10 survivors, the residents and the bereaved families who  
 11 were so appallingly let down by their local council and  
 12 by central government.  
 13 The council leader, Nick Paget—Brown, speaking on  
 14 BBC Radio 4's the World at One at the time, sought to  
 15 defend himself and officials against criticisms. He  
 16 said staff had been on the ground since soon after the  
 17 fire started, and added:  
 18 "All I'm keen to say is there is an effective,  
 19 co-ordinated relief effort on the ground, and I'm sorry  
 20 if people have not seen that."  
 21 Those comments were patently untrue and, quite  
 22 frankly, errant nonsense. The painful accounts of what  
 23 people had to endure in the immediate aftermath of the  
 24 disaster should make us all ashamed. RBKC failed to  
 25 provide a planned, effective emergency response. This

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1 was a council whose response was chaotic and seemed to  
 2 be gripped with paralysis and inertia. There was  
 3 a leadership vacuum. People who were at the very nadir  
 4 of their suffering were left without proper direction.  
 5 They required relief, shelter, warmth, sustenance and  
 6 psychological support. This council's invisibility and  
 7 failure to communicate with the survivors and people who  
 8 wanted to help exacerbated the trauma.  
 9 In our written submissions, we quoted the words of  
 10 Karim Mussilhy, whom the Inquiry heard at the beginning  
 11 of this module. I would like to revisit those words  
 12 again. They are well worth repeating, as Karim so  
 13 eloquently articulated the thoughts and experiences of  
 14 many. He said this:  
 15 "I thought we lived in a country where the people we  
 16 vote for and the people that are put in place to look  
 17 after its people, its most vulnerable people, would  
 18 help, would come swooping in, and it never happened.  
 19 The sad part about that ... is that they never planned  
 20 to. They don't care about us. They care more about  
 21 themselves, their pockets, and I won't go into detail,  
 22 because you questioned these crooks, you sat here and  
 23 spoke to these criminals who acted so fraudulently and  
 24 with this constant detachment. I mean, how many more  
 25 politicians, ministers and lords are going to insult our

3

1 dead families before something is done about what  
 2 happened to us? And it's sad.  
 3 "I've almost completely lost faith in humanity.  
 4 I've almost completely lost faith in the world, because  
 5 it's always the same thing everywhere. We suffer, and  
 6 they prosper. And I've said this before: the system  
 7 isn't broken; it was built this way specifically to  
 8 benefit them.  
 9 "Our families died in the most public and horrific  
 10 way possible, and here we are, five years later, with no  
 11 arrests, no accountability, but yet the ones who were  
 12 put in charge or the ones who were involved have been  
 13 able to prosper since the fire, and how can we allow  
 14 this to happen?  
 15 "I feel like as time goes on, the general public  
 16 have forgotten about us, or every time they hear about  
 17 us, they're fed up, and this is the problem. People  
 18 need to see themselves in us. People need to understand  
 19 that what's happened to us and what's happening to us is  
 20 also happening to them.  
 21 "Putting aside these corporates that behave the way  
 22 they behave, because it's in their nature, it's what  
 23 they do, but the government, the government's duty is to  
 24 protect us, to look after its people. But yet only last  
 25 week, a lord was sitting here, calling our families

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

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

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

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

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

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

3 When questioned about that, he said that he thought:

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

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

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

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

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

17 They did not care about us.

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

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

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

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

14 RBKC, as a local authority, had obligations under  
15 section 149 of the Equality Act, specifically to have  
16 due regard to the aims of the general equality duty when  
17 making decisions and setting policies. With respect to  
18 the PSED, this meant having due regard to the need to:  
19 (a) eliminate discrimination, harassment, victimisation,  
20 and any other conduct that is prohibited by or under the  
21 2010 Act; (b) to advance equality of opportunity between  
22 persons who share a relevant protected characteristic  
23 and persons who do not share it; and (c) to foster good  
24 relations between persons who share a relevant protected  
25 characteristic and persons who do not share it.

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1 The CCA, chapter 5, "Emergency planning",  
2 specifically states that plans:  
3 " ... should have regard to the vulnerable (i.e.  
4 those with mobility difficulties, those with mental  
5 health difficulties or who are dependent, such as  
6 children) and survivors and others affected (those  
7 directly affected by the emergency or the anxiety of not  
8 knowing what has happened)."

9 Chapter 7 of the Act, "Communicating with the  
10 public", stipulates that:  
11 "[Category] 1 responders need both to plan their  
12 communications and to regularly test their  
13 communications arrangements to ensure they are  
14 effective. The message must be right for the targeted  
15 audience and this must be coordinated with other Cat 1  
16 responders and engaging Cat 2 responders and the  
17 voluntary sector."

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

9

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

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

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

10

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

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

11

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

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

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

19 Town clerk Nick Holgate perhaps epitomises  
20 indifference and casual disregard with his lack of  
21 awareness as to RBKC's ability — or inability,  
22 rather — to identify vulnerable persons out of hours.  
23 Mr Kerry flagged this problem in emails in March of  
24 2017, so a few months before the fire, and it was  
25 discussed during humanitarian assistance board meetings.

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1 Mr Holgate admitted he should have been aware of this  
 2 issue .  
 3 They did not care about us.  
 4 Race, ethnicity and religion .  
 5 It was an obvious and basic need that communication  
 6 would need to be targeted to non-English speakers in  
 7 order to provide them with accessible emergency advice  
 8 and information. This was not done. This is  
 9 discriminatory .  
 10 There was a delay or failure to provide counsellors  
 11 who spoke the language of the bereaved, survivors and  
 12 residents . This was not done. This was discriminatory.  
 13 There was limited or lack of flexibility in  
 14 accommodation offered to make allowances for Muslim  
 15 mealtimes during Ramadan or attendance at prayers and  
 16 meetings, and food provided was not culturally  
 17 appropriate in some instances, and in other instances  
 18 Halal food was not provided at all . This was  
 19 discriminatory .  
 20 The panel will have recalled Nabil Choucair's  
 21 evidence during this module inviting the panel to  
 22 examine the issue of institutional discrimination and  
 23 its role in the disaster . In his words, "We need to  
 24 have institutional discrimination looked at as part of  
 25 the terms of reference".

13

1 Members of the panel, questions of race are, we say,  
 2 inextricably linked with Grenfell . We need to look no  
 3 further than the MPS's categorising of risk and threats  
 4 in the aftermath. The MPS Grenfell community impact  
 5 assessment created by RBKC police branch to record the  
 6 actions taken by the police and its partner agencies in  
 7 the aftermath of the fire attributed imminent threats of  
 8 an outbreak of crime and disorder to the Muslim  
 9 background of the victims. The entry of 18 June read:  
 10 "Imminent: Local, national or international events,  
 11 taken alone or in combination, expected to lead to  
 12 outbreaks of crime and/or disorder within hours ...  
 13 "Rationale: There is an expectation that the final  
 14 death toll from the fire could rise substantially and  
 15 with the cause still unknown, any subsequent disclosure  
 16 could have an impact on community tensions. Especially  
 17 when the majority off those affected are believed to  
 18 come from a Muslim cultural background, combined with  
 19 the incident occurring during the [holy] month of  
 20 Ramadan."  
 21 Members of the panel, this is Islamophobia, it is  
 22 racism, the elephant staring back at us in the room.  
 23 Disability .  
 24 Disabilities were known to RBKC and to the TMO.  
 25 They were known to adult services, they were known to

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1 RBKC disability services. Yet still they too were  
 2 treated with indignity and disregard.  
 3 We had, in the aftermath, people who were  
 4 frightened, they were grieving for friends, relatives ,  
 5 for neighbours, they were bereft of all their worldly  
 6 possessions. These residents were placed nonetheless in  
 7 hotels on high floors, in rooms that were not adapted  
 8 for their most basic needs. There was no consideration  
 9 of mobility issues or non-visible disabilities . To use  
 10 the phrase that Mr Simms has used already, it was  
 11 inhumane and cruel.  
 12 Pregnant women.  
 13 A number of expectant mothers who survived the fire,  
 14 traumatised enough by that, found themselves in hotels  
 15 or shelters which were not equipped to meet their  
 16 medical needs and requirements. They were living and  
 17 sleeping in entirely inappropriate accommodation. This  
 18 impacted upon their physical and mental wellbeing.  
 19 Children.  
 20 Children are a particularly important group here,  
 21 and we spent some time, both in the opening and in the  
 22 closing written submissions, addressing the issue as to  
 23 children, and the disproportionate number of children  
 24 that not only died in the fire, but those who suffered  
 25 as a result in the aftermath. The Equality and Human

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1 Rights Commission report entitled "Following Grenfell"  
 2 was based on interviews with family, and they found that  
 3 many children who lost a friend or family member or  
 4 their home in the fire struggled to access help.  
 5 David Isaac, the commission chair, said this:  
 6 "'There are so many children going to the same  
 7 school and still affected,' one respondent said. 'They  
 8 just don't know where to turn because there aren't the  
 9 services available.'  
 10 "'Supporting families who lost friends and loved  
 11 ones that night should have been a primary concern, but  
 12 especially the children involved ... While authorities  
 13 sought to respond to the disaster, children received  
 14 disjointed mental health and educational support. Their  
 15 needs and rights have slipped through the cracks.'"  
 16 Families found themselves in hotel rooms with no  
 17 facilities to sterilise bottles and cots if they had  
 18 small children, babies and infants. School-age  
 19 children, some of whom had exams to sit that week, had  
 20 no uniforms to go to school in, they had no room to  
 21 study. Often whole families were sharing one hotel  
 22 room, so teenagers had no privacy and no space.  
 23 At the other end of the spectrum are the elderly,  
 24 and although Module 4 focused on the seven days after  
 25 the fire, the response to the fire is long-lasting and

16

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

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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:

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"... 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

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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

20

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

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

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

21

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

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

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

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

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

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

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

23

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

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

25 The TMO had previous fires from which lessons should

24

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,

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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

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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

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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

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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.

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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.

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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

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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

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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

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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.

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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

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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

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1 ministerial appointment as Minister of State for  
 2 Policing and the Fire Service. In answer to questions  
 3 as to whether he was adequately briefed for the role,  
 4 he, not surprisingly, admitted he was not:  
 5 "I don't see how I could have been, given that this  
 6 was day two."  
 7 In their written closing submissions, DLUHC says  
 8 this:  
 9 "... the Department recognises that the commitment  
 10 to re-house all affected individuals in the local area  
 11 in three weeks was too ambitious and could not be  
 12 achieved."  
 13 This was not only an error, and it wasn't the only  
 14 error. In its oral opening, the department also  
 15 acknowledge that it should have been:  
 16 "... clearer in the way that the commitment was  
 17 communicated. It should have emphasised that affected  
 18 people would be provided with temporary accommodation  
 19 before being offered permanent accommodation, and that  
 20 they weren't obliged to accept [this] offer."  
 21 Now, it is one thing for someone to decide whether  
 22 to move into temporary accommodation for six months or  
 23 a year; a decision about whether to accept a council or  
 24 housing association tenancy intended to be your  
 25 permanent accommodation is of a totally different order.

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1 At a time when absolute clarity was necessary, it is  
 2 truly extraordinary that both central government and  
 3 local government in the form of RBKC could not (sic)  
 4 send out such confusing messages. RBKC should have been  
 5 clear in its own mind that the commitment was to provide  
 6 temporary accommodation.  
 7 An email from Fiona Darby, DCLG's deputy director of  
 8 homelessness, to Laura Johnson on 17 June summarised  
 9 what had been promised to RBKC the previous day. The  
 10 government was, in effect, offering RBKC a blank cheque  
 11 to cover the whole cost of temporary accommodation in  
 12 the private sector until permanent accommodation could  
 13 be provided. RBKC could book everything available, even  
 14 if it was not used, because the government would bear  
 15 cost. In light of this email, astonishing, it is clear  
 16 from Laura Johnson's written and oral evidence that she  
 17 understood the commitment to be the provision of  
 18 permanent housing.  
 19 The three-week target was not just ambitious, it was  
 20 totally irresponsible. It should have been obvious to  
 21 the government that it was impossible to meet the  
 22 deadline, given the commitment to rehouse locally, the  
 23 acute shortage of housing and the sensitive decisions  
 24 that were involved ensuring that accommodation was  
 25 suitable for each and every family's needs.

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1 RBKC was placed in a situation where it made offers  
 2 of accommodation to families even when it knew that  
 3 those offers were unsuitable. As Laura Johnson put it  
 4 in her written evidence:  
 5 "We were making offers we knew survivors would  
 6 refuse, in order to meet their three-week target, and to  
 7 make sure everyone had an offer."  
 8 Indeed, many residents moved into temporary  
 9 accommodation which was subsequently found to be  
 10 unsuitable and then had to move again and again. Many  
 11 waited months or even years to obtain suitable  
 12 accommodation, and many still have not achieved that and  
 13 have not been provided with proper permanent homes.  
 14 Insufficient steps were taken to address these  
 15 concerns, and the lack of leadership was not functioning  
 16 properly. Despite considering the issue of  
 17 an intervention during the weekend following the fire,  
 18 a decision was made against intervention due to the role  
 19 played by Gold Command having taken over RBKC's  
 20 leadership and the replacement of the chief executive  
 21 and leader of RBKC. This raises further issues  
 22 regarding the pan-London approach, the legislation, the  
 23 effectiveness of the legislative framework and clear  
 24 lines of activating the intervention.  
 25 In terms of central government, there were clear

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1 failings. There was a failing by central government to  
 2 act upon known information that RBKC and its leadership  
 3 were out of their depth and that people were suffering.  
 4 Nick Hurd had met with volunteers. He knew that they  
 5 were filling the leadership vacuum in the response. The  
 6 system of which Mr Hurd was a part itself failed. Data  
 7 provided did not add up. It was inconsistent. Further,  
 8 there were inadequate resources in place to monitor or  
 9 oversee RBKC.  
 10 Sir, in conclusion, we say with a large population  
 11 and complex society that we live in now, the probability  
 12 of something very unlikely happening is actually very  
 13 high. In one year alone, there was the Manchester Arena  
 14 bombing, the London Bridge terrorist attack and the  
 15 Grenfell Tower fire. Unlikely disasters all of them,  
 16 but they all happened, and they were all met with very  
 17 different responses and very different levels of  
 18 effectiveness.  
 19 The response to the aftermath of the Grenfell Tower  
 20 fire was woeful and laid bare a catalogue of breaches  
 21 and failings. The BSRs demand and expect those  
 22 responsible to take full ownership of these failings and  
 23 to acknowledge these and all statutory breaches. It is  
 24 only by such acknowledgement that the process of  
 25 accountability can begin.

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

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

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

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

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

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

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

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

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

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

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

9 Thank you very much, Chair.

10 SIR MARTIN MOORE-BICK: Thank you very much.

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

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

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

18 (11.10 am)

19 (A short break)

20 (11.25 am)

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

25 Yes, Mr Friedman.

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1 Module 4 closing submissions on behalf of BSR Team 1  
2 by MR FRIEDMAN

3 MR FRIEDMAN: Good morning.

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

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

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

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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

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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

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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

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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

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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

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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

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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

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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

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1 aftermath would have been immediate. It would have been  
2 present. It would have been felt”?

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

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

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

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

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

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

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

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

12 “... human—centred response [that] requires all of  
13 us to develop new approaches to empower and put people  
14 and communities at the heart of emergency response.”

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

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

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

7 “... the activities of bodies (other than public or  
8 local authorities) whose activities are not carried on  
9 for profit.”

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

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

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

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

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

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

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

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

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

13 Turning then to the borough.

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

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

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

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

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

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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

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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

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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

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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

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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

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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

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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

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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

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1 a place—specific disaster that has led to mass  
 2 displacement of socially , economic and otherwise  
 3 disadvantaged populations. Grenfell has shown how  
 4 subsidiarity provides central government with great  
 5 discretion even when the system is manifestly failing .  
 6 First , government departments are not scheduled  
 7 responders under the CCA. That leaves them with various  
 8 powers but not duties. Powers include that government  
 9 can make orders to require or permit responders,  
 10 third parties or itself to take action, with such orders  
 11 subject to affirmative resolution by parliament.  
 12 However, in a case of urgency, a minister may make  
 13 a written direction to act in place of orders that  
 14 remain in force for up to 21 days and which require no  
 15 prior legislative consent. Before and during the  
 16 Grenfell aftermath, these powers lay unused, and instead  
 17 Holgate had a new system pushed upon him in that  
 18 corridor .  
 19 Second, central and regional government had no means  
 20 of effectively predicting the resilience of the local  
 21 government response because there was no national  
 22 inspectorate or oversight function, and there still  
 23 isn't. It is especially untenable that subsidiarity  
 24 should prevail without proper independent auditing and  
 25 inspection. That left RBKC not on the radar of DCLG's

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1 RED team; Barradell, by his own admission, being overly  
 2 impressed by RBKC's positive posture; and Sawyer being  
 3 ignorant of the weakness in RBKC's system until he  
 4 physically attended the Town Hall.  
 5 Third, the lack of accountability of contingency  
 6 planning places ordinary people at risk because they  
 7 cannot easily complain to courts. Any public law  
 8 challenge to state failure in response and recovery  
 9 would face litigation difficulty , in that the executive  
 10 is legally regarded as enjoying a discretionary area of  
 11 judgement in the governance of security and emergency.  
 12 Sir Martin, with respect, will know as a judge that  
 13 a 5.30 application for interim relief on that Wednesday  
 14 afternoon would have got pretty much nowhere. What that  
 15 means is that if planning does not take place in  
 16 an effective and accountable way beforehand, then once  
 17 the emergency begins, people and communities are  
 18 dramatically exposed to the discretion of the state,  
 19 particularly when it collapses in its function.  
 20 Without its own planning and conduct duties under  
 21 the CCA, the cabinet secretariat and DCLG were able to  
 22 play by their own rules and, on that basis, they  
 23 floundered, because they did not appreciate in time that  
 24 the system had crashed.  
 25 Hammond has convinced herself that a pick—and—mix

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

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

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

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

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1 what was going on.

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

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

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

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

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

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

25 People suffered in the aftermath of Grenfell Tower

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

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

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

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

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

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

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

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

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

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

25 The admissions which it considers it right to make

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

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

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

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

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

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

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

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

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

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1 The council should have had a humanitarian  
2 assistance plan.

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

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

10 The council had not trained enough rest centre  
11 managers.

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

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

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

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

4 The council has made changes since the fire. We  
5 identified some of them in a document served shortly  
6 before the oral opening statements, and I outlined some  
7 of them in my opening statement. You will recall that  
8 these changes were in a wide range of areas, including  
9 oversight of contingency planning, communications,  
10 community engagement, training and exercising.

11 The council is committed to making improvements and  
12 changes continue to be made. We will update the Inquiry  
13 further in the recommendations part of Phase 2 later  
14 this year.

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

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

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

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

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

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

4 Council witnesses who spent time in the borough  
5 emergency command centre were asked about how  
6 effectively it operated once it was set up. In the  
7 light of their evidence, the council admits that it  
8 should have been more organised and efficient than it  
9 was. The council also admits that there were times on  
10 14 June when it was overwhelmed.

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

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

25 The council had not trained enough rest centres

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 London Gold arrangements earlier.  
 2 3. Holgate should have done so at some point after  
 3 the 17.30 meeting on 14 June. We have identified this  
 4 time rather than an earlier time because of the  
 5 following factors, each of which would legitimately have  
 6 discouraged him from activating the London Gold  
 7 arrangements earlier than that.  
 8 First, the fact that activating London Gold had  
 9 historically happened so rarely.  
 10 Secondly, the viewpoint commonly held within London  
 11 at the time that the London Gold resolution was more  
 12 pertinent to an emergency which affected several local  
 13 authorities than one which was geographically limited to  
 14 a single borough.  
 15 Thirdly, the council's contingency management plan  
 16 encouraged the view that activating London Gold was not  
 17 a step intended to be taken immediately.  
 18 Fourthly, the existence of the tri-borough agreement  
 19 meant that the council would more easily be able to draw  
 20 on resources from two neighbouring local authorities.  
 21 Fifthly, nobody involved in the conference call with  
 22 Holgate at 5.30 pm on 14 June advised him that he should  
 23 activate the London Gold arrangements. The evidence was  
 24 that activation was not discussed.  
 25 Sixthly, Hetherington's evidence was that he

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1 personally did not think that Holgate's decision was  
 2 wrong. At the time, Hetherington was the deputy head of  
 3 London Resilience. He has been head of it since 2018.  
 4 His views, therefore, carry weight.  
 5 So that is the council's position and the reasons  
 6 for it. I end this topic by making it clear that  
 7 the council stands by the admission made in its opening  
 8 statement that its leadership was unable to cope in the  
 9 days after the fire.  
 10 My next topic is the impact of the council's  
 11 failings.  
 12 Mr Chairman, as you know, our written closing  
 13 statement contains a lengthy section entitled  
 14 "Reflections on the impact of the council's admitted  
 15 failures". Today I'm not going to repeat the detailed  
 16 analysis in that section, but I'm going to summarise the  
 17 key points.  
 18 There are two main themes. The first is that, had  
 19 the council performed to the level that it should have  
 20 done, the experiences of the bereaved, survivors and  
 21 residents would overly have been significantly better  
 22 during the first seven days. The second is that it  
 23 would be unwise to assume that everything would have  
 24 been fine if only the council had performed to  
 25 an adequate level. That sort of thinking breeds

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1 complacency about the robustness of the current national  
 2 and local system for dealing with emergencies. It also  
 3 runs the risk of ignoring an excellent opportunity to  
 4 learn valuable lessons for the future.  
 5 Taking the first theme first, the following are  
 6 important respects in which an adequate level of  
 7 performance by the council would have significantly  
 8 improved the experiences of the bereaved, survivors and  
 9 residents during the first seven days.  
 10 First, training.  
 11 The council has made substantial admissions in  
 12 relation to its programme of training and exercises. It  
 13 fully accepts that its response would have been better  
 14 if it had conducted training and exercises to  
 15 an appropriate standard. The following measures which  
 16 should have been in place would all have assisted in  
 17 improving the quality and effectiveness of the response:  
 18 (1) a formal training programme for Council Gold,  
 19 Council Silver, and officers who worked in the borough  
 20 emergency command centre; (2) more senior officers  
 21 trained as Council Gold; (3) more trained BECC officers;  
 22 (4) more training events; (5) a higher level of  
 23 attendance at training events; (6) more trained  
 24 rest centre managers; (7) a training programme which  
 25 ensured that the contingency management plan was

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1 exercised at all levels at least once a year.  
 2 Second, rest centres.  
 3 Getting both more people and the right people to  
 4 rest centres earlier on 14 June would have made a real  
 5 difference at a crucial time. More trained rest centre  
 6 managers would have made a difference. In the absence  
 7 of a trained cohort of such managers within the council,  
 8 the deployment of senior council officers in greater  
 9 numbers and at an earlier time would have made  
 10 a difference. The full deployment of the council's  
 11 crisis support team would have made a difference.  
 12 Earlier deployment of the housing officers and social  
 13 workers who arrived at around 10.00 am would have made  
 14 a difference.  
 15 Third, communications.  
 16 Having a communications plan in place which was fit  
 17 for purpose and had been exercised would unquestionably  
 18 have improved matters. Had the council's communications  
 19 function performed at an appropriate level, the number  
 20 of residents who, through no fault of their own, missed  
 21 out on elements of the support package would undoubtedly  
 22 have been reduced.  
 23 Fourth, better pre-existing relationships with local  
 24 community organisations.  
 25 It was clear from the evidence heard in this and

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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

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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

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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

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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

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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

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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.

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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

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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

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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

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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

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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.

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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

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1 lectern, we'll be pleased to hear you. Thank you.  
 2 Module 4 closing submissions on behalf of the London Fire  
 3 Commissioner by MS COLLINS  
 4 MS COLLINS: Thank you.  
 5 Good afternoon, sir, Ms Istephan and Mr Akbor.  
 6 The London Fire Commissioner is acutely aware of the  
 7 suffering and distress of the bereaved, survivors and  
 8 residents in the aftermath of the fire, having heard  
 9 about their experiences in his meetings with the  
 10 Grenfell community groups, and again in their powerful  
 11 evidence in Module 4. Their experience shows that the  
 12 framework for responding to emergencies in London failed  
 13 them in the aftermath of the fire.  
 14 In these brief closing submissions on behalf of the  
 15 London Fire Commissioner, we wish to start with  
 16 a general point about the role of the London Fire  
 17 Brigade within the resilience framework, before touching  
 18 upon two issues arising from the evidence as it  
 19 developed throughout Module 4: first, the role and  
 20 function of the London Resilience Group; and, secondly,  
 21 the critical importance of accurate information  
 22 gathering and sharing.  
 23 The London Fire Brigade fulfils two functions within  
 24 the resilience framework. Firstly, and most obviously,  
 25 its role as a category 1 responder under the Civil

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1 Contingencies Act, which requires no further explanation  
 2 or discussion for the purposes of this module.  
 3 Secondly, together with the Greater London Authority and  
 4 London local authorities, the London Fire Commissioner  
 5 jointly funds and governs the London Resilience Group to  
 6 act on their behalf to co-ordinate and support  
 7 resilience in London.  
 8 The Fire Brigade acts as the host of the London  
 9 Resilience Group, which means that it employs London  
 10 Resilience Group staff and provides them with their  
 11 office space at London Fire Brigade headquarters, with  
 12 all of the administrative and human resource support  
 13 that comes with that. But the cost for that is split  
 14 between the three organisations who fund the London  
 15 Resilience Group, as I have explained: the Fire Brigade,  
 16 the Greater London Authority and London local  
 17 authorities.  
 18 I don't propose to rehearse the foundation and  
 19 development of these arrangements, which were touched  
 20 upon in our opening written statement and also that of  
 21 the Mayor of London, and also dealt with in detail in  
 22 the witness statement of John Hetherington.  
 23 What I do wish to touch upon, which leads to the  
 24 first issue arising from the evidence, is the remit of  
 25 the London Resilience Group.

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1 At times in Module 4 there was a tendency by  
 2 witnesses to conflate or confuse the component parts of  
 3 London Resilience, the brand, as John Hetherington  
 4 described it in his evidence to the Inquiry. This in  
 5 turn risks creating or fostering confusion about the  
 6 scope of the London Resilience Group's remit.  
 7 By way of clarification, and I hope not undue  
 8 repetition, the broader London Resilience term or brand  
 9 encompasses three elements: first, the London Resilience  
 10 Forum, which is, as you know, a local resilience forum  
 11 within the meaning of the Civil Contingencies Act, which  
 12 is chaired by the deputy mayor for fire and resilience,  
 13 and which is responsible for setting the strategy and  
 14 objectives for resilience in London; secondly, the  
 15 London Resilience Partnership, which is a term, rather  
 16 than an entity as such, which groups together all the  
 17 agencies involved in emergency response and preparedness,  
 18 including category 1 and 2 responders; and, thirdly, the  
 19 London Resilience Group, which, as I've already stated,  
 20 is tasked with supporting and co-ordinating resilience  
 21 in London. It does this principally by carrying out  
 22 three related functions: first, it provides business and  
 23 secretariat support and administrative structure for the  
 24 London Resilience Forum; secondly, it provides support  
 25 for the London Local Authority Gold arrangements, which

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

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

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

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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

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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

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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

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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

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1 a note that "rest centre managers will get up and  
2 running soon".  
3 Commissioner Roe is recorded as asking the local  
4 authority for numbers and where people in rest centres  
5 were coming from, in addition to his request for plans  
6 for the tower itself .  
7 The evidence in Module 4 revealed a chaotic  
8 situation at the various rest centres in the immediate  
9 aftermath and the lack of any effective system for  
10 recording and sharing the details of those who had been  
11 affected by the fire . The inadequacy of this  
12 information is apparent in the meeting minutes for the  
13 strategic co-ordination group, which show that there was  
14 a lack of clarity as to the numbers and identities of  
15 affected people.  
16 The evidence of Colin Brown and Michael Adamson from  
17 the British Red Cross paints a stark picture of this  
18 failure , revealing an absence on the part of RBKC of any  
19 centralised system of recording the details of those  
20 affected , which ultimately took close to one week to be  
21 coherently organised.  
22 The evidence in Module 4 highlighted the vital  
23 importance of accurate data collection and sharing so  
24 that all emergency responders and those that support  
25 them can fulfil their vital functions in both the

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1 response and recovery phases of an emergency, thereby  
2 providing effective assistance to those who need it.  
3 In conclusion, sir , the London Fire Commissioner  
4 recognises that the framework for resilience in London  
5 can be viewed as complex and not easily understood by  
6 those not operating within it . However, this may  
7 perhaps be understandable given the complexity of the  
8 undertaking in a city such as London, and the need for  
9 flexibility or elasticity when responding to  
10 emergencies.  
11 In due course, the London Fire Commissioner, drawing  
12 on the knowledge and experience of the London Resilience  
13 Group team, will make considered submissions regarding  
14 recommendations, and will welcome any findings and  
15 recommendations that the Inquiry may make so that local  
16 communities like Grenfell are not let down again.  
17 Thank you.  
18 SIR MARTIN MOORE-BICK: Thank you very much.  
19 Next we're going to hear a statement made on behalf  
20 of the Mayor of London by Ms Anne Studd Queen's Counsel.  
21 So, Ms Studd, when you're ready, thank you.  
22 Module 4 closing submissions on behalf of the Mayor of  
23 London by MS STUDD  
24 MS STUDD: Mr Chairman, in his evidence to the Inquiry, the  
25 Right Honourable Nick Hurd said:

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1 "I'm ashamed ... of the failure of the system I was  
2 part of to provide ... fellow citizens with the most  
3 basic support and comfort that they had every reason to  
4 feel totally entitled to in arguably their darkest  
5 hour."  
6 Each core participant with a commitment to public  
7 service must endorse that sentiment. For those directly  
8 affected by the tragedy at Grenfell Tower, the damage  
9 inflicted by the failures during the aftermath of the  
10 fire has caused unimaginable additional and unnecessary  
11 distress and pain, which continues to this day.  
12 As you were told powerfully at the beginning of this  
13 module by Hanan Wahabi:  
14 "No one from government looked for us. No one  
15 helped us. We were left exposed and vulnerable, and  
16 when the authorities eventually did come, it felt like  
17 a tick-box exercise."  
18 And this from a family who had walked out of that  
19 burning building and had to watch as other members of  
20 their family died in it .  
21 The bereaved, survivors and residents consider that  
22 they were treated as they were because we, as the state,  
23 did not care about their community. As Mark Simms from  
24 the Rugby Portobello Trust so clearly articulated :  
25 " ... but who was really looking after people who had

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1 lost their children in the fire was far from people's  
2 minds, because they were left to God and good  
3 neighbours, and that can't be right in 2017 in central  
4 London."  
5 The issues which the Mayor will focus upon in this  
6 closing statement are: first of all , the resilience  
7 framework; then the humanitarian response; and, finally,  
8 in brief , reforms for the future. An examination of  
9 these topics will illustrate why this community was  
10 failed so badly in the immediate aftermath of the fire  
11 and what this Inquiry can and must do to prevent such  
12 a situation being repeated.  
13 I turn to deal with the resilience framework.  
14 It may be easy for this Inquiry , faced as it was  
15 with numerous documents, guidance and acronyms, and no  
16 experience of the workings of the resilience framework,  
17 to reach the simplistic conclusion that the system was  
18 overcomplicated, a suggestion put to many of the  
19 witnesses in the course of the Module 4 hearings.  
20 Such an approach would be misguided. The Mayor does  
21 not doubt that the documentation might be slimmed down,  
22 that reviews of the guidance material might be conducted  
23 periodically as a single piece of work, and that there  
24 might be a need to clarify responsibilities , focus on  
25 roles and review some of the arrangements in the light

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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

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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

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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

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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

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1 explained in his evidence:  
 2 "Structures are very important in emergencies,  
 3 because they provide a framework within which people can  
 4 request, ask, direct. Without the structures being  
 5 sensible and robust, the likelihood of a response being,  
 6 frankly, adequate is diminished significantly."

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

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

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

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

25 Of particular note, there was no trained operational

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1 humanitarian assistance liaison officer in RBKC at the  
 2 time of the fire. The absence had been highlighted in  
 3 2016 by the minimum standards for London review, and had  
 4 not been capable of remedy because no one in adult  
 5 social care would step up to volunteer, not assisted,  
 6 perhaps, by the absence of any additional remuneration  
 7 or ringfenced preparation time to undertake the role, on  
 8 top of the doubtless demanding job they already held  
 9 within RBKC. David Kerry's solution to this was that  
 10 RBKC would rely upon mutual aid. Such an approach, as  
 11 well as ignoring that mutual aid should be a reciprocal  
 12 arrangement, lacked the advantage of local knowledge and  
 13 contacts within RBKC and pre-existing relationships with  
 14 the local community and the voluntary sector.

15 Unfortunately, mutual aid was not immediately  
 16 invoked. Instead, Sue Redmond was given the role in her  
 17 "why me" moment. She was notified of the role on  
 18 14 June, read the definition for the role that evening,  
 19 and was formally appointed at 10.00 am on 15 June 2017  
 20 at the RBKC Gold Group meeting. Her appointment was  
 21 made because she was the director of adult social care,  
 22 and the framework provided that:

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

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1 That was her only qualification for the role and,  
 2 even using her best endeavours, did not equip her in any  
 3 respect. She was not trained and she only received the  
 4 definition of the HALO and what the role entailed on  
 5 14 June 2017.

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

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

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

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

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

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

25 However, the lack of strategic oversight, the

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

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

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

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

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

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

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

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

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

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

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

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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.

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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.

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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

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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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 There is no better way to conclude this closing

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1 submission than by re—telling what Mohammed Rasoul told  
2 you:  
3 "The British public kind of stepped up, and they  
4 filled in those gaps in an amazing way. But it  
5 shouldn't have been the case. This should have been the  
6 responsibility of the people who were in charge of us,  
7 the people — you know, the politicians,  
8 the councillors, who are in charge of the local  
9 authority ... this is their role. They're meant to be  
10 leaders, looking after us and kind of attending to our  
11 needs, but they were nowhere to be seen during the  
12 whole — like the majority ... the immediate aftermath  
13 and afterwards."

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

18 Thank you.

19 SIR MARTIN MOORE—BICK: Thank you very much.

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

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

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

3 MR BEER: Yes, not at all, sir.

4 SIR MARTIN MOORE—BICK: Thank you.

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

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

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

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

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

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

25 The issues which I shall address are accordingly as

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

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

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

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

25 Having considered all of the oral and written

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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

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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.

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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

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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

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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

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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

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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,

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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.

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

5 In conclusion, this department remains committed to  
6 supporting those affected by the Grenfell Tower fire.  
7 In total, central government has committed over  
8 £160 million to supporting the community since 2017,  
9 including £132 million that has already been spent to  
10 support rehousing efforts, to deliver bespoke health and  
11 wellbeing support, and the refurbishment of the  
12 Lancaster West Estate.

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

18 Thank you, sir.

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

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

23 (3.06 pm)

(A short break)

24 (3.20 pm)

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

4 So, please, Mr Warnock, come to the lectern.

5 Thank you.

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

8 MR WARNOCK: Thank you, sir.

9 Chairman, members of the panel, the  
10 Metropolitan Police Service, the MPS, falls outside  
11 the Inquiry's terms of reference for this module, which  
12 focuses on local and central government. However, the  
13 MPS has had a representative in court throughout the  
14 Module 4 hearings, and has listened to the evidence. It  
15 recognises that, as a category 1 responder, it formed  
16 part of the wider response to the aftermath of the  
17 tragedy. It took a key role in chairing the strategic  
18 co-ordination group for an extended period after  
19 14 June 2017, and it also fulfilled a key role in  
20 policing the local area and supporting the local  
21 community in the weeks and indeed months thereafter.

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

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

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

16 First, the Casualty Bureau.

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

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

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

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

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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

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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

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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.

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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

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1 facilitated bereaved families' access to a range of  
 2 other agencies who were able to provide support  
 3 services.  
 4 One additional matter: the possibility of  
 5 Islamophobia has been raised by Ms Munroe  
 6 Queen's Counsel in relation to a community risk  
 7 assessment. This was not a matter explored in the  
 8 evidence, certainly not as regards the MPS. The writer  
 9 of the risk assessment has not been called to give  
 10 evidence. We draw your attention to the fact that,  
 11 following on from the passage cited by Ms Munroe from  
 12 that risk assessment, the assessment said:  
 13 "Community leaders from local Mosques have been  
 14 contacted and are working with the police and to support  
 15 those affected, as are community leaders from other  
 16 faith groups."  
 17 The MPS sought to work in a positive way with all  
 18 those affected by the tragedy. Whilst it will not have  
 19 got everything right, it would strongly refute any  
 20 suggestion that Islamophobia affected its response to  
 21 the tragedy.  
 22 In conclusion, the MPS acknowledges the difficulties  
 23 faced by the bereaved, the survivors and the residents  
 24 in the aftermath of this awful tragedy. The touchstone  
 25 for the success of the joint agency response in the

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1 immediate aftermath can fairly be judged by the lived  
 2 experience of those impacted by the tragedy. From the  
 3 outset, the MPS has been concerned to engage with  
 4 bereaved and survivors as part of its ongoing criminal  
 5 investigation and enquiries on behalf of Her Majesty's  
 6 Coroner. The MPS is keen to assist this Inquiry in any  
 7 way it can in trying to ensure that, should an event  
 8 occur again, the experience of those affected would be  
 9 significantly better.  
 10 A full submission will be provided to the Inquiry in  
 11 accordance with the recommendations timetable to inform  
 12 the Inquiry, as well as core participants, what  
 13 improvements have already been made since June 2017 and  
 14 what work is ongoing by those charged with responding to  
 15 major incidents which result in mass casualties.  
 16 That is our statement.  
 17 SIR MARTIN MOORE-BICK: Thank you very much, Mr Warnock.  
 18 Well, that brings to an end the oral closing  
 19 statements in Module 4. There will be no sitting of  
 20 the Inquiry tomorrow, but we shall be resuming our  
 21 hearings on Wednesday morning at 10 o'clock, when we  
 22 shall begin hearing evidence from Professor Purser, the  
 23 expert toxicologist instructed by the Inquiry.  
 24 So that's it for today. We resume at 10 o'clock,  
 25 please, on Wednesday morning.

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1 Thank you all very much.  
 2 (3.40 pm)  
 3 (The hearing adjourned until 10 am  
 4 Wednesday, 29 June 2022)  
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