GRENFELL TOWER INQUIRY RT

Day 309

November 7, 2022

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Monday, 7 November 2022

(10.00 am)

SIR MARTIN MOORE-BICK: Good morning, everyone. Welcome to today's hearing. Well, today we begin our last set of hearings, during which we're going to hear final closing statements from a number of the core participants.

We're going to start with Ms Barwise King's Counsel on behalf of the bereaved, survivors and residents whom she represents. She is there ready.

No rush, but we're ready to hear from you when you're ready, Ms Barwise.

Closing submissions on behalf of BSR Team 1 by MS BARWISE

MS BARWISE: Good morning, sir. Good morning, Ms Istephan. Good morning, Mr Akbor.

We end Phase 2 very much as we began it, in the sense that few core participants accept significant responsibility for what happened. The Department for Levelling Up and RBKC do acknowledge their significant errors, but otherwise, introspection is lacking, apart from those who admit historic but non-causative mistakes. Self-interest is unhumbled by the disaster and, indeed, by this Inquiry. The leitmotif of Grenfell is the failure of anyone to take responsibility, either then or now.

Other than central and local government, no

core participant accepts any responsibility for the disaster, each instead seeking to diminish its own role. Each core participant continues to blame others and, predictably, now blames the regulatory regime for its permissiveness and tendency to be abused. This is to overlook that the designers and contractors of Grenfell all failed to address properly what the statutory requirements actually were, and used a system including foam insulation patently in breach of the linear route, which was the only route to compliance they could have been following.

Whilst of course the Building Regulations were an outcomes-based regime at the time, it was still necessary to demonstrate compliance with the functional requirements to the building control officer. Each of the designers and contractors were untroubled both by what the regime required and whether they complied with it.

Manufacturers were all too aware of both the functional requirements and ADB, but sought to circumvent ADB's linear route which prevented the use of their products. Pausing there, Arconic well knew that its ACM PE, once made into cassette panels, did not even conform to ADB's diagram 40, because it was neither class 0 nor B. The entirety of the cladding system at

Grenfell did not conform to the linear route, yet Arconic's BBA certificate applied to both riveted and cassette panels. When we say little has changed since the beginning of Phase 2, we mean that, incredibly, Arconic remains in denial as to the lethality of its ACM PE product.

Studio E, although silent in this round of submissions, when it last spoke inaccurately sought to minimise its central role as lead designer.

Exova makes no mention of its own failures to produce an adequate fire safety strategy, nor the fact that its strategy was misleading, both on the subject of the cladding and means of escape for disabled people.

Harley, who shamelessly drove the use of the ACM PE product at Grenfell for illicit profit which it shared with Rydon, expresses dismay that manufacturers were able to take advantage of flaws in the regulatory system, and insists industry at large did not know ACM PE to be unsafe in fire. This submission is brazen, given Harley well understood ACM PE was highly combustible. One of its own designers contemporaneously said, "As we all know, ACM will be gone rather quickly in the event of a fire".

BRE argues that if regulations had been complied with, intolerable fire spread would not have occurred.

That may be true if the BS 8414 route had been utilised, but not if the linear route was followed, but without due regard to the functional requirements. BRE also defends its desktop assessment, criticised by Professor Bisby.

NHBC, in misplaced reliance on Professor Bisby's desktop report, seeks to justify its irresponsible role in jointly producing Technical Guidance Note 18, which introduced the concept of façade desktops as a route to compliance.

We are acutely aware that the panel must examine all the circumstances of the disaster, including both the immediate causes of fire spread and subsidiary causes, which exacerbated the consequences of the fire, such as lack of means of escape for disabled people and the general management and maintenance of Grenfell. Indeed, we've encouraged and continue to encourage the panel to address even issues which were insufficiently causative, such as poor workmanship during the refurbishment, or not directly causative, such as dishonest marketing by the insulation manufacturers, together with the BS 8414 testing regime and supervision of it by UKAS. It is clearly vital to explore the role of insulation manufacturers, despite their products not being responsible for the uncontrollability of the fire.

Whilst we did not suggest Kingspan's K15 product was causative at Grenfell, we had characterised Kingspan's behaviour as seminally causative, and we remain of the view that they and Celotex were seeking to misrepresent to the market that foam insulations were universally safe for use at height to overcome the prohibition in the linear route of ADB. As Kingspan acknowledged in its 2015 "Reasons why" campaign, it was seeking to instill confidence in K15 used in buildings with a habitable storey 18 metres or more above ground and to prevent increasing specification of Rockwool, and to spin such that the story is not "Fire, fire, fire" all the time. It wanted to educate the market as to the insignificance of combustibility of individual products in the overall scheme of things.

Even in the immediate aftermath of Grenfell, before it could have known whether its product had been causative to any degree or not, Kingspan sought to educate government by its political campaign to demonstrate materials of limited combustibility would fail. Kingspan did this by its subsidiary, Euroclad, building weaknesses into Kingspan's tests of limited combustibility products. This was not honest science. It was seeking to manipulate the impact of the government's building safety tests.

Kingspan should take little comfort from its K15 product not being the catalyst for fire at Grenfell becoming irreversible by comparison with a product whose core equates to diesel or lighter fluid. The evidence should not be seen as universally vindicating the use of foam insulations.

First, according to Bisby, K15 may have been relevant in the initial escape from flat 16 due to its ease of ignition, and K15, unlike RS5000, produced burning debris.

Second, Bisby is clear that K15 might be causative in other cladding configurations, and these should be considered. Given the Phase 2 experiments show K15 is easily ignited and combustible, one might question its use in both timber-framed buildings and buildings using structurally insulated panels.

Similarly, as Grenfell's cladding was not subjected to a BS 8414 test, it might be argued -- and BRE does argue -- that it is not for the Inquiry to consider such testing. We disagree. Both the testing and certification process should be examined. It became clear in Module 2 that the whole certification regime by bodies such as BBA and the veneer of supervision of those bodies by UKAS is in itself part of the problem.

Despite that invitation to the panel to explore all

such avenues, none causative in the legal sense, we have nevertheless sought in our written submissions to identify the principal effective causes of the disaster so as to arrive at a minimalist rogues gallery; by definition, not definitive. Given the scale of the disaster and the number of those who died, it is vital the Inquiry ascertains the principal effective causes so that those most accountable are identified, and to prevent recurrence by targeted and robust recommendations. This is the least that the bereaved and survivors can expect of us. Identifying the actual causes of the disaster is necessary for catharsis and to prevent distraction by false narratives, which are dangerous, in that they distort or conceal the steps necessary to prevent recurrence.

Before attempting to allocate responsibility, there are certain implications of an outcomes-based regime which were made clear in the Module 7 evidence and which influenced responsibility.

First, as Professor Torero told the panel, the fire safety engineer bears a pivotal responsibility for safety, in that it is their job to explain the functional requirements, including those for B4, external fire spread, within the fire safety strategy. This includes defining what "adequately resist fire

spread" means, and explaining what, if any, degree of fire spread in the external walls is acceptable. This task is building-specific and influenced by the evacuation strategy. In the case of a high-rise building with a stay-put strategy, no external flame spread can be tolerated. Thus, the fire safety strategy is the blueprint for a building's fire safety and demonstrates compliance with the functional requirements.

Second, it is incumbent on designers and contractors, whether following the linear route or test route within ADB, will achieve compliance with the functional requirements. Implicit in this is that neither routes to compliance with ADB, nor the BBA certificates demonstrating conformity with tests, can be slavishly adhered to without the designer applying their own judgment.

Third, whilst desktops, in the sense of legitimate engineering assessments, were always a means to compliance with the functional requirements, the concept of façade desktops was introduced and expressed to be a third route to compliance with ADB not by government, but by BCA's TGN, drafted by industry. Whilst Professors Torero and Bisby rightly stress the outcomes-based nature of the regime, the reality of ADB

was that it was intended to be and was -- wrongly, as it transpired -- regarded as a safe harbour, namely a reasonably safe way of achieving compliance with the functional requirements. Whilst there were caveats within both in the Building Regulations and ADB to the effect that the approved documents were not a guarantee of compliance, nevertheless, partly through ignorance and partly as it suited their purposes, designers and contractors overfocused on ADB as a safe route, instead of considering the functional requirements.

Two important issues on which the panel may wish to make findings are: first, that the fire safety engineers' failure to define the functional requirements in the fire safety strategy was not legitimate; and, second, that designers' and contractors' reliance on ADB without the exercise of judgement, and reliance on BBA certificates without interrogation, was not legitimate.

The panel should bear in mind, when reflecting on whether to hold a Phase 3 on its proposed key recommendations, as some suggest, that there are several areas -- this is but one -- in which the panel will have to find groups of stakeholders in a given field acted in a way which is not logically supportable. This narrows yet further the field of those able to give reasonable, unbiased input to the Inquiry. There will be no

shortage of tendentious arguments against sensible recommendations.

In our ranking of responsibility, we split the protagonists into three groups: first, those with responsibility for speed of fire growth and spread, namely those responsible for the use of ACM PE; second, those with responsibility for contribution to spread of toxic smoke due to poor compartmentation; third, responsibility for failure to ensure adequate means of escape for disabled people. The need for concomitant PEEPs is addressed by others.

In our first group, those responsible for the selection of ACM PE, we split the protagonists into two groups and rank them in order: first, Arconic, manufacturer of the ACM panel material; second, Studio E, as lead designer and architect; third, Exova, as fire engineer. Those bearing secondary responsibility are Harley, as cladding design subcontractor; Rydon, as design and build contractor; RBKC building control; and government, as custodian of the statutory regime.

Arconic still insists its product in rivet form achieving a Euroclass B, despite subsequently achieving as low as an E in cassette form, means its product was theoretically safe. Arconic invites you to conclude

there was nothing irregular about the test by which the B was achieved on the basis of Mr Burnham's statement that, although the air gap may be an important parameter, there is no unequivalent correlation between the air gap and performance.

Arconic's submission completely ignores Mr Wehrle's contemporaneous email saying that the test in which a B was achieved for the riveted panel was "arranged to pass", and overlooks Arconic's own evidence that the 50-millimetre gap used in practice.

More fundamentally, Arconic sidesteps the fact that its BBA certificate deliberately gave a wholly misleading impression as it related to both cassette and riveted panels. Arconic's argument that the material itself before fabrication into panels was capable of achieving a B therefore comes to nothing.

Arconic argues it is wrong to equate its product to petrol or other fuel, given Bisby and Torero's experiments show that, without the cavity and insulation, ACM PE would self-extinguish. Given most cladding systems comprise both a cavity and insulation, Arconic's point is clearly bad. It ignores the Inquiry experts' findings that the PE core is a highly volatile material. Once the aluminium skins delaminate, PE core is a catalyst for an uncontrollable fire.

Studio E, as lead designer, bears the ultimate responsibility for the selection of ACM PE. The NBS specification it drafted predominantly in proprietary form was designed to ensure its aesthetics were achieved, without considering fire performance of the cladding panel. Studio E never considered the functional requirements for the external wall, and the route to compliance was nowhere stated.

Studio E should, according to Mr Hyett, have reverted to Exova to produce the B4 analysis of the chosen system. The lack of thought by Studio E as to whether and how the selected rainscreen met the functional requirements was evidenced by Sounes' failure to read beyond page 1 of the BBA certificate. He never attempted to ascertain ACM PE's performance in fire.

Exova ought to have produced a fire strategy which explained how the functional requirements for the external wall were to be met, by determining what, if any, fire spread was tolerable within Grenfell's façade. Instead, Exova gave no guidance, but created a false sense of security by saying the proposed changes, which it knew involved cladding, would have no adverse effect. This set a complacent tone for the fire safety from the outset.

In Exova's subsequent and ad hoc involvement on the

project, it became aware that combustible insulation was proposed, yet at no stage did it intimate that it now needed to carry out an external wall analysis, nor question what route to compliance was being followed.

Given Exova was repeatedly a top-tier fire engineer, had it examined the chosen cladding system and advised Studio E that it was non-compliant, it is likely Studio E would have changed the system. Given Exova's primary business was fire testing and research, of which the consultancy division was merely a part, Exova should have been aware of the dangers of unmodified ACM PE.

Our second group is led by Harley, also untroubled by compliance. Harley's subcontractor designer, Mr Lamb, failed to check whether ACM PE was compliant with the functional requirements and ADB, and did not even read the BBA certificate. Harley seeks to limit the importance of its role to mere cladding subcontractor, but the letter of intent against which it worked recorded the subcontract was for the design of the façade works. It avails Harley nothing to suggest, as it does, that it was merely a labour-only subcontractor as opposed to a designer.

Nor is it of great significance that the contract was not signed. It was clear from the documents Rydon and Harley exchanged that a contract for the design of

the cladding had been made and a price agreed. Harley clearly undertook a degree of design by its Mr Lamb. As such, Harley owed a duty to warn if the NBS specification was patently defective.

Second in our group 2 line-up is Rydon, who, as design and build contractor, clearly had a responsibility to at least check compliance of the façade, but failed to do so, and also selected the uPVC window surrounds which permitted the fire to escape so easily.

Third in group 2 is RBKC building control. Whilst the disaster would not have happened without the acts and omissions of the construction professionals and manufacturers, it is conceivable that it could have been avoided if building control had identified the non-compliance of the cladding system. That said, building control is only likely to have noticed the insulation was non-compliant, and even had it required a change to mineral wool, the disaster would still, based on the Phase 2 experiments, have occurred.

Ms Menzies, however, considers Hoban should have interrogated the BBA certificate and established that the panel chosen at Grenfell was not class 0. Even had Hoban identified both non-compliances, it is likely, given the permissive nature of Building Regulations, and

given the design team's financial motivation to use ACM PE, that the team would have persuaded Hoban the design complied by some way other than compliance with the linear route, possibly by desktop. DCLG's Martin was, after all, contemporaneously concerned that BCOs would be swayed by dubious desktops.

Whilst the contractors and designers all claim it was building control's role to be the final arbiter of whether compliance had been achieved, this is neither sensible in practical terms, nor is it fair. Contractors and designers are generously paid to focus on whether the building, including its façade, is compliant, whereas a local authority has to consider many buildings, and its staff are necessarily not the same calibre as highly paid, highly specialised designers and contractors. Historically, the courts have considered local authorities are not underwriters of building projects, and that seems correct. Whilst we do very much criticise RBKC building control, we do not consider they're as culpable as the manufacturer, architect, fire engineer and contractors.

Last in our group 2 line-up is government. Clearly, as the Department for Levelling Up admits, the department facilitated the disaster, but the real questions are whether the department could and should

have acted earlier, and, if it had, whether it would have prevented the disaster, given the many deceptions practised by industry to circumvent even those elements of ADB which were clear. Some of these deceptions came even after Grenfell, showing some industry protagonist's unswerving commitment to circumventing inconvenient regulation.

These practices included manufacturers' deceptive marketing, extending to corrupting BBA certificates; the production of self-serving guidance, such as TGN18, using desktops to circumvent ADB's linear and test routes; Kingspan's post-Grenfell myth-busting campaign against non-combustible products; and NHBC's 2016 guidance approving a build-up of ACM PE and combustible insulation.

I now turn to responsibility for exacerbation of the consequences of the fire.

Primary responsibility for this falls into two categories: those who caused or contributed to poor compartmentation, and those who failed to ensure adequate means of escape for those with disabilities.

As to compartmentation failures, these are attributable to a variety of factors, including doors, the installation of the gas pipe in the stairwell, and breaches in compartmentation caused by the smoke control

system.

Responsibility for lack of operational door-closers falls on RBKC and TMO. There was no system of planned maintenance or routine inspection of the doors, and RBKC's Laura Johnson rejected an annual door-closer inspection programme on the grounds of cost, despite LFB having required it. This conscious cost-benefit analysis, with human life as the cost, was not a legitimate way for a local authority to behave. Johnson should have sought increased funding and stressed to her superiors the gravity of the situation.

TMO simply went along with RBKC, despite understanding the importance of a door maintenance regime to life safety.

TMO also bears responsibility for failure to ensure rectification of unsealed holes in the compartment walls made by pipes for the new gas supply, about which it had been warned.

The designer of the smoke control system, PSB, bears responsibility for breaching compartmentation via the north and south shafts of the system. PSB's failure to appreciate that the shafts were protected shafts is a fundamental and serious issue, compounded by PSB's specification of substandard dampers. The dampers should have been smoke control dampers, but instead were

fire dampers, the lowest possible standard. The panel should disregard PSB's attempt to blame lack of clarity in the regulations and to assert that functional requirement B3 does not extend to prevention of smoke within or from the protected shafts. Dr Lane was clear that the dampers were required to be smoke dampers.

The second way the consequences of the fire were exacerbated is perhaps one of the most important lessons Grenfell teaches us, namely the failure, principally by Exova and Studio E, to ensure adequate means of escape for disabled people.

Exova and Studio E failed to ensure that Grenfell was designed in accordance with the principles of inclusive design, contrary to ADB. Exova's witnesses were strident that ADB did not require means of escape for disabled people in general needs residential buildings. As a result, Exova's fire safety strategy was silent on means of escape for disabled people, and worse, repeated the misdescription of the lifts as firefighting lifts, despite Exova having been told by Mr Sounes that they were not.

Dr Lane was clear that ADB required means of escape for disabled people, and that the description of the so-called "evacuation lift" in Stokes' FRAs should have prompted Exova to consider means of escape for disabled

people. Instead, Exova simply assumed disabled people would evacuate or, at worst, wait in the stairwell until the fire has been put out. It is troubling that an allegedly world-class fire engineer in the 21st century could consider such an approach acceptable, given it involved an abdication of Exova's duty as fire safety engineer to ensure people's safety in fire. This is a classic example of an industry professional blaming the regulator for something which is not a weakness in the regulation, but the professional's own ignorance or wilfulness.

Studio E was aware of the inclusive design requirement and the presence of disabled people in Grenfell, hence Sounes commissioning Bonnett Associates to consider access in stage E. The resultant accessible design guidance was however silent on egress, contrary to ADB. Studio E simply assumed the vulnerable would take refuge in flats on the same floor, but without verifying that assumption. This failure is made worse by Sounes' awareness that the lifts were not firefighting lifts. He claimed he may have been confused about this, in that he knew it was not a firefighting shaft, but that alone should have caused him to ascertain whether the lifts were firefighting lifts.

Means of escape for disabled people would have been uppermost in Exova and Studio E's minds as, prior to Grenfell, Exova provided for disabled evacuation in its fire safety strategy for the neighbouring Kensington Leisure Centre.

Exova and Studio E's failure at Grenfell was exacerbated by the failure of others. RBKC had been a trailblazer for accessible housing, and had received advice in 2010 and 2012 that those with disabilities being housed on the ground floor, or a refusal to house them, was a failure to comply with ADB. RBKC was also aware that those with disabilities might take up to four times longer to evacuate, yet it did not ensure Grenfell, its flagship renovation project, provided adequate means of escape for disabled people.

TMO also failed, despite being acutely aware of those with disabilities in Grenfell, to ensure the refurbishment provided adequate means of escape, and made things worse by knowingly misdescribing the lifts as firefighting or evacuation lifts.

Stokes, the fire risk assessor, also furthered the dangerous impression that the lifts were firefighting lifts, and stated Grenfell had "reasonable arrangements" for the evacuation of disabled people. He fell below the standards Lane considered were required of him.

Finally, government also bears responsibility for the failure to ensure means of escape for disabled people were fully explained in ADB. Undoubtedly, ADB required inclusive design but, as explained in our Module 6 submissions, government had been aware from 2004 that means of escape guidance was inadequate, and from 2015 at latest that the guidance was widely regarded as insufficient.

To conclude, those we consider primarily at fault for the disaster had or ought to have had specialist knowledge, and were in a position to alter the outcome by deploying that knowledge in the interests of safety. One of the Inquiry's most important tasks is to bring about a sea change which instills, both within government and across the sector, the importance of the fire safety burden that they bear. This requires an appreciation that the built environment poses a danger to end users, not only to workmen working within it, a risk which has largely been cured by the CDM Regulations. If the Inquiry can effect this sea change, it will be a turning point in the industry's long history.

Those are my submissions.

SIR MARTIN MOORE-BICK: Thank you very much.

I understand we're going to hear also from

Mr Friedman. Is that right?

Yes, Mr Friedman, if you come up, when you're ready.

Closing submissions on behalf of BSR Team 1 by MR FRIEDMAN

MR FRIEDMAN: While Grenfell Tower still burned, this Inquiry was established. The urgency reflected the scale of the disaster, still one of the most fatal known cladding fires anywhere in the world.

Since then, the Inquiry has revealed an industry of manufacturers, architects and contractors who were allowed into Grenfell Tower by the council owner and its agent. You will be in a position to describe wrongs done in relation to design, materials, engineering and management. You will have the detail of the instability of the various regulatory regimes which state actors tolerated and corporate actors capitalised upon. You will now know just how out of its depth emergency response to catastrophic events was and still would be in the major cities of this country, particularly firefighting, but more generally disaster management. And you will have come into contact with people and the community of a social high-rise building and its surrounding area. Their disaster began with how they were treated by RBKC and the TMO before the fire, and continued through to an aftermath where they were left to build their lives back up from nothing.

Grenfell's victims -- and some of its perpetrators -- come from all over the world, but this disaster was made in Britain. Without detracting from what you have just heard as to where discrete responsibility lies, it is important to ask: what is it about modern Britain that allowed the grave wrongs of industry to take root, for the emergency response to crash, and for its socially housed population to be treated as objects and problems, rather than people with rights worthy of respect?

One of the few places in British society where those types of social contract questions can be rightly asked and legitimately answered is a public inquiry. Inquiries are commissioned by government, but they are for the public. They are not trials or ordinary legal processes. The panel properly investigates policy, governance, economics, in a manner beyond the means and purpose of ordinary courts. Unlike civil and criminal proceedings, an inquiry can adopt flexible standards of proof, paper and oral analysis, and engage in fact-finding that does not only arise from direct causation of events, but identifies context, contributing factors and broader matters of system and culture. An inquiry cannot make determinations of civil or criminal liability, yet it can pave the way for both.

You have heard the BSRs' call for justice. One part of that justice is in this process of publicly accountable learning.

In an inquiry concerning mass fatality and complex technical investigation, it would be wrong ever to lose sight of those who died. So too would it be wrong to ask the bereaved to undergo yet further proceedings after the conclusion of your work to obtain findings about the deaths of their loved ones. That is why the Inquiry agreed at its outset to do its best to establish who, when, where and how each individual died, and to place those facts in the context of the causation and circumstances of the fire. The reporting of the Module 8 presentations and their cross-reference to the Inquiry's findings in the other Phase 2 modules will be the final part of that endeavour.

The Inquiry has also invited submissions on recommendations. Where the nature of a potential recommendation justifies it, there should be further expert opinion and a public hearing to ensure transparent ventilation of the issues. The panel does not need me to tell it that robustly testing and explaining Inquiry recommendations is key to their success. But it goes beyond that: the Inquiry's function to correct features of governance that cannot

necessarily be trusted to correct themselves. It is an important part of the Inquiry's remit to draw out vested interests and opposition to essential change and to publicly dismiss unwarranted objections. The alternative is that such objections only surface later behind closed doors and within corridors of power. It is a root cause of this disaster that its subject matter, from construction to residents' rights, has never evolved on an open, equal and accountable playing field. To regain trust, things must be different now.

When one hears of the reckless and at times predatory behaviour of those responsible for the fire and its spread, it inevitably begs the wider question: what type of society allowed this to happen? On this, we offer seven, observations.

First, we live in a particular type of post-industrial risk society, in which advances in science and technology, with all their possibilities, also generate threats. This paradoxical dynamic of modernisation is aggravated by globalised processes that expose us to materials made and tested in one country, sourced in another, lawyered in a third, and then installed in and onto buildings by multiple contractors.

Second, when we fail to properly consider low statistical risk events with foreseeably devastating

consequences, we particularly expose ourselves to disaster. As Professor Torero put it, foreseeable risk must always be multiplied by the enormity of consequence, especially so when the chance of the event happening was actually increasing, as it was with cladding fires. The LGA guide statistics on the low number of evacuations from high-rise blocks is the Inquiry's now well known example of a false counsel of security. It took no account of severity, overlooked near misses, assumed no underreporting and left out local and international knowledge on the very danger it offered assurance against.

Third, in disaster risk analysis, complacency about what is normal and abnormal is inherently problematic, and the misdirection and miseducation of the LFB is a case in point. At a normal incident, almost every one of the failings in LFB's competency at Grenfell Tower would not have mattered. Standard compartment firefighting with little incident command or communication would have sufficed. What events like Grenfell show is that a risk-related service that knows only the bounds of past or frequent experience will be fragile in the face of what is unexpected and new. This predisposition to normalcy undid the LFB on the night of the fire, but it is no doubt something that affected

other bodies studied by this Inquiry across its modules.

Fourth, fundamental weaknesses in the relevant regulatory regimes were not acted upon as they should have been. Other submissions have dealt with Building Regulations, building control, and the circumvention of testing and certification. To that we add that fire safety enforcement and emergency response lagged far behind in their understanding and capacity to respond to contemporary building challenges, and were not even close to being up to the job of deterring, detecting and punishing non-compliance.

You have seen that competency was compromised by the inferior status of fire engineering in general as an academic and vocational discipline. Within LFB, organisational culture manifested in a way where there was a particular disconnect between the fire safety department and station-based or operational firefighting. The resulting instability in the regime of itself should have caused government to identify the risk of high-rise residential fire as an issue of national resilience. Instead, civil servants and the local fire services' managers held an unwarranted belief that the notorious cladding fires in locations like Dubai were not going to happen here.

Our fifth point concerns localism and deregulation.

The political imperative to devolve power and responsibility from a centralised state in order to unencumber public services and businesses from regulatory restrictions is not new. However, the post-2010 politics of the coalition government produced a civil service mindset that was deeply resistant to progressive reform and overly beholden to the private sector.

Aside from the unreconstructed fate of the Building Regulations, there were other damaging consequences. For example, the machinery of central government dedicated to fire safety was comprehensively scaled back in terms of its civil service expertise, oversight and leadership. Local fire services lacked external scrutiny and challenge. Recommendations to review fire safety and operations, most significantly after the Lakanal House fire, were not implemented, even following undertakings to do so. National high-rise firefighting policy via the revised GRA 3.2 was chaotic in its drafting, irresponsibly devolved to the local fire services, and constitutes a further series of missed opportunities: (1) to acknowledge the risk supposed by cladding fires; (2) to query the inflexible reliance on stay put; and (3) to review the manifest dangers posed by the do-nothing advice in the LGA guide

on the issue of evacuation of vulnerable persons. All these risks were foreshadowed; none of them were addressed.

Sixth, the Inquiry has learned of a host of public sector services in decline, including the privatisation of the management of local authority housing, and the degraded function of its building control. The long-term cause lies in political decisions to roll back state services and various iterations of free market economics. Again, neither began in 2010, but both were accelerated as part of austerity politics following the global financial crash in 2008. And RBKC, it is fair to say, aligned itself with both that politics and its economics.

However, the causes of decline can also be found in the shortcomings of organisational life. The Inquiry's study of the LFB shows a 20th century service that is structurally and culturally ill-suited to 21st century challenges. There are basic deficiencies in management competence. Necessary reforms that have been repeatedly and cyclically identified in reports spanning 30 years have been institutionally resisted. Training, when done, replicates past practice and ignores advances in fire science, clinical psychology and genuine integration of the control room into an incident

response.

There is over-politicisation of service issues, with a management/union divide that obscures the traditional monoculture of the service and its outdated methods.

A more mundane function of localism is that political responsibility for the lack of reform is pinned on local authorities and chief officers. As a result of no formal inspection for more than a decade, this state of affairs was left unacknowledged and unchallenged. Until responsibility for fire and rescue services moved back to the Home Office in 2016, successive governments regarded themselves as positively virtuous in not intervening.

Our seventh point is that the UK has no disaster management system. The regime under the Civil Contingencies Act 2004 wages preparedness for disaster on the postcode lottery of the approach of any given local authority. That regime collapsed at Grenfell when the fire and aftermath were in one place. RBKC was both overwhelmed and fundamentally compromised by its long disengagement from affected communities and its obvious conflict of interest as the owner of the building.

The necessary integration between central, regional and local government and other statutory responders floundered for three days while the council carried on,

unwilling to admit its incompetence and lack of authority.

In the absence of an external inspectorate system for emergency planning, RBKC's weaknesses were unknown. The London/regional system was labyrinthine, overly horizontal and duplicating, but most importantly had no power to intervene in RBKC without invitation to do so.

As to central government, the best description remains that of Professor Clive Walker: that it is a ghost in the machine. Under part I of the legislation dealing with local emergency, the government does too little. Under part II, which has never been used, it takes over. Between those two extremes there are neither sufficient powers nor duties to scale up when the nature of the local crisis requires, as it did so much here.

Failure to prepare for disaster matters, not least because, when disaster strikes, it invariably impacts hardest on those least able to cope. Failing to prepare, therefore, becomes a denial of equal protection. That is why we have often pressed for the panel to enquire beyond the essential immediate technical causes and circumstances of the fire. What this Inquiry has ended up learning goes to the most fundamental questions a society must ask itself. The

common feature of the evidence, cutting through all modules, is how little the fate of ordinary people mattered when key decisions were taken. People either did not factor in the equation at all, or they were objects without agency -- statistics, profit, beneficiaries, the crowd. What happened to BSR was borne of a failure of human accounting, a point that Counsel to the Inquiry felt bound to express at the conclusion of Module 8. We say that it does not have to be this way.

Firstly, beyond left and right politics, it is essential to bring the concept of the state out of its long ideological eclipse and ask anew: how can it act as a source of common good? The timeline for the eclipse is generally regarded as beginning in the 1980s. Subsequent Conservative and Labour administrations limited the role of government, in contrast to the era after 1945 when it played a more significant part in welfare and planning. We are still in the era of the rolled back state, and Grenfell is one of its greatest failings.

The centre of government, particularly the ministries of everyday life like housing, fire and building, has been hollowed out, with the numbers of civil servants reduced, ministerial responsibility

diminished, and decisions between subject matter experts shed. With all these diminutions, the capacity to act to prevent and respond to a disaster of this nature was lost. Inevitably, market forces and malpractices have filled the gap. That is the paradox of the free market. When the state leaves a governance vacuum, other powerful organisations and actors will seek to take advantage, and usually for their own benefit, rather than the public good.

A second defining feature of the relationship between state and society since the 1980s has been to increasingly disconnect economics from collective morality. The disconnection is pertinent to the times when relevant Grenfell decision-makers resorted to commercial cost analysis without properly including in the balance the value of human life and safety.

The Inquiry will have in mind:

1. Laura Johnson's decision in March 2017 to have no door-closer inspection regime at all, rather than taking emergency action to alleviate a known, long-term, estate-wide fire safety danger. The TMO stood by. The LFB let the matter go.

2. Colin Todd and the commissioners of the LGA guide's justification for doing nothing to meet the fire safety needs of vulnerable persons was made on the

basis of common practice of trade, without considering its moral and legal implications.

3. Civil servants and ministers allowed the timescales for review of Approved Document B to repeatedly slip over years, despite knowledge of its flaws, with Brian Martin conceding that what government was trying to do was to "balance ... cost of regulation with its benefits ... so that industry was freer to improve the economy", even if improvement, in his sense, was at the price of weakened fire safety standards.

All these decisions reflect a prevalent, learned bureaucratic ethos and culture that prioritised what things cost in the most economic narrow sense to the exclusion of what they were worth. Economics needs to be reclaimed as a dialogue about moral as well as financial wellbeing.

The instances of actual engagement with residents before, during and after Grenfell is a chronicle of disempowerment. Before the fire, they were subject to institutional bias and prejudice. The attitude of RBKC, the TMO and their contractors was that people should be thankful for what they got or be ignored, even targeted or maligned. This was a relationship of master/servant that has no place in a modern democratic society. Critical to the ill-treatment was that important

information relevant to residents' safety was deliberately kept from them, and, collectively, they were repeatedly denied a voice.

Then during the fire, without any foundation in research, experience or training, the possibility that neighbours might act in a rational and collaborative manner when escaping from the building they knew was discounted.

After the fire, when local government collapsed, the displaced community reconstituted itself in the surrounding streets, but not before different levels of government saw the situation primarily as a threat to public order. The primary motive of civil contingency response in those first seven days of aftermath was security and containment, not compassion for human welfare.

Responsibility for risk-based decisions such as these will often have a technical dimension, dependent on expertise and the judgement of appointed officials, delegated contractors and elected representatives. That cannot mean that people who bear the consequence can be excluded or disregarded. Utilising the insight and experience of those affected by decisions is always in the service of better outcomes and makes obvious good sense and shows due humility. But it goes beyond that:

without diluting legal duties, effective engagement with residents is essential to demonstrating respect for them as equals, even if respective roles differ. None of us would accept otherwise for ourselves or our loved ones; why should BSR have been different?

We say much of the answer to that lies in social inequality. The fire disproportionately killed people with disabilities, those of Middle East, African and other migrant background, and those living in social housing. The high number of deaths amongst disabled residents at Grenfell is a landmark fact of this disaster, but it is yet to be acted on. The LGA guide, which not just permitted but positively encouraged those with fire obligations to do nothing to plan or provide for the escape of such persons, is unchanged.

On the eve of the fifth anniversary of the fire, the Home Office pivoted from implementation of the Inquiry's Phase 1 recommendations on personal emergency evacuation plans that had been supported by an overwhelming proportion of consultees to its current ill-conceived proposals. Shockingly, the government would not only disregard the lessons of the fire, but would water down existing protections. The proposals do not apply to stay-put buildings at all. They would not impose any legal duty on responsible persons to put in place

an evacuation plan. They are inexplicably limited to persons with mobility impairments, and they would place primary responsibility for enabling escape on the fire services, contrary to both long-standing principle and all the Inquiry evidence of FRS incapacity and incapability, at least at the present time.

That leads to our emphatic plea: the Inquiry must issue an urgent interim report to leave the government in no doubt as to why the intransigent do-nothing status quo is dangerous and in violation of current law under the RRO and applicable human rights. This Inquiry, combining legal authority, evidential wisdom, and objectivity, is uniquely placed to incontrovertibly say this. Waiting until the publication of your final report is too late.

The national, ethnic and cultural backgrounds of those who died at Grenfell Tower has in itself always called for further reflection on the issue of race. Despite the diversity of London, the evidence heard across the modules has been of an absence of engagement with the implications of race or religion by relevant public authorities, whether in terms of linguistic, cultural or other implications. At best, this shows an unhealthy lack of curiosity about the needs and experience of an important body of service users. But

it needs to be seen as part of a broader syndrome.

The fact is that every Inquiry module has revealed serial ignorance and non-compliance with the public sector equality duty, by all relevant public bodies, across all relevant protected characteristics, even where the issues cried out for attention to the statutory or equality objectives.

The important purpose of that duty trace back to the Stephen Lawrence Inquiry report and the problem of institutional -- in that case race -- discrimination within the public sector, meaning disadvantage caused by unwitting prejudice, ignorance, thoughtlessness and stereotyping. It is important for this Inquiry to robustly reaffirm the value of the public sector equality duty in the context of this mass disaster, and to consider recommendations directed to its future effective embedding, assurance and enforcement.

Beyond this, the socioeconomic duty in section 1 of the Equality Act -- in force in Scotland and Wales but not yet in England -- offers an obviously pertinent and promising legal tool to combat the institutional socioeconomic discrimination experienced by Grenfell residents and those living in social housing. We urge the Inquiry to say as much.

Can we conclude by asking what effective change

looks like.

This disaster is about the failure of the duty of care in its broadest sense: legal, political, and social. The question of, "Who is my neighbour?", posed nearly a century ago by Lord Atkin in the case of Donoghue v Stevenson, and what this should mean in terms of legal duties and social values, calls for re-evaluation and evolution in our modern risk society.

The legacy of Grenfell must be to intensify duties between state, organisations and people. In the main areas of building and fire safety, the duty of care will require legislative reform, tougher regulations, new offences, higher penalties.

However, well-designed laws are not enough. They cannot work without sufficiently competent and properly resourced enforcement, which will not exist in Britain without a fundamental change in education and accreditation across a range of disciplines.

Law and policy can quickly become out of date due to design innovation or cynical circumvention. Laws can always be amended so as to stall or roll back protections, perhaps especially so in areas of risk lying outside the public gaze, where the lessons of the past are most liable to be sidelined or forgotten. And so safeguards must be embedded into organisations and

systems to enable us to trust them more.

On this, we highlight three:

First, the statutory duty of candour could serve as an essential constitutional innovation, provided it applies to public authorities and private bodies contracted to do public works, as well as those whose products or services have implications for the health and safety of the public. Even then, many of the organisations studied by this Inquiry are not self-accountable and, therefore, would find it difficult to be truly candid and frank without significant changes in organisational culture and ethics.

Second, a national oversight mechanism, as long advocated by the organisation INQUEST, would serve to break the current lamentable pattern of unlearnt lessons and repeated failure to act on recommendations to prevent future deaths, which includes, of course, the promptly lost lessons of Lakanal House.

Third, the relationship between bureaucrats, experts, technicians and those they serve requires a reset, so that people affected by risk-based decisions, who in some cases must live or die with the consequences, are duly informed, engaged with and listened to.

But legal innovations are doomed to fail absent

wider societal transformation of existing ways of doing things.

Grenfell was a human rights disaster, a systematic failure of state and private actors to protect the life, security and dignity of people. There are undoubted individual wrongdoers in this tragedy, but there was also wider institutional and societal indifference that allowed them to act with impunity. What happened at Grenfell Tower demonstrates an essential problem with the way the golden rule of faith and ethics is applied; that we don't necessarily do unto others as we would have them do unto us when we do not or cannot conceive of being in their position. We do not imagine that their home could be our home. We do not appreciate the power imbalances they endure. We do not live by the premise that, in all of life's profit and loss, we are ultimately neighbours. The evidence painstakingly assembled and heard by this Inquiry tells us that we must.

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

The next closing statement is going to be made by Mr Michael Mansfield King's Counsel on behalf of, again, the bereaved, survivors and residents whom he represents.

Yes, Mr Mansfield.

Closing submissions on behalf of BSR Team 2 by MR MANSFIELD

MR MANSFIELD: Good morning, Chair, Thouria Istephan, Ali Akbor.

In a sense I'm going to close the file, and I'm going to speak, as it were, hopefully from both the heart and the mind, because I'm treading a rather treacherous path here. I don't want to repeat any of the very fine words that have already been spoken, which we endorse as Team 2. I don't want to repeat matters that you've read in our written submissions on this as well. They're detailed, as you've seen. But I want to, as it were, touch on the themes that are already emerging.

Stephanie Barwise talked about -- in a sense, both speakers talked about necessity for a sea change in approach, a society which we don't live in at the moment, and in fact is at risk of deteriorating even further.

So behind all of this, the theme that I want to start with is by just a flashback of time, it's easy to forget, because the question I'm going to ask is: I hope there isn't another one, another Inquiry, following another disaster, in 50 years' time, where all the same points are being made. Because the assiduous manner in which you have approached all of this and the patience

that you have shown over the many weeks, months and years now will go to waste unless there is a commitment, because whether it's called a human rights disaster or characterised in other ways, what happened was criminal, in the colloquial sense and in the legal sense. This Inquiry has begun, obviously, the process of achieving some kind of justice, but it's only the beginning.

What I wanted to do was just to flash back for a moment as to why the significance of what you're about to embark on -- you may have thought that you had almost got there, but in fact there is a further stage which I want to propose.

In 1973, there was another disaster. It's forgotten. We certainly do need a national disaster plan. We need a resource, we need a mental capacity that remembers, lest history repeat itself, those who don't learn those lessons. It wasn't a high-rise, maybe that's why it isn't thought about. It wasn't on the mainland, in the sense it was in the Isle of Man. A large number of people died and were injured. But the points that have been made this morning to you, a large number of them were all made then, in another inquiry, by another High Court judge, Cantley, the Cantley Inquiry. It didn't take as long as this one, but that's not the point. The point was that they

touched on the very same issues that are now being touched upon, issues to do with compliance, because the three components that were put up on the façade of that building, in a sense a high-rise entertainment centre, a prestigious project no doubt, none of the three complied, interestingly, with legislation in the Isle of Man, which proscribed the use of combustibles.

So the question arose then, as it does now: how did they get around that law? How was it permitted to happen then, that there should be, as it were, cladding? And the cladding burnt very fast. So don't anybody say -- it's not the same cladding, but that's not the point. That's what the academics try and say, "Oh, well, there is a distinction, it wasn't high-rise, it wasn't quite the same cladding", but it was the same result, because there was an unwillingness then. It's developed since that time.

But that wasn't the only issue, because the other issues discussed in the same breath, almost, were to do with evacuation, which is why a large number -- not because -- there it wasn't just the single staircase point, it was a way in which -- it was open plan and there were too many people to get out, and there weren't enough people who knew how to operate the evacuation procedures. Nobody had been trained to do it.

So the similar sorts of points are coming up, including sprinklers, suppressants, including fire extinguishers. They had them, but they didn't have enough trained people to use them.

Now, these may seem, in a sense -- of course, because it's a long time ago, but I raise them because unless there is the sea change that is being talked about, there will be another Inquiry following another disaster of this kind. We are going to phrase it slightly differently, that what one is looking for here, as a result of what kind of society and the sea change, I think you yourself used the term during the hearing, we're looking for a change in the mindset, a change in the culture that has pervaded many, many years since 1973. And that mindset is one in which there are forces at work you've heard about. They are political forces. I began the opening in Phase 1 by reference to the red tape initiative which was meeting on the very morning of the fire, meeting in order to see if it was possible to disassemble regulations. So a very strong political stream of thought, set against, obviously, a much longer period of deregulation.

So political forces are at work in this particular field.

Economic forces of which you've seen, cost-benefit,

or the power of profit, if I can put it that way as well. So they're the economic forces that are at work.

But there are the social forces as well also at work which you've heard described this morning, the social forces which are concerned with race, with class, with social housing. All of those merge together to form another force that ensures that the mindset we need to change, what do we need to change it to?

It needs to be changed -- going to put it into one proposition. It's one that is the theme of our submissions throughout Phase 1 and Phase 2, and that is fire safety first. It's a simple thought and a simple proposition. But, as Mr Friedman was just saying, nothing is going to change unless there is a change in values, unless there is a change in mental approach to these matters.

How do you effect change? We say, sir, you're in a -- and your colleagues are in a really extraordinarily powerful position to effect change.

Can I just interpose at this point how that might happen. I fear it may be that you have already considered this. Please forgive me if you have. But it's been hinted at this morning, but I'd like to just develop it a little more.

Developing it a little more means that -- of course,

it's not for us to say when your final report will be, but we anticipate it certainly won't be this year, and some time late next year, possibly earlier than that, and the enormity of the task is appreciated by all the families, many of which are here today. They appreciate the efforts that have gone in already and they're not, as it were, unappreciative at all. But, if the effects of what you have been doing for these years is going to be felt, then you have an opportunity to ensure that effect yourselves.

The suggestion we make for your consideration is that, over the ensuing months, at some point you issue an interim report -- that's been mentioned this morning -- it could be a series of interim reports, in order that nobody is confused about what is intended. Within those reports, you specify recommendations. We know clearly you will make constructive, far-reaching recommendations, which you did after Phase 1, or at the point of Phase 1, one of which, of course, hasn't been implemented, an important one, already mentioned, a serious violation of human rights, the Human Rights Act, the Equalities Act, section 2 and section 14, read together, almost ignored. Ignored on the basis -- and I just again interpose this -- the Minister for Fire Safety, House of Lords, spring of this year,

an unimaginable -- I hope this is not, as it were, an exaggeration or, as it were, placing too much on a few words, but it wasn't just, "It's not practical", or "It's not proportionate, it's not reasonable"; he actually used the simile that, well, the disabled might get in the way of the able-bodied getting out of the building. He didn't use those words, but that was what he was saying.

That, if anything, demonstrates the depth to which our public life has descended, never mind the Nolan principles which we have emphasised several times, of which there are seven, one of which being the duty of candour which should be embraced, we say, as -- it shouldn't have to be. Why should we be thinking about legislation to try and set the agenda of candour? But that's in a sense where you and your colleagues come in, because in an interim report or a series of interim reforms in which you specify particularly important recommendations -- it's not being suggested, for example, that you would take time on what you regard as perhaps minor recommendations, but major recommendations which will, we hope, have an impact on the approach of industry, on the approach of local government, on the approach of central government. And the approach of central government, although there have

been some concessions in that field, perhaps I don't need to do more than mention one name: Lord Pickles. I don't need to spell out what he said and how badly he got it wrong. Not misspeak, Lord Pickles; it's indicative of a frame of mind.

Now, in those, as it were, attempts that I hope you might consider making, you have the power under the Inquiries Act —— so it's entirely within the framework and, again, I don't need to spell that out, you have a highly competent team of lawyers and advisers, and anyway you probably know —— sections 24 and 21 allow you to, as it were, issue the report, but you can also say, "We'd like answers". The importance of that is to find out publicly to what extent this is not going to be a report that is left to languish on a dusty shelf, although no doubt digital these days, because it's almost what happened with the Isle of Man, but I'll come back to what's happened on other occasions since then. That's not the only one by a long way.

Now, this scheme that I'm suggesting that you might consider involves the issue of the report and for a response. You can monitor the response, if you wish, by suggesting to the recipients, "We'd like to know within 28 days", a familiar phrase I've no doubt to many departments. Whether they can stick to that's another

matter. And they have a choice: they can either not respond, which will be made public, or they can respond saying why they accept the recommendations and what they're going to do about it, or they can say, "Well, we don't accept them and these are the reasons", and then you can have, if you wish —— I know this must sound daunting, this must sound forbidding —— a further hearing in relation to that with expert advice, as already has been hinted at, in relation to that.

This is extremely important for public confidence, because one of the aspects of a public inquiry is the regeneration of public confidence in the system, because no one can say anything other than Grenfell Tower is the epitome of the complete collapse of a system, not just the construction system, but a system of governance which hasn't got the principles which I have already alluded to, namely the Nolan principles.

Now, I'm saying all this not without precedent, because three other inquiries at the moment have inaugurated —— it's not exactly the same, they each do it slightly differently, and obviously it would be a matter for your discretion whether you even do it at all, but the Infected Blood Inquiry are doing it, as well as the Manchester Arena, which was —— only part of it —— there was a report issued just before the weekend.

So these inquiries are doing it, and most of all the Child Abuse Inquiry, and they're setting a timeframe within which they require answers in writing and then hearings no doubt at some stage in public. And we say that that is perhaps one of the most important —— you may have thought the most important has already passed. Well, in one sense it has, because although the Grenfell Tower is still standing as we leave London on the west side, there it is as a monument, bereft of life, but the community that lived there still stands. The community that lived there require this level of involvement and participation in a further stage, as do the British public, because, as we've learnt since, there have been, unfortunately, during the currency of your Inquiry here, other fires, other fires where —— if I just pause for a moment on a recommendation.

PEEPs, obviously we've put that top of the agenda, a priority, part of the mindset: fire safety first. PEEPs, right at the top. How anybody can, as it were, humanely reject that. But there are obviously other priorities that follow.

One of them is —— and I've posed this once before —— if I were to go round the room here today and say —— first of all identify who lives in a high—rise, and I know there are some people in this room that do. If

there is a fire in your block, what do you do? What do you do? What's the answer? You would think by now, since 1973, somebody would have thought of how to work this out. It's not, as they say often, sort of rocket science to work this out. It has to be tailor—made. It has to be, as it were, building—specific. But on the other hand, it's one of the things that the Lakanal coroner put first —— put first —— in her letter to Lord Pickles —— well, and others. There needs to be, not just national disaster, a plan, of course, there needs to be guidance —— this is what she was saying —— on evacuation procedures.

So the answer to the question is: most people don't know, because there has been no national guidance. The London Fire Brigade perhaps have made strident steps towards at least a solution of a kind. Otherwise, we don't know any more than we did before. How can this be?

If —— I give it as an example —— you do want to make suggestions about —— in the context particularly of high—rise, because obviously where ladders can't reach, where hosepipes might not get, where water pressure may not be sufficient, all the points you know about, then they need to, as it were, at this moment in time —— if you make that recommendation, it needs to be, as it

were, canvassed and it needs to be properly investigated, as do other simple measures, like the suppressants I've mentioned already, namely sprinklers, fire extinguishers, but there are many others that you might want to do, and these propositions are all constructive.

I just end this part of what I'm saying -- I'm looking at the clock carefully -- is this: that -- and the reason why I've taken time to emphasise this. As you may know, I have been involved in other inquiries, so have many people here, but particularly the Lawrence Inquiry. Another High Court judge familiar to you, Lord Justice Macpherson, very anxious, he was, that what he had to say, what he had discovered, over quite a long period -- not as long as this, but over the course of nearly two years -- he was anxious that they were implemented, and he kept saying this to various authorities that appeared in front of him, that the 77 recommendations that he was in the end going to make about how matters could be resolved, he didn't want them to rest on a shelf. But, of course, once you have issued the report, there is no legal -- and I hesitate to say, as far as current governments are concerned, I suspect no moral obligation either -- to necessarily do any -- that is why the precursor of a procedure

before you issue the final report is so significant, because in Lawrence what happened was that the family -- it wasn't, obviously, under the Inquiries Act, but the family decided -- we say quite rightly -- to engage in the process of ensuring implementation. In other words, they became what INQUEST have suggested, they became the national oversight body for the proposals.

What happened on a practical basis was that Mr and Mrs Lawrence hired the Central Hall Westminster once a year for a number of years and requested -- and it was a request that was met -- the authorities, the government ministers and others, and police force chiefs, to attend, and they would, as it were, have a book of reckoning on account. They would ask, "Well, have you done these? What about this one? What about that one?", not expecting that they would all be implemented overnight, but they were expecting some kind of feedback, some kind of positivity, some kind of recognition. And that happened. It still hasn't finished, but the process was begun by them.

Well, we say here the families have said to you very clearly on many occasions -- Hanan Wahabi said it, and others -- it lives -- every day, they live with it. This is not a forgotten tragedy, because they've lost a home and in many cases -- some cases the whole of

a family has, in the flick of a finger, gone. Therefore, their anxiety is to ensure, for the benefit of others, that they don't have to go through this, and this process that I'm suggesting to you might, I hope, appeal to you, because I just want to, as it were, emphasise two -- there are two quotations, and only two -- I was going to ask for a document, but I'm not going to ask for that. But I do want to pray in aid the, as it were, thoughts of residents and occupants and the way they have perceived long before anyone else.

There was a meeting with residents later in 2017, in December, where this was said by one of the residents. I'm not going to name this particular resident or any of the others, for that matter, because they speak with one voice. And December 2017, this particular resident said:

"What is clear here is that Grenfell Tower was no accident. Grenfell Tower was a catastrophic incident that should never have happened and was preventable. Grenfell Tower happened due to the serious systems failure, due to a culture of neglect ..."

I pause for a moment. Grenfell Tower was uninhabitable for ten years because, for example, the ventilation system was beyond economic repair. It's not just an attitude to a building, it's an attitude to

occupants.

And he went on to say:

"... due to a culture of self-interest and due to the fact that residents were treated at certain times as second-class citizens."

Which is precisely why all the examples you have had in this Inquiry are interestingly and not coincidentally social housing: Knowsley Heights -- well, you know them, Garnock Court and so on. I don't need to go through them.

But the other matter which I wanted to -- I don't ask for it to come up on screen. I know you will have heard of it before because I read passages in Module 3. But I wanted to end on it because we hope this type of letter never has to be written again, by the Grenfell Tower Leaseholders' Association in September 2010, seven years before this fire, relating to the conditions in Grenfell Tower. It begins, the passage, I just -- it's on the fifth page:

"We are very shocked to learn from you ..."

That is the Royal Borough of Kensington and Chelsea TMO. Under the heading "Fire". It's a very long letter, very considered letter, health and safety:

"We are very shocked to learn that you considered the defects in the building exposed by the fire as

a minor fault, when it had potentially fatal consequences."

It wasn't a cladding fire. That doesn't really matter. What matters here, as we know, is the toxic fumes, which can be traced back to the cladding and the insulation. Both have contributed to that.

He goes on to say —— they go on to say they consider it a major fault. But when describing the conditions of evacuation, the effect and impact of smoke —— because that's the cause of death in most of these cases —— in all of these cases, it may be difficult without the pathological evidence to go further than it's commensurate or consistent with exposure to fire, however we would say there is a very obvious inference that can be further than that. It's toxic, acrid black smoke:

"The staircases of the surrounding high—rise buildings are exposed to open air and natural light and so, in case of a fire, the smoke can easily escape. But Grenfell Tower, with its interior staircase, malfunctioning ventilation system, there is certainly a high probability that in the event of another fire, the whole building can become an inferno."

1973, 2010. When is somebody going to sit up and make the connections? And that is not happening because

of the forces I mentioned at the beginning, the political and economic forces that have to be counted, and we would ask, sir, that this is the opportunity beyond measure that you have, and the families want to join with you in order to do that part of the suggestion that I've made, and I haven't been through all the other matters, where there has been demonstrable failure and deplorable characteristics of arrogance, complacency, lies, deceit, all the way through. Whenever I mention those words, I'm sure particular witnesses will be conjured up in your minds, as it were, representing those. We say this Inquiry should end, we hope, on a positive note, in which the families can stand alongside their tower and say they've achieved something for later generations.

Thank you.

SIR MARTIN MOORE—BICK: Well, thank you very much, Mr Mansfield.

Well, at that point we'll take the break for the morning. We'll rise, and then we'll all resume, please, at 11.45. Thank you very much.

(11.32 am)

(A short break)

(11.45 am)

SIR MARTIN MOORE—BICK: Now, next we're going to hear from

Mr Adrian Williamson King's Counsel on behalf of his group of BSRs.

Yes, Mr Williamson.

Closing submissions on behalf of BSR Team 2 by MR WILLIAMSON

MR WILLIAMSON: Thank you, sir, and members of the panel.

It's now more than five years since the fire, and more than four years since Mr Millett said this on the first day of Phase 1 of the Inquiry:

"... the fundamental question which lies at the heart of our work is how, in London, in 2017, a domestic fire developed so quickly and so catastrophically that an entire high—rise block was engulfed, and how it was that 71 people lost their lives in a matter of hours ... leaving hundreds without a home ... and for an inheritance, an abiding sense of injustice, betrayal and marginalisation, leading to an overwhelming question: why?"

Although we now sadly substitute 72 for 71 in that quotation, Mr Millett's question and the topics which he raised remain at the heart of this Inquiry.

Following the publication of the Phase 1 report, the Inquiry reconvened in the January of 2020, and on the first day of that hearing Mr Millett reminded all concerned that he had invited, he said, the core participants not to engage in a merry—go—round of

buck—passing. But, he said, with limited exceptions, that invitation had not been accepted, and instead their case remained that everything was someone else's fault. As Ms Barwise has explained this morning, that largely remains the case.

Now, in this short presentation I'm going to discuss a number of aspects of the evidence which shed light upon the question why, asked by Mr Millett. But, before doing so, I would like to make some general observations about the evidence you have heard, in particular the expert evidence.

So far as that expert evidence is concerned, we, Team 2, have in general been impressed by the commitment shown by the Inquiry's experts and by the high quality of the work they have produced. However, the Inquiry should be careful not to follow, we would say, too unquestioningly the lead given by its experts, however distinguished. In the end, it is for the panel and not the experts to answer Mr Millett's question.

A good example of that is the testimony given by Professors Torero and Bisby as to the experiments carried out in Edinburgh which formed work packages 1 and 2. The important overall conclusion of this exercise was the ACM and not the insulation products was the primary cause of the fire, a conclusion I think

largely adopted by Ms Barwise this morning.

By contrast, we would submit that an appropriate finding is that whilst the Reynobond PE was primarily responsible for the rate and extent of fire spread during what has been referred to as "vertical fire spread up", both the ACM and the insulation contributed to the fire, and it is impossible to say the exact proportions in which they did so.

We would say there are important reasons why the Inquiry should proceed with caution in relation to the experiments and the conclusions to be drawn from them.

First, the experiments were conducted by the Inquiry experts alone and the core participants and their experts had no input into devising them or analysing the results. That is not to criticise the professors or the Inquiry; such a procedure was no doubt unavoidable given the circumstances, particularly the pandemic. However, such a unilateral approach is clearly far from ideal and would not be acceptable in litigation.

Secondly, and associated with that first point, it is the case that the Inquiry has not heard the views of other experts either upon the experiments or in relation to the causation issues generally. Again, that would not be acceptable in litigation, nor have the Inquiry's

own experts been subjected to searching cross-examination as they would be in High Court proceedings.

Thirdly, the experiments carried out are innovative and, indeed, untried. The design and specifications of the experiments have not been shared as yet with the wider fire expert community. Before other experts could accept the validity of the tests, there would need to be more experimentation to understand what Professor Bisby himself describes as "the immense complexity of the heat transfer environment with a ventilated rainscreen cladding cavity".

Fourthly, the experimental results obtained are limited to the experimental apparatus build size of about a metre. Given the small-scale nature of the experiments in work package 2 and the absence of a whole system test, it is submitted that only limited conclusions can reasonably be drawn regarding the contribution of the insulation to the spread and intensity of the Grenfell Tower fire.

We would also suggest that this Inquiry needs to sup with a very long spoon when considering submissions from Kingspan and others to the effect that the insulation ultimately played no part in the fire. After all, Professor Bisby has concluded that the ease of ignition

of K15 and of RS5000 might well be relevant to the initial growth of the fire outside flat 16, as well as the absence of foil facers on combustible insulation around windows.

I turn now to deal with some of the substantive issues.

In these brief oral submissions, I'm not aiming to, and in any event cannot, repeat the many matters which have been covered in the vast amount of oral and documentary evidence you have received. Rather, I want to use this opportunity to seek to bring together some of the larger themes.

Fundamentally, we would submit, the question why and the so-called merry-go-round of buck-passing are two sides of the same coin. A fundamentally fragmented and inadequate construction industry, a dysfunctional marketplace, and an unfit testing and regulatory system combined to lead inexorably to this terrible fire.

The story begins with the evidence we heard in Module 1. The very structure of the construction industry was one of buck-passing, and the buck was being passed between incompetents. The cost-cutting that has characterised procurement in the construction industry for the last 40 years, especially in the public sector, was to lead inexorably to the events of June 2017.

Indeed, the evidence led in Module 1 showed that the key players in the refurbishment -- Studio E, Rydon, Harley, Exova -- were grossly negligent and wholly ignorant of the fundamentals of what they were supposed to be doing. Their organisation, both individually and collectively, was woefully inadequate. The main aim of each individual organisation was to get the buck off their desk and onto someone else's.

As Professor Torero explained in Module 7, what was needed was "a very competent professional, a professional that has some level of understanding and is interacting in an effective manner with professionals in other disciplines". In fact, there was a tragic mismatch between a system, or rather a failed system, which could only operate safely if manned by highly competent, well co-ordinated professionals, and the inept, ill-prepared personnel and firms who were in fact engaged.

Moreover, those whom the residents might expect to be the guardians of the public interest, RBKC and the TMO, were equally inept. In particular, RBKC's building control officers did not know what they were doing and were in any event overwhelmed by pressures of work in a world of austerity. Indeed, the gulf between what was required to deliver a safe building and what

was provided was vast.

Professor Torero explained that there needed to be a complete harmonisation between fire safety strategy and building design, a feature wholly absent at Grenfell. Instead, it was apparent from the entirety of the expert evidence adduced in Modules 1 and 7 that there was a chasm between the level of competence required to ensure fire safety and that actually on display.

To take one example, Professor Torero was extremely damning about the quality of Exova's work, saying, "The people who were doing those reports lacked the requisite competence to do a proper job, or chose not to do a proper job". This was sadly not only true of Exova, but of almost everyone associated with every aspect of the refurbishment.

The evidence given in Module 1 was shocking, in that it revealed a construction industry which was wholly unfit for purpose, and this was not an isolated situation. Rydon, Harley and co were probably typical of many in the industry; they just happened to get caught.

But what Module 2 has showed is even more horrifying. The Inquiry will need to condemn the actions of the manufacturers, Arconic, Celotex and

Kingspan, in the strongest possible terms. They were at the very least reckless in pushing dangerous products into the market. In selling those products, they were fraudulent in their sales tactics and in their dealings with those who were charged with testing and certifying the products.

In their overarching submissions, Arconic seek to justify the use of ACM PE on the basis that its characteristics were well known in the industry, but those submissions fly in the face of the contemporaneous internal evidence. You'll recall Mr Wehrle saying internally that PE was dangerous on façades and everything should be transferred to FR as a matter of urgency. You'll recall Deborah French of Arconic sending Wehrle a link to a BBC News story reporting on a fire in the UAE on an ACM façade building. Ms French accepted in evidence that the dangers of PE cladding panels on high-rise buildings were well known, and yet she was continuing to offer PE core as standard, including in respect of Grenfell Tower. Moreover, Arconic were at pains to hide the true circumstances, the true facts, relating to PE, Wehrle, for example, saying internally that, "This is something we have to keep as VERY CONFIDENTIAL!!!!"

Nor were Celotex any better. They seek to criticise

other parties to the refurbishment, but they are silent as to their own role, knowing as they did that RS5000 would not meet BR 135 criteria on the proposed wall system and, by extrapolation, neither would a desktop study nor a fire engineering assessment. Yet they were still happy to take the sale, and did so on this and many other projects.

Of course, the producers should only have been selling safe products which had been thoroughly and openly tested by reputable independent bodies, and which were then marketed to the construction industry in a transparent fashion. None of this happened.

For example, as Professor Bisby explained, the way Kingspan were allowed to do their testing "in order that a claim could be made that the surface of the K15 was class 0", was utterly indefensible, "both by any manufacturer and/or by any compliance testing laboratory who knowingly undertook and reported such testing". Indeed, the manufacturers, rather than taking an honest and open approach, were simply trying to game the system so as to place unsafe products on the market.

For example, Professor Bisby said that Kingspan, by testing the foil facer on its own, was "just completely and utterly nonsensical and could never be defended".

Moreover, these companies are still operating openly

and unrepentantly, a fact which causes particular offence to those whom we represent. Celotex claim to have cleaned up their act, Arconic do not even pretend to have done so, and Kingspan still assert that their products are safe on high-rise buildings. Indeed, incredibly, even after the fire, Kingspan have been lobbying government and others in seeking to show that cladding with European classification A2 could also lead to a failed BS 8414 test.

This is a glaring example of the lengths to which manufacturers have gone to ensure their products continue to be marketed. For example, Kingspan set up a test using an A2 cladding panel which they suspected would cause even a robustly designed BS 8414 test to fail. They then drew that result to the attention of the select committee in relation to its Hackitt Inquiry, seeking to persuade them that the products used in the system tested would be permitted under the government's proposals to ban combustible cladding.

So how could these rogue companies operate so successfully and so shamelessly? Well, the story there is that the testing and certifying bodies -- the BRE, the BBA and the LABC -- were at best asleep at the wheel in engaging with these manufacturers, and at worst positively collusive with them in their sales tactics.

On any view, they were far too close to their "clients", and far too reluctant to bite the hand that fed them.

As Professor Bisby also explained, the problem was compounded because those who were charged with invigilating the likes of Kingspan were in practice conniving with their fraudulent conduct. As he said in evidence:

"The issue is that somebody somewhere within this process of Building Regulation and oversight needs to be the person who stands up and says, 'No, this is not okay, we can't be doing tests like this', and that didn't happen, and that's the issue."

In fact, the evidence given in Modules 2, 6 and 7 showed clearly that the so-called system of regulation, testing and certification was not in fact a system at all; it was completely defective. The bodies charged with testing and certification were unable to provide an adequate system. Central government was at best completely indifferent to the unfolding disaster that was the supposed system. The ADB provided an inadequate code to regulate the industry, a code which the government was unable or unwilling to reform.

As Professor Bisby said, "The system was created specifically to enable people to circumvent the rules". In fact, the actual "system" in place put a burden upon

professional competency which those operating in the field were in no position to discharge. This fault must ultimately lie with central government, for it was they alone who could devise a more appropriate regulatory framework. Indeed, as Professor Bisby explained, the Building Regulations and ADB should have been much more explicit in setting out what was required of the professionals carrying out design.

This problem was compounded not only by a lack of competent personnel in the industry, but also by the fact that the judgements required by the Building Regulations and ADB were unclear and subjective, as Professor Bisby also explained.

At the heart of all this was a government machine unable or unwilling to provide adequate guidance and supervision to a construction industry in desperate need of such direction, this despite the experience of numerous serious fires, as Mr Mansfield has referred to.

Not only was government supine, but it missed the chance to make matters better when the Garnock Court fire occurred. Instead, it chose to make matters even worse. Further, as Professor Bisby also noted, if Knowsley had been properly analysed, "maybe we wouldn't have had many other fires, including Grenfell Tower".

What is striking about the British government's

handling of these issues is the startling ignorance of those supposedly in charge. Lest it be suggested otherwise, this is not a case of requiring the British government to do the impossible or to consider issues which have become clear only with hindsight. On the contrary, it is apparent that other jurisdictions have managed these issues much better; see the Australian experience cited by Professor Torero as to what could and should have been achieved in Britain.

The Inquiry will therefore have to make sweeping criticisms of the failed system of testing and regulation, a "system" which has been shown to be totally deficient. This criticism should extend to the testing and certifying bodies, but it should be particularly unstinting in respect of the governmental bodies which have allowed this disastrous situation to develop.

I turn then to the way in which the tower has been inspected and maintained in the years leading up to the fire. This is a sorry story of neglect and indifference of which time allows two examples only.

The first relates to the so-called fire risk assessments carried out in the years before the fire by Carl Stokes, as to which you heard evidence in Module 3. These were or at least should have been a crucial

preventative measure. Both the assessment and the assessor needed to provide vital advice. The basic object was to discern what might cause a fire, how to stop it spreading, and how residents could escape. In fact, Mr Stokes was woefully unqualified to carry out the assessments, and the FRAs to which he put his name were repeatedly wholly inadequate. Nor did the TMO have any systems in place to interrogate his work or thereby to safeguard the interests of the residents.

The second example relates to the smoke control system, as to which you have heard evidence more recently. This system too had a long history of neglect, non-compliance and being inoperative. It is staggering that there is no evidence of any attempt to fire safety engineer any aspects of the primary refurbishment, not least the SVS, the smoke ventilation system, the requirements for which Exova omitted from its fire safety strategy. There was no attempt to develop an engineered fire safety design integrating other fire safety systems within the building. None of PSB, Exova or RBKC had any regard to BS 7974 or any other fire safety design framework.

The objective of any extract system, as emphasised in ADB, and the fundamental purpose of the design of any mechanical SVS for the tower, was to maintain tenable

conditions for means of escape in the extended travel lobbies and for means of escape and firefighting in the single stairway. In fact, very little regard was had to maintaining tenable conditions at the design stage.

Furthermore, in December 2013, RBKC rejected enlargement of the shafts. There was no engineering justification for this decision, which did not place safety at the heart of the project. Had there been competent construction management of the project, capital works to enlarge the shafts should have been considered at an early design stage. Similarly, had there been competent building control, this fundamental early design consideration would have been considered. Consequently, the SVS extract shaft size represented a limitation on the capacity of the system to exhaust smoke. This was the first of many abject failures.

The design approach actually taken amounted to looking at the system as it presented itself, a system which was non-operational and had not been maintained for many years, and then applying the non-worsening principle so-called to a dilapidated system.

PSB did not demonstrate compliance with either the regulations or the original performance requirement. They ought to have aimed to produce a design that complied with one or the other. In the event that was

not possible, the system should have been condemned and a root and branch review of performance considered. Therefore, and in summary, the design and design delivery failed the residents in numerous important respects. The design actually adopted amounted to cherry-picking selected performance parameters, was not a recognised industry approach and was not recommended by the relevant guidelines.

Turning then to the smoke control dampers.

British Standard EN 12101-8 of 2011 sets out the performance requirements and relevant test standard and classification standard for these dampers. Based on sections 8 and 10 of ADB 2013, the minimum performance duration of performance for the dampers protecting an escape route is EI20S. A smoke control damper tested to British Standard EN 1366-10 of 2011 and classified to British Standard EN 13501-4 of 2007 as EI20S would satisfy the requirements of ADB 2013. However, those standards were not considered at the time of the renovation project. The construction therefore allowed smoke to pass across different fire compartments.

I should next and almost finally say something about water, yet another area where the residents were badly let down, in this instance by the LFB and Thames Water.

When considering water distribution systems, the

required outcome is that the flow rate at the point of use is sufficient to meet the service requirement. The advantages of testing supply are self-evident, but the LFB never did so. A lack of record information and technical knowledge, combined with communication failures and an absence of training, precluded the efficient management of the network.

Thames Water do not appear to have been cognisant of the substandard discharge coefficients of the distribution valves and did not communicate that to the LFB. Of course, even if the LFB had been told, they would no doubt have been unaware of the significance of the fact due to a want of familiarity with the standards.

Furthermore, Dr Stoianov rightly formed a highly critical view of the quality of communication between Thames Water technicians and engineers. It seems there was little communication on the night of the fire, and the quality of the communication did little to advance appropriate fire water supply to the tower when and where it was needed.

I turn finally to the topic of LFB testing, rated inlet pressure and flow rate.

There were gross failings here also in technical competence. Professor Torero was rightly scathing about

the LFB's operational response, saying:

"The evidence shows that the real competency is so low that it leads to practices that endanger the public and LFB staff and prevents the organisation from learning."

The evidence of Messrs Torero, Johnson and Stoianov show that the LFB has failed to engage with technical matters within their various areas of expertise. Mr Johnson referred to poor communication as a particular issue. Professor Torero showed that the LFB were out of date and one-dimensional, capable only of fighting the fire they are presented with, with the equipment immediately available to them.

In conclusion, and looking at this Inquiry overall, you are clearly going to have to make highly critical findings about a large number of people and organisations, but this is not just a story of incompetence or worse on the part of individuals and companies. They were all operating within a culture which did not encourage either competence or honesty, a market and a system in which there was a headlong race to the bottom, and that culture had flourished because governments and regulators had not put in place adequate procedures to root out the fraudulent and the unskilled.

The fire, therefore, was the result of catastrophic

failures on a personal, corporate, regulatory and governmental scale, and we urge the Inquiry to so find in the strongest possible terms. The bereaved, survivors and residents expect the panel to so find, and they wait expectantly upon your report. They have waited patiently, but the time for waiting is now over.

Thank you very much.

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

Next we're going to hear a closing statement by Mr Imran Khan King's Counsel on behalf of another group of bereaved, survivors and residents.

So take your time, but when you're ready, Mr Khan, we shall look forward to hearing from you.

Closing submissions on behalf of BSR represented by Imran Khan & Partners by MR KHAN

MR KHAN: Good afternoon, panel.

When we first raised the issue of closing submissions with our clients, the overwhelming view was that it was going to be a complete waste of time, not because they think that you wouldn't produce recommendations, or that you will, in the words of the advert, probably produce the best recommendations in the world. They thought it was a complete waste of time because they didn't think and don't think that despite your recommendations anything will change. That's the

concern that they have, because governments in the past -- today's government and successive governments -- are unlikely to make the change that's needed.

The fact is that, immediately after the fire, our clients, and all those that were in Grenfell, knew what happened and who was at fault. In fact, the world knew what had happened and who was at fault. What they wanted, first and foremost, what they expected, immediately after the fire, was arrests, prosecutions, and imprisonment of those that were culpable. But instead what they got was five years of this Inquiry, this public inquiry. But for all of its advantages, what public inquiries do is they give the appearance of change without any change. They give the appearance of difference without making any difference.

Also, our clients, our cohort of clients, weren't particularly interested in contributing to closing submissions, but they were persuaded, more in hope than expectation, that they should do so, and they wanted us to focus on four key elements, which we've done in the written submissions that we have submitted. I'm not going to read all of those, but part of it. And it starts with a plea from our clients -- a desperate, impassioned plea -- that this Inquiry produces a set of recommendations and conclusions such that it leads to

a wholesale change to the housing sector in the UK.

Our clients believe that the fire will forever be remembered, we hope, in the history of this country, and depending upon what you and your colleagues, Chair, do, this Inquiry and its recommendations could either be recorded in that history as a forgotten footnote to the disaster, or the one single moment in time which changed everything. The choice is yours.

We have subtitled these submissions as "The Magic Pencil". It's taken from the words of a child affected by the fire. You knew the family, sir, panel. Our clients' son lost his brother on the night. When asked what he would want if granted three wishes, he said that one of the wishes would be for him to have a magic pencil, so that anything he drew with it would come to life. In his case, he wanted the power to draw his brother back to life.

In a sense, this Inquiry has that magic pencil, not of course to bring the deceased back to life, but to write recommendations which have the power to ensure that lives are not lost in the future. Not just here in the UK, but elsewhere in the world, as disasters like Grenfell are not limited by borders and boundaries. You may recall the events of Sunday, 29 August 2021. A fire took hold of a tower block in Milan which had cladding

identical to that on Grenfell Tower. In that case, the absence of victims apart from two pets was considered miraculous, and down to the fact that the fire took place in the afternoon of a hot Sunday in late August, when most of the residents were not at home, as well as the fact that the fire service did not even attempt to put the fire out, but instead broke the doors down to get everyone out. If nothing else, the Milan fire shows the global nature of this problem, and this Inquiry and the UK and this panel can be a leader in addressing it.

On behalf of our clients, we do not today seek to rehearse the evidence heard. That would be impossible. It seems to our clients and us that it's self-evident to anyone who has had even a passing interest in the hearings as to what happened during the events that led up to and occurred in 2017. You and your colleagues are well aware of it and, in any event, others more skilful who have come before me have addressed you more persuasively and more eloquently than I could ever do.

Our clients seek to address you in more general but equally emphatic terms on four discrete matters: race and social inequality, foreseeability, implementation, and apology.

The first issue we address is that of institutional racism. Giving the tower's history and the make-up of

its residents, the fire was, we say, simply waiting to happen. We have repeatedly, sir, urged upon you to consider whether race and social background of the residents of the tower played any part in the disaster. We did that from Day 1 in our opening submissions. That plea unfortunately has fallen on deaf ears and represents a failure, we say, on the part of this Inquiry, and a missed opportunity to change the lives of millions of people of colour in this country. The reality is that, without understanding the context in which the tower came into being and why it was populated as it was, this Inquiry will have failed to understand why the disaster happened and how it can be avoided.

The tower's genesis is best described by the social and political theorist Ida Danewid, who wrote this:

"When Grenfell Tower was built in 1974, the surrounding area in Ladbroke Grove was known as one of the most degraded places in London. The harsh conditions of the piggeries in the 19th century, the slums of the 1930s and the race riots of 1958 had earned the area a notorious reputation ... Populated by the poorest of the English working class and people of Irish, Jewish and Spanish descent, after 1948 and Empire Windrush, Ladbroke Grove also became home to the Afro-Caribbean immigrants excluded from living

elsewhere, alongside a sizeable Moroccan community ... Grenfell quickly became known as the 'Moroccan Tower' — a result of its large number of Moroccan immigrant residents ..."

From the outset, we say, the tone was set, and the destiny of the residents arguably determined.

As Robert Booth, social affairs correspondent for The Guardian, noted in an article published in June 2022, at the time of the Grenfell Tower refurbishment:

"Many councils had seized on property development, some to fill holes left by government cuts, others out of free-market instinct and desire to boost home-ownership. A prime potential redevelopment zone in Kensington and Chelsea was Grenfell Tower and its surrounding 1970s estates. This had long been the genteel borough's poorest area. In the 1930s the Labour MP Sir Stafford Cripps lamented: 'Of all the slums in England, those in north Kensington are the most tragic.'

"Inside the council, the tower was assessed as one of the borough's 'worst property assets' and 'a poor cousin' that 'blights' the surrounding area. From a purely financial perspective, the council viewed Grenfell as worthless. Laura Johnson, director of housing, wrote a memo to the effect that anything spent

on Grenfell was money down the drain."

It would seem a tower block filled with mainly so-called immigrant residents was viewed by the council as worthless.

Social inequality in wider society is unfortunately inextricably linked to social inequality in the housing sector. If you are poor and marginalised, you will be neglected. If you are poor and marginalised, you will be treated differently. If you are poor and marginalised, you will receive less care, receive less attention, receive less security. If you're poor and marginalised, you're more likely to die.

We submit that this was and continues to be indicative of the pervasive attitudes of our society towards the residents of social housing. Had the tragedy occurred in a different community, those involved in the refurbishment would have likely taken a very different approach. As Adam Smith noted in the Theory of Moral Sentiments:

"This disposition to admire, and almost to worship, the rich and the powerful, and to despise, or, at least, to neglect persons of poor and mean condition, though necessary both to establish and to maintain the distinction of ranks and the order of society, is ... the great and most universal cause of the corruption of

our moral sentiments."

These words were written in 1759. Some 250 years later, they still regrettably apply here. It cannot and should not be the case that, in 2017, the wealth, social standing, class or race of a person determines their future, determines whether they live or die. Yet that is, we say, precisely what happened in this case.

Those who died in the fire were largely from low income homes, at least 85% of them from minority ethnic backgrounds. The government's race disparity audit in 2017, the year of the disaster, said that those from minority ethnic communities were the most likely groups to rent social housing. Kieran Yates writing for The Guardian in 2020 noted that:

"Official housing surveys have found that 40% of high-rise residents in the social rented sector are from black, Asian and minority ethnic communities, which make up 14% of the population."

Throughout the UK, children from minority ethnic communities are more likely to live in dilapidated and overcrowded housing than white people and are 75% more likely to experience housing deprivation.

The connection between policy and the economic reality for most people is not one that is readily recognised by those in power. Yates' article

highlighted that:

"The disproportionate ethnic pay gap that communities of colour experience, for instance, has knock-on effects. Lower incomes mean greater reliance on state provision and more likelihood of ending up in low-quality housing; this may account for the one in six ethnic minority families in the UK who have a home with a category 1 hazard (one that poses an immediate and serious risk to health and safety)."

The effect of this, sir, is therefore that minority communities are disproportionately at risk from hazardous living conditions due to an unavoidable need to rely on social housing.

As such, not only was race crucially relevant to the disaster in the context of social housing, but also to the attitudes of those engaged in fighting the fire and those providing relief to the survivors.

We told you previously, sir, of a comment made in an article in March 2021, the head of the London Fire Brigade, Andy Roe. He told The Guardian that:

"A culture of casual racism and misogyny remains so prevalent within pockets of the [organisation] that ... he feared his mixed-[heritage] daughter might not be treated with 'dignity and respect' at some fire stations."

The Westway Trust, the charity involved with assisting residents in the aftermath of the disaster, said it accepted the findings of the review by the Tutu Foundation in 2020 that the charity has been and remains institutionally racist. The foundation's report further found that:

"The Grenfell fire brought into the wider public domain the long-held accusations by the local community that the Royal Borough of Kensington and Chelsea (RBKC) had failed to listen to their repeated concerns, which they believed was as a result of institutional racism, historic disenfranchisement, marginalisation and inequality."

Our clients find it astonishing, sir, astonishing, that given the history of the tower, you, the panel, have persistently refused to consider this vital issue. Our clients implore you, appeal to you, that you still have both time and opportunity to rectify this failure by applying Sir William Macpherson's definition of institutional racism referred to earlier. It is not to point a finger at any one individual that they're racist. The definition is clear and its worth repeating:

"The collective failure of an organisation to provide an appropriate and professional service to

people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour that amount to discrimination through prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people."

In applying this definition to the conduct of those organisations involved, our clients ask you to find that institutional racism infected every aspect of the disaster, from who was placed in the tower to how they were treated during and after the fire. The sad, unavoidable truth is that racism contributed to the loss of 72 lives. Our clients urge you to make this finding. Nothing less than this will do.

The second issue we address is foreseeability. We submit that the disaster was not only foreseeable, but foreseen by the many public and private sector institutions and individuals involved. As this Inquiry has heard, cladding fires of this nature are not a new occurrence, and Mr Mansfield KC already referred to the Summerlands fire in 1973 in the Isle of Man. 50 people died and a further 80 were seriously injured. It has been recommendation after recommendation. There has been Knowsley Heights in Liverpool in 1991, Garnock Court in Scotland in 1999, Harrow Court in

Stevenage, Hertfordshire, in 2005, and Lakanal House in London in 2009.

Since Summerland, and the multitude of fires in between that date and Grenfell, the position is best summed up by MP Harriet Harman speaking in relation to the fire at Lakanal House, and she said this:

"... whatever all of us did, it wasn't enough because if you've got something that happened and 6 people died and exactly the same happens again, and even more people died, then none of us did enough, whether it was me as the local MP, or whether it was the ministers, or people heading up the fire brigade – none of us did enough."

Our clients ask that you make a finding, perhaps the easiest of the findings that you can make, that the fire on 14 June was both foreseeable and foreseen by those involved in its refurbishment, with greed in the form of cost-cutting, profit being the key motivator, leading to at one point we indicated 15 readily identifiable opportunities where components of the cladding used on the tower could and should have been identified as unsafe.

All of the correspondence and information gathered for this Inquiry demonstrate that cost-cutting, profit, greed, was prioritised at the expense of the quality of

the work, and far above any consideration of our clients' safety and the importance of their lives. As is commonplace in the private sector, there existed "a callous indifference to anything -- morality, honesty, life safety -- that was not related to the bottom line of the business". This meant that corners were cut, avoidable errors were made, at every single stage of the works, from conception all the way through to completion. The fact is that this should not have happened in the wealthiest borough in the country.

Long chains of subcontracting gave everyone involved a false sense of security that even if they made mistakes, others in the chain could compensate for their shortcomings. Perhaps the most troubling aspect was that for many of those working in those long complex chains of subcontracting, the question of whether they were at fault was not even considered.

As Robert Booth again noted in the 2022 article:

"The sociologist Zygmunt Bauman once wrote that violence in our age is defined by distance. Summarising Bauman's idea, the journalist Daniel Trilling has written that this means not only physical distance, 'but the social and psychological distance produced by complex systems in which it seems everybody and nobody is complicit."

The buck-passing we have heard about from Mr Williamson King's Counsel. This theory may provide at least some explanation of why such a large number of individuals and institutions made a slew of fatal errors, despite being fully aware of the dangerousness of their decisions. As Booth noted, this is the reason why until we change the way our society is organised, it might happen again. Our clients say it's not a question of whether a fire like Grenfell might happen again, it is for them a question of when it will happen. It's only if we change the way our society is organised can we possibly have any chance of such a disaster not happening again.

And for that to happen, our clients seek recommendations in relation to increased state regulation of the housing industry. Because, as you're aware, consecutive governments, particularly from the latter half of the 20th century onwards, have pledged to cut red tape, reduce regulation on industry and free companies. The recent history of Building Regulations shows that the flagrant disregard for the health and safety of residents has been institutionalised. It has produced a culture which engenders a race to the bottom caused by ignorance, indifference and because they do not facilitate good practice.

Accordingly, it's vital for recommendations to be made such that the state properly regulates the construction industry to ensure that homes do not become flammable death traps, rather than to leave this matter to the mercy of the markets, which has been the case until now.

The third discrete matter our clients seek to address you on through me is in terms of implementation of the recommendations. Mr Mansfield King's Counsel has already addressed you on some parts of it.

The starting point in our submission is from the case from R v Secretary of State for the Home Department ex parte Amin, where Lord Bingham spoke of the purpose of holding an inquiry into the death in that case of Zahid Mubarek, who was murdered in his cell at Feltham in March 2000.

Lord Bingham said in that case an inquiry was required:

"... to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is alleged; that dangerous practices and procedures are rectified; and that those who have lost their loved ones may at least have the satisfaction of

knowing that lessons learned from his death may save the lives of others."

Those were prescient words uttered in 2003. In the context of this Inquiry, our clients suggest that culpable and discreditable conduct has been plainly and incontrovertibly exposed, and there has not just been suspicion of deliberate wrongdoing but actual evidence of the same.

What then remains now? Well, it's making the findings official, and making recommendations which ensure that the dangerous practices and procedures which have clearly been identified during the course of the Inquiry are rectified for the future. Only then will they -- those who have lost loved ones and those who have suffered in other ways -- have the satisfaction of knowing that lessons learned from the disaster may save the lives of others. That, Chair, members of the panel, is a heavy burden that you and your colleagues bear and are required to discharge.

You may be aware of a report published in December 2017 by the Institute of Government, which found that, over the years, the inquiry has become the gold standard when it comes to independent investigations of disasters such as Grenfell. We have three or four happening as we speak, one here only

a few weeks ago. The report identified that 638.9 million has been spent by central and devolved governments on more than 68 public inquiries since 1990. In late 2010, there were as many as 15 inquiries taking place at the same time.

However, despite becoming the choice method of independent investigation, their efficiency has been inadequate. Since 1990, it has taken an average of two and a half years for reports to be produced, and for at least nine inquiries it's taken five years or more. We're in that category.

Within the 16 inquiry reports received by the UK and devolved governments between 1990 and 2017, there were at least 2,625 recommendations for change. Of the 68 inquiries that have taken place since 1990, only six have received a follow-up by a select committee to ensure that the government has acted.

What the report found was that:

"Overall, the formal checks and procedures we have in place to ensure that public inquiries lead to change are inadequate. There is no routine procedure for holding the Government to account for promises made in the aftermath of inquiries, the implementation of recommendations is patchy, in some cases repeat incidents have occurred and there is no system for

allowing inquiries to build on the learning of their predecessors."

How much money has been spent on this Inquiry? And how do we ensure that that money is well spent so that there is real change for the future?

The report states that:

"Even in cases where government decides not to implement change, a process of government being called to explain its decisions is appropriate – not least so that members of the public who have been directly involved in an inquiry understand why change has not been taken forward."

We have already listed a number of fatal fires which preceded Grenfell in our written submissions. I referred to them earlier. The most disturbing aspect of these incidents is perhaps a lack of meaningful action by responsible institutions to prevent future loss of life. It appears that those in power simply dither and dawdle, waiting for these events to dissolve from public consciousness -- who remembers Summerland in 1973, for example -- so those in power can evade taking any remedial action to prevent future disasters.

Summerland 1973, Knowsley Heights, Garnock Court, Harrow Court, Lakanal House. Sir, our clients ask: given that these events have happened time and time

again, and recommendations made time and time again, and legislation changed time and time again, what could you, what could this Inquiry do which previous inquiries have not been able to do?

The reality is that whilst recommendations from the Inquiry will go, it is hoped, some way to making buildings more secure, the fact is that if property remains a valuable commodity and is treated as a means to make a profit, corners will still be cut, and the dangers that exist today will still be the dangers that exist tomorrow and the dangers that exist in the future. Lives will be lost unless change occurs.

We're not asking the kind of change which is no more than, at best, second-order change, that is an adjustment of policy and practice, but wholesale change; a change to the overall paradigm, not a tinkering of it.

Whilst Chair, panel members, you may feel unease at addressing what might be seen as a political part of the process, our clients have come to the inexorable conclusion that it is only when social inequality is entirely removed from the housing sector can they and their children truly sleep safely in their beds.

It will be a matter for you and your colleagues to determine how much and in what way your recommendations

can deal with this issue. Whatever your recommendations are, we have grave concerns that this government in particular and successive governments in the future, of whatever persuasion, will implement what you recommend.

So to ensure public inquiries can lead to real change, we refer again to the 2017 Institute of Government report, which referred to a need to have some form of monitoring mechanism. You have heard some suggestion from Mr Mansfield KC. We propose and ask that you take up what INQUEST have recommended: the setting up of a national oversight mechanism. And to go on from what Mr Mansfield said about the Lawrence recommendations and the committee that was set up which was attended by Mr and Mrs Lawrence, the Labour government soon disbanded it, forgotten about. Those were scenarios where everyone assumed, after the Lawrence and Macpherson recommendations, that (inaudible) dealt with the issue of race: we have a report, we have recommendations, that's done and dusted. That is not what we want to happen in this case.

A national oversight mechanism to examine regular progress and the state of implementation of recommendations of this Inquiry. An INQUEST campaign to establish such a mechanism says this. It's to:

"... ensure that recommendations arising from inquiries, inquests, and investigations into avoidable deaths are implemented. This would mean that once recommendations are made, an independent body would monitor and hold state and public bodies accountable for their decisions in response to recommendations."

Not only this, but our view is that it should go further. It's not, we say, simply a question of asking and giving 28 days to find out whether recommendations have been made or what progress is made, but to punish and have punitive measures for those who don't comply with those obligations and those responsibilities. It's to ensure that organisations are not allowed to continue their egregious evasion of responsibility.

Our clients truly, truly hope that this Inquiry does not prove to be yet another administrative formality or box-ticking exercise.

Sir, at Summerland, 50 died. At Garnock Court, one died. At Harrow Court, three died. At Lakanal House, six died. At Grenfell Tower, 72 died.

As it stands, it's not a question of if but merely when and where the next fire will occur and how many will die. Our clients' hope is that when this Inquiry concludes, they and their families can be confident that your recommendations constitute a genuine attempt to put

an end to this fatal line of history.

Moving on, much has been said by the lawyers for the core participants who are not bereaved or survivors or residents, including what might have been intended as an apology for acts, omissions and failures. Whilst I haven't seen what will be in their closing remarks, it seems to our clients that what is now required from each of them is an unequivocal, unambiguous and forthright apology for their part in the disaster, and we look forward to those apologies when each of the lawyers makes their closing submissions. As Sir William Macpherson rightly said, unless there is recognition from those who failed, recognition, acknowledgement and acceptance of the problem, it cannot be solved. We look forward to, as I say, each and every legal representative on behalf of these clients to make that apology during their closing remarks. In the event that any does not, our clients will consider this to be injustice heaped upon injustice and a mark of disrespect.

Finally, sir, we have been specifically asked to repeat that which was said at the fifth memorial commemoration at Westminster Hall, because it bears repeating. We set out a part of what was said, which we have rephrased for today:

After this Inquiry has finished and reported, you and your colleagues, indeed, all of us, will go back to our homes and offices and back to our work, whilst our clients will go back to empty houses -- not homes. Their actual homes were destroyed in the fire. Houses that are missing family photographs and heirlooms. We, all of us, will see our family and loved ones. The bereaved will be haunted by the memories of theirs. No longer will they be able to embrace their family members, tuck their children into bed, read them a bedtime story or have a family meal around the dinner table. Every morning they will have to wake up to an empty bed and an aching heart knowing that they won't be taking their child to school or teaching them how to ride a bike or swim. No longer will they attend parents evening or see the smile on their children's faces when they pass their first exams or driving test. No longer will they see their child graduate from university or get married. And they will be haunted daily with the guilt of what more they could or should have done to save the life of their loved one.

No parent should outlive their child. No parent should be deprived of the joy and wonder of seeing their child grow up and care for them when they themselves get old. This -- all of this -- has been lost to so many

people. And all because of a fire that could -- and should -- have been avoided. And, if this was not enough, our clients have had to suffer the indignity and pain of having to fight for justice, within this Inquiry, with the Metropolitan Police and with those who were legally responsible.

And what does this justice look like? Our clients are clear. If nothing changes, their loved ones will have died in vain, and they are not prepared to accept that. They want wholesale change to the housing sector in this country so that there is safe and suitable housing for all, not just the white, able-bodied and wealthy. They want meaningful recommendations to come from this Inquiry and they want those recommendations implemented in full and in a timely manner. They want the law to change so that those who are considered criminally culpable are swiftly prosecuted and properly punished. They want those who are responsible for failures to be forced to accept responsibility at the outset, rather than playing the blame game as almost every party has done during the Inquiry. And when tragedies such as this occur -- and they will -- when everyone knows what happened and why it happened and who was at fault, they don't want the victims to have to wait for half a decade, as they have had to do here.

They also want 14 June to become a national day to memorialise the Grenfell Tower fire so that it is a lasting and permanent legacy of something that is never forgotten, so that it cannot be forgotten.

Sir, a last plea, on behalf of our clients, panel, is for you to recommend 14 June a national day of remembrance, so that this disaster, this tragedy and those that suffered so much are never, ever forgotten.

Thank you.

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

Well, it's 12.55. I think that's a good point at which we break for the morning. We will resume, please, at 2 o'clock.

Thank you very much.

(12.56 pm)

(The short adjournment)

(2.00 pm)

SIR MARTIN MOORE-BICK: Now, the next statement is going to be made by Mr Martin Seaward on behalf of the Fire Brigades Union.

Yes, Mr Seaward.

Closing submissions on behalf of the Fire Brigades Union by MR SEAWARD

MR SEAWARD: Thank you, sir.

Good afternoon, sir, members of the panel, and

assessors.

I intend to address six topics this afternoon: the contribution made by deregulation to the disaster; the complacency of the refurbishers; water supplies; the response of the LFB; the fire control switch; and the smoke control system.

I would like to start by acknowledging the hard work of the FBU officials, especially Gareth Beeton and Steve White, who have supported the effort on behalf of this Inquiry from the beginning, and the legal team representing the FBU, that's Gerard Stilliard and Harry Thompson of Thompsons, Nick Toms and Lord Hendy KC of counsel. There are others, of course, but I particularly wanted to thank these.

Starting with deregulation, the disaster was a direct consequence of a generation of government policies which combined to create a death trap for the residents of Grenfell Tower. The private sector companies involved in the refurbishment bear a heavy responsibility; however, it would be wholly wrong and provide no justice to victims to leave the blame there. They were encouraged to act as they did by 40 years of political decisions in the service of an ideology based on the prioritisation of commercial interests and profit above all else, including public safety.

Deregulation encompasses privatisation and cuts to public services as well as statutory deregulation, replacing prescriptive rules with functional requirements. It's part of the ideology of neoliberalism, which prioritises above all else the liberation of entrepreneurial freedoms and private business interests through a largely unfettered free market. The role of the state is limited to creating and maintaining an institutional framework to support the free market.

Commercial interests and profits have thus been prioritised over and above the needs of citizens, even in relation to fire safety. There were, as you have heard, no life safety exceptions to protect citizens from harm by fire.

Deregulation serves the interests of a social system based on profit and greed, has led to gross inequality in society and has failed the vast mass of the UK's population, including the residents of Grenfell Tower.

The culture of health and safety has been deliberately and irresponsibly undermined by ministers pursuing their deregulatory agenda. Regulations have been repeatedly depicted as pointless, time-wasting, administrative bureaucracy that impedes private enterprise.

Deregulated legislation has not been effectively enforced, neither the Fire and Rescue Services Act 2004, the Fire Safety Order 2005, nor the Building Regulations 1985. Effective enforcement, seen as another burden on business, has instead been progressively weakened by successive governments since 1985, with ever greater ambiguities and loopholes being introduced, with confusing guidance, with part-privatisation of regulatory bodies and cuts to enforcing authorities. This has allowed the construction industry to effectively ignore fire safety.

By way of example, the number of RBKC's area surveyors was halved from 12 to 5 prior to the fire. In the four years before the fire, their building control department lost 10 surveyors, with between them 230 years of experience, and gained just one graduate replacement. The agenda of deregulation as pursued by successive governments is thus inimical to human rights, health and safety and equality.

The anti-health and safety culture engendered by deregulation informed the approach of all the private sector companies involved in the refurbishment of Grenfell Tower. Encouraged by government and not deterred by enforcement authorities, they focused solely on getting the work done as quickly, cheaply and, for

them, as profitably as possible. This widespread culture of complacency materially contributed to the prevalence of "worrying standards", adopting Dr Lane's phrase from Module 7, and so also to the failure of anyone involved in the Grenfell Tower refurbishment to think fire.

We ask the GTI to find the promotion of this culture was a consequence of the deregulation policies pursued by successive governments and a significant factor leading to the Grenfell Tower disaster. The FBU believes these policies tragically came together on 14 June 2017 to create the worst residential fire since World War II.

It informed government policy since 1979 and has remained the mantra of the current government, despite Grenfell, until at least 22 October 2022, with Downing Street inundated with advisers recruited from neoliberal think tanks. The Brexit Freedoms Bill, for example, is now intended to remove all regulations derived from EU law on 31 December 2023 unless the government determines particular provisions should be kept. This further threatens public safety and workers' rights.

Deregulation has become synonymous with central government abandoning responsibility for large areas of

our society, including Building Regulations, building control, testing and certification, fire and rescue services and fire safety.

We look at each of these areas in turn, starting with the building regulatory regime.

Statutory deregulation significantly weakened the protection provided by the Building Regulations. Their dramatic and fundamental revision in 1985 saw detailed technical provisions replaced by functional requirements, without any resources to achieve the competency required to meet them or to enforce them, and without clear and updated national guidance in ADB. You're familiar, of course, with Dame Judith Hackitt finding that the regime was not fit for purpose, and left room for those who want to, to take shortcuts. We agree and ask the panel to find the same. The Department of Levelling Up now admits as much in paragraph 5(f) of its overarching statement. This was central government's abandonment of responsibility in the wake of deregulation.

Likewise, building control has been a story of part-privatisation and deregulation. Since 1984, local authority building control has been forced to compete with private sector approved inspectors as an alternative to and in competition with local

authority building control bodies, who have had to cover their costs by selling their services to the very developers they were supposed to control. The fear of losing work and income introduced a conflict of interest and deterred them from a rigorous approach to their enforcement duties. Public expenditure cuts also undermined them.

Thus, a further important protection for public safety had been eroded by deregulation. We have seen, for example, how the Local Authority Building Control served the interests of Kingspan, not of the public, by wrongly certifying K15 as a product of limited combustibility.

The Building Research Establishment is another story of cuts and privatisation. Since 1987, the BRE was made to work closely with the construction industry in the run-up to its privatisation and to be, citing Nicholas Ridley in the House of Commons, 1987, "more concerned at present with fostering competitiveness and less with performance standards".

On 2 April 1990, the BRE was turned into an executive agency of government in order to help extend its ability to compete for commissions from both the public and private sectors. Staffing was halved from 1,350 in 1975 to just 654 in 1989. Privatisation

in 1997 brought with it significant conflicts of interest that impacted on BRE's ability to protect the public. It was no longer rigorous and independent, but instead had increasingly close links with the construction industry. That of course was the purpose of its privatisation. In breach of its charitable objective, the privatised BRE failed to warn the public or the building sector of the unique hazards associated with the use of ACM PE on the exterior façade of a high-rise.

Likewise, the British Board of Agrément, always in the private sector, always with extensive links with the construction industry, with its board members representing the construction and cladding industry on which the BBA depended for income. The BBA could not explain the false and misleading entries on the Kingspan certificate, which served the interests of the sponsor, not the public. At best, they acted in a way which was, to quote Counsel to the Inquiry, supine and leaden-footed.

So into the deregulated fire and rescue service.

Deregulation led to the passing of the Fire and Rescue Services Act 2004, which directly weakened the ability of the fire and rescue service to do its job. By the Fire and Rescue Services Act, central government

abandoned its responsibility, so it abolished the Central Fire Brigades Advisory Council, CFBAC. This was the one body that, had it remained in existence, could reasonably have been expected to have developed operational guidance in relation to high-rise buildings, including cladding risks and stay put. Its abolition limited the fire and rescue services' abilities to learn lessons from cladding fires and/or to address and resolve recurring issues, such as poor communications and the provision and use of water when fighting fire in a high-rise residential building.

Secondly, the Act forced reliance solely on chief officers bodies. The Chief Fire Officers Association, CFOA, and their successor, the National Fire Chiefs Council, NFCC, these chief fire officers were the only advisers to ministers and were given responsibility for operational guidance. The FBU was sidelined. Rather than resist deregulation, the CFOA and the NFCC facilitated it. Rather than resist austerity cuts, chief officers implemented them. Deregulation even deterred leaders of the LFB from raising issues of simplifying or clarifying fire safety legislation as they feared it would lead to more deregulation based on the government's one in, two out policy, as Ron Dobson told the panel on Day 211.

The FBU is disappointed that the Inquiry hasn't put CFOA and NFCC representatives on the witness stand during its proceedings, with the exception of Mr McGuirk, who was of course given the protected status of an objective witness, rather than someone who had played a key role in creating many of the problems identified within the fire and rescue service.

Thirdly, the Fire and Rescue Services Act removed the requirement for cuts to a Brigade's establishment to be approved by a minister. Chief fire officers and fire authorities, including London under the control of Boris Johnson as mayor, could thus cut the establishment -- ie staff, stations, equipment -- without constraint, and they did.

Further, the Fire and Rescue Services Act also removed national standards of fire cover. This meant that the same fire in the same type of building could attract a different attendance in different parts of the country. In London, this led to cuts to the number of firefighters, fire stations and appliances and to the pre-determined attendances, and to cuts in the control room and the fire safety department, all of which directly impacted on the Grenfell Tower disaster. At the same time, the government abolished Her Majesty's Inspectorate of Fire Services, HMIFS, and that led to

the loss of oversight of local fire brigades.

Thus, central government delegated all responsibility for the provision of fire and rescue services to 47 -- now 45 -- local brigades. Government's abandonment of responsibility is evidenced by the dearth of guidance issued to local brigades under section 21 of the Act or otherwise, even regarding recommendations made by proper authority following investigations into disasters preceding Grenfell.

It's evidenced by the petering out of the national framework for integrated risk management planning, a process by which local brigades are supposed to assess the risks in their area and budget for the resources needed to cover them. Instead, in the vacuous national framework, the IRMP process rapidly became a tool to implement phased cuts instead of an intelligent assessment of what was needed.

Deregulation also led to privatisation in the fire and rescue service. The privatisation of training damaged the ability of the LFB to respond to training needs. The ongoing threat of privatisation meant that control was prohibited from recruiting, despite the numbers of control room staff being below the minimum required, which in turn impeded training.

The Regulatory Reform (Fire Safety) Order of 2005

replaced the certification and enforcement regime of the Fire Precautions Act 1972 with a far looser self-compliant system. Fire risk assessments became the responsibility of a responsible person, usually the landlord, who would employ third-party fire risk assessors for complex or high-risk premises. They were not required to have any competency or professional qualifications.

Its purpose was deregulatory. The Office of the Deputy Prime Minister clarified this regulatory purpose in a statement issued on 19 April 2004:

"The aim of the proposed reform [that is the Regulatory Reform (Fire Safety) Order] is to reduce burdens on business."

In Grenfell Tower, RBKC's and the TMO's fire risk management systems established under the new Fire Safety Order were under-resourced and unfit for purpose. It led to the appointment of Carl Stokes, who was neither qualified nor competent to risk assess a complex building like Grenfell Tower. He was appointed after submitting the lowest tender. He was largely unsupervised. Brandon Lewis accepted before this panel that the government failed to address concerns about the competence of unqualified fire risk assessors because of its presumption against regulation. So Mr Stokes

remained in his role, and a further layer of protection for the residents of Grenfell Tower was thus stripped away as a direct consequence of central government policy.

This led to the failure to risk assess the rainscreen cladding system, or the vastly increased need for effective compartmentation, or the lack of fire safety measures in Grenfell Tower, without any evacuation plan, not even for those who needed help to evacuate: no firefighting lift; no working fire control switch, with a triangular key; no smoke control system protecting the lobbies; no wet rising main; and many flat entrance doors not adequately resisting fire or self-closing.

Deregulation impacted central government itself and led the DCLG into breach of Article 2 of the European Convention on Human Rights, the right to life. Lord Pickles could not explain why he and his department failed to address concerns about ambiguities in Approved Document B, the need to withdraw class 0 and the prevalence of ACM PE, despite the best efforts of the Lakanal House coroner, and the All-Party Parliamentary Fire Safety and Rescue Group, who repeatedly raised the issue between 2014 and 2017. Instead, he and his department deliberately downplayed the risk of rapid

fire spread associated with combustible cladding systems, thereby contributing to the widespread misunderstanding of the dangers of using combustible cladding on high-rise. Nor could he explain why, contrary to his self-serving and untrue evidence, the Building Regulations and Approved Document B were not exempt from the deregulation policy.

The explanation lies, we submit, in the government's continuing adherence to the deregulatory agenda, which stifled its ability to protect society. As Mr Ledsome told the panel on Day 241, the fact that there may be societal benefits as a consequence of the regulation was not something that was taken account of in one in, one out terms. It was the net annual equivalent cost to business which was the key metric.

The government would not fetter the ability of manufacturers of cladding and insulation to market their products with impunity. Instead, the government ignored and suppressed evidence that cast doubt on its policy, as revealed by the request to play down the issue of the fire following Knowsley Heights, as revealed in the departmental memorandum unearthed by Professor Bisby. It failed to introduce or adopt EU standards, even prior to Brexit, and far from correcting the confusion in Approved Document B, they added ambiguity by extending

the routes to compliance to include desktop studies.

Deregulation directly led to the reduction in staff in the civil service, including in the DCLG, and so reduced its effectiveness in addressing these issues. The head count in the Building Regulations section of the DCLG reduced by 40%. In 2006, there were 14 construction professionals in a division with a much smaller scope, with three grade 6s supporting the deputy director. By 2015, this had reduced to five technical specialists with one grade 6. That was Mr Martin, who lamented to the panel his lack of peer review which contributed to his failure to confront ministers with the need to resolve ambiguities in ADB. These staff reductions reflect central government's abandonment of responsibility.

Deregulation also damaged social housing. The decay and neglect of social housing by central government and the local authority, one of the richest in the UK, did not just mean that the occupants of Grenfell Tower had poor quality homes; it cost, we say, 72 of them their lives.

Since 1979, publicly-owned social housing has been subject to part-privatisation and neglect. Part-privatisation was achieved through the introduction of management companies, such as the TMO, and the Right

to Buy policy. We saw the sale of large amounts of council housing, much of which has ended up in the ownership of private sector landlords. Unsold properties have been starved of funds.

Grenfell Tower was no different. As the evidence in Phase 2 demonstrated, prior to refurbishment, the block was in a bad state of repair. It was described as one of the TMO's worst property assets. It was refurbished due in significant part to being considered an eyesore next to a brand new school academy building. Its disrepair was then hidden beneath the cladding.

Not surprisingly, given the funding climate of social housing, the main driver of the refurbishment was cost, ahead of quality and programming. The desire to keep costs down pervaded nearly all the really important decisions made in the refurbishment, including the initial choices of architect, fire consultant, and design and build contractor; the use of ACM PE cladding panels in preference to zinc metal ones; and the amount of work done by Studio E and Exova, particularly after Rydon became the design and build contractor.

Grenfell Tower was a disaster waiting to happen in consequence of all these policies introduced pursuant to successive governments' deregulatory agenda coming together to create an unparalleled housing disaster.

The policies were ruthlessly exploited by private sector companies taking advantage of changes they had sought through sponsorship and party funding donations. The FBU believes the real culprits of the disaster are those in power at the top, ie ministers following their deregulatory agenda to the detriment of fire safety, and the directors of industry on which they depended for sponsorship and party funding.

Turning now briefly to the complacency of those in the refurbishment. The key players amply demonstrate the widespread disregard of fire safety, the failure to think fire.

Starting with RBKC and the TMO, they bear a heavy responsibility, principally for the flawed appointments of Studio E, Exova and Rydon; for prioritising value over quality at the expense of life safety; for the widespread failures of their fire risk management systems; for not planning for the evacuation of their residents, especially those unable to evacuate unaided; for not upgrading to a firefighting lift with a triangular key to operate the fire control switch; for the failings of building control; and for the failing to engage effectively or meaningfully with the residents of Grenfell Tower.

The cladding manufacturers, including Arconic,

Kingspan and Celotex, failed to disclose material test results or to correct glaring errors in marketing literature. They dishonestly fabricated test rigs and manipulated the testing and certification system. They treated testing bodies such as the BRE and certification bodies such as BBA and building control bodies such as NHBC and LABC with contempt. They did all of this, knowing of the uniquely hazardous nature of ACM PE, to push their products onto high-rise buildings to further their own commercial interests.

The private sector companies involved in the refurbishment were chosen because they were cheap. They operated in a culture of complacency, ambiguity and weak enforcement encouraged by government. Due allowance may be made for that. But their directors chose to put profits ahead of residents' safety and to exploit the known weaknesses of building control. We have detailed in previous submissions what we see as their devastating failings and merely try to summarise them here.

The architect, Studio E, artificially suppressed their fees below the level which would have required an open tender, and were appointed without tender by the TMO in breach of the public procurement regulations. They had no previous experience of refurbishing a high-rise. None of Studio E's staff had or made any

effort to acquire the knowledge needed to work competently on Grenfell. They didn't know what they were doing. They shouldn't have taken on or persisted in the project, which they were not competent to carry out. They failed to ensure adequate fire safety engineering advice was obtained, and they specified ACM PE cladding. They knocked the refurbishment project off the rails from the start.

The fire consultants, Exova, an experienced fire safety consultancy, were appointed as fire consultants by the TMO without tender and with a poorly specified brief. Neither the TMO, Studio E nor Rydon used them properly at key stages of the project. They used unqualified or junior staff for the project, who notably failed to complete the fire risk strategy, or even to consider the effect upon fire safety of installing a combustible rainscreen. Their involvement was a dangerous token gesture. It was dangerous because it gave building control and others the false impression that fire safety was being properly considered.

The design and build contractor, Rydon, were appointed through a flawed and illegal tendering process from which it emerged as the lowest bidder following secret negotiations with the TMO, a process that smelled strongly of corruption, and agreeing to make further

savings of over £1 million. This led directly to the use of the cheaper face-fixed ACM PE cladding panels. Rydon neither had nor obtained specialist cladding or fire safety advice and cut corners by not consulting Studio E or Exova on fire safety issues.

The subcontractors, both Harley Façades and CEP Architectural Façades, knew of the dangers of ACM PE on high-rise, and so both were complicit in Rydon's cost-cutting at the expense of health and safety. Gerard Connell, a fabricator at CEP, states that ACM PE was easier to work with than safer varieties. Once again, profits were put before people.

They all grievously failed the residents.

Moving on to water.

Rejecting the LFB's tests, Dr Stoianov confirmed his opinion in Module 7 that, despite poor flow rates from most hydrants, the quantity of water available for firefighting was more than adequate, with the benefit of certain adjustments, and that the aerials deployed were theoretically capable of projecting water jets to or very close to the full height of the tower. The aerial appliance on the pre-determined attendance for Grenfell was removed in 2006 and, despite being called for early in the incident, no aerial arrived at Grenfell until 1.32. We have submitted extensively on this subject and

refer to our previous written and oral submissions.

We submit the failure to maximise the water flow to the pumps at Grenfell was the result of systemic failings, not only individual failings of operational firefighters, save only the failing to discharge the role of bulk media adviser.

As to inadequate training, there was no evidence that operational firefighters, other than specialist bulk media advisers, were given the necessary training to make the adjustments needed, for example to use more than one hydrant to augment the supply to a single fire appliance, or to specify to Thames Water the water flow they needed on the night for a particular appliance, or otherwise how to maximise the water flow. This training failure is institutional.

As to the poor discharge rate from hydrants, Dr Stoianov would have expected the flow coefficients of the hydrants installed at Grenfell to be higher than they turned out to be. In this context, he referenced a paper which was published a year before the fire by a firefighter who had carried out about 600 flow tests on fire hydrants in southwest London, and his conclusion was that about 20% were inoperable and about 30% had flow rates less than 500 litres per minute. In light of this paper, Dr Stoianov concluded it seems that this is

a very representative sample of what's happening in London, that most of these fire hydrants do not have the discharge characteristics which we expect them to have. He identified a need for the fire and rescue service to undertake periodic flow rate tests of hydrants in operation. This, the lack of such flow rate tests, was another institutional failure.

The incomplete and inaccurate information in the mobile data terminal, which comes from the operational risk database, was another institutional failing which further hindered operational firefighters on the night. No blame attaches to individual firefighters for the poverty of this information. There was no aerial on the pre-determined attendance and there was thus no expectation on firefighters conducting a section 7(2)(d) visit to a high-rise to consider the water supply set-up for an aerial such as at Grenfell Tower, as can be seen from the list in appendix 1 to PN 633, which was cited extensively in Phase 1, where there was no mention of the water supply for an aerial appliance.

Likewise, Thames Water operatives were not given the training they needed to ask appropriate questions to elicit this information from the fire ground.

Coroner Thomas had made recommendations about water supply following the Harrow Court inquest into the

deaths of Firefighters Michael Miller and Jeffrey Wornham, and a resident, Natalie Close, who all died on 2 May 2005 in flat 85 on the 14th floor of an 18-storey high-rise known as Harrow Court in Stevenage, Hertfordshire. Like so many others, these recommendations had not been implemented by 14 June 2017.

These institutional failings flowed, we submit, principally from the dearth and deficiencies of national research and guidance for local fire and rescue services, as reported by Dr Stoianov, for which individual firefighters should not be criticised. Dr Stoianov expressly disavows any personal criticism of the individual firefighters. He added in his oral evidence that it was not practicable for firefighters to have tested the mislabelled wash-out hydrant on the night.

The FBU agrees and additionally submits that firefighters developed workarounds to the best of their training and ability. Just one example, on the night Firefighter Keene, who operated pump appliance G272 supplying water to a turntable ladder, which is a type of aerial, A213, told the police:

"The water I was supplying only lasted less than a minute and then we had to wait another 20 seconds for

the tank to fill back up. After about 20 minutes to half an hour I changed strategy, and instead of giving them the full 10 bars I dropped it down to 7 or 8 bars so that the supply was more continuous."

We say that was all he could do in accordance with his training and experience.

The response of the fire and rescue service.

The FBU recognises that the role of the fire and rescue service and the LFB is an important part of the Inquiry. The LFB did not cause the fire at Grenfell Tower and did its best to respond to it. It has never been the position of the FBU or the members we represent that everything went as well as possible in their attempts to deal with the disaster. There were failings and weaknesses. There are lessons that must be learned for future fires, not least because the materials used in the refurbishment of Grenfell Tower remain in place on many other high-rise buildings. And still, five years on, and three-plus years after your recommendations, there's still no national guidance on evacuating a high-rise.

We are concerned, however, that by starting with a microanalysis of the emergency response in Phase 1 and then returning to the fire and rescue service in Phase 2, the GTI risks distracting from the real causes

of the disaster and creating a scapegoat that would allow those truly responsible, including senior politicians and company directors, to evade responsibility.

Firefighters risked their lives going into the blazing inferno to try and rescue residents and extinguish the fire. They and the control staff did their duty professionally, bravely and to the best of their abilities in the face of a rapidly developing fire that was beyond anything any of them had ever experienced or trained for. They followed their procedures and applied their training as much as the extreme conditions allowed.

Professor Torero calls for upskilling fire and rescue service personnel to provide a greater level of competency in all their functions. Dr Stoianov's identified water supply as an area in which greater training is needed. Professor Johnson has identified communications as another. Mr McGuirk has identified section 7(2)(d)s, amongst others. The list is long. The FBU welcomes these calls and fully supports better training for firefighters, control staff and fire safety officers. The FBU cautions, however, that significant additional investment of time and resources will be needed to implement these recommendations, not cuts and

redundancies.

The fire control switch for the lifts in Grenfell Tower —— I can see your spirits rising —— I just want to say a few words about this. We have already submitted extensively in writing and orally detailing the evidence and argument in support of the findings we ask the panel to make about the fire control switch. Steve Walsh KC for the London Fire Commissioner broadly agreed with our opening submissions for Module 3 also on Day 115.

It was impossible for the firefighters to use the lift or to protect residents from using it. It was crucial to the emergency response that it worked, but it didn't on the night. This is because, we say, it wasn't maintained or tested before the fire, but was allowed to remain blocked with builders' debris following the main refurbishment. We ask the panel to consider the submissions we've made, to analyse the evidence and to make the following key findings:

1. The fire control switch was not checked and tested by lift engineers after 19 February 2016.

2. The fire control switch was blocked on the night by builders' debris and, for this reason, could not be operated.

As to the first finding, not being checked and

tested by lift engineers in the 16 months from 19 February 2016, some lift engineers from PDERS and Bureau Veritas now claim they did inspect and test the switch, but their self—serving assertions are not supported by the defective condition in which the switch was found, nor by any documentary evidence. We have already submitted, and we do not repeat here, why we ask the panel to conclude this witness evidence is unreliable.

As to its condition, the condition of the switch, the WASP inspectors on behalf of Operation Northleigh found the switch was defective and observed:

"As the mechanism on the fireman's switch on the ground floor was defective, then we can assume this has not been examined by the lift service company at regular intervals."

We agree with the WASP inspectors. There is no record of any such check by PDERS or Bureau Veritas lift engineers after 19 February 2016. The natural inference is that it did not happen. Unlike Mr Haggarty 16 months earlier —— that's the one on {PDR00000047/24} —— Mr Wallis didn't even record doing an electrical safety switch check or any of the annual checks associated with an S—type service visit following his S—type service visit on 9 May 2017.

I don't need to go into detail, just to remind you that had anybody checked the safety switches and devices, they must surely, we contend, have noticed that the automatic fire recall function wasn't working, had been cut with straight ends, and the potentially confusing presence of the redundant fire control switch at the walkway level, which needed to be removed and was still there, but no such mention was made. We contend the inference is that they didn't check the safety switches and devices.

Moving on to the blockage with builders' debris.

Please screen side by side the photographs of the fire control switch taken in the Grenfell Tower on 18 April 2018 {RHO00000004/108} —— that I think will be the one on the left —— yes, that's the one on the left —— and photo 19 taken in Deer Park {RHO00000004/234}. Thank you very much.

I have asked you, sir, and members of the panel, to look at this before. The reason I'm asking you to look at it again isn't just by way of repetition, it's because when I came to look at these photos again, I noticed something which I hadn't noticed before, and I wanted to point it out to you.

If you would be kind enough to look on photo 19, that's the same fire control switch which was taken out

of Grenfell Tower. It was actually removed from Grenfell Tower in July of 2018, following the WASP inspectors' recommendation made in April 2018, but it was kept in a sealed evidence bag and taken to Deer Park, where it was examined in a workshop by police inspectors, WASP inspectors, on behalf of Operation Northleigh. But if we look at BJG/74, which is the one on the left, it's photo 19 on the left, we do see some significant changes from the one that was taken out of Grenfell Tower.

So look at, first of all, the left.

If you would be kind enough to take the cursor to photo 108, that's it. I don't know if you're able to enlarge it a little bit, maybe not to the full size, but just a little bit. Because the trouble is, as we enlarge it, it becomes a bit fuzzier. That's fine, thank you very much.

We can see there the encrusted builders' debris around the actual inside of the faceplate. Could you move the cursor up and down the labyrinth. That's it, perfect. That's the labyrinth where the drop key is supposed to drop. Obviously it's upside-down at the moment because it's been taken -- the faceplate has been removed from the fire control switch and it's hanging down, but you have to imagine it's up the right way when

it's in place. You can see how that labyrinth bar is encrusted with builders' debris.

Now look over the page to photo 19. There, it doesn't bear any comparison. That is shiny. You can see right into the edges of the labyrinth bar. If you run your cursor up and down the labyrinth bar so people can see. Thank you. There on the left you can see the edge, which is perfectly clean. Shiny and clean.

Now, more significant, if you go up to the top, where the labyrinth bar is secured to the frame, the switch frame, that's like two bookends, which is the switch frame. The labyrinth bar is secured to the switch frame by four screws. You can see two screws at one end and two screws down the other end, and that's what I hadn't noticed before.

If you go back over to the fire control switch as it came out of Grenfell Tower, there is no sign of any screws. In my submission, that supports our submission that the fire control switch we see in photo 19 was the result of substantial cleaning. We can see shiny bits on the faceplate, it's obviously been wiped with a cloth, and we can see that the actual mechanism of the fire control switch has been extensively cleaned. But because of the screws, we can see that it must have been dismantled, cleaned and then reassembled, and that's the

condition of the fire control switch which was then examined by Mr Horne and Mr Howkins and others in Deer Park on 15 February 2019. So when Mr Howkins describes a quarter of a teaspoon of builders' debris retrieved from the fire control switch, he is talking about the fire control switch as cleaned. He is talking about the builders' debris which remained after that cleaning operation had taken place.

I'm not making -- casting any aspersions over the cleaning of the switch. The purpose of its investigation in Deer Park on 15 February 2019 was to examine it. It's very hard to see how it could have been examined without being cleaned from a technical engineering perspective. But so far as drawing conclusions about the extent of the builders' debris that blocked it in Grenfell Tower, we have to make due allowance for the fact that it has been cleaned there, and I ask you please to look at the photograph as it came out of Grenfell Tower, and to bear in mind that the most likely explanation for it not being turned and operated effectively was that it was jammed with builders' debris.

So, a few more points.

On 15 March, site visit 1, the independent WASP inspectors visually inspected the ground floor fire

control switch in Grenfell Tower without removing the faceplate and reported it had not been damaged by the fire or water. So if you look at the upper photograph on page 108, I wonder if you could just bring that -- that's it. So that's how it was in Grenfell Tower, and you can see no sign there, like the WASP inspectors reported, of damage of the switch by fire or water. It's not as if it's in a part of the wall that has obviously been subjected to fire or water.

On 18 April, they returned for their site visit 2 -- these are the WASP inspectors -- and they found -- and if we could just reduce the size of the pictures to look at the text -- they tried to operate it, because they say on the left there, "The fireman's switch was difficult to operate" and then, "The faceplate was removed to determine the reason for failing to operate the switch". We say you don't need any explanation, it's obvious from the photograph what was the reason: it was blocked.

They couldn't operate the switch despite using the correct drop release key and applying reasonable force, and this was finally and for the first time accepted by Mr Howkins at the end of his oral evidence to the Inquiry on Day 165; too late, regrettably, for him to properly consider its significance. It shows, we

submit, that the fire control switch could not be operated on the night, even using the correct drop release key and applying reasonable force, and (b) that it was the builders' debris that stopped it operating on the night.

The WASP inspectors recorded —— and we can see this —— that the faceplate was removed to determine the —— and towards the bottom of the page:

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

Then they observed at the end of their report —— this is page 132 of Mr Howkins' appendices {RHO00000004/132}, that's their report —— that:

"The drop key used to operate the fireman's switches proved to be very difficult to operate and may prevent the fireman from gaining use of the lift to fight the fire."

And they recommended a replacement with a triangular—type key.

So I do ask you, sir, members of the panel, to compare those two photographs and draw the conclusions that we're asking you to draw.

Now, that does, unfortunately, clash with Mr Howkins' opinion, and he has formed a completely opposite opinion. We say that opinion is unreliable.

It's based upon his factual error about the extent of the blockage found by the WASP inspectors, and that factual error has led to his flawed conclusion at paragraph 163 of his supplementary report that:

"Overall, in my view, considering the amount and size of debris on the switch and the testing carried out, if an ordinary authorised adult had used a fitting express drop key in the fire control switch and had used a reasonable amount of force, it is likely the debris would have cleared, as it did for us in the testing."

There he was only talking about the little bit of debris that remained behind, which still blocked the operation of the microswitch on February 15.

So thank you for your patience. I have just got a few words to say about the smoke control system and then I'll come to a conclusion.

We have set out the FBU's submissions on smoke control as designed by PSB and don't repeat them here, but we do ask you to take those into account, particularly on the unreliability, as we say, of Mr Lay's expert evidence, where it differs from Dr Lane's, and we endorse the submissions already made today by Stephanie Barwise, Michael Mansfield, and Adrian Williamson KC on behalf of the BSRs.

So, in conclusion, what has been demonstrated during

the last five years of this Inquiry is the widespread failure to prioritise fire safety. What must come out of it is a greater awareness of fire risks and the enormity of their consequences if they materialise. That deregulation must give way to life safety. There must be more investment in the training of those involved in ensuring and enforcing fire safety and providing fire and rescue services. There must be greater respect for social housing and those who live in it. There must be more listening to those affected by fire risks, in particular the firefighters who lay down their lives and put them on the line. There must be proper oversight of the implementation of recommendations coming out of careful investigations like this.

Thank you for your patience.

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

Well, now, finally this afternoon we're going to hear a closing statement by Mr Stephen Walsh King's Counsel on behalf of the London Fire Commissioner.

So, Mr Walsh, when you are ready, we shall be pleased to hear from you, and I may say we are pleased to see you here in person.

MR WALSH: Well, sir, thank you. I always intended to come,

actually. The remote issue was just in case there was a major issue with the strike.

SIR MARTIN MOORE—BICK: Yes, of course.

Closing submissions on behalf of the London Fire Commissioner by MR WALSH

MR WALSH: Thank you very much, sir, good afternoon, and good afternoon, Ms Istephan and Mr Akbor.

Just while it's in my mind, because I hadn't heard those submissions before, the submissions that have just been made by Mr Seaward, the revised submission concerning the lift key mechanism, are, I think, persuasive, and probably deserve renewed consideration. So we'd endorse them to that extent and say no more about it than that.

Sir, in common with others who have made submissions to you today, certainly in the time available this afternoon, I won't be taking you through the entirety of our written overarching statement. It's obviously now a matter of public record for all to read, and I know that you, sir, and your colleagues will carefully consider the issues which are addressed in it and take them fully into account in your work on the Phase 2 report.

Of course, the same applies to the numerous statements which have been provided to you on behalf of

the LFC in both phases of the Inquiry, both written and oral, the most recent of which were the closing statements for Modules 5 and 6. Those statements dealt with much of the evidence which we have heard during Phase 2, so to a significant degree they perform many of the functions which this overarching written statement we have provided to you is intended to do.

But, that said, in this current overarching statement, in which a degree of repetition is inevitable, we have sought in three parts to address from a slightly different perspective the key most important aspects of the Phase 2 evidence insofar as it impacts on emergency responses to high-rise residential fires.

The first part of the written overarching statement clarifies -- in many instances affirms -- the key concessions or admissions that have been made by the LFB through the candid evidence of past and present employees during Phase 2.

In light of those concessions, the second part of the statement highlights previous submissions made to you on behalf of the Brigade which have been confirmed and strengthened by the rich context which the evidence in Phase 2 has provided. That includes issues which deal with the singular nature of the fire -- without

going into detail about any of this -- the principal cause of the fire, which you addressed of course in Phase 1, in your Phase 1 report, but no doubt will revisit again in the Phase 2 report; and the reliance on the regulatory system, the Building Regulations and others, including the important evidence in Module 6B concerning the role of the responsible government department and others.

The third part of the statement elaborates upon the continuing challenges faced by fire and rescue services in planning for and responding to fires in high-rise residential buildings where there has been, as there was at Grenfell Tower, a fundamental subversion of the system of fire safety regulation, which was revealed so shockingly in relation to Grenfell Tower, of course, for various modules of Phase 2, and that is for the vital purpose of effecting meaningful changes for the future, which is really what I'm going to address you about in the time I have available this afternoon.

The issues in that third part of the statement concerned the emergency evacuation of entire buildings which are built and designed to a certain principle; control room procedure and the challenges which will continue to exist there; firefighting, in light of the restrictions which the regulations provide; risk

information-gathering; and the often underestimated, sometimes to some extent unrecognised, but extremely important issue of firefighter safety. You will recall all the evidence which has been adduced about that, and submissions which we have made in previous submissions. But we've repeated it, effectively, in the written statement.

So all of that can be gleaned from the written overarching statement, and indeed from previous statements and oral submissions, so I won't expand upon those further.

But, I do need to spend a little time on the concessions which are dealt with in the first part of the written statement, which were made by a number of past and present officers and employees of the Brigade.

In both phases of the Inquiry, as I hope you recognise -- and I think you have been kind enough expressly to do so previously -- the London Fire Commissioner and the organisation he leads have been fully committed to assisting the Inquiry with its investigations in a number of ways, which are identified in the written statement.

127 Rule 9 witness statements were provided at your request, in addition to the hundreds of witness statements which were provided to the police, and about

100 -- I think it's 100 of those persons attended this Inquiry to answer detailed questions from your counsel on a number of issues, and during that evidence former and present senior staff made frank concessions on a number of issues by accepting shortcomings in operational planning and training in the years leading up to the Grenfell Tower fire, and accepting unequivocally where certain practices should have been managed better.

In your Phase 1 report, sir, you recognised the many acts of extraordinary bravery and selflessness of firefighters, individual firefighters, who responded to the Grenfell Tower fire, and I've said before, the London Fire Commissioner is very grateful to you for that recognition.

It is, as we have said before -- I think I said this in Phase 1 at the beginning -- in the DNA of all fire and rescue service personnel to do all that they can to protect and save life. That's what they did on the night of the Grenfell Tower fire. But, of course, this Inquiry focuses on systemic issues, which are the responsibility of senior staff. But, of course, those senior staff in nearly all cases came through the ranks and share that same DNA.

So for those senior staff who came to give evidence

in both phases, often having retired some years ago, to assist the Inquiry in an open manner, their approach to the work they did when they were at the Brigade or are still at the Brigade was at all times driven by a genuine desire to do the best they could in the interests of keeping Londoners safe. That's what drove them.

They accepted, though, that mistakes were sometimes made, sometimes significant mistakes, which is why they made those frank concessions, accepting where things could and should have been done better. And may I make it clear, in case there's any doubt about it, that there was never any point when any of them even considered seeking an undertaking from the Attorney General, through you, that their evidence to you would not be used against them in other proceedings. It just wasn't considered by any of them or the Brigade.

In the written statement, a number of the key concessions or admissions are set out, as I've said. They include matters connected with the development of policies and procedures; training, particularly in control; pre-planning; risk information-gathering; and communications. The London Fire Commissioner reaffirms those concessions in the form set out in the written statement -- you can see how that's done -- as he did

when he gave evidence, and apologises for the shortcomings they reflect and to anyone affected by them.

But what really matters is effecting real change where change is needed, and you will recall what the current commissioner said about that in his evidence in Module 5. I've used this quote before, but it's terribly important. He said this:

"I think the public should judge us on the outcomes we deliver to London. So I don't ask for trust. I don't think we deserve to ask for trust until we demonstrate different outcomes."

And to that end, an extensive account of the work which the Brigade has been doing since 2017 has been provided in a separate statement to you, quite a long one, detailing the extent and nature of those reforms which have been implemented, and that includes radical improvements to the system of assurance, which is particularly important from the perspective of those changes. That statement builds on the LFB improvement progress report of October 2021, which was prepared by former Assistant Commissioner Andy Bell, a summary of which, of course, can be found in the LFC's closing submission for Modules 5 and 6A, but it's obviously been updated in that more recent statement signed by former

Assistant Commissioner Andy Bell.

So, sir, may I return now to where I finished in my last relatively brief address to you at the end of Module 6B, by emphasising the vital importance of the rich context which the evidence in Phase 2 has provided to so many of the issues which were explored with the LFB witnesses in Phase 1.

At the conclusion of the Phase 2 evidence, sir, you encapsulated what the Inquiry's thorough and uncompromising process exposed in Phase 2, and I quote you here, as the:

"Many decisions taken by many different people over the course of many years that conspired to create a building which, in June 2017, was vulnerable to a catastrophic fire resulting from the failure of a common type of domestic appliance."

With that in mind, I want to stand back in the time I've got left here this afternoon and look at a small number of interlinking -- actually, overarching -- issues which are crucial, we say, to a proper understanding of the LFB's response to the fire at Grenfell Tower. Together, they provide the central context to the Brigade's primary acceptance, concession, that it did not plan for or train incident commanders or firefighters to abandon the stay-put strategy for

an entire building in favour of carrying out a simultaneous evacuation of the entire population.

The first of those issues -- firmly established, of course, in the course of Phase 2 -- is the series of revelations that the building had been allowed by the cumulative actions and omissions, of course, of several people and organisations who were responsible for its safety to present a grave danger to residents in case of fire, but also to the emergency services who have to respond to fires of that kind.

The second issue concerns the stay-put principle itself, to which I'm afraid I will return yet again in a moment, but I will be as brief as I can.

The third issue is that the Grenfell Tower fire was, as a whole incident, unprecedented, and on the admission of the Brigade was not foreseen. Whether or not that lack of foresight was reasonable, of course, is a matter that you may well consider during your deliberation on the Phase 2 report. But nonetheless it wasn't foreseen.

I'll deal with the second and third, those two issues, together, because they're inextricably linked.

The stay-put strategy. As I've said, I will be brief, having addressed you so many times on this topic before, but we have need to reiterate the basics.

It is simply wrong to categorise the single safety

measure, stay put, which underpins all of the multi-layered active and passive fire safety measures which are required to be in place to support it, as dogma, or that reliance on it is to take a dogmatic approach. It's quite the contrary, because whether we like it or not, the whole design, construction and maintenance of buildings such as Grenfell Tower is governed by the stay-put strategy and no other, as we know, and still is.

Forgive me for repeating yet again the important summary which Dr Lane provided in her Phase 1 report, but it seems it needs repeating again and again. She said this:

"The fire protection measures must be constructed and then maintained to ensure they are fit for purpose in the event of fire. The stay put strategy is provided through design construction and ongoing maintenance. All building occupants, including the Fire Brigade, rely on it in the event of fire. It is the single safety condition provided for in the design of high-rise residential buildings in England. The statutory guidance makes no provision within the building for anything other than a stay put strategy."

So the principles upon which that strategy for high-rise residential buildings are founded are

well known to the Inquiry, of course. They have been the subject of expert evidence at both stages. It's common ground, certainly among the Inquiry's experts and others, that the regulatory regime makes the following assumptions, and these are important assumptions when looking at what can fire and rescue services do in the future.

First of all, only single-unit fires are anticipated or allowed for. Multiple fires on multiple levels are not anticipated or allowed for, for example by stipulating the requirement for dry rising mains, which can be accessed at each floor level internally, but which are incapable of effective operation on two or maybe three floors at a stretch at one time. Vertical or lateral fires on the exterior are not anticipated or allowed for, the regime assumes, and indeed only provides facilities for firefighting internally. I'll come back to that in a moment. And simultaneous evacuation, crucially, on a large scale, is not anticipated or allowed for.

So it follows that in buildings in the UK and overseas which are required by the regulations to provide for evacuation strategies and so on in case of fire, those kind of buildings must be distinguished for the purposes of comparatives from high-rise residential

buildings with a stay-put strategy.

For example, in the UK, buildings such as care homes, hotels, offices, all sorts of other buildings, and residential buildings overseas such as the Lacrosse Building in Melbourne and The Torch in Dubai, are all required by law to provide systems which support the simultaneous evacuation of occupants of the entire building in case of fire.

Just as an example, in relation to the Lacrosse Building and The Torch, that is achieved by the provision of safety measures such as modern building-wide alarm systems, often phased by height of the floors, with regular fire drills to occupants; sprinklers and other fire suppression measures; additional evacuation stairwells, separate from those used by fire and rescue services; refuge areas which assist in the evacuation of the disabled and vulnerable; and firefighting lifts expressly for the use in the evacuation of occupants.

Grenfell Tower and other high-rise buildings with a stay-put strategy had, have, none of these measures in place. They are not required or expected to have them because they are deemed by the regulatory system to be unnecessary, on the basis that if the buildings are broadly compliant with the regulations, a simultaneous

evacuation of the entire population will never be required. It's the basic assumption of the regulatory system.

So when the stay-put strategy entirely fails in the event of fire, fire and rescue services are left with addressing a situation which is neither provided for by the regulatory regime nor the building in question. Why? Because it's not supposed to happen because the regulatory regime is expressly intended to ensure that it cannot happen.

The reasons, then, why it is imperative, therefore, that buildings designed and built with a stay-put strategy must be maintained appropriately to support that strategy in a thorough and rigorous manner have been explained in previous statements that we've made to you before.

Now, the London Fire Commissioner does not suggest that full compliance with the regulations should be assumed by the LFB or any other fire and rescue service in the country, and of course a number of warnings had been given by the Brigade to government over the years in relation to the dangers of non-compliance, as you know. But -- and this is such an important point in this case -- compliance is expected, at least to a broad degree, when compliance has been checked and verified by

local authority building control departments, and when certificates of completion following construction or major alterations are issued. That is why the certificate of completion issued by RBKC building control department for Grenfell Tower following the refurbishment is so terribly significant in this case.

That said, as Stephanie Barwise King's Counsel said this morning, and we agree with her, in the case of Grenfell Tower, so much had gone wrong before the certification process was completed that the building control department would probably not have known of quite a bit of what had gone wrong previously.

So if such buildings are maintained so as to fundamentally undermine the stay-put strategy upon which they were designed and built, it must be acknowledged that fire and rescue services are faced with an immense impediment -- and I use that word advisedly, an impediment -- to any emergency response which the regulations don't provide for and, more importantly, the buildings they govern don't comply for.

Perhaps the starkest example of this is the absence of any meaningful requirement in the regulations to enable the evacuation of the vulnerable or disabled in a building which is designed and built according to

a stay-put strategy, whether assisted or otherwise. I will come back to that particular issue just before I conclude.

Of course, the LFC supports and shares the Inquiry's primary objective, namely the imperative that meaningful changes are made in an endeavour to ensure that this tragedy never occurs again, and such changes can really only be effected and sustained in part through the recommendations that you will make in due course, if there is a proper understanding of the challenges faced by fire and rescue services in preparing for, responding to and seeking to overcome where reasonably possible -- and that's what it's about -- significant failures on the part of building owners.

To reach such an understanding, it's also essential to acknowledge the fact that buildings of this kind can't be compared to the majority of stock in the built environment, nationally or internationally, which actively provide for the evacuation of occupants in case of fire. And, similarly, to make any sense of how the tragedy at Grenfell Tower could be avoided in the future, it is necessary frankly to accept that serious and, in some respects, inescapable consequences flow from allowing or positively developing a stay-put building to present such serious risks to the lives of

residents.

So, sir, a few words on foreseeability, which we have touched upon in the written statement.

The LFC does not seek to dilute its express acceptance from a very early stage in Phase 1 that, while the LFB and other fire and rescue services identified and addressed certain foreseeable risks associated with high-rise residential buildings, the possibility of a devastating fire on the scale of Grenfell Tower was not foreseen and it wasn't planned for, and that is the reason why policy and training was not developed to respond to such a disaster, either operationally or in the control room.

Informed, we say, and guided by the well established -- one must remember this -- and historically effective design principle relating to high-rise buildings, that is stay put, it was not contemplated that an entire multistorey residential building which was built and designed with a stay-put strategy might require simultaneous evacuation of its entire population by reason of the total failure of its external façade cladding system and its internal active and passive fire measures, which actively promoted the spread of fire. As I have said, whether the absence of such foresight can be regarded as reasonable, of course,

will be a matter for you to consider.

But it does remain the position of the London Fire Commissioner, as he said during his evidence to you:

"The totality, the scale and the extremity of that failure of every single part of regulation and human behaviour that should underpin it, would have been difficult to predict."

Here I'd just come to some of the expert evidence, because some support for that position -- some support for that position -- is found in the Phase 2 report of Mr McGuirk, your firefighting expert, when he was addressing external firefighting. He recognised the singular nature of the Grenfell Tower fire in the context of external fire spread in the cladding system and the "formidable" challenges faced by fire and rescue services when he said this:

"From the outset ... I would state that any evaluation of the effectiveness of external firefighting is extremely difficult.

"This is because of the multiple obstacles associated with design and access difficulties, as well as numerous construction and building design failures, but most especially the impact of the cladding ... However, I do emphasise that the fact that the internal firefighting provisions of Grenfell Tower failed

simultaneously with the failure of virtually all the other passive and active fire safety features, meant that the standard operational firefighting method normally employed for high-rise buildings by the LFB, could not be implemented. This presented a truly formidable challenge to the LFB, especially to the first crews. Expressed simply, Grenfell quickly moved from being a compartment fire; to multiple compartment fires; to multiple compartment fire concomitant with the building itself being on fire. The circumstances meant that any operational response was always going to entail extensive improvisation."

He finishes this part of his evidence by saying this:

"I think it is unreasonable, therefore, to suggest that the LFB ought to have anticipated an external fire of this nature and it is against this backdrop that my subsequent comments should be considered."

Well, that's his evidence in his Phase 2 report.

But, of course, with that recognition of the impact on the operational response which the dynamic and multifaceted nature of the fire had, it's convenient now for me to turn to the evidence of Dr Stoianov, which has been addressed in a separate statement to you under Module 7.

Can I make it very clear that throughout Phases 1 and 2 of this Inquiry, the experts instructed by you, by the Inquiry, have without exception provided highly informed and cogent evidence which has been of significant value to the LFC and fire and rescue services more broadly for the purposes of developing policy and procedure for the future across a wide range of topics. Dr Stoianov is no exception. His unquestionable standing as a leading expert in his field is underpinned by his impressive history of academic research.

You can tell there's a "however" or a "but" coming here, and it's coming now.

In common with Professor Torero, who supports certain of Dr Stoianov's findings, he doesn't, though, suggest or purport to be an expert in the provision of operational firefighting or rescue operations, and nor does he have practical experience of it. That's not a criticism of him, that's just what he accepts in a straightforward way.

So while the LFC has found his evidence to be extremely informative and of a high degree of utility on a variety of issues, it must be, we say, utilised in a practical way by -- according to the realities, actually, which fire and rescue services in a dynamic

operational incident scenario face.

Given that there has been no live evidence from the LFB to explain how and by what means certain of Dr Stoianov's findings might be impacted by such practical considerations, the attention of the Inquiry is drawn to the statements of Deputy Assistant Commissioner Philip Morton, who touched upon these issues and provided statements to you.

In the most recent of those statements, Mr Morton provides examples of common real-life scenarios faced by fire and rescue services which demonstrate an occasional divide between academic theory and practice in the field. And there has been so much harrowing evidence of the dangerous conditions which existed both inside and outside Grenfell Tower on the night of the fire. One recalls in Phase 1 the extraordinary bravery of the Metropolitan Police officers who provided, with the use of their shields, cover for firefighters entering and leaving the building while debris rained down from above. It's just one example.

Among the practical examples given by Mr Morton in his statement, which I won't address here in full, obviously, he speaks of the real challenges on the fire ground when he said:

"In the Grenfell Tower fire, activity took place at

night, under falling debris, in an area cluttered with parked cars and other buildings. This leads to a number of challenges, including the siting of appliances (aerial appliances require a flat surface in order to maximise water jet height) and the laying of hose to optimise flow ..."

Just pausing there, I'm going to add here: and, of course, on that night, there was a constant concern that the hoses which were laid out -- and it takes a fair period of time to lay them out -- would be damaged by the falling debris, so that had to be considered.

Mr Morton then speaks of the tests which were done at the Fire Service College. He says of that:

"It was possible at the Fire Service College in sort of quasi-perfect conditions to site multiple appliances directly adjacent to each other on flat and clear surfaces."

He is dealing there with Dr Stoianov's suggestion that you combine a series of fire engines, pumps, so as to improve the flow rate.

But the point that Mr Morton is making is that that simply wouldn't have been possible at Grenfell Tower.

"... and it is often not possible [says Mr Morton] to attain maximum height in throw of an aerial appliance

in the operating environment due to trees, cars, balconies and other things that may impede access."

And the challenge is heightened, he says, when there is time pressure to set up an appliance and immediately bring water to bear on the fire.

Of course, leaving his statement aside, it's also important to remember that the deployment of aerial appliances at Grenfell Tower was only possible on two of the four elevations of the tower, because of access problems, and that isn't an uncommon occurrence. It reflects the fact that the Building Regulations, because they don't anticipate external firefighting, make no provision or requirement to provide access for aerial appliances to high-rise residential buildings.

So, in short, on that issue, the LFC urges you gently, as it were, because we have great respect for Dr Stoianov, but nonetheless to exercise caution when making findings based on his evidence, Dr Stoianov's evidence, noting, of course, the persuasive submissions of Thames Water, which you will hear later this week, about the practical maximum use and reach of water which might have been achievable on the night of the fire. I say no more about it than that.

So returning quickly to the issue of evacuating a stay-put building.

It is extremely important to acknowledge that, during a fire, the evacuation of those directly affected by fire or smoke, while leaving others in place, is not -- occasionally it's been described as that -- the partial abandonment of the stay-put strategy; it is actually the application of the stay-put strategy. The Brigade's policy and procedure, for example, of sectorisation to implement partial evacuation of such buildings is well established, and just for example it was implemented at Shepherds Court.

But if residents of an entire building are directly affected and likely to become so, that is a very different matter, because the entire building is the fire sector. In such circumstances, the abandonment of the only fire safety strategy for buildings of this kind is and can only be a dangerous measure of last resort. While fire and rescue services will do all they can to effect rescue and assist in an emergency evacuation, such a course of action will inevitably require many residents, those who are able, to fend for themselves when firefighters can't reach them in a perilous attempt to escape the building through life-threatening toxic gases, with limited visibility, down several flights of stairs, and so on.

As we know from the evidence in Phase 2, such

an appalling state of affairs only arises where a building is allowed to fail in all aspects of fire safety affecting the entire building effectively, again, as an inferno. That's what happened at Grenfell Tower. It had never happened before in the UK in a stay-put high-rise residential building and, in that basic sense, it was unprecedented.

But, of course, the LFC accepts that, notwithstanding the nature and scale of the Grenfell Tower fire, there were many elements of operational pre-planning, information-gathering, and training, particularly in control, which could and should have been done better in the years leading up to 14 June 2017. That much, as I've said, has been expressly acknowledged by the commissioner. The commissioner also accepts that certain characteristics of the fire at Grenfell Tower were foreseeable, and that they should have been planned for.

In relation to some of those features, the LFB had policies and procedures in place which had been the subject of training. However, you are -- if you bear with me on this particular point -- urged to pay careful attention to the extent to which, on a fair analysis, a presumed understanding or awareness of the appropriate operational response to a fire on the scale of

Grenfell Tower can be extrapolated from knowledge of the constituent risks which were present.

For example, the LFB is well aware that breaches of compartmentation in high-rise residential buildings are a relatively common occurrence, and that strict compliance with compartmentation requirements can't be relied on. It's entirely accepted. Such breaches occur in a variety of ways: poor internal firestopping, so fire breaking out through windows and façades, entering through windows above via the coanda effect, or burning and charred debris falling into open windows below, as occurred at Lakanal House in 2009, which of course did not involve extensive fire spread over a continuous façade cladding system.

I do need to spend a minute or so on this, just to be clear about what was being learned or what should have been learned from the Lakanal fire.

The primary causes of the severity of the Lakanal fire were the serious internal failings in compartmentation, the most serious of which was the use of defective or flammable materials, which should have been fire resisting, which allowed fire to break out from a flat, take hold in the concealed void above a suspended ceiling in the common corridor, public access, race along the whole length of that corridor

void, which was fuelled by a variety of flammable materials within it, spread below into the corridor itself, engulfing the entire corridor and therefore preventing any escape from the flats that gave access on to it, and to re-enter another flat with fatal consequences.

That's an oversimplification, obviously, but it puts it sort of in a nutshell, of that terrible incident, but it was the serious breaches of internal compartmentation, among other things, which was the focus of the subsequent training package provided by the Lakanal House case study, just to make that clear.

I come now to the final topic for this afternoon, and return to my earlier observation that one of the starkest examples of the consequences of allowing a stay-put building to become a serious danger to all residents in case of fire is the absence of any meaningful requirements in the Building Regulations to provide for the evacuation, in an emergency or otherwise, of the vulnerable or disabled.

Of course, I have in mind the recommendation which you made to government on this issue in your Phase 1 report in relation to PEEPs. Now, the government has relatively recently consulted on proposals that in the London Fire Commissioner's opinion do not go far enough

in addressing the intent of that recommendation. While the LFB supports the government's initial focus on buildings with the highest risk, it believes in the principle that all residents, including those with disabilities, should have equality with regard to the right to evacuate a building in the event of fire.

The Brigade has long advocated the benefit of an approach that properly considers the individual characteristics, behaviours and capabilities of residents that may be at higher risk from fire in their own accommodation, and the LFC supports the principle behind the government's proposals for emergency evacuation information-sharing, but that's as far as that goes. But information-sharing should not, on the commissioner's view, on the LFB's view, be considered a substitute for a plan in place to support residents to evacuate before the arrival of the fire and rescue services. And that's the key thing: it should be done quickly and before the arrival of the fire and rescue services.

It's the duty of the responsible person for any building to give effect to adequate procedures for all residents in case of fire. It should be clear that where evacuation of residents is concerned, either to a place of relative safety within the building itself or

external to the building, that should commence at the earliest possible stage. The LFC and the Brigade itself firmly believes that new-build buildings should be designed and built to be safe, and fully consider the needs of those with disabilities, not just those with mobility issues, to ensure that buildings are designed to be inclusive from the outset.

Well, sir, in conclusion, then, over the course of more than four years, this Inquiry has conducted the most extensive and forensic examination of the events of a major fire and its causes ever undertaken in the United Kingdom and most likely worldwide. That reflects the scale of the tragedy, the breadth and the complexity of its causes, and the depth of the Inquiry's commitment -- your commitment, as a panel, and that of your team, which you have demonstrated so robustly over the last few years -- to ensure that meaningful changes are implemented and sustained so that a tragedy such as Grenfell never happens again. That much at least is owed, of course, to those who lost their lives and to those who survived and have suffered so much, as well as to the wider public.

The London Fire Commissioner reiterates the strong commitment of the Brigade as a whole to use this terrible tragedy as an opportunity to honour the

bereaved and those who lost their lives by creating a legacy of positive change for the future.

This is not only a time, in his view, to reframe the Brigade's relationship with London, but also to embrace criticism and learn from it.

Sir, those are my final submissions. Thank you very much.

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

MR WALSH: Thank you, sir.

SIR MARTIN MOORE-BICK: Well, that brings us to the end of our proceedings for today, so we shall rise now, but we shall sit again tomorrow morning at 10 o'clock, when we shall hear closing statements from other core participants.

Thank you very much. 10 o'clock tomorrow, then, please.

(3.33 pm)

(The hearing adjourned until 10 am on Tuesday, 8 November 2022)

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