Monday, 7 November 2022

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 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-causal mistakes. Self-interest is unhumbled by the disaster and, indeed, by this Inquiry. The leitmotif of Grenfell mistakes. Self-interest is unhumbled by the disaster.

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.
25 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.

26 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. As Kingspan acknowledged in its 2015 “Reasons why” campaign, it was seeking 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.

27 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.

28 It was seeking to manipulate the impact of the government’s building safety tests. 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.

29 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.

30 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 is 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 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. 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 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-servicing 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 a firefighting lift, despite Exova having been told by Stokes, the fire risk assessor, also furthered the dangerous impression that the lifts were firefighting or evacuation lifts. Stokes, the fire risk assessor, also furthered the dangerous impression that the lifts were firefighting or evacuation 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.

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 around 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 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-references 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 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 Toreno 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 normality 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 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...
that has no place in a modern democratic society.

It was a relationship of master/servant 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: the balance the value of human life and safety.

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:

... 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.

... repeated slips over years, despite knowledge of its flaws, with 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
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.

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
treachery 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 prevailed 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,

or 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 sections 24 and 21 allow you, first of all identify who lives in a high rise, because obviously where ladders can’t reach, you do want to make it rise, and as it were, at this moment in time — — if you make that recommendation, it needs to be, as it was?

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, 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 was?
were canvassed and it needs to be properly investigated, as do other simple measures, like the 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 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
morning. We’ll rise, and then we’ll all resume, please, Well, at that point we’ll take the break for the morning. We’ll rise, and then we’ll all resume, please, (A short break)
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 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.

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 supplement 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
cought.

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,
incrediably, 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 the 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 unctitious 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 PS5, 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
25

conditions for means of escape in the extended travel
24
lobbies and for means of escape and firefighting in the
23
single stairway. In fact, very little regard was had to
22
maintaining tenable conditions at the design stage.
21

Furthermore, in December 2013, RBKC rejected
20
enlargement of the shafts. There was no engineering
19
justification for this decision, which did not place
18
safety at the heart of the project. Had there been
17
competent construction management of the project,
16
capital works to enlarge the shafts should have been
15
considered at an early design stage. Similarly, had
14
there been competent building control, this fundamental
13
early design consideration would have been considered.
12

Consequently, the SVS extract shaft size represented
11
a limitation on the capacity of the system to exhaust
10
smoke. This was the first of many abject failures.
9
The design approach actually taken amounted to
8
looking at the system as it presented itself, a system
7
which was non-operational and had not been maintained
6
for many years, and then applying the non-worsening
5
principle so-called a dilapidated system.
4
PSB did not demonstrate compliance with either the
3
regulations or the original performance requirement.
2
They ought to have aimed to produce a design that
1
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
5
respects. The design actually adopted amounted to
6
choosing selected performance parameters, was not
7
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enovation 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 standard 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 seemed 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
impassioned plea starts with a plea from our clients written submissions that we have submitted. I'm not to focus on four key elements, which we've done in the expectation, that they should do so, and they wanted us particularly interested in contributing to closing this public inquiry. But for all of its advantages, instead what they got was five years of this Inquiry, 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
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 ... 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 Johnstone, director of housing, wrote a memo to the effect that anything spent on Grenfell was money down the drain.”

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 experience housing deprivation. 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

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’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.”
highlighted that:

“... 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 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 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 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 Grenfell Tower Inquiry RT Day 309 2023 25

The disproportionate ethnic pay gap that was treated with ‘dignity and respect‘ at some fire stations in Garnock Court in Scotland in 1999, Harrow Court in 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.”

As we have heard from Mr Williamson King’s Counsel. This theory may provide 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...

89

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.”
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
eventually remove 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

... 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 Harewood 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 it 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)
(Short adjournment)
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
time-wasting, 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

November 7, 2022
GRENFELL TOWER INQUIRY RT
Day 309
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...
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 pouting 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
departamental 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...
We 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 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 Stolianov’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)(e)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 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 1
Grenfell Tower in July of 2018, following the WASP 2
inspectors’ recommendation made in April 2018, but it 3
was kept in a sealed evidence bag and taken to 4
Deer Park, where it was examined in a workshop by police 5
inspectors, WASP inspectors, on behalf of 6
Operation Northleigh. But if we look at BJG/74, which 7
is the one on the left, it’s photo 19 on the left, we do 8
see some significant changes from the one that was taken 9
out of Grenfell Tower. 10

So look at, first of all, the left. 11

If you would be kind enough to take the cursor to 12
photo 108, that’s it. I don’t know if you’re able to 13
enlarge it a little bit, maybe not to the full size, but 14
just a little bit. Because the trouble is, as we 15
enlarge it, it becomes a bit fuzzier. That’s fine, 16
thank you very much.

We can see there the encrusted builders’ debris 18
around the actual inside of the faceplate. Could you 19
move the cursor up and down the labyrinth. That’s it, 20
perfect. That’s the labyrinth where the drop key is 21
supposed to drop. Obviously it’s upside-down at the 22
moment because it’s been taken — the faceplate has been 23
removed from the fire control switch and it’s hanging 24
down, but you have to imagine it’s up the right way when 25
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 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

\[ \text{...} \]

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 apologies 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
designed 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
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 firefighting, 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...
I come now to the final topic for this afternoon, the Lakanal House case study, just to make that clear.

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 LFB. It's the duty of the responsible person for any service, to evacuate residents in case of fire. It should be done quickly and before the arrival of the fire and rescue services. And that's the key thing: it should be done 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.

Thank you very much.

BICK: Well, thank you very much indeed, Mr Walsh.

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)
INDEX

PAGE

1 Closing submissions on behalf of BSR ..........1

Team 1 by MS BARWISE

2

3 Closing submissions on behalf of BSR ..........22

Team 1 by MR FRIEDMAN

4

5 Closing submissions on behalf of BSR ..........42

Team 2 by MR MANSFIELD

6

7 Closing submissions on behalf of BSR ..........59

Team 2 by MR WILLIAMSON

8

9 Closing submissions on behalf of BSR ..........77

represented by Imran Khan & Partners by

10 MR KHAN

11

12 Closing submissions on behalf of the Fire ....101

Brigades Union by MR SEAWARD

13

14 Closing submissions on behalf of the .........136

London Fire Commissioner by MR WALSH

15

16

17

18

19

20

21

22

23

24

25

165

166