Tuesday, 5 June 2018

(10.00 am)

SIR MARTIN MOORE-BICK: Well, good morning, everyone, and welcome to today's hearings. We're going to hear opening statements from a number of the lawyers for the core participants.

Before we start, can I just raise one thing. Yesterday we showed some video footage and still photographs which might well have been disturbing to some people. Can I just ask that if any of those who are going to address me today want to show similar sorts of things -- videos, stills or whatever -- which might be distressing to those in the room, could they please make sure that an adequate warning is given so that those who don't want to see them can have a chance to leave.

Right, thank you very much.

Now, Mr Johnson, you are going to go first.

Opening statement on behalf of the Metropolitan Police Service by MR JOHNSON

MR JOHNSON: Chairman, we're grateful to Mr Millett and his team for yesterday's detailed overview of Phase 1.

In this very short opening for the Metropolitan Police, I'm not going to be showing any video footage or stills or anything of that nature.



The commencement of Phase 1 of your inquiry is a significant milestone in the response to the tragedy that occurred almost a year ago on 14 June and which claimed the lives of those who have been honoured over the last two weeks with such vivid and moving commemorations. The process of achieving a measure of justice for those who died and for those who suffered so grievously must, we respectfully submit, continue to be at the centre of this inquiry, as I'm sure it will.

The Metropolitan Police, for its part, is committed to supporting the inquiry in its difficult and important work, whilst also conducting its own thorough criminal investigation into all potential offences arising from the devastating fire at Grenfell Tower.

The police are a core participant in the inquiry principally because of their role in conducting a parallel criminal investigation, and the consequential need to ensure appropriate co-ordination and co-operation between two distinct investigations into the same events.

We will continue to provide material to the inquiry during the course of the hearings in accordance with the memorandum of understanding.

Chairman, we do not consider that it would be appropriate for us to ask questions in the course of the



inquiry for the purpose of gathering evidence for the criminal investigation and we will not do that. Evidence for the criminal investigation is being and will continue to be gathered in accordance with the police's quite separate powers.

Our aim during the inquiry is, therefore, to continue to honour the terms of the memorandum of understanding, to deal with any associated queries and to attend and to observe the proceedings in order to review the potential for the impact on the criminal investigation and any future criminal proceedings.

The LFB had lead emergency responsibility on the night of the fire, and an important part of your terms of reference is to enquire into that response. There was also, of course, a police presence on the night of the fire, and we will shortly provide to the inquiry a statement to explain that police response in order to assist with the fact-finding picture of exactly what was happening in terms of the emergency response in the early hours of 14 June.

Chairman, a word on the progress of the criminal investigation.

The criminal investigation is progressing in accordance with the intended timescales that we have previously indicated. The on-site forensic



investigation of the tower is complete. Off-site testing and reconstruction work is ongoing.

It's anticipated that Grenfell Tower will be released as a crime scene in July or August of this year. The Metropolitan Police is in the process of facilitating site visits by core participants in accordance with the process that you set out in writing on 8 May.

That process aims to ensure that all those who have a proper reason for attending the site are able to do so under your supervision, whilst also according proper respect to the fact that these were the homes of those who lived there.

At previous hearings we've given an update on the progress of the criminal investigation. We will not, however, continue to announce publicly every development in the investigation, perhaps for obvious reasons.

The police's objective is, though, to keep the victims properly informed as a priority. That will be done separately in accordance with well-established procedures.

Just as they should be at the centre of your inquiry, so too, in accordance with the statutory Victims Code, they are rightly entitled to be kept properly informed as to the progress of the criminal

1 investigation.
2 Finally, a word on the agreements between the
3 inquiry and the Metropolitan Police.
4 Sir, as we've repeatedly set out, it is important to
5 manage this inquiry and the associated criminal
6 investigation in a way that allows the inquiry fully to
7 do its work, whilst also enabling the police to carry
8 out an independent and fearless investigation without
9 risk of prejudice to that investigation or subsequent
10 criminal proceedings. The Metropolitan Police remains
11 focused on facilitating your inquiry whilst minimising
12 the risk of prejudice.
13 That sometimes has been a difficult path to tread,
14 but it continues to be the case that you have been
15 provided with everything you have asked for from the
16 police and nothing has been held back from core
17 participants because of a risk of prejudice.
18 The magnitude of the police investigation is
19 unprecedented and extremely demanding. But as well as
20 focusing on the important task of investigating,
21 officers within Operation Northleigh continue to
22 dedicate a substantial proportion of their time to
23 providing material to the inquiry as requests arise in
24 addition to the established programme of proactive
25 disclosure on a weekly basis. Great effort has been



1 made to be as responsive as possible to requests for
2 material and to provide the inquiry with everything that
3 has been asked for as soon as possible.
4 The strictures of a criminal investigation and the
5 necessary procedures for gathering and recording
6 evidence mean that it is not always possible to complete
7 investigative tasks and to provide disclosure
8 immediately upon request, but we will continue to
9 endeavour to act promptly and we're very mindful of the
10 pressing need to assist the efficient running of these
11 hearings. That's exactly why there will be
12 a Metropolitan Police presence at the inquiry throughout
13 the hearings.
14 SIR MARTIN MOORE-BICK: Thank you very much indeed.
15 Now, Mr Friedman, I think you are going to speak to
16 us next; is that right?
17 Opening statement on behalf of BSRs (G4) by MR FRIEDMAN
18 MR FRIEDMAN: Sir, as you know, my name is Danny Friedman
19 and I appear with Stephanie Barwise QC on behalf of the
20 firms Bhatt Murphy, Bindmans, Hickman & Rose,
21 Hodge, Jones & Allen, and our junior counsel are
22 Liz Davies, Jesse Nichols and Raj Desai.
23 The bereaved and the surviving people of
24 Grenfell Tower come to this inquiry in a calm rage. The
25 basic facts are stark: in the second decade of 21st



1 century London, governed by a regulatory framework
2 designed to ensure fire safety, a local authority
3 instigated and oversaw the refurbishment of a social
4 housing high-rise tower block in such a way as to render
5 it a deathtrap. RBKC and the TMO did this, and they did
6 so using public funds, paid to an array of
7 professionals, contractors and subcontractors, none of
8 whom have yet accepted any responsibility for their part
9 in what happened.
10 Residents -- some of the people commemorated last
11 fortnight and some of the people sitting here today --
12 told them this could happen. But they were fobbed off,
13 certainly not treated as equals, and denied access to
14 the information that they could have used to save
15 themselves or to save others.
16 72 people have died. Those who escaped owe their
17 lives primarily to chance rather than risk assessment
18 and contingency planning by either the council or the
19 Fire Brigade.
20 Sir, you have had the experience of witnessing the
21 bereaved and some of the survivors tell their stories
22 over the previous two weeks, and so, perhaps more than
23 any other judge who has started an inquiry in modern
24 times, you know that what has gone on here makes it
25 inevitable, justifiable and reasonable that trust in



1 government, industry and firefighting requires
2 restoration.
3 Trust can only begin to be restored through
4 a fearless process of publicly conducted listening,
5 learning and truth-telling that inquiries of this nature
6 are able to achieve. The people you are coming to know
7 have been left to build something from nothing, and one
8 of the places for them to do so is here.
9 This morning, myself and Ms Barwise want to address
10 the inquiry on four matters and we'll divide them up
11 between us.
12 First, I'll deal with the fire itself and what it
13 means to its victims. On that, we want to reflect on
14 the unprecedented and unforgettable way in which this
15 inquiry has now begun, opened really not by its
16 chairman, its counsel or any other filter, but by the
17 people who are most affected.
18 Second, I will ask Ms Barwise to focus on the
19 building and the extraordinary new dangers that were
20 caused by the work that was done to it. This is
21 an opening and, therefore, it is responsible for us to
22 wait for certain evidence to be assessed. But there are
23 also some features of the building works that were so
24 obviously dangerous, reprehensible and contrary to
25 regulations that it would be irresponsible not to

1 indicate where we stand now.
2 Equally, it is time for the technical and sometimes
3 obscure construction matters to be the subject of
4 informed public debate, no longer the property of the
5 experts and the vested interests, and that is one of the
6 important things we understand to be on offer in
7 Phase 1.
8 Our third topic is the firefighting response and
9 I will come back to deal with this after the short
10 break. There are instances of deep gratitude and
11 respect for what was done that night, but solace in the
12 heroism of individual firefighters is not a route to
13 learning lessons that sorely need to be learnt. The
14 response failed to realise quickly enough that this was
15 a fire that could not be fought and required evacuation
16 that could not be delayed. Now is the time for
17 courageous and fully informed examination of how things
18 could have been done differently.
19 Our fourth and final topic this morning will look
20 towards Phase 2. We want you to begin to consider what
21 was absent in our society, and in our law, that meant
22 that people, who you and we have begun to know on a very
23 human level, counted then for so little.
24 Other colleagues will add to this point, but it
25 comes down to this: ill fares the land that left these



1 people to be so exposed to such trauma and death in such
2 a way. Why this was so and what is to be done are the
3 questions that bring us together.
4 Can I turn, then, to the fire and what it means to
5 the people who experienced it. The way to do that can
6 only now be through reflection on the work that was done
7 by the bereaved and the survivors in the commemoration
8 hearings over the last two weeks.
9 All of us have been to funerals. There are public
10 spaces, including places of worship and theatre, events
11 of protest and courts of law, where profound things are
12 said and powerful emotions are felt. But any one of
13 those involves a narrower landscape than the one we
14 looked out on over the last two weeks. This was not
15 a memorial, still less a funeral. People came before
16 you to work in a dignified space before a judicial
17 investigator to put you and we on forensic notice of
18 what has been lost and why that should concern us all.
19 It is true that at inquests up and down the country
20 each week, parents and family members normally start the
21 proceedings by telling coroners who their loved ones
22 were and something about them. Also, the long-belated
23 new Hillsborough inquest began with families giving oral
24 portraits about those who were killed. Truth and
25 reconciliation commissions around the world normally



1 begin with these type of events.
2 But inquests into controversial deaths, let alone
3 truth and reconciliation commissions, don't normally
4 begin within 12 months of an atrocity. So the events
5 last week were raw, rawer perhaps than any of us who
6 were not there that night and who asked you to do this
7 could ever have contemplated.
8 Still in mourning, families nevertheless were
9 exercising their judgment about what they wanted to say
10 and how they wanted to say it. They were supported by
11 the solicitors who act for them and your team, sir, but
12 ultimately it came down to them. They took their place
13 in this inquiry as its principal witnesses and
14 advocates.
15 And yet there was something more about why this
16 event was unprecedented. That is to do with the sheer
17 diversity of the people who came to testify. They gave
18 you an intimate history of humanity. Not just where
19 they came from, which was close on every continent of
20 the world, but the diversity of their experience: their
21 jobs, their incomes, their services to others, their
22 religions, their sensibilities and the principles they
23 lived by and, in many cases, died by.
24 It is also impossible to walk away from that
25 experience and not acknowledge the importance of social



1 housing and immigration in helping to make that
2 commonwealth of the human spirit, the people who lived
3 in Grenfell Tower, into the very precious thing it was.
4 So the commemorations provided a first important
5 opportunity to listen to the bereaved. We said this
6 would perform a positive human rights function by
7 respecting the dignity of the people who should be at
8 the centre of the process, but as much as this was about
9 dignity, it was also about utility. This was not just
10 very articulate lessons in love; they were reference
11 points for you to connect names to floors and flats in
12 the coming weeks.
13 What our clients are choosing to do is to recreate
14 for you, your experts and the public the story of the
15 building in the last few hours of their life in it. It
16 is primarily through the people that were in the
17 building that one ultimately measures how the fire
18 spread into what type of lives and to what fatal effect.
19 If one then asks why inquiries need to function as
20 cultural events, as public inquiries, it is because they
21 need to filter through into politics, economics and
22 organisational life. Your report and recommendations
23 will perform an important public service. But for you
24 to facilitate public empathy with what has been lost
25 will change the psychology of everyday lives, and that





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is where commitments to prevention really take root.
That is why we say that our clients have come here to work and why it is both dignitarian and utilitarian to be asking: who were they, who lived, who died, how and why?
Sir, you will be able to create a record for all to know of the movements of those who died. When we first asked you to do this, we believed it was the right thing to do. But more and more, with the collection of statements, we are reaching a practical judgment, shared with your counsel, that such a recording will be possible. Where it is not reasonably possible to discover a particular matter, we will know that we tried and you can confirm that.
By way of an opening, acknowledging that we have a way to go, let me just give a first-draft effort of some of the things you now know or will be able to know about 23 floors, 129 flats and 72 dead.
It's a work-in-progress. My legal team know more about some of the people in the flats than others, but we will work and are working with the different teams, the bereaved and survivors and counsel to the inquiry to fill in the gaps, correct and clarify, and make everyone wiser.
So in that first-draft spirit and with a readiness



to correct, sir, you now know that Rania Ibrahim, a Muslim woman of great faith, died in flat 203 on floor 23 with her two young children, Fethia and Hania.
You know that Hesham Rahman died on the same floor, flat 204, and you will hear that he made repeated 999 calls which made it clear that he could not walk the stairs alone.
Flat 205 was the home of the Neda family. They gave other people shelter, including Ahmed Elgwahry's mother and sister, Eslah and Mariem from flat 196, and the two sisters from Iran, Sakineh and Fatemeh Afrasiabi, they came up from flat 151.
In flat 206, Abufars Ibrahim and Isra Ibrahim stayed with their mother, Fathia Ali Ahmed Elsanosi. Sister and mother were found dead in flat 203; there will still be work to do as to how Abufars came by his death. You know that the Neda family, Farhad and his mother, Flora, survived, but that Saber Neda, their husband and father, did not.
You already know that there were a number of elderly people who lived on these higher floors, often with mobility issues, which gave rise to specific legal duties to protect, who could not have escaped without assistance. Equally, you can know that many of their older children stayed with their parents when they might



have saved themselves.
These upper floors would fill with more people taking refuge from below. They included two friends, Debbie Lamprell and Gary Maunders visiting her, who had come up to the 23rd floor from flat 161 on the 19th floor. You would discover there were others with different reasons to move.
Let me mention Jessica Urbano Ramirez, the 12-year-old girl from flat 176 on the 20th floor, and Berkti Haftom, who lived with her youngest son, Biruk, from flat 155, and Hamid Kani from flat 154, all from the 18th floor. These people, as well as Debbie Lamprell, were invited into the home of Raymond "Moses" Bernard in flat 201.
Finally, for flat 202, I mention a couple from Italy, Gloria Trevisan and Marco Gottardi, who sheltered Marjorie and Ernie Vital, mother and son, from flat 162 on the 19th floor.
You will also learn from the real-time voices inside the building of the speed with which this fire penetrated its compartments. Naomi Li from flat 195 reported to the control room at 121 that she could smell smoke. And Mariem Elgwahry, having already left flat 196, reported at 1.30 that multiple families had migrated to the top floor, that the roof doors would not



open and that, contrary to the operator's suggestion, her own flat was already on fire. She's talking about flat 196, 18 floors up on the same east column of the building where the fire was first reported half an hour earlier. Now, at 1.30, she's telling the authorities about what is going on inside and we have seen the video yesterday of what was going on outside.
You know that Sirria Choucair originally moved from flat 191 on the 22nd floor. This was despite her severe arthritis. She and her daughter Sawsan, who was not in the tower that night, made the move to the one-bedroom flat to be close to her other daughter Nadia and her son-in-law Bassem, and the three grandchildren, Mierna, Fatima and Zainab, all in flat 193.
Grandmother, parents and children from the Choucair family came together in flat 193 on the night of the fire with the Kedir family. They sought refuge from their own flat at 192.
Hashim Kedir and Nura Jemal. We can know quite a lot about who they were as people based on what we learned about their children, Firdaws, Yahya and Yaqub. In due course, you'll hear from Naomi Li and Lydia Liao who lived in flat 195, who took refuge in flat 193 and managed to make it out unassisted at approximately 3.21 in the morning.

1 On this floor I mention Tony Disson from flat 194,
2 who did not survive.
3 The 21st floor. That is a floor you will hear
4 a great deal about because you have available to you
5 witnesses who escaped, including Marcio and
6 Andreia Gomes, whom you have already heard from, but
7 none of the five members of the El-Wahabi family from
8 flat 182 survived. Neither did Ligaya Moore in flat 181
9 or Logan Gomes from flat 183.
10 You have been the recipient of so many unforgettable
11 accounts of how people love one another: parental,
12 sibling, romantic, religious. On floor 20, Vicky King
13 lived very privately with her elder daughter,
14 Alexandra Atala. That is just one of several flats
15 where one parent was living with their child through the
16 different stages of life.
17 You will hear a great deal more about the movements
18 and fate of the other floor 20 families from my
19 colleagues and the witnesses over the coming months.
20 I just mention Mary Mendy and Khadija Saye, mother and
21 daughter, who lived in flat 173, and all but one of the
22 five members of the Belkadi family who died.
23 You know that Jessica Ramirez from flat 176, on the
24 same east column as flat 16 where the fire started, was
25 out of her flat very quickly to the higher floors, where



1 she and Debbie Lamprell would make emergency calls from
2 the home of Moses/Raymond in flat 201 before 2 o'clock.
3 That will be difficult but important evidence to
4 indicate how quickly the top of the building had been
5 compromised by smoke.
6 On the 19th floor, just below Vicky King, another
7 mother, Marjorie Vital, was with her son Ernie in
8 flat 162, and I told you they went upstairs and were
9 found in the home of the Italian couple, Gloria and
10 Marco.
11 You will hear more evidence from Nicholas Burton to
12 see that he absolutely would have stayed to die with his
13 wife, Pily Burton. She was too unwell to walk the
14 stairs. Firefighters got to them in flat 165 sometime
15 before 2.30 and brought them down.
16 Pily was one of three people in the building that we
17 presently are aware of who suffered from some form of
18 dementia or Alzheimers. One died at the scene, Pily
19 died within six months and we know of another family who
20 have been made homeless with the added burden that one
21 of their number suffers from the disease.
22 Also from flat 19 can I mention the Tuccu family and
23 Amna Mahmud Idris, who was visiting them.
24 Firefighters got to Paulos Tekle and Genet Shawo's
25 family at 153 on the 18th floor, where they live with



1 their two young sons, one of them Isaac. This was at
2 some point shortly after 2 o'clock, perhaps 2.10.
3 Before that, other friends had gone out and told Paulos
4 to do the same, but the operators told him to stay put.
5 Despite these telephone calls and the views from
6 outside to indicate that the floor was not safe and was
7 deteriorating, the firefighters also told Paulos to stay
8 in the flat, they say reflecting a judgment that they
9 could not get the people on the floor down the stairwell
10 safely.
11 Well, if that was their judgment, firefighters on
12 a search and rescue deployment, you can at least know
13 that the inquiry should investigate what should or could
14 have happened. No one went back to get them straight
15 away. Knowing that the journey was only going to become
16 more perilous later, no relay was set up from the
17 bridgehead and up the stairs to try to shepherd them
18 down. The family were thereafter again told to stay
19 where they were by the control room operators, until at
20 some junction around 3 am they were told to get out by
21 any means necessary. When the family finally made the
22 trip, you will hear that Isaac, the five-year-old son,
23 was lost in the dire conditions of the stairwell.
24 On floor 17, we know that Sabah Abdullah got
25 separated from his wife, Khadija Khalloufi, who did not



1 survive the fire. They lived in flat 143.
2 I also mention Vincent Chiejina, who lived in
3 flat 144, and the family of Kamru Miah and Rabeya Begum,
4 who died with their sons, Mohammed Hamid and
5 Mohammed Hanif, and their daughter, Husna Begum. All of
6 them lived in flat 142.
7 For floor 16, I mention, if I may, Joseph Daniels
8 from flat 135 and Sheila, as she wanted to be called,
9 from flat 132. There are a number of survivors who will
10 be able to describe how quickly the fire spread to that
11 floor, but, importantly, how quickly it compromised the
12 lobby.
13 We know that Steve Power died in flat 122 on the
14 15th floor, and you have already heard something from
15 his family, including on behalf of his daughter, who
16 lived with him, about how the stay-put advice dictated
17 his fate.
18 There was a similar lost opportunity to evacuate on
19 the 14th floor. Firefighters will tell you that they
20 spoke with a group of residents, including two men
21 described to be of Middle Eastern appearance in
22 flat 112. That would be Mohammad al-Haj Ali and his
23 brother Omar at around 1.55/2 o'clock. They also spoke
24 to Denis Murphy from flat 111 and the young mother from
25 Sierra Leone, Zainab Deen, and her two-year-old boy,

1 Jeremiah, who lived in flat 115. All of these people
2 were advised to congregate in one flat, flat 113, and
3 stay put rather than initiating an evacuation to get the
4 group of them down the stairs.
5 You will hear that Omar al-Haj Ali was later taken
6 out by firefighters, but that the others congregated in
7 flat 113 were not. These brothers, Omar and
8 Mohammad al-Haj Ali, who made the journey to this
9 country together from Syria, were then definitively
10 parted.
11 Omar made a desperate attempt to get back in the
12 building. Their flatmate, Mahmoud Al-Karad, has told
13 you of a final telephone call in which Mohammad told him
14 he was not prepared to leave Zainab and Jeremiah, two
15 people he did not know, who he stayed with until it was
16 too late for any of them to live.
17 You are going to hear from many of the people who
18 escaped from floors 13 downwards, most because they left
19 early, despite the stay-put advice, and told others to
20 do the same, but others because of extraordinary
21 fortune, as well as bravery on their part and on the
22 part of firefighters.
23 On floor 11, two other men died. Ali Yawar Jafari
24 lived in flat 86. His wife and two daughters were able
25 to escape but he did not. And finally Abdeslam Sebbar



1 from flat 81. You have not yet heard from his family,
2 but they are very engaged in the process and will be
3 able to assist you with what occurred on the night in
4 terms of telephone calls that were made.
5 Sir, that is just a thumbnail sketch,
6 a work-in-progress that I know can be vastly improved,
7 but I am sure that the surviving community want it, in
8 your words, to be laid bare. Allowing the stories of
9 the fire to be told and to chronicle them yourself in
10 due course is what has begun to make this inquiry
11 a cultural event and not just a technical or legal one.
12 And that is an important junction to turn to our
13 second topic, which is: what on Earth was wrong with
14 this building?
15 Before handing over to Ms Barwise, may I briefly
16 expand on my earlier observation about it being time for
17 the knowledge to become public property and part of
18 a public debate.
19 Grenfell is also a story of disempowerment through
20 withholding knowledge, including technical knowledge,
21 and not enough people in society being included in
22 conversations about what risks this country should be
23 prepared to tolerate.
24 In order to prevent the construction disasters of
25 the future, we -- and that means all of us -- need to



1 understand more about the technical side. The science,
2 the law and the debates about both cannot be the
3 exclusive property of the experts. The Building
4 Regulations may be complex and could be simplified, but
5 they are not rocket science and some of the people who
6 are now saying otherwise are the people who should and
7 did know better.
8 On these matters, I now hand over to Ms Barwise to
9 address you. I can then return with final remarks on
10 the firefighting and the broader context after the short
11 break.
12 Thank you.
13 SIR MARTIN MOORE-BICK: Thank you very much, Mr Friedman.
14 Yes, Ms Barwise.
15 Opening statement on behalf of BSRs (G4) by MS BARWISE
16 MS BARWISE: I propose to address you, sir, if I may, on two
17 matters: first, the manner in which the cladding
18 compromised the safety of Grenfell Tower, and the
19 question of the obvious non-compliance of that work with
20 the Building Regulations; second, the lack of engagement
21 of the corporate core participants with the obvious
22 non-compliance issue.
23 I preface my submission with the observation that
24 listening in the last fortnight to the moving
25 testimonies of those lost, I was struck by how many of



1 the residents of Grenfell came to London seeking safety.
2 And yet, as firefighter Ashman observed when he arrived
3 to find the fire still raging seven hours after it had
4 started, Grenfell Tower appeared to him as a war-torn
5 country, and the only other comparable which came to him
6 was the Twin Towers on 9/11.
7 Devastation on this scale arising from what started
8 as and should have remained a kitchen fire suggests
9 failures at every level of design and construction of
10 the refurbishment, albeit once the fire had taken hold
11 it became an inferno for which no one had legislated.
12 Of the six commonly recognised layers of protection
13 against fire -- namely prevention, detection,
14 evacuation, suppression, compartmentation and the
15 resistance of the structure to fire -- at
16 Grenfell Tower, five of those layers failed. That the
17 structure survived is testament to its original, solid,
18 concrete, virtually incombustible construction. The
19 failure of the other layers is the subject matter of
20 this inquiry and, in particular, in Phase 1, the inquiry
21 has agreed, if it finds itself able, to make findings of
22 any obvious non-compliance with Building Regulations.
23 As to the failure of the cladding in the fire, as we
24 have heard from counsel to the inquiry, the provisional
25 views of the relevant experts, Professor Bisby, Dr Lane

1 and Professor Torero, tell more or less the same story.
2 All hold the cladding as a system responsible for the
3 incredibly rapid spread of a fire which ultimately
4 engulfed the whole building. All recognise the
5 complexity of such a system in terms of the way in which
6 it will cause a fire to spread.
7 Whilst recognising that the reports are necessarily
8 provisional, we suggest they are already sufficient to
9 enable consideration of the obvious non-compliance
10 question.
11 Dr Lane's conclusion is that the entire building
12 envelope system could not adequately resist the spread
13 of fire over the walls. Both Dr Lane and
14 Professor Bisby consider the Reynobond aluminium
15 composite panels responsible for the most rapid flame
16 spread. These panels, according to Dr Lane, should have
17 been to a national standard known as class 0 throughout.
18 In fact, there has been no evidence produced to her and
19 none that she can find that the panels were class 0.
20 The only certification shows European class E.
21 Whilst the national and European classifications are
22 not directly comparable, in the European standards, A1
23 is described in our Building Regulations as
24 non-combustible, A2 as limited combustibility, but the
25 class E panels used at Grenfell were the second from the



1 lowest classification, class F.
2 Both Dr Lane and Professor Bisby considered the
3 geometry of the building also contributed to rapid fire
4 spread, in particular the 14 columns around the building
5 which, uninhibited by effective cavity barriers, became
6 giant vertical pathways for upward flame spread to the
7 top of the building and potential downward spread. The
8 fact that these channels were well-ventilated, lined
9 with combustible materials and kept hot by the
10 insulation made them pathways for flame and smoke in
11 which everything could ignite. Professor Bisby tells us
12 that the channels facilitated elongation of the flame by
13 up to five to ten times its normal length.
14 The insulation used to line the original wall of
15 Grenfell was predominantly the product Celotex RS5000,
16 but, when that ran out, Kingspan Kooltherm K15 was also
17 used. All the insulation was supposed to be of limited
18 combustibility or class A2, but Dr Lane finds none of it
19 was.
20 The sandwich infill panels between windows were
21 Aluglaze, namely the white aluminium panels with blue
22 Styrofoam filling we saw on the screens yesterday, which
23 ignite at 356 degrees and for which no public
24 performance test evidence has been supplied. These
25 panels contribute to three out of Dr Lane's six routes



1 to fire spread that counsel alluded to yesterday.
2 The lack of test certificate for this significant
3 product raises the question, as do so many facets of the
4 Grenfell refurbishment, whether either designer or
5 contractor ever thought to ask what the product's
6 resistance to fire was or considered its implications
7 for safety. It is these issues which lead Dr Lane to
8 conclude that there was a culture of non-compliance.
9 Behind these highly combustible sandwich panels was
10 insulation which Dr Lane discovered was the lowest
11 class, namely F, and therefore woefully below the
12 required standard, A2 or limited combustibility, and
13 absolutely predisposed to allow for fire spread.
14 All three experts highlight the uPVC window
15 surrounds, which become liquid between 75 and
16 100 degrees, to have been the route not only by which
17 the fire escaped into the cladding, but also a potential
18 route for the fire to repeatedly break back into the
19 building as it did.
20 Dr Lane finds that the insulation behind those uPVC
21 window surrounds was Celotex TB4000, class F. Again,
22 woefully low and likely to facilitate rather than
23 prevent fire spread.
24 This leads Dr Lane to conclude that once any fire
25 occurred near a flat window, the majority of the



1 materials around the window had no ability to resist
2 fire.
3 Dr Lane also considers the top and bottom and edges
4 of the window also created routes for fire spread.
5 Counsel explained yesterday that the gap formed at the
6 window and column edges by new windows being smaller
7 than the old was filled with EPDM, a rubber damp-proof
8 course derived from crude oil in which the air is
9 trapped in the pre-foaming process; the perfect medium
10 for flame spread at the edge of the window and into the
11 aluminium clad columns.
12 Dr Lane found no effective cavity barriers around
13 the windows and no cavity barriers between the cladding
14 and its junctions with compartment walls and floors, nor
15 were there cavity barriers within the cladding rails,
16 either within the columns or window edges, nor at the
17 top of the cladding, where it joins the crown of the
18 tower, thereby creating further routes to fire spread.
19 The combination of these highly combustible
20 materials and omissions of cavity barriers amounts to
21 a collection of catastrophic failures in construction
22 safety.
23 As counsel mentioned yesterday, Professor Torero
24 believes the Celotex RS5000 insulation's ability to
25 spread flame may have been increased by the way the

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1 aluminium cladding panels burn, and in turn, the way the
2 insulation burned then affected the rate at which the
3 cladding panels melted, potentially causing less flame
4 spread but greater falling molten debris, which we saw
5 on the video yesterday and which the eye witnesses
6 experienced with disbelief on the night.
7 Second, Professor Torero notes the faster lateral
8 spread at the crown and considers that as debris fell
9 from the crown, it ignited fires by landing on ledges,
10 resulting in rapid internal penetration on floors 20 and
11 upwards.
12 This explains some of the otherwise inexplicable 999
13 calls reporting fires within flats on the upper floors
14 very early on in the evening. So, for example,
15 Jessica Urbano Ramirez and Debbie Lamprell, who had both
16 migrated from lower floors to flat 201 on the 23rd
17 floor, and called at 1.40 and 1.41 respectively
18 reporting very heavy smoke and fire within that flat.
19 One of the repeated themes of the last fortnight was
20 how many bereaved and survivors have so many unanswered
21 questions and a desperate need for answers. Although
22 they are the ones with the greatest right to know, the
23 general public and the construction industry also
24 desperately need those answers.
25 At and following the second procedural hearing, the

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1 inquiry indicated its willingness in principle to
2 consider obvious non-compliance of the cladding and fire
3 protection measures to the extent that was possible.
4 Insofar as the cladding system is concerned, the
5 starting point to the non-compliance question is: what
6 were the requirements of the Building Regulations 2010
7 which apply to the construction of new buildings or the
8 extension of existing ones?
9 There are three key points as to the nature of the
10 obligation imposed by those regulations.
11 First, the purpose of the regulations is the
12 protection of human life, not property. The regulations
13 produced pursuant to the Building Act 1984 are, by that
14 Act, expressed to be for the purpose of securing the
15 health and welfare of those who may be affected by the
16 building.
17 Second, the regulations require compliance with the
18 functional requirements listed in schedule 1 of the
19 regulations, which are simply the results or outcomes
20 required to be achieved by the finished work.
21 Third, the regulations provide that the works must
22 not render the building any less compliant than it was
23 before the works were carried out, the so-called
24 non-worsening principle.
25 A change to the building which renders it

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1 non-compliant with the regulations, where previously it
2 was, is called a material alteration. We say, based on
3 Dr Lane's report, that the entirety of the cladding
4 constituted a material alteration, since as it stood
5 before the refurbishment, Grenfell was constructed of
6 virtually incombustible concrete. It was, however,
7 covered by the polyethylene cladding now openly
8 described by some within the industry as petrol.
9 Patently, in the event of a fire the cladding did
10 not adequately resist the spread of flame over its
11 surface; on the contrary, it promoted flame spread.
12 Our understanding is that the ignition of the
13 polyethylene within the cladding panels produces
14 a flaming reaction more quickly than dropping a match
15 into a barrel of petrol.
16 The effect of this material alteration was that from
17 the moment of the cladding's installation, given it was
18 attached to every flat, it undermined the principle of
19 compartmentation whereby each flat is a fire rated box,
20 which underlay Grenfell Tower's defence to fire: namely
21 stay put or defend in place.
22 That fundamental non-compliance was then compounded
23 by a failure by RBKC or its advisers to address the fire
24 risk posed by the cladding, with the result that
25 CS Stokes, which carried out the last fire risk

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1 assessment before the fire, concluded there was only
2 a risk of "slight harm" in the event of the fire.
3 "Slight harm" was defined as "unlikely to result in
4 serious injury or death of any occupant". This starkly
5 contrasts with Dr Lane's analysis that the building
6 envelope created an intolerable risk on the night of the
7 fire, resulting in extreme harm.
8 By way of preamble to the requirements of the
9 Building Regulations, industry has been aware for some
10 time that cladding panels incorporating polymeric
11 materials such as polyethylene are highly combustible.
12 This knowledge was derived from fires such as
13 Knowsley Heights in 1991 and Garnock Court in 1999,
14 which led to a House of Commons select committee report
15 which concluded all cladding materials should either be
16 non-combustible or be proven by large-scale testing.
17 Further, the very specific danger of using polymeric
18 materials such as polyethylene near materials such as
19 uPVC window surrounds was known certainly to government,
20 which was warned of that precise risk by BRE's report
21 in November 1992 following the Knowsley Heights fire in
22 1991, in which fire spread vertically up the cavity
23 behind the cladding, melting the aluminium supports and
24 attacking the uPVC window frames.
25 Both Knowsley Heights and Garnock Court resulted in

significant changes to the Building Regulations. More recently, the cladding fire at Lakanal House of 2009, on which the coroner reported in 2013, would have been in everyone's minds.

Both Mr Stein and Mr Weatherby are going to address you further on the extent of this knowledge, but it amounts to this: since the turn of the century, both internationally and in the UK, fires involving external cladding systems have become the archetypal form of mass fire disaster. This fact put construction and fire engineering professionals on notice of the imperative to develop their risk assessment systems accordingly, and also ought to have informed London Fire Brigade contingency planning.

Industry openly acknowledges that polyethylene equates to petrol. As we mention in our written submissions, one of Arconic's distributors of a different Arconic product, Reynodual, is openly referring to the Reynobond product used on Grenfell as petrol in order to advertise as safe the Reynodual product said to be non-combustible.

Arconic are on notice of this advertising. We shall wait to hear whether they disavow it. But if they do not, we will ask for the advert to be admitted into inquiry evidence and, with an appropriate warning, ask



that what is a distressing and distasteful piece of marketing be shown up on the screens.

The fuel load imposed by both the panels and the insulation at Grenfell Tower must have been considerable, leading Professor Bisby to conclude that the fire spread was self-accelerating, in that its growth rate increased exponentially. Professor Bisby's conclusion is that although the cladding materials were composites, the overall phenomena was similar to those that would be broadly expected for vertical flame spread up a solid fuel surface.

He considers that such ACM products represent a clear, significant fire hazard that ought to be explicitly considered by anyone contemplating their use on buildings.

I turn now to the outcomes required by schedule 1 of the Building Regulations insofar as relevant to the cladding.

Regulation B3(4) requires that the building shall be designed and constructed so as to inhibit unseen spread of fire and smoke within concealed cavities. In other words, effective cavity barriers are required, including within the cavity created by the cladding.

Regulation B4(1) requires that the external walls of the building shall adequately resist the spread of flame



over the walls.

Guidance as to how to achieve those outcomes is given by Approved Document B, also produced pursuant to the Building Act. The guidance does not relieve the designer or contractor of the obligation to achieve the outcomes imposed by the regulations. Document B makes clear that the designer is not required to adopt any solution in the approved document, but may instead achieve the outcomes required in some other way, including by carrying out a fire engineering study of the whole building.

In inviting you to consider obvious non-compliance with the regulations within Phase 1, we're not overlooking the fact that guidance document B is a profoundly unsatisfactory document which has developed organically, in part in response to fires over the years, and requires urgent overhaul.

All that being said, in the rush to reform Approved Document B, we do not wish to exonerate contractors and designers who have blatantly disregarded the outcomes clearly required by the current regulations, which we submit are clear, and those portions of the approved document which are clear and were well understood.

We should also point out that we confine our allegations of non-conformity to the building



regulations as they stand now rather than any aspirational standard. With that caveat, I now turn to how the designer demonstrates that he or she has achieved the outcomes required by the regulations.

The guidance in Document B offers, but does not prescribe, compliance by two precisely explained routes in addition to the fire engineering option: the first route is by testing the cladding system by means of large-scale test, and the second is by achieving precisely specified criteria by reference to British or European standards, which is the prescriptive route.

If the designer chooses the prescriptive route, he must, as required by appendix A of Document B, prove compliance by proving the materials have been independently certified to conform to the relevant standards.

For the sake of completeness, a further possible means of compliance by way of desktop study has been suggested by the leading industry bodies. This concept and the fire engineering option for compliance contemplated by Document B are academic in this phase of the inquiry since there was no suggestion that either method was attempted.

The relevant section of Document B, part B4, is headed "External wall construction" and begins with what





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1 the inquiry's expert Mr Todd has called the "health
2 warning". It warns of the dangers of combustible
3 materials in cladding. Paragraph 12.5 reads:
4 "The external envelope of a building should not
5 provide a medium for fire spread if it is likely to be
6 a risk to health or safety. The use of combustible
7 materials in the cladding system may present such a risk
8 in tall buildings."
9 The paragraph then suggests compliance by either the
10 prescriptive or test route. The contractor or designer
11 is therefore faced with a choice: he or she either
12 elects the prescriptive route, or the test route, or
13 a desktop study or a holistic engineering solution.
14 Starting with the prescriptive route to compliance,
15 it is contained in paragraph 12.6 to 12.9 of Document B.
16 Paragraph 12.6 introduces the concept that on a building
17 over 18 metres tall, the outer surfaces of walls should
18 be national class 0.
19 It is universally accepted that the insulation
20 material is required by paragraph 12.7 to be of limited
21 combustibility. There appears to be a debate, which
22 will be for Phase 2, about whether paragraph 12.7 also
23 requires the filler or core of the cladding panel to be
24 of limited combustibility. The inquiry's experts are
25 split 50/50 on this issue; Mr Todd and Professor Bisby



1 considering clause 12.7 requires limited combustibility
2 panels and Professor Torero and Dr Lane considering it
3 does not.
4 Dr Lane considers the panels and core must be
5 class 0 throughout and, as there were no class 0
6 certificates for these panels, considers them
7 non-compliant.
8 Mr Todd notes that industry considers that the
9 inside or core of the panels is required to be of
10 limited combustibility. He relies on a guidance note
11 produced by the Building Control Alliance, BCA, which he
12 defines as acting as the voice of building control in
13 consultation with government and other bodies. The
14 relevant BCA guidance note issued in June 2014 makes
15 clear that if the building is taller than 18 metres, all
16 elements of the cladding system should be of limited
17 combustibility.
18 Pausing there, Arconic's opening accepts that
19 Document B requires the inside or core of the panels to
20 be of limited combustibility and acknowledges that it
21 would've been obvious that its Reynobond panels were not
22 of limited combustibility.
23 Returning now to the contractual designer's options
24 for compliance. He or she may not wish to follow the
25 prescriptive route; it may not suit their design and



1 limited combustibility materials may be too expensive.
2 The contractor or designer therefore considers whether
3 the test route might suit better. In doing so, the
4 designer must at least open BR 135, which is expressly
5 referred to at paragraph 12.5 of the regulations and
6 introduces the large-scale test, BS 8414, and has been
7 a central document in this part of the industry for
8 25 years.
9 Please may we now have on screen INQ0000092, thank
10 you.
11 The introduction of the version available to those
12 who worked on Grenfell Tower tells the contractual
13 designer that the large scale test was introduced
14 following the Knowsley Heights cladding fire in 1991,
15 and that following a fatal cladding fire in
16 Garnock Court, the second edition of BR 135 was
17 produced. As the designer or contractor turns on to
18 this page, section 3, mechanisms of fire spread,
19 graphically depicts the consequences of high-rise
20 cladding fires, critically the fire breaking out of and
21 then repeatedly back into the building. The narrative
22 reads:
23 "The key stages associated with fire spread on the
24 outside of a building envelope are:
25 "Initiation of the fire event.



1 "Fire breakout.
2 "Interaction with external envelope.
3 "Fire re-entry.
4 "Fire service intervention."
5 Returning to our designer, even if his or her
6 interaction with BR 135 ended there, they would be well
7 aware of the risks posed by combustible cladding and,
8 indeed, precisely the scenario which occurred at
9 Grenfell Tower.
10 If, however, the designer reads on to the next
11 page -- please go to 12, thank you -- he is told,
12 paragraph 3.3, that the fire performance of the cladding
13 system is critically important. Once flames begin to
14 impinge upon the external fabric of the building, either
15 from an internal or external source, there is the
16 potential for the cladding system to be involved.
17 Critically it reads on at paragraph 3.3.2,
18 "Cavities":
19 "If a flame becomes confined or restricted by
20 entering cavities within the external cladding system,
21 they will become elongated as they seek oxygen and fuel
22 to support the combustion process. This process can
23 lead to flame extension of five to ten times that of the
24 original flame lengths, regardless of the materials used
25 to line the cavities."

As I've already mentioned, that extension of five to ten times the length of flame is exactly what Professor Bisby considers happened in the 14 columns which surrounded Grenfell Tower.

Returning again to our designer, armed with the knowledge that if there is a fire inside a high-rise it may reach the cladding, and if it does will result in a catastrophic, multi-storey fire involving elongated flames within the cavity, the designer turns to consider his options under the prescriptive route and, thus informed, should favour limited combustibility panels.

Even if the designers and contractors of Grenfell did not trouble to open BR 135, they must have looked at the insulation manufacturer Celotex's compliance brochure for specifying the insulation RS5000 on buildings over 18 metres. When they did, they would've been confronted by the very same break-in and break-out diagram as that contained in BR 135, which is replicated exactly within Celotex's brochure.

We will submit in Phase 2 that reasonable and prudent designers, if in doubt about whether paragraph 12.7 required limited combustibility material inside the panels, would conclude that they were, in order to comply with B4, required to use limited combustibility cladding panels.



Taking a purposive approach to the interpretation of the Building Regulations, safety of human life is paramount. Therefore, in the case of doubt there was only one way to resolve this consistently with the purpose of the regulations.

At Grenfell, given that it is clear that neither designer nor contractor sought to adopt the test route, by default they adopted the prescriptive route of needing to prove compliance of both insulation and cladding panels by reference to British or European standards. Dr Lane has found that there are no relevant certificates.

Accordingly, there are three clear ways in which Grenfell can be said to be obviously non-compliant, without establishing the responsibility for such non-compliance.

First, it is clear that the cladding system is non-compliant because the insulation does not comply. Therefore, because the prescriptive route was adopted, the entire system is non-compliant. The insulation, which unarguably should have been of limited combustibility, so class A2 or better, was not, and the insulation between the original and new window infill panels was as low as class F, as is the Celotex TB4000 insulation behind the uPVC window surrounds.



Second, the fact that, as Dr Lane concludes, the cladding at Grenfell Tower did not adequately resist the spread of flame and, on the contrary, promoted it, is also sufficient to show non-compliance, together with the absence of proof of compliance.

Thirdly, another way of looking at it is that Dr Lane says from the moment the tower was enveloped in cladding, it immediately compromised compartmentation and therefore was a material alteration which left the building not compliant with B4(1) of the regulations, whereas it had been before the works were carried out.

In order to answer the non-compliance question in Phase 1, it is necessary to reach an overall view on what the Building Regulations and Document B currently require. The non-compliance is a failure to comply with the functional requirement or outcome contained within the regulations themselves, namely that the external wall should adequately resist the spread of fire.

You, sir, should not be deterred from reaching a concluded view within Phase 1 as to whether there is obvious non-compliance with the regulations or Document B by the suggestion made in Rydon's opening that the regulations can only be interpreted by how a reasonable, reputable cladding designer would interpret them.



Within Phase 1, that is academic for two reasons. First, while the Building Regulations must be read together with Approved Document B, the outcomes contained within schedule 1 of the regulations are clear and unambiguous as a matter of statutory interpretation, and patently have not been achieved.

The guidance is merely guidance, and expressly makes clear it need not be followed at all if the designer or contractor prefers to achieve compliance with the functional requirement in a different way. In any case, there was no attempt here to comply with Document B.

Debates as to the detail of Document B are divorced from the straightforward question of whether the cladding system at Grenfell was compliant with the regulations. It patently was not, and compliance with the prescriptive route has demonstrably not been proven.

Second, it is not at all clear that the designers or contractors in this case will seek to argue that they have complied with the Building Regulations. Not one core participant makes that assertion, even though that had originally been Rydon's position in the media in the immediate aftermath of the fire, albeit solely in reliance on the regulations completion certificate issued by RBKC.

It would have been helpful if the corporate core

participants had indicated their position on the compliance question. Only Arconic has addressed it, and it concludes that the panels should have been of limited combustibility but patently were not. This is a matter that Mr Weatherby will address, and we endorse what he has to say, in particular with regard to the question of compliance with the regulations.

May I then, sir, perhaps state the obvious as far as the industry is concerned.

The contractors and designers were under an obligation to achieve the outcomes required in the Building Regulations and to demonstrate that their work was compliant. Rydon, the main contractor under a design and build contract, is being obtuse in arguing, as it does in its position statement, that it was not responsible for critical decisions.

Rydon was retained pursuant to the preconstruction agreement to carry out preliminary facade design work, obtain planning permission and prepare a mock-up for the cladding. It was to be paid £350,000 under the agreement, of which £35,000 was expressly referable to those items. Such work was expressed by the preconstruction agreement to be carried out under the terms of the design and build contract to be entered in due course.



Whether or not others had suggested or dictated the use of certain materials, Rydon would anyway have been under an obligation implied either by the design and build contract and/or the preconstruction agreement to warn RBKC if the materials were unsuitable or hazardous or non-compliant.

In any event, Studio E's specification had previously required higher quality materials than were in fact used. Fire resistant Celotex, FR5000 not RS5000, was specified originally, and the rainscreen cladding proposed for the spandrel and column panels was an aluminium honeycomb core bonded between two zinc skins.

Rydon was asked to submit alternative costs for Reynobond over Alucobond and zinc but, as detailed designer of the cladding, it would have been for Rydon or its subcontractors to consider the degree of resistance to fire necessary and to warn if it considered them insufficient. It is therefore disingenuous of Rydon to suggest that someone else made all the critical decisions before it became involved and it was stuck with them.

No doubt others may share responsibility, but attempts such as this to reduce the significance of Rydon's role are misleading.



As to Rydon's subcontractors, CEP, the subcontractor which purchased and fabricated the Reynobond panels, claims it cannot participate at all until it has had full disclosure. If CEP wishes not to incriminate itself, that is its choice, but it is disingenuous for CEP to plead inability to comment on the compliance of its own work. The same applies to Harley, as it does also to Studio E. These parties make no comment on the detailed criticisms of their work, nor do they even comment on drawings which they themselves drafted. Significantly, they do not indicate how they propose to achieve compliance, assuming, that is, that they ever applied their minds to that question.

The time has come -- indeed, is overdue -- for the contractors and suppliers to clearly state their positions, and also to respond to the positions taken by others. Their stance that they need more than the documents they already have before engaging at all with any of the criticisms made of them is demonstrably untenable and disingenuous.

These contractors should not be allowed, by their deliberate refusal to participate, to derail determination of the compliance issue, even though we are concerned with blatant non-compliance.

Despite their words of condolence to the victims,



these corporates have no desire to assist this inquiry, even though their participation could save lives in the immediate future.

The inability to produce a basic account of how, if at all, they considered Grenfell Tower complied with the Building Regulations is itself indicative of the culture of non-compliance which Dr Lane has identified.

The corporates' silence deprives the families of the degree of resolution and understanding to which they are entitled and has only served to increase their pain and uncertainty. It is inhumane to remain silent when so many seek understanding and answers, answers which are within the corporates' gift.

Those are my submissions, sir. I wonder if this would be a convenient moment for the break before I hand the baton back to Mr Friedman.

SIR MARTIN MOORE-BICK: I think it would. Thank you very much.

So we'll have a break now for 15 minutes and then, when we resume, we'll hear further from Mr Friedman.

Thank you very much.

(11.15 am)

(A short break)

(11.35 am)

Opening statement on behalf of BSRs (G4)

by MR FRIEDMAN (continued)

SIR MARTIN MOORE-BICK: Yes, Mr Friedman.

MR FRIEDMAN: Thank you, sir.

The firefighting response.

The culture of non-compliance that you've just heard referred to predetermined the fatal risk to which the residents were exposed, but it also bore direct consequence for the experience of the firefighters on the night. The subject adds a further emotional layer to the inquiry and it is important to underscore why.

If dying in a fire is the stuff of nightmares, then you are about to meet a group of witnesses who make their life's purpose to prevent that from happening.

The firefighters have suffered damage to their professional and personal lives by failing to save lives, as well as life-threatening trauma themselves. Yet it is important to respect the event as an opportunity for learning and improvement, as well as ensuring that the bereaved and survivors, as the first and foremost victims, are able to ascertain if and how their bereavement and trauma might have been prevented.

As you were told yesterday, we've now read more than 250 firefighter statements; difficult statements to give and a vast piece of work on the part of the police to obtain them.



The near universal view of those witnesses is that this was a fire utterly beyond their professional experience. But it is also clear that it was a fire beyond their training, or indeed the London Fire Brigade's operational contemplation, and we say it should not have been.

In that recognition of systemic failure of foresight, the inquiry can join this and other fire brigades in remedying what is a violation of the state's responsibility to have training and policy in place that is fit for responding to foreseeable risk to life in cladding fires of this nature.

When Mr Weatherby takes this up with you this afternoon, he will reflect on how the positive human rights duties to protect life have been breached by the lack of contingency planning in this case.

That takes us to what we see as a fundamental question: did the LFB waste limited temporal and spatial opportunities in trying to fight a fire that could not be fought, rather than immediately prioritising the evacuation to save lives?

A range of firefighter witnesses, as well as Dr Lane, have emphatically queried the logic of maintaining the stay-put advice up to 2.47, given that compartmentation had already begun to fail by 1.15 and



had substantially failed by 1.26.

Both the experts and the non-experts can view the video from yesterday and reflect on the fact that this was not a fire to tell people to stay put in.

Standing London Fire Brigade and national policy required consideration of withdrawing stay-put advice, although no Incident Commander appears to have done so until AC Roe shortly before 2.40. Somewhat bizarrely, DAC Fenton came to the same conclusion at roughly the same time in the control room at Stratford, without prior communication with the incident command and triggered, he will tell you, at least in part as a result of turning on the television and viewing the fire on Sky News.

One of the other consequences of more than 250 firefighters telling you that they have never seen anything like it is that each of them in their own way has expert knowledge to offer you about it. What we believe is going to happen once all these accounts are read and heard is that the initial instinctive judgment that nothing more could be done will be replaced by a more nuanced and constructive appreciation that all sorts of things could have been done differently, and we base that observation on what many of the firefighters of different ranks have endeavoured to confront, with



quite a few of them making clear that they bore those realisations in real time and not with the benefit of hindsight.

It's from our reading of those statements that we now make the following observations about the core matters that the inquiry, listening to your counsel yesterday, will look to investigate.

First, operational matters. These include:

1. The failure to appreciate the futility of firefighting within that early window of opportunity for evacuation.

2. The real-time appreciation by firefighters of various ranks and staff in the control room that stay-put advice was untenable.

3. The haphazard extent to which the narrow staircase was crowded by firefighter deployments and equipment that obstructed effective evacuation. Policy specifically warns against congestion.

4. How hoses and other pieces of equipment kept fire doors to the lobby open and so increased the spread of smoke into the stairwell.

5. The acute and multiple failure of communication at various junctions between the control room, the command units, the firefighting bridgehead and the deployed and returning units of personnel that went up

1 and down the stairs. In that first 30 minutes, adequate
2 communication between outside command watching the
3 uncontrollable lateral spread and the knowledge of the
4 inside deployments that the compartment principle was
5 collapsing on several floors above flat 16, should only
6 have led to a focus on one objective and one objective
7 only: enabling evacuation down that staircase.
8 6. It seems to us -- a view shared by a number of
9 firefighter witnesses -- that there was very rudimentary
10 and wholly inadequate local familiarisation knowledge of
11 the tower itself, which was in breach of section 7(2)(d)
12 of the Fire and Rescue Services Act 2004 and
13 a fundamental breach of standing policy, which mandated
14 rigorous operational intelligence gathering and
15 contingency planning in relation to at risk high-rise
16 buildings.
17 The second matter is equipment, and there is a range
18 of technical and equipment issues being raised again,
19 I emphasise, by firefighters who were there and sought
20 to cope with this:
21 1. Earlier availability and deployment of what they
22 call extended duration breathing apparatus, EDBA, and
23 the trained fighters to use that equipment that would
24 enable them to make longer and more effective journeys
25 up the stairwell and onto the various floors.



1 2. Discrete provision of what they call flash
2 masks, cheap and easy to carry in pockets and which can
3 assist the breathing of the evacuees, the residents,
4 which is what was needed for those coming down the
5 staircase.
6 3. Higher ladders and pumps.
7 4. The feasibility or otherwise of other aerial
8 responses, including by helicopter. The BSR wish to
9 understand whether it could or could not have been done
10 here.
11 5. Electronic communication coverage and the
12 difficulties with that in high-rise blocks, and the
13 failures of the communication devices, particularly
14 within the breathing apparatus masks.
15 6. Whether the earlier deployment of a positive
16 pressure ventilation system, equipment new to the London
17 Fire Brigade but used by other brigades, might have made
18 a difference to the smoke-compromised stairwell.
19 Third matter, the control room and the answering of
20 the emergency calls.
21 The overriding conclusion to be derived from the 999
22 transcripts that we have seen is that the control room
23 was deprived of essential operational information about
24 the drama and the scale of events unfolding on the
25 ground, leaving the operators manifestly ignorant about



1 the advice they were giving, but also unable to
2 sufficiently react to the clear information that they
3 were being given from the residents that smoke and fire
4 had penetrated much of the building in minutes.
5 The resulting Fire Survival Guidance was therefore
6 confusing, dangerous and too often fatal. This despite
7 belated efforts by control room staff in many of the
8 later calls to implore evacuation in any way possible.
9 Just as there was no plan B for the stay-put policy,
10 there was no training or conception of how to advise on
11 any type of plan B at the control room level.
12 Finally, command, control and co-ordination.
13 This became a 20-pump fire in 20 minutes, and
14 a 40-pump fire in 60 minutes. 10 fire and rescue
15 service vehicles had been called by 2.16. There was
16 a considerable lack of organisation in that first
17 90 minutes, which resulted in the two features of the
18 night so fatal to the residents: the maintenance of
19 stay-put when it should've been amended or withdrawn and
20 the hindering of evacuation because of the
21 overdeployment of firefighters and equipment into the
22 stairwell.
23 Sir, I emphasise again that the list of matters for
24 an opening that I've just been through quickly reflects
25 disquiet that both the BSRs and many of the firefighters



1 share in.
2 We did one unprecedented thing last fortnight; we
3 need to do another in the weeks to come as the
4 firefighters and the residents return in their minds
5 back to the building that night. Courageous accounting
6 for what could've been done differently is
7 an opportunity to save lives in the future, and a final
8 service of not just getting the people out of the tower
9 alive, but also giving them some peace of mind to live
10 on.
11 The last topic from us this morning is the broader
12 context. You will hear from my other colleagues on
13 this, but I would like to foreshadow just one piece of
14 evidence that is already widely available in the public
15 domain.
16 On 20 November 2016, Edward Daffarn of flat 134 on
17 the 16th floor and a previous long-term resident of the
18 area Francis O'Connor wrote a blog in their capacity as
19 the Grenfell Action Group. May I read from it.
20 "Anyone who witnessed the recent tower block fire at
21 Shepherds Court, in nearby Shepherd's Bush, will know
22 that the advice to remain in our properties would have
23 led to certain fatalities and we are calling on our
24 landlord to re-consider the advice that they have so
25 badly circulated.

1 "The Grenfell Action Group predict that it won't be
2 long before the words of this blog come back to haunt
3 the KCTMO management, and we will do everything in our
4 power to ensure that those in authority know how long
5 and how appallingly our landlord has ignored their
6 responsibility to ensure the heath and safety of their
7 tenants and leaseholders. They can't say that they
8 haven't been warned!"
9 Sir, it goes on, using the language of activists and
10 giving no quarter to deference, to quote again:
11 "It is a truly terrifying thought, but the Grenfell
12 Action Group firmly believe that only a catastrophic
13 event will expose the ineptitude and incompetence of our
14 landlord, the KCTMO, and bring an end to the dangerous
15 living conditions and neglect of health and safety
16 legislation that they inflict upon their tenants and
17 leaseholders. We believe that the KCTMO are an evil,
18 unprincipled, mini-mafia who have no business to be
19 charged with the responsibility of looking after the
20 everyday management of large-scale social housing
21 council is a recipe for a future major disaster."
22 And finally they say:
23 "Unfortunately, the Grenfell Action Group have
24 reached the conclusion that only an incident that
25 results in serious loss of life of KCTMO residents will



1 allow the external scrutiny to occur that will shine
2 a light on the practices that characterise the malign
3 governance of this non-functioning organisation ...
4 "It is our conviction that a serious fire in a tower
5 block or similar high-density residential property is
6 the most likely reason that those who wield power at the
7 KCTMO will be found out and brought to justice!"
8 One of my clients is Mr Daffarn and he is here
9 today. He wasn't the only person who tried to push back
10 on how the residents were being treated; many people
11 tried in many different ways. He is lucky to be alive
12 and there were at least two firefighters who were
13 involved in saving him.
14 He does not wear his now well-known prediction as
15 a badge of honour; he carries the weight of the
16 information which caused him to reach and publish that
17 conclusion at least until he can know that you have
18 received the information and can understand the
19 incivility with which this community was treated.
20 If he and others sought to speak truth to power,
21 they did so because, as you will hear, relevant legal
22 remedies available to residents in social housing are
23 simply not effective enough in this country. They
24 cannot compel remedial works when it comes to safety
25 unless and until personal injury or death occurs.



1 But even if they could, residents would need access
2 to the information to take to the lawyers, to obtain
3 legal funding and to be granted permission for the case
4 to be heard, which is why every lawyer sitting in this
5 room right now knows that if these people came to their
6 office in the spring of 2017 wanting to challenge the
7 legality of the as-built refurbishment, they would
8 almost certainly have been told, "There is little we can
9 do", which is why these bloggers made sure that every
10 time they accused their landlords, they backed it up
11 with evidence.
12 The major obstacle in their path was that the
13 Freedom of Information Act 2000 did not apply to the
14 Kensington and Chelsea TMO, despite their exercise of
15 public functions, and refusals to disclose did not
16 therefore attract an automatic, free and speedy right of
17 appeal.
18 Without such judicial oversight, the TMO could
19 withhold important information on the basis of bold
20 assertions of commercial confidentiality, which is what
21 they did in October 2014, when the Grenfell Action Group
22 requested copies of the minutes and communications
23 between the TMO, Rydon and Studio E, at which the
24 progress of the Grenfell Tower improvement works was
25 discussed. Access denied on the above confidentiality



1 basis.
2 This inquiry is in some ways a tragic review of what
3 would have been discovered and perhaps prevented if the
4 relationship between the TMO, the council and its
5 tenants and leaseholders had been different and had been
6 conducted as a relationship of equals.
7 In the end, the Grenfell Tower fire is an example
8 writ large of how inequalities of political, legal and
9 economic power can kill people.
10 I don't now need to tell the inquiry that this was
11 a community that was wealthy in many ways. We contend
12 that you will see that the greatest poverty they
13 suffered was the poverty of how they were regarded and
14 treated, not who they really were. Their poverty in
15 this sense lay in the lack of concern by local and
16 central government, contractors predisposed against
17 regulations and red tape and too much of society as
18 a whole.
19 It is that failure of human accounting, and
20 indifference, both institutional and societal, that
21 renders more explicable this worst housing fire disaster
22 in modern British history.
23 Sir, thank you.
24 SIR MARTIN MOORE-BICK: Thank you very much, Mr Friedman.
25 Now, we are going to hear next from Mr Weatherby or

Mr Stein; I'm not quite sure which order you plan to
speak in.
Mr Stein first. Good, thank you very much.
Opening statement on behalf of BSRs (G3) by MR STEIN
MR STEIN: Sir, on 14 June 2017, the nation looked on in
shock as they saw a ring of fire consuming the
Grenfell Tower.
Over the past two weeks, we've been privileged to
learn so much more about the individuals who survived
that inferno and those who did not. What we learned was
that this was a virtual village which was an example of
the very best that is Britain today: rich, diverse,
filled with positive aspiration, with love and
neighbourly concern.
What this inquiry will uncover is that this terrible
loss of life was wholly avoidable. The people of
Grenfell Tower and the walk were not given a chance.
They were not allowed to participate in the decisions
taken regarding a significant and substantial
refurbishment. They were not listened to when they
complained, entirely accurately, about the shoddy work
that they could readily see. They were slighted and
ignored in the aftermath of the fire by both local and
central government and abused online.
We use in this inquiry the term "corporate" to

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identify the manufacturers, building contractors and
subcontractors. The term "corporate" or "corporates"
tends to avoid the fact that these companies are run by
people, and it was people who made the decisions who
caused the deaths and caused the injuries.
The fire safety system in place at the
Grenfell Tower was based upon ensuring that the flats
were safe places to stay, and ensuring that each flat
was a compartment into which fires should not spread.
This fire safety design for high-rise buildings was
not some newfangled and untried safety system being put
in place for the first time; it was the basis of fire
safety systems for the majority of high-rise blocks for
decades. The guidance issued by the local government
association in May 2012, described as "Fire safety in
purpose-built blocks of flats", states:
"Compartmentation requires a higher standard of fire
resistance than that normally considered necessary
simply to protect the escape routes. This is to ensure
that a fire should be contained within the flat of fire
origin. Accordingly, those in flats remote from the
fire are safe to stay where they are."
This is the essence of the stay-put principle. It
has underpinned, the local government association
described, fire safety design standards from even before

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the 1960s, when national standards were first drafted.
Mr Weatherby QC will look at this policy in some
more detail, but let's have some understanding of the
viewpoint of a resident who did escape from the block
regarding the stay-put advice on the night of the fire.
This is from the statement of Marcio Gomes,
flat 183, 21st floor:
"I have nothing but praise for the ordinary
firefighters of the London Fire Brigade who rushed into
that tower and risked their lives to save people like
us. Two of them saved my daughter's life and the life
of Helen's daughter. Words cannot express my gratitude
to them. However, those in charge are a different issue
for me. Someone in charge was clearly telling the Fire
Brigade operators to tell us that firefighters were
coming to rescue us. The delay in telling us to
evacuate nearly killed us and it did kill my baby son.
I have no doubt of that."
What was happening was that the very fire safety
system which was meant to preserve life had been
perverted into a fire killing system.
Although Phase 1 of this inquiry has a limited
target, we ask you not to delay in identifying
non-compliance where evidence already makes it clear,
and most importantly, don't let the people who are or

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were in control of the local authority, the TMO and
companies involved delay in explaining their conduct.
Which is why we welcome the call yesterday from counsel
to the inquiry for more information and statements from
those companies that he set out and targeted yesterday.
We also need to exercise great care in dealing with
this phase of this inquiry that it does not ignore the
fact that it was the decision by the Kensington and
Chelsea local authority, the TMO and its contractor to
try to refurbish on the cheap that led to this
devastation and this disaster.
Cladding fires are not new; they have happened
around the world and they have been a cause of concern
for many years. As a result of the Garnock Court fire
on 11 June 1999, a disabled pensioner, William Linton,
died and four other people were taken to hospital
suffering from the effects of smoke inhalation. One
local resident told reporters at the time that yellow
cladding on the corners of the building was behind the
speed with which the fire spread, saying it took
5 minutes. Another witness said the building went up
like a match. It took 60 firefighters to bring the
blaze under control.
The Garnock Court block was owned by North
Ayrshire Council, who ordered the removal of the

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cladding. A Scottish select committee review reported in January 2000, and this led to the mandatory regulation which came into force on 1 May 2005 in Scotland. Every building must be designed and constructed in such a way that, in the event of an outbreak of fire within the building or from an external source, the spread of fire on the external walls of the building is inhibited.

After the Lakanal House high-rise social housing block fire in south London in 2009, the All-Party Parliamentary Fire Safety and Rescue Group called for a major government review of Building Regulations, as did the coroner.

Has this failure to deal with dangerous cladding something to do with serial incompetence, or has industry become too close to government?

Remember that the Celotex director Rob Warren made clear on the company website that they were working inside government to influence policy and regulation of the insulation industry.

The BRE group had itself expressly recognised the dangers of this type of cladding for years, as has already been referred to by Ms Barwise QC, and even Celotex published its own rainscreen cladding compliance guide, which will just be briefly put up on the screen.



Celotex repeated BR 135's diagram, demonstrating the way a fire can move from one floor up the cladding, through the other floors of the buildings. That guide was removed from their website shortly after the fire.

The warnings about cladding were not just broadcast in this country but also around the world. In 2000, the Fire Code Reform Centre funded a research report on fire performance of exterior cladding and it presented a review of facade ignition and fire spread scenarios.

A 2011 report by Exova Warringtonfire Australia, another part of Exova UK Limited, who are a core participant within this inquiry. In that report, Exova Warringtonfire Australia provided fire safety advice as regards the question of potential facade fires in the future.

A report in 2014 for the National Fire Protection Association, a worldwide organisation which advises regarding fire, electricals in buildings and life safety commented that it is a difficult task to provide due credit to all previous work relating to fire performance of exterior combustible walls. This is due to the large amount of literature that has been generated in this area over past decades.

Well, let's compare the state of knowledge within the building, planning and construction industry with



what the residents of the Grenfell Tower knew about any potential dangers posed by the cladding and rainscreen.

One resident states that Rydon placed a sample of the cladding outside of the tower for residents to see:

"I did not believe the cladding was flammable as I did not think that the TMO or the contractors would put flammable cladding on the tower."

Ms Choucair, who lost six family members in the fire, recalls that she didn't really have any concerns about fire safety as she assumed that the council would comply with all regulations and that a landlord, especially a public body, should ensure that the tower was safe.

So what information did the people of the tower have about the cladding and rainscreen?

Well, we know that from notes taken in August 2012 they were consulted on the choice of colour of the rainscreen. The issue of fire safety was not raised, only the question of the advantages of a zinc cladding system referring to sound and thermal insulation.

The Grenfell Tower residents were not told that D+B Facades had provided a quote to Leadbitter, the original proposed contractor for the refurbishment, for the overcladding of the Grenfell Tower, that they would install, if contracted to, their system, which comprises



only inert solid aluminium panels with mineral wall insulation and fire breaks that are non-combustible.

Nor of course were the residents told that in mid-2014, good costs were required for Councillor Feilding-Mellen and the planner, and that those costs in fact led to the replacement of zinc cladding with cassette fixed aluminium cladding, leading to a saving then described as being £293,368, which subsequently increased to £376,175, that saving being from using the cheaper, more combustible cladding.

So what would this group of residents have done if they had had any cause for concern? What did they think of the quality of the work and the communication between them, the contractor, Rydon, and the TMO?

Well, we know they formed, as has already been described, the Grenfell Action Group following the start of the refurbishment work in the tower. The group would contact the TMO and Rydon on behalf of the residents to discuss complaints and concerns. Jose Cotelo from flat 103 says:

"We were not happy with all the exposed pipework."

There were concerns about the lack of lagging. His impression was that the whole job was finished in a very rough and ready way and a highly unprofessional manner.

In addition to the pipes, he says:





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1 "We also had concerns about the way our windows were
2 installed. For example, one of the windows that was
3 installed had a broken hinge from day 1 and was faulty
4 for six months. We complained to the TMO about this on
5 several occasions, and nothing was done until we finally
6 received a message from Rydon's just in the days before
7 the fire saying that they would come round and repair it
8 on 15 June 2017."
9 Alejandro Serrano from flat 114 states that he can
10 clearly remember that if you put your hand under the
11 outside lip of the windowsill you could feel wind and
12 cold coming in:
13 "We never complained about the windows. In the end,
14 we were so tired of complaining and nothing happening
15 that we didn't bother. They weren't going to do
16 anything about it. No one was going to give new windows
17 so we didn't bother. I now understand that it was one
18 of the ways that the fire came into the flat."
19 Our simple suggestion is that where there are
20 significant and substantial works taking place, the
21 voice of residents must be heard before the work starts,
22 before it's complete, and they must be allowed to take
23 active, informed and advised part in the building
24 process.
25 It is clear that the work carried out on the



1 Grenfell Tower was poor quality. It is clear that
2 residents used their voices and raised their concerns.
3 If they had been alerted to the possible danger posed by
4 the cladding and rainscreen, we know that they would've
5 made their presence felt. They were not, sir, given
6 that chance.
7 In our written opening at paragraph 20 we ask this
8 question: how was such a combustible cladding system
9 ever seriously countenanced as an option with which to
10 envelop a high-rise residential tower?
11 Rydon have said that the fire engineering advice was
12 provided by Exova Warrington, who they say provided
13 detailed advice and specialist input on fire safety
14 during the project.
15 Studio E in their position statement identify Exova
16 Warrington as the fire consultant.
17 The TMO state that Exova noted that the proposed
18 changes would have no effect on the building in relation
19 to external fire spread but that this was to be
20 confirmed by future analysis.
21 The TMO goes on to say that they believe that Exova
22 conducted that further analysis and gave such
23 confirmation to Studio E, although the precise terms of
24 that confirmation are not known to the TMO.
25 Yet Exova, who have more recently become a core



1 participant, claimed in their position statement that
2 their significant involvement ended a year before Rydon
3 was appointed, and that, further, Exova was not involved
4 in discussions or asked to advise on matters such as
5 the choice of materials to be used in the project, nor
6 was it asked to certify any items for use in the project
7 or verify the quality of work carried out.
8 Their single Grenfell Tower outline fire strategy
9 thus far disclosed states, under compliance with B4,
10 external fire spread, that it is considered that the
11 proposed changes will have no effect on the building in
12 relation to external fire spread, but that this will be
13 confirmed by an analysis in a future issue of this
14 report.
15 It is worth asking the question: what plans was
16 Exova ever asked to report on if they did not identify
17 the exterior cladding and rainscreen?
18 At present we have no reason offered for their
19 preliminary conclusion that the refurbishment works will
20 have no adverse effect on the building in relation to
21 external fire spread. Nor is it even identified what
22 changes are being preliminarily approved as having no
23 adverse effect.
24 If Exova are saying that they were not told about
25 the cladding and rainscreen, we need to know. And when



1 we say we need to know, we mean the residents and the
2 people from the walk we represent. They need to know.
3 We have seen documentation which has Exova included
4 on the distribution list that includes reference to the
5 proposed cladding. But if that is not right, how is it
6 that the report they completed makes no reference to the
7 exterior cladding being part of their area for comment
8 and fire safety?
9 If we can have the images put up on the screen.
10 This is from the fire strategy document provided by
11 Exova. You will see that under the heading "The
12 refurbishment comprises", if we cast our eyes down, the
13 various bullet points refer to the ground storey level,
14 the reception area, nursery office accommodation and so
15 on, the mezzanine level, the walkway level, creation of
16 a boxing club and office accommodation, walkway plus one
17 level, the creation of four new residential apartments
18 and generally improvements to the building services.
19 Thank you.
20 We can see from that that there does not appear to
21 be a reference to the external rainscreen and the
22 cladding. Plus, we have also seen in the documents
23 provided by the inquiry minutes of a minute that took
24 place where it was agreed between the TMO and Rydon that
25 Rydon will contact Exova about continuing to use them

for future fire strategy.
We therefore need to see all of the communications between Exova, Studio E, Rydon and the TMO and we suggest we need to see that now.
This goes beyond the question of relevance to Phase 1 and Phase 2, handy compartmentalisation. The people of the Grenfell Tower and the walk have had enough of compartmentalisation. Some material is required now. Some material can be provided now.
Exova, having had the opportunity to consider what Rydon and the TMO reported about its role, have not even made an opening statement offering any response. As we have identified, it remains wholly unclear on what basis it reached its preliminary conclusion about no adverse impact on fire spread.
Rydon accepts that it was employed by the TMO as principal contractor in respect of refurbishment works at Grenfell Tower, and that the retainers of the employer's architect, Studio E, and the other consultants were assigned or novated to, moved to or directly appointed by Rydon.
Yet their submission to the inquiry states that key discussions about the refurbishment and materials to be used were dictated by specialists prior to Rydon's involvement. However, the specialist -- presumably the



architect, Studio E -- was engaged by Rydon following its appointment, and Rydon's responsibilities under the design and build contract included dealing with building control and ensuring compliance.
The TMO, the Tenant Management Organisation, say this:
"Why combustible cladding was used at Grenfell Tower is something this inquiry will have to consider."
As the commercial client, it is, we suggest, extraordinary that their opening statement suggests that the TMO is waiting for the inquiry to tell it why it wrapped Grenfell Tower in combustible material. The TMO was not a small management organisation; they managed 10,000 homes.
The failure of corporate and public authority core participants to explain how they came to design, build and approve this highly combustible envelope highlights the inability or unwillingness to take responsibility and the problems in this industry.
As we have said in our opening statement, paragraph 23, the extraordinary lack of clarity as to who was accountable for fire safety already evident in the very limited material thus far disclosed highlights the importance of the inquiry's interim recommendations following Phase 1, which is the rationale for producing



an interim report.
Celotex's position statement says that they had no direct contractual relationship with the owner of the Grenfell Tower or with the contractor or subcontractors working on the refurbishment, but then goes on to say that their employee who was principally involved in the supply of RS5000 to the Grenfell Tower left Celotex's employment in August 2015, and then goes on to say that Celotex to date have been unable to speak to him to ask him for his recollection of relevant events and its efforts in this regard are ongoing. Well, we suggest that this individual, as yet unidentified to us, be located and be prepared to answer some questions.
We finally see what Celotex are trying to say later on in their position statement when they refer to meetings at the Grenfell Tower in May 2015, which are apparently part of a marketing or relationship-building exercise. Therefore, we are forced to assume they are saying that that has nothing to do with accepting any level of responsibility for cladding this tower with lethal material.
The residents, families and people from the walk need to see these communications between Celotex and they need to see the correspondence they refer to. As with the Exova questions, they have a right to know and



a right to know now.
We deal briefly with the Phase 1 and Phase 2 divide of this inquiry.
In our written opening, we say at paragraph 24 that you, sir, have emphasised the flexibility with which the inquiry will continue to approach the question of what falls to be considered in the Phase 1 hearings and addressed in the interim report, and counsel to the inquiry confirmed that approach yesterday.
Rydon, though, seeks to limit the scope of Phase 1 and presumably the interim report as it says in its written opening, paragraph 17:
"While Rydon appreciates that there is a need for some degree of flexibility between Phase 1 and Phase 2 of the inquiry, it is concerned by the extent to which the inquiry experts have travelled outside the objects of Phase 1."
Now, we know, and our clients from the tower and from the walk know, that they are going to have to accept that the whole truth and the full analysis of responsibility will not come in Phase 1, and therefore also it will not be fully set out in the interim report.
However, what has been absolutely clear from the start and is in your terms of reference, sir, is that the rationale for producing an interim report part-way

1 through your inquiry is to allow for the earliest
2 possible recommendations to prevent another such
3 disaster.
4 The rationale for the interim report was reflected
5 by the Prime Minister's statement that it is vital that
6 the inquiry conducts as expeditious an investigation as
7 possible, not only to provide answers for all those
8 affected by the tragedy who wish properly to understand
9 what went on that night, but also to identify any
10 ongoing risks that may be pertinent to other high-rise
11 buildings of a similar nature.
12 We submit that you must make urgent recommendation
13 to save people's homes from becoming or remaining
14 deathtraps, and that this is the very rationale of the
15 interim Phase 1 report, and the expert evidence is of
16 value in doing so. In your December 2017 ruling you
17 stated:
18 "It would be unwise to draw a hard and fast line
19 between Phase 1 and Phase 2, particularly in relation to
20 evidence that may be relevant to a number of different
21 questions."
22 You noted in your December ruling that it is open to
23 the inquiry to publish interim reports as and when it
24 discovered something of importance and considered that
25 it was in the public interest to do so.



1 Depending upon the evidence emerging,
2 a recommendation aimed at ensuring the safety of people
3 in similar tower blocks may be appropriate at any stage,
4 including before the full interim report dealing with
5 all of the Phase 1 issues.
6 In your March ruling, sir, you stated that at least
7 some of the questions identified in section 8 of the
8 list of issues should be addressed as part of Phase 1.
9 Section 8 of the list of issues is communications with
10 residents and includes matters such as systems of
11 communication with residents and their concerns about
12 fire safety. Yet Rydon have offered no explanation
13 whatsoever, despite the TMO's position statement at
14 page 10, which states:
15 "All residents' issues arising during the
16 refurbishment works were directed to Rydon."
17 The newsletters to residents in particular
18 identified that if residents had any issues in relation
19 to the refurbishment works, these were to be directed to
20 Rydon's resident liaison officers. All issues raised by
21 residents were therefore logged, monitored and responded
22 to by Rydon.
23 It is in any event, sir, we suggest, important to
24 have an explanation by Rydon of what they did, and
25 Rydon's failure to respond to the alarming evidence in



1 the expert reports served -- including, of course,
2 Dr Lane's report -- about what materials were used,
3 where and why is particularly concerning. It is
4 necessary to understand what was put on the tower by
5 Rydon and how it was done in order to understand the
6 fire spread. As we have already considered in our
7 opening today, our clients' witness statements for
8 Phase 1 address the appallingly shoddy way in which the
9 refurbishment was conducted by Rydon and those it
10 engaged, and, of course, the consequences of that.
11 What about the manufacturers of the combustible
12 rainscreen, Arconic? Did they watch the video
13 yesterday? Did they not see how their ACM rainscreen
14 burned? If so, are they at all embarrassed by their
15 submission to the inquiry that the ACM that they
16 provided was at most a contributory factor to that
17 inferno?
18 Our clients have some serious questions about the
19 role of the London Fire Brigade, and particularly those
20 in a command and control position. However, theirs is
21 a responsibility for not managing to rescue more people
22 from the inferno. That is not to be confused with those
23 who carry primary responsibility for creating the
24 disaster; that is the design and build contractors, the
25 suppliers of the combustible materials for high-rise



1 blocks and the council and its TMO, determined to build
2 on the cheap.
3 We suggest that any failings of the Fire Brigade
4 should not be exploited by those who created this
5 disaster in order to kick examination of their own
6 conduct into the long grass, in their hope that justice
7 delayed will be justice denied.
8 It will be a travesty if the contractors and clients
9 were able to hide behind any possible failings of the
10 Fire Brigade faced, as they were, with the largest
11 single operation of its kind in England since
12 World War II.
13 As you know, sir, we've already addressed you in
14 previous procedural hearings on the question of the
15 Hackitt Review and I turn to that now.
16 The Hackitt Review was commissioned on the basis
17 that addressing these issues were urgent, hence her own
18 interim report from Dame Judith in December 2017.
19 In laying her final report before Parliament on
20 17 May 2018, the Housing Secretary said that determining
21 how to proceed in its light was urgent. Why, when the
22 purpose of the inquiry's interim report is to make
23 urgent recommendations, would this inquiry determine
24 that it will either decline in Phase 1 or delay dealing
25 with those recommendations until mid-2019?

1 We urge you, sir, to look carefully at some of the
2 Hackitt Review recommendations and consider those as
3 part of Phase 1. We understand that referring to all
4 may be difficult, but some can, we suggest, be managed.
5 Presenting her December 2017 interim report to the
6 housing select committee, Dame Judith was asked whether
7 Grenfell survivors had been able to engage with the
8 process. She replied that she had checked but could not
9 identify any engagement from Grenfell survivors, and the
10 committee sought reassurance that she would do so in the
11 future.
12 In your ruling in March this year, you said:
13 "I understand why those who Mr Stein [myself]
14 represents would like to have a voice in Dame Judith's
15 review."
16 You said you had no doubt that the inquiry would be
17 considering Dame Judith's report and that our clients
18 would be able to scrutinise her work and make
19 submissions on her conclusions at that stage.
20 Well, Dame Judith has already so stated to the
21 housing collect committee giving evidence to that
22 committee on 18 December of last year. She stated:
23 "We will share all the information that we generate
24 with the public inquiry. I would expect that
25 information to inform their work. I am more than happy



1 to give evidence to them and I anticipate having to do
2 so."
3 Well, let me say that we welcome the opportunity to
4 ask Dame Judith some questions.
5 Of course, we approached the Hackitt Review --
6 that's myself, Martin Howe, the senior partner of
7 Howe & Co, and my junior, Mark Henderson -- and we had
8 a meeting with Mr Patterson, the director of the
9 Independent Review of Building Regulations and Fire
10 Safety, the Hackitt Review. And meeting with him and
11 one of his colleagues, we were told by Mr Patterson that
12 they would be happy to meet with residents and seek
13 their views, and that they were seeking direct
14 experience of residents' engagement with landlords,
15 meetings with local authorities, but they were not
16 prepared to provide any access to the materials provided
17 by their working groups.
18 In fact, our clients have for the most part received
19 nothing from the review inviting them to participate or
20 explaining how in practice they could participate
21 effectively without support. The list of
22 persons/organisations who have engaged with that review
23 annexed to both the interim and final report does not
24 appear to include any Grenfell bereaved, survivors or
25 residents, whereas voices associated with industry



1 predominate.
2 The membership of the Hackitt Review working groups
3 listed at appendix G2 of the final report amply
4 illustrates the lack of effective resident
5 participation.
6 Dame Judith's position, as communicated by her
7 secretariat, that Grenfell survivors required no support
8 to participate on an equal footing with industry, also
9 sits uneasily with the recognition in her final report
10 that funding would be required to support residents to
11 engage effectively on safety issues with landlords.
12 It is obvious and important that all material
13 submitted to and produced by the review in their process
14 of considering its recommendations is disclosed to this
15 inquiry without delay and then onwards to our clients,
16 so that the core participants we represent can have
17 a fair opportunity to formulate the questions that they
18 would wish Dame Judith to answer about how and why she
19 reached her recommendations, and so that they can
20 understand the positions taken by industry voices in the
21 Hackitt Review working groups.
22 Let me make our position very clear. This is
23 an industry that cannot be trusted. The Hackitt Review
24 cannot make up its mind about the industry and what is
25 wrong. Perhaps the residents of the Grenfell Tower



1 could have helped Dame Judith come to a better
2 conclusion. After all, Dame Judith described the
3 attitude she found in the industry as being
4 indifference. The primary motivation is to do things as
5 quickly and cheaply as possible, rather than to deliver
6 quality homes which are safe for people to live in.
7 When concerns are raised, Dame Judith went on to
8 say, by others involved in the building work or by
9 residents, they are often ignored. Some of those
10 undertaking building work failed to prioritise safety,
11 using the ambiguity of regulations and guidance to game
12 the system.
13 Also, Dame Judith refers to the lack of clarity on
14 roles and responsibilities and inadequate regulatory
15 oversight and enforcement tools. This has helped to
16 create a cultural issue across the sector which can be
17 described as a race to the bottom, caused either through
18 ignorance, indifference or because the system does not
19 facilitate good practice.
20 However, she nevertheless recommended that the
21 industry should now take ownership of the approved
22 guidance rather than government. She stated,
23 Dame Judith, in her words:
24 "An outcomes-based approach to regulation and
25 a packet of guidance that is owned by industry can





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facilitate innovation and reflect changes in building practices, techniques and technology."

Dame Judith does not address the incongruity of handing ownership of the guidance and regulation to an industry which she describes as primarily motivated by a race to the bottom, where their motivation appears to be build cheaply, make profits and indifference to whether the people in their buildings will be safe, the very sort of conduct which turned the Grenfell Tower from a basically safe vertical village into a combustible deathtrap.

Within the Hackitt Review report, there is a professed commitment given to Dame Judith by cladding manufacturers and developers to mitigating the risk from cladding. This is far from new. In December 1999, the select committee on environment, transport and regional affairs reported on the potential risk of fire spread in buildings via external cladding systems following the cladding fire in Irvine, Ayrshire in June 1999, and referred then to the responsible attitude taken by the major cladding manufacturers towards minimising the risks of excessive fire spread has been impressed upon us throughout this inquiry.

That select committee said, in words that now appear sadly prophetic:



"Notwithstanding this, we do not believe that it should take a serious fire in which many people are killed before all reasonable steps are taken towards minimising the risk."

I move on now, sir, to deal with the question of combustible materials.

There was clear and obvious widespread shock when the Hackitt Review did not expressly recommend the ban on combustible materials. The shock came obviously from Grenfell survivors and their families, but also was echoed by the Royal Institute of British Architects, the RIBA, which is calling for a requirement that external wall construction for existing or new buildings with a storey of 18 metres or so above ground to be comprised of non-combustible materials only. The RIBA submit that this standard should be imposed forthwith by regulation.

On 17 May 2018, following the publication of the Hackitt Review, the Housing Secretary announced in the House of Commons that it would consult on imposing a barn on combustible materials. However, it has just emerged that, contrary to that indication, the Housing Secretary wrote to social housing providers on 25 May 2018 asking them to replace the cladding with materials that were either Euro class 1 or A2.

Although he referred to both as if they were



non-combustible materials, in reality and as recognised in ADB itself, only A1 is non-combustible. A2 is combustible but classed as limited combustibility.

No reason has been given for this advice to social housing providers, despite what was announced in Parliament or the clear position that has been put forward by such an august body as the RIBA.

However, Dame Judith, adding to frankly the mess surrounding her final report, made clear after her report that she in fact supported the ban on combustible cladding and upon which the Home Secretary would consult.

In evidence to the housing select committee on the day her report was published, Dame Judith stated:

"I absolutely agree with the line the RIBA is taking."

Sir, our clients want the imposition of basic minimum standards now, without loopholes, to secure the safety of people living in these tower blocks. They need rules, not guidance that the industry can take or leave, pick or mix.

Dame Judith told the housing select committee in May of this year in the past it has been shameful the way in which people living in these buildings have been ignored when they have raised issues. They have not been



listened to. Had Dame Judith or her secretariat been more open to enabling our clients to engage with her on the same footing as the construction industry, her report might have been more responsive to public concern rather than industry concern.

It is now important that the inquiry take responsibility for these matters, as was intended by the Prime Minister in seeking an interim report on urgent safety matters. The fair procedure and independent scrutiny of the inquiry is essential in order to guard against construction industry attempts to chip away at firm safety proposals in consultations in which residents cannot engage on an equal footing.

In reality, the vast majority of tower blocks that have cladding are either waiting for the combustible cladding to be removed or have that work started but not finished.

Residents need assurance that the replacement cladding for their blocks will not be combustible. They do not wish to live in a tower block which has cladding which is described as being of limited combustibility.

In the meantime, "stay put" is being abandoned as a general policy for high-rise blocks with combustible cladding. Many residents are dependent upon an emergency simultaneous evacuation policy, since

compartmentation has been frustrated by combustible cladding. They go to sleep at night in the knowledge that they may be awoken by a waking watch trying to evaluate them down a single staircase not designed for the evacuation of numbers down through a block.

We make it clear that for an unsafe tower block simultaneous evacuation is the lesser of two evils, the other being stay put. However, consideration of the current guidance demonstrates how problematic it is in a social housing single-staircase block, and ever more so for people of age, with ill-health or people with children and those of limited mobility.

The London Fire Brigade's opening statement makes clear the difficulties in the current emergency interim simultaneous evacuation policy. There is a pressing need, they say, to address the question whether it is reasonably practical in the public interest to expect fire services to develop operational policy on the presumption that buildings such as Grenfell Tower are inherently unsafe because they have not been maintained in accordance with the principles on which they are originally designed and built.

After this disaster, our clients want to ensure that other communities do not have to live in fear in their homes. Residents need to know that what their high-rise



blocks are replaced with are safe.

Thousands of people are in the hundreds of blocks which are unsafe and are looking to the recommendations of this inquiry to make their homes safe again.

Our clients therefore urge you to fulfil the purpose of the interim report by recommending that cladding should not be replaced with combustible A2 or below cladding in high-rise blocks.

As to future regulation, we already appreciate how this inquiry is the only way that Grenfell survivors, on behalf of the thousands of other people living in the hundreds on other high-rise communities, can make their case on anything approaching equal footing with industry.

We submit that regulatory regime change is required for the future so that the industry cannot start to undermine the protections you recommend in the years following their report.

People should not have to put their lives in the hands of contractors like Rydon and their subcontractors.

In the meantime, we ask you to recommend in your interim report that the industry-heavy membership of the Building Regulations Advisory Committee, BRAC, a committee which is statutorily bound to be consulted



as regards changes to the Building Act 1984 is drastically changed to include lay and preferably tower block resident membership.

The outcome-based regulatory criteria preferred by Dame Judith in her report using descriptions of terms such as "adequacy" and "reasonably practical" hand power to the construction industry and building owners to choose their own routes to compliance and to game the system, backed by tests and reports they fund themselves and therefore own.

Regulation is about risk-management and is capable of both proscribing the use of certain materials and methods of construction, and of describing the characteristics of what is to be avoided.

The onus on self-regulation by industry and industry-dominated bodies and for profit organisations that depend on industry funding must end. The cosy industry cabal must be replaced by a modern system of regulation with real independence, lay membership and expert capability and which regulates in the public interest.

It is, sir, difficult to conceive of any other system of regulation of an activity so eminently and utterly dangerous as building and maintaining high-rise tower blocks where it will be left to the judgment of



industry groups and private consultants and professionals paid by the industry to determine such fundamental questions as what is adequate.

In the hands of the regulatory position in the future there lies the protection from the spread of fire for a diverse community of men, women, children, the elderly and the disabled. The facts as we are learning them through this inquiry so far revealed demonstrate the industry cannot be left to have those people in their care.

Sir, those are our submissions.

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

Now, Mr Weatherby, I think you are going to address us next, but since it's 12.40, you might prefer to start at 2 o'clock?

MR WEATHERBY: I'm in your hands.

SIR MARTIN MOORE-BICK: Shall we give ourselves a slightly longer break and we'll start at 2 o'clock.

Thank you very much.

(12.40 pm)

(The short adjournment)

(2.00 pm)

Opening statement on behalf of BSRs (G3) by MR WEATHERBY

SIR MARTIN MOORE-BICK: Yes, Mr Weatherby.

MR WEATHERBY: Thank you, sir.

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1 As you know, I'm instructed by Jhangir Mahmood of
2 Bishop, Lloyd & Jackson and Arfan Bhatti of Oliver
3 Fisher, leading Fiona Murphy and working with the G3
4 group, including the Howe & Co team.
5 I make no apology for starting where others have.
6 Last week and the week before we heard powerful words of
7 those who lost loved ones. Nothing anyone can say will
8 speak with more eloquence than those who have lost so
9 much, and the personal portraits have placed the inquiry
10 in its true context.
11 Those of us who were here for the seven days of
12 personal portraits learned about how communities are
13 formed, nurtured and destroyed. Those of us not
14 directly affected should have come away resolved to
15 build better communities wherever we are, to form them,
16 to nurture them, but most importantly to prevent them
17 from being destroyed.
18 Apart from the poignant and moving tributes to the
19 dead, you will not have overlooked the close and
20 cohesive community that was Grenfell. It was a decent,
21 tolerant place, populated by decent, tolerant people who
22 deserved to be treated better.
23 As well as the extraordinary memorials to those who
24 were loved and lost, you were also called upon to
25 deliver justice. The demands of justice are as clear as

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1 they are challenging: truth, accountability, prevention.
2 Truth requires candour. Accountability requires
3 conclusions about acts and omissions which caused or
4 contributed to the disaster. Prevention requires
5 responsibility, named, defined, accounted for.
6 In a time of high emotion, the real challenge that
7 brings meaning to such intolerable suffering is justice
8 and accountability on the one hand, real change to
9 prevent future such disasters on the other. It requires
10 clear thinking, it requires transparency and it requires
11 that those affected by the tragedy are involved to the
12 fullest extent.
13 The most effective public inquiries of recent times
14 and other inquisitorial investigations, such as inquests
15 into violent and unnatural deaths, have been
16 distinguished by full disclosure and a culture of fully
17 involving the bereaved. Effective participation.
18 The mistakes and in some cases miscarriages of
19 justice of the past are starkly illustrated by two
20 things also: failures in disclosure and the exclusion of
21 those most affected by the disaster, whether by design
22 or by paternalism, a mistaken view that experts,
23 lawyers, judges know best. We have made those points
24 consistently through the proceedings so far.
25 In due course I'll return to a related

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1 issue: candour and frankness by those bearing
2 responsibility for public safety with respect to
3 Grenfell Tower.
4 To the public authorities, we will say: your mission
5 is to work for the public, and a part of that mission is
6 to tell them the truth, the whole truth.
7 To the manufacturers, suppliers, professionals: you
8 were employed on behalf of the public, on a public
9 housing project, and therefore you have the same duty to
10 the public to come clean, to tell the truth.
11 Mr Millett indicated yesterday that the inquiry was
12 moving to compel the public authorities and corporate
13 CPs to produce witness statements addressing key issues
14 by the end of September and to produce further
15 statements for Phase 2 in 2019. We noted the
16 acknowledgement that this was necessary because of the
17 reluctance of those CPs to assist the inquiry so far
18 and, in particular, through their written opening
19 statements.
20 The inquiry has allowed a further generous period
21 for this to be done, no doubt because the inquiry's
22 processes must be scrupulously fair.
23 However, you all know the role of your authority or
24 your company, and you've had a year to consider your
25 position. The time for candour is now. The opportunity

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1 is your opening statements.
2 You heard last week during the personal portraits --
3 or you should have heard, if you were there -- the
4 repeated calls for truth and justice from those who lost
5 loved ones. Now that you know that you will be required
6 to answer key questions in due course, we say that you
7 should do so now through your opening statements.
8 You should tell us all what your role was, what you
9 did and what you should have done. What you did that
10 contributed to the disaster; what you failed to do that
11 would have adverted the disaster. And if you did
12 nothing wrong, help this inquisitorial process, help the
13 inquiry and help the chair by telling us all, loud and
14 clear, what you know, where the failures were.
15 This is not a time for technicality. This is not
16 a time to pretend that you don't want to usurp the
17 chair's role or to suggest that you can't be frank
18 because there is outstanding disclosure. This is the
19 time to assist the chair by identifying what happened
20 and what should have happened, a time for telling the
21 truth and not for smoke and mirrors, not for
22 prevarication, delay, defensiveness, silence.
23 The inquiry is entitled to your help in focusing its
24 inquiries going forward and, moreover, the inquiry needs
25 information and explanations now through which it can



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make interim safety recommendations that may be required. Those who lost loved ones and those who lost their homes and communities want to understand what happened now. They've already waited a year; a year of uncertainty and pain.

I'll return to this theme in due course.

Sir, a lot has been said regarding the refurbishment itself and the cladding system in particular, and I'm not going to add much to that. I simply want to reiterate two points before moving on.

The first is that, on behalf of those who I represent, we certainly support the call for an interim recommendation that nothing less than A1 class European standards should be used on buildings over 18 metres, at least until the final report of this inquiry.

With remedial work about to get underway, it's vital that public safety is not left at risk and public money wasted on combustible or limited combustible materials. An interim recommendation from this inquiry is the least that those living in buildings with combustible cladding, sometimes without sprinklers and without second staircases, typically social housing tenants, deserve, and it's the least that those who have lost because of the Grenfell disaster deserve too.



There does appear to be widespread political support for baseline prescriptive regulatory requirements for non-combustible cladding, and as you've heard already, support from informed sources, the RIBA, supporting baseline prescriptive regulatory requirements of A1 for new and existing buildings over 18 metres. We interpret that as encompassing both the insulation and the rainscreen.

So we therefore do call for a moratorium on the use of any insulation or rainscreen products that are below A1 standard, at least until your final report.

In addition, we take this opportunity to invite the other core participants, public authorities and companies both, to express their support for such a moratorium or, indeed, their opposition to it, again within their statements.

Secondly, in supporting such a position, we emphasise that the use of flammable materials was but one part of the failures and the banning of these materials will not be a panacea for the raft of other failures in regulation, manufacture, design, construction and maintenance. A contribution at each stage should not, with respect, be overlooked.

Emergency response and stay put.

We break this down into three key parts:



Why was there no prior contingency plan, no plan B within the stay-put strategy?

Why was stay put maintained for so long?

Why was no plan put in place once it was abandoned?

The issue of stay put and the absence of contingencies before and on 14 June is of vital, urgent importance, and you, sir, have indicated that stay put should be under scrutiny during Phase 1.

In September 2017, the London Fire Brigade issued guidance note 90, an interim policy with respect to high-rise and evacuation, recognising that stay put was compromised by modern cladding systems involving ACM rainscreen because compartmentation was likely to be breached in a fire, and that for the time being at least there should be a simultaneous evacuation policy in its place. This guidance was followed on 1 May by similar guidance from the National Fire Chiefs Council.

We call on this inquiry, sir, to urgently address this pressing need through further consideration and interim recommendations based on the evidence which emerges during Phase 1 so that the limitations of stay put is apparent to all, not just those in the Fire Brigade and the Fire Chiefs Council, and to give anxious consideration to the question whether the current interim guidance goes far enough given that it relates



primarily to systems involving ACM rather than other flammable products. We note that any such interim consideration would be subject to further review in Phase 2, following expert evidence.

In looking at the emergency response, it is first vital to draw a distinction between the decisions of the firefighters themselves and the decisions of the commanders, between the bravery of the front-line firefighters and the decisions that are made with regard to policy and training, and we must remember that, so far as the firefighters are concerned, theirs is an emergency response. The fire service did not start the fire. They were not responsible for the disastrous refurbishment. Nevertheless, we must not let the obvious heroism of many of the individual firefighters blind us to what appears to be equally obvious errors of command and policy, the failures of the brigade itself.

It's important I make that distinction loud and clear. It's important also that I make it at this stage, because we're all aware that there are many people in high-rise residences in London and across the country -- indeed, across the world -- who are anxiously awaiting change to better ensure their safety. It is important also because changed policy also affects the safety of firefighters themselves.





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1 I started with the post-Grenfell interim guidance.
2 The brigade, the LFB, have accepted in their September
3 guidance that stay put is not a safe policy in tower
4 blocks with cladding systems comprised of flammable
5 materials and have brought in interim immediate
6 evacuation measures.
7 The LFB have provided an organisational overview,
8 which is LFB 1905, a detailed time-line of the first
9 hour that Mr Millett referred to, LFB 1914, and indeed
10 a written opening. Although these documents are helpful
11 to some extent, what is completely lacking is any hint
12 that the LFB accept that their operation on the night
13 went wrong or that the events expose significant
14 strategic, tactical and policy failures. Why?
15 We fully get it that Phase 2 will deal with
16 accountability issues, but in working out what happened,
17 the inquiry will plainly be assisted by the LFB sharing
18 what analysis it has brought to bear on these questions
19 in the year since the fire.
20 The September policy change was, of course,
21 a reaction to this fire, and the stay-put policy was the
22 policy of the building and its owners, but it was the
23 LFB who failed to have its own contingency plan and it
24 was the LFB who failed to formally abandon stay put for
25 two hours.



1 These LFB documents fail to address these obvious
2 and central points, but focus only on the difficulties
3 they faced with evacuation.
4 No doubt hindsight is a wonderful thing, and no
5 doubt it will be claimed that, because stay put has been
6 largely successful for the 70-odd years that it's been
7 standard policy, this disaster was something that could
8 not have been foreseen. But does Grenfell really
9 involve hindsight? Just because the firefighters
10 involved have not seen the like of it before and,
11 indeed, this was by far the worst such fire of modern
12 times does not mean that an out-of-control tower block
13 cladding fire should not have been contemplated.
14 It's therefore pertinent to ask: what did LFB know
15 long before June 2017?
16 First and foremost, LFB knew that while major fires
17 were happily rare in tall buildings, they were hardly
18 unknown. We've attached a schedule of fires to our
19 written submissions dating back many years and across
20 continents. Some have involved deaths, multiple deaths
21 in certain notable cases such as Lakanal, some in the
22 LFB area and some in recent times.
23 No doubt others may make an array of
24 distinctions: some of these fires were in fact not
25 cladding fires; some did not involve external fire



1 re-entering the building; some did not involve
2 fatalities; some involved different building systems and
3 different cladding materials; some had sprinkler systems
4 and no doubt some had alarms and/or second staircases.
5 However, some of these previous fires were cladding
6 fires; some did involve fire re-entering the building or
7 spreading through it; some did involve fatalities; and
8 some did involve similar materials. Whatever the
9 distinctions, these previous fires provided stark
10 warnings of huge fires out of control on buildings
11 containing hundreds of people; stark warnings that
12 building methods using flammable external envelopes
13 sometimes catch fire and with spectacular and
14 uncontrollable effect.
15 Whatever the arguments over regulations so far as
16 fire safety is concerned, there has long since been
17 a distinction between low-rise and high-rise because of
18 the obvious difficulty or, indeed, near impossibility of
19 fighting a fire externally if it is at height.
20 Apart from the generality of the warnings from all
21 of these fires from Dubai and Sharjah to Glasgow,
22 Liverpool, Melbourne, Shanghai, there were far more
23 specific warnings from nearer home. You, sir, have
24 already been referred to Lakanal.
25 Fatalities at Lakanal led to recommendations from



1 the coroner in March 2013, which was a flashing blue
2 light both for the government and for the London Fire
3 Brigade -- or it should have been. The recommendations
4 included that the DCLG should provide national guidance
5 on "stay put" and its interaction with "get out and stay
6 out"; raise awareness that insecure compartmentation
7 could spread fire and smoke and jeopardise lives;
8 encouraged retrofitting of sprinklers; and it called for
9 a review of ADB and B4 of the Building Regulations, with
10 particular regard to spread of fire over cladding
11 envelopes and to whether refurbishments might reduce
12 fire safety.
13 The LFB were on notice that this sort of fire
14 happens and were on notice that they would have to deal
15 with it.
16 Aside from the recent fires, the G4 group have cited
17 in their written submissions in particular the Roubaix
18 tower fire in 2013 in France, the Lacrosse fire in
19 Melbourne in 2014. The operational key in both of these
20 cases and the obvious case study lesson was an almost
21 immediate recognition of the need for total evacuation
22 given the rapidity of external spread of the fire and
23 obvious attendant risks for occupants.
24 You've already been referred, sir, to the 1999 House
25 of Commons regional affairs committee report with

1 respect to external cladding systems, which followed the
2 fatality fire in Irvine of the same year. There are
3 other parts of it I just want to point up.
4 The committee wrote to all of the directors of
5 housing in metropolitan borough councils asking for an
6 assurance that:
7 "... any cladding systems that may be used on any
8 buildings (particularly multi-storey tower blocks) in
9 your area are not in any way susceptible to the risk of
10 serious fire spread on the face of or immediately behind
11 the cladding."
12 1999.
13 In producing the report, the committee heard
14 evidence from the FBU and from a Dr Moore, the chair of
15 the technical committee of the Fire Safety Development
16 Group. Asked about the known risks with the
17 overcladding system, Glyn Evans of the FBU said this:
18 "The main risk is the vertical envelopment of
19 a building in fire."
20 Going on to explain that since the 1666 Great Fire
21 of London, fire had been seen as a horizontal problem
22 and it remained the case that firefighters could not get
23 to external fires at height.
24 Dr Moore continued with the problem of composite
25 sandwich panels comprising foam insulation between metal



1 sheets. He said that class 0 rating could be achieved
2 because of the metal sheet, but that fire could still
3 destroy the plastic foam and it would then contribute to
4 the fire. 1999.
5 Fast forward to April 2017, history repeated.
6 Apparently prompted by the high-rise fire which spread
7 over external cladding at another block not far from
8 Grenfell, the one you've been referred to previously,
9 Shepherds Court, the LFB itself issued a letter to the
10 director of housing at RBKC. Indeed, they sent
11 a similar letter to all 33 of the London boroughs.
12 Now, this letter may have a variety of other
13 consequences for RBKC, possibly for the fire risk
14 assessor, CS Stokes, assuming that Mr Stokes ever saw
15 the letter, during Phase 2, but the issue here for
16 Phase 1 is not so much the recipient but the sender.
17 What this letter really speaks to here is that the
18 LFB were well aware of fire spread across cladding
19 systems on high-rise in its own area, that it was
20 a health and safety issue, that it impacted fire safety
21 and fire risk assessments, all matters referred to
22 expressly in the letter. In short, LFB are here in this
23 letter telling the councils that these cladding systems
24 raise clear fire spread issues. If they raise clear
25 fire spread issues then they raise clear



1 compartmentation issues.
2 In particular, there was mention of windows and
3 filler panels and a clear reference to defamation and
4 the delamination of panels -- all very familiar,
5 depressingly.
6 The alarm bells were really quite simple: there was
7 a risk of further high-risk fires which LFB knew they
8 could not control. There were risks that such fires
9 would breach compartmentation and a risk that stay put
10 would become untenable. In particular, it was
11 manifestly not enough without robust contingencies.
12 Let's move on, then, if I may, to the issue of
13 policy and robust contingencies.
14 Central to policy is the generic risk assessment
15 3.2, LFB 1255.
16 In that document it's clearly stated that
17 information-gathering and planning are key to safety.
18 This includes the visits that you've heard and know
19 about under section 7(2)(d) of the 2004 Act. It makes
20 the point that such gathered information is useless
21 unless it's communicated to those on the ground at
22 an incident, specifically noting the importance to
23 command decisions.
24 It remains to be seen what LFB had understood about
25 Grenfell Tower, and it remains to be seen exactly what



1 was recorded by them on the operational risk data
2 system, or indeed what was supplied to the firefighters
3 deployed on the night by their mobile data terminals.
4 But the information LFB had, or should have had, was
5 that there was one stairwell, no alarm, no automatic
6 fire suppression, flammable overcladding and, more
7 generally, they knew about the potential for
8 compartmentation breach after the fires to which I've
9 already referred.
10 At page 16 of the policy document it's noted that
11 one of the pieces of information that the LFB would be
12 expected to have is the evacuation protocol, whether
13 stay put or phased or full evacuation or a combination.
14 Most crucially, perhaps, for present purposes is the
15 next page, where the document refers to the necessity
16 for contingency plans in the event that compartmentation
17 breaks down. Expressly noted is "an operational
18 evacuation plan being required in the event the stay-put
19 policy became untenable".
20 Incidentally, further specific required
21 contingencies are noted with respect to bridgeheads
22 becoming compromised, alternatives to radio
23 communications if there are blind spots and the failure
24 of fixed installations -- all eventualities that
25 materialised on 14 June. All should have had

1 predetermined contingencies.
2 The policy document goes on to expressly mention
3 arrangements for those unable to leave the building
4 because of disability, mobility problems, illness or the
5 effects of fire. It refers to the responsible person
6 having an evacuation plan, here the chief executive of
7 RBKC. It states that the Incident Commander should
8 follow the evacuation plan where known unless the fire
9 situation dictates otherwise.
10 Absent from the current LFB responses to Grenfell
11 are a consideration of these required
12 contingencies: what were they? Where can we find them?
13 Did they exist? Was the absence of contingency planning
14 a factor in the failure to abandon stay put long after
15 it's manifestly untenable? We ask LFB to help with all
16 of these questions in their opening.
17 The suggestion that the Incident Commander should
18 follow the fire risk assessment evacuation policy where
19 known is interesting. The 2016 FRA, LFB 66, contains
20 the legend:
21 "You do not have to give a copy of your risk
22 assessment to anybody [in bold type], not even the fire
23 authority. If you do give them a copy, this could be
24 used against you at a future date."
25 The very idea that this sort of statement is made in



1 a safety document is truly shocking. The fire risk
2 assessor is essentially advising that the evacuation
3 plan and other matters can be kept from the fire
4 service.
5 We await evidence as to whether the assessment was
6 in fact shared with the London Fire Brigade with respect
7 to the tower.
8 I also note that in the fire risk assessment,
9 Mr Stokes refers to the new cladding as fire rated and
10 approved by building control. Fire rated was
11 an inaccurate term to describe the overcladding and
12 would be inaccurate even against higher standards.
13 The evacuation strategy asserts there is a stay put
14 evacuation strategy. Accepting that stay put is
15 referred to as an evacuation plan or protocol, that may
16 be thought to be something of a contradiction, stay put
17 being in fact an alternative to an immediate or phased
18 or even zonal evacuation plan. Stay put may have worked
19 well in respect of a building that was capable of
20 maintaining compartmentation, but there were clear
21 occasions where tall building fires have got seriously
22 out of control, as we've seen, many involving cladding,
23 and there was equally clear policy that required
24 contingency in the event that fire spread went beyond
25 compartmentation of the origin and stay put becoming



1 untenable.
2 Mr Stokes seemed to nod to this in the assessment
3 with the evacuation plan when he continued:
4 "The fire service or TMO employees will arrange for
5 a general evacuation of the whole building at any time
6 if this is appropriate to do so."
7 One wonders whether the fire service or TMO
8 employees knew anything of this or how it would be done
9 or in what circumstances. We hope they will explain in
10 their openings.
11 The reality was that the refurbishment had seriously
12 compromised the condition precedent for stay put
13 compartmentation and that meant that stay put was no
14 longer an appropriate evacuation plan. The lack of any
15 contingency compounded that fundamental problem.
16 How had that come to pass, given the warnings that
17 the LFB had? How had that come to pass given the
18 letters they'd sent in April and May? Was their conduct
19 consistent with the responsibility to the residents of
20 the Grenfell Estate, to their own firefighters?
21 I'll return to when stay put became untenable in
22 a moment, but before I do, let me deal with the
23 vulnerable -- the young, the old, the infirm, the
24 disabled, the mobility impaired.
25 Mr Stokes referred to disabled residents in the FRA.



1 According to him, the TMO had introduced a comprehensive
2 programme to gather information on disabled residents
3 with mobility issues and that information was to be held
4 centrally on what he described as a "TP tracker system"
5 for use in responding to an emergency. He goes on to
6 refer to personal emergency evacuation plans, PEEPs. He
7 refers to the potential for the TMO to provide early
8 warning devices to vulnerable people, and he notes that
9 the lifts were firefighter lifts and so could be used in
10 evacuating the disabled.
11 My client, Mohammed Hakim, lost his whole family in
12 the fire. They were on the 17th floor. He's already
13 told the inquiry during the personal portrait phase that
14 he and his family had complained that their elderly
15 parents were given a flat on the 17th floor, his dad
16 immobile because of two strokes and a heart attack, his
17 mum with mobility issues too. If they had not taken the
18 flat, they would have lost their place on the list. His
19 was not the only such account that you've heard, sir.
20 Mohammed Hakim would very much like to know about
21 this TMO central information database regarding disabled
22 or infirm residents. He would like to know if his dad
23 or mum were on it, if it was shared with the fire
24 service and he'd like to know about their PEEPs or if
25 individual plans were ever developed. He was unaware of

1 any of this.
2 Of course, the inquiry knows already that the
3 firefighting lifts did not work as such. No one came
4 for Mohammed Hakim's family. There appears to have been
5 no plan, no contingency, no thought for the vulnerable.
6 Having dealt with the national policy, can I very
7 briefly turn to local policy, policy number 633 of the
8 LFB.
9 The policy notes that the Incident Commander should
10 normally follow the evacuation plan on the risk
11 assessment unless contrarily indicated. But equally, it
12 makes clear that evacuation may become necessary where
13 the plan is stay put. It expressly notes that the
14 incident commander and the bridgehead need to update
15 each other about what's happening in real time, and
16 there's express reference to the problem of fire spread.
17 In an appendix, the policy notes that the
18 familiarisation visit process should include
19 consideration of fire spread, breach of compartmentation
20 and evacuation, as well as considering fixed provisions
21 such as the firefighter lifts, a 2008 policy,
22 incidentally.
23 National and local policies plainly required
24 contingency plans for when stay put became untenable
25 because of fire spread and breach of compartmentation.



1 Well-known out-of-control facade and cladding fires in
2 high buildings across the world and in London itself
3 showed the clear need for such contingency planning.
4 Post-Lakanal, the coroner had made express reference to
5 stay put in the context of where compartmentation was
6 compromised and people died. The 2017 April letter
7 evidences the LFB's knowledge and concern.
8 Article 2 of the European Convention on Human Rights
9 required that the LFB had a practical and effective
10 policy framework for known risks. The failure to have
11 any contingency plan was a breach of this fundamental
12 duty.
13 Why did it take so long to abandon stay put?
14 Question number 2.
15 You, sir, have already heard a number of submissions
16 regarding timing, so I'll work quickly.
17 The first report of the fire was at 00.54.
18 Professor Torero in his report indicates that stay put
19 was the obvious and correct plan initially. However,
20 objectively, he suggests in his conclusions that the
21 basis for stay put was already beginning to be
22 undermined by 1.05, when flat 16 was compromised and the
23 fire was reaching the cladding. From around that point,
24 abandoning stay put was, in his words, "an option to
25 consider".



1 Taking up events from the operational review of the
2 LFB that I've referred to already -- and we appreciate
3 that this will have to come out through evidence --
4 using this for present purposes, the first
5 Incident Commander saw flames emerging from flat 16 at
6 a very early point. By 1.08 minutes, firefighter
7 O'Beirne indicates that the occupants of flat 26 on
8 level 5 were reporting that their flat was on fire.
9 1.08. An unequivocal compartmentation breach.
10 1.12, flames licking up the side of the building,
11 the Incident Commander noted that he saw the cladding
12 was burning like magnesium, sparking and spitting,
13 "making me feel uncomfortable".
14 By 1.15, various videos have shown that the fire was
15 well-established on the outside of the building.
16 Compartmentation was compromised.
17 1.15, Mr O'Beirne radioed the Incident Commander to
18 tell him fire had spread to level 5.
19 1.21, firefighters were tasked to put that fire out
20 on the fifth floor.
21 1.22, Mr O'Beirne again radioed the
22 Incident Commander, this time to tell him the fire had
23 spread to level 7.
24 During this period there were 999 calls too alerting
25 the brigade to fire or smoke higher up the building.



1 The compilation that we watched yesterday which was
2 so powerful and which, sir, you commented on being so
3 shocking, what may not have been picked up by everybody
4 yesterday was the full extent of the audio.
5 At a time between 1.16 and 1.20, we can clearly hear
6 a member of the public shouting up at the tower, "Get
7 out of the tower".
8 At 1.22, the person filming is saying, "The fire's
9 getting bigger and bigger. People are going to die.
10 I am scared."
11 Professor Torero refers to a significant number of
12 999 calls between 1.20 and 1.30 indicating that smoke
13 and flames were within the tower.
14 By 1.24, the fire travelled almost to the top of the
15 building, and again on the video we can hear people
16 shouting, "Get out, get out".
17 Of course, these people shouting were untrained
18 members of the public, but it was patently clear by 1.15
19 that the fire was out of control, spreading at
20 a frightening speed and had gone well beyond the
21 compartment of origin.
22 It's clear from the policies we've referred to and
23 expressly clear from the inquiry experts that stay put
24 is dependent upon containing the fire within
25 a compartment. An alternative must be pursued once that

1 fails.
2 Dr Lane indicates that stay put was failing by 1.15
3 and was untenable before 1.26.
4 Of course, there have been fires in the past that
5 have burnt themselves out or have not ingressed back
6 into the building, but there are other fires, of course,
7 where this has not been so and there have been multiple
8 fatalities.
9 The questions our clients want to hear answers to
10 start with why there was apparently no consideration of
11 abandoning stay put at this point and evacuating the
12 block. Why not?
13 I started with the visual appearance of the fire as
14 it rapidly got out of hand because that's an obvious
15 starting point because that was the view of the first
16 Incident Commander, who gave such a graphic description
17 of the magnesium-like fire.
18 Did he or those who came after him do a dynamic risk
19 assessment? If a dynamic risk assessment was
20 undertaken, why did it not lead to the prompt
21 realisation that stay put had become untenable? Why did
22 the firefighting effort not shift to assisted urgent and
23 total evacuation? Why did subsequent Incident
24 Commanders who took over not abandon stay put until much
25 later when it was too late?



1 We know from an early stage residents were coming
2 down from flats above flat 16, reporting to the
3 bridgehead that their flats were on fire. We know that
4 the bridgehead sent officers to investigate -- indeed,
5 to try to put one of those fires out.
6 The precise evidence will of course have to emerge
7 in Phase 1, but let's just pick it up from some of the
8 initial findings from Dr Lane. Dr Lane says that by
9 1.18 there was smoke in the lobbies of level 5, level 6,
10 level 15 and level 16. Compartmentation obviously gone.
11 The key factors that ought to have driven an early
12 decision to abandon stay put and evacuate include the
13 fact that there was no means to fight a raging fire at
14 height when it was out of control. Secondly, the
15 information available to firefighters, certainly by
16 1.20, that there was smoke and fire on multiple floors
17 in the block, and information about the same time that
18 999 calls were saying that compartmentation had been
19 breached in multiple places.
20 We do not seek to say at what time stay put should
21 have been abandoned because we've not heard the
22 evidence, but it's clear from what we know now that it
23 should have been under urgent serious consideration
24 almost from the outset.
25 Each of the Incident Commanders ought to have been



1 in a position to factor these three key factors into
2 a dynamic risk assessment and realise that there had to
3 be a rapid evacuation. Sticking to the default position
4 could not improve the situation and time was of the
5 essence.
6 If evacuation had been ordered -- question 3 -- at
7 an early stage, would it have made a difference?
8 According to the analysis of Dr Lane, the stairways
9 were clear of smoke until 1.38. Although smoke began to
10 enter the stairway from about 1.40, residents still
11 managed to escape from floors up to and including
12 level 23 in the period up to 02.58. Indeed, residents
13 were still escaping from levels between 12 and 22 up
14 until 3.55. Only after that point does it appears that
15 no one managed to escape above level 11.
16 The factual analysis so far known tends to suggest,
17 we say, that if evacuation had been ordered at an early
18 stage, rescue of many more, even all of the residents,
19 was possible.
20 I go on. The LFB 3 time-line points to another
21 series of key decision points: 1.26, when the Met Police
22 declared a major incident; 2.04, when the LFB escalated
23 to 40 pumps; 2.06, when the LFB declared a major
24 incident; 2.17, when the LFB called for a dangerous
25 structure engineer.



1 If there were potential issues with structural
2 integrity, surely stay put should have been well and
3 truly abandoned.
4 All of these points, we say, were points at which
5 consideration should have been given if stay put hadn't
6 been abandoned by that point.
7 Mr Friedman opened mentioning Steve Power, who died
8 in the fire. Sir, you heard from his family and, in
9 particular, from Rebecca Ross last week, from whom you
10 heard a poignant pen portrait. She had argued with her
11 father as to whether they should stick with the policy
12 of stay put or escape from their 15th floor flat. At
13 about 2.50 she got out -- just -- and her father died.
14 She would like to know why stay put was not abandoned
15 much earlier.
16 Mr Hamdan. His daughter, son-in-law and grandchild
17 died on the stairwell between the 19th and 20th floor,
18 probably at about 2.15. A second grandchild died later
19 in hospital. A third mercifully survived, due in no
20 small part to the heroism of firefighters. Earlier the
21 family had been told to stay put. He too would like to
22 know why stay put had not been abandoned much earlier,
23 when his family might have escaped and lived.
24 The final point on stay put is that even when it was
25 abandoned, it appears that there was no alternative

1 plan. On the available evidence, it appears that
2 control simply told people to get out by their own means
3 if they could. It may be a matter of common sense that,
4 having abandoned the policy too late, there was nothing
5 that could be done; however, that was a consideration
6 that should have loomed large for the LFB long before
7 14 June, particularly in relation to contingency plans.
8 Finally, with respect to the emergency response,
9 you, sir, have indicated that training will be a matter
10 dealt with in Phase 1. We have as yet had no disclosure
11 of training material. The headline questions are:
12 What training did those involved in the
13 familiarisation visits get, the firefighters, the
14 Incident Commanders, the other commanders and the
15 control room staff have on high-rise firefighting?
16 Did it include contingencies and decision-making
17 when there was a breach of compartmentation?
18 Did it include evacuation from high-rise blocks?
19 We understand there was a post-Lakanal training
20 package; what did that contain and who was it given to?
21 Let me spend the last few minutes -- and I'm afraid
22 I'm going to slightly overrun -- dealing with the issue
23 of candour.
24 We persistently argued for candour from all core
25 participants, but so far the inquiry has only been



1 provided with limited position statements from most CPs
2 and, of course, limited opening statements from some of
3 them.
4 This is a public search for the truth. It's not
5 a game of cat and mouse, nor, as I said before, a matter
6 of smoke and mirrors. The bereaved and the survivors
7 have spent a year in pain waiting to know what had
8 happened. We call on all of the CPs who have yet to do
9 so to set out most fully their positions in their
10 opening statements.
11 Let me start, if I may, with the MHCLG, the
12 department of state with responsibility for this area.
13 As the DCLG, this department failed over many years
14 to rewrite the guidance under the Building Regulations
15 long after everyone knew that it was defective. There
16 has been widespread reference to headline comments of
17 the interim report of Dame Judith Hackitt that the
18 regulations were "not fit for purpose". But the
19 Building Regulations were criticised long ago, including
20 following the Lakanal disaster. Why were they not
21 drafted by 2017?
22 We remind the current minister from open source
23 material of the number of former officials and junior
24 ministers who prevaricated and thought that such an
25 exercise was not a priority. Between 2010 and the time



1 of the fire, the All-Party Parliamentary Fire Safety and
2 Rescue Group sent a series of letters to the department.
3 Ministers, senior officials, including then minister
4 Eric Pickles, Stephen Williams MP, James Wharton MP,
5 Gavin Barwell MP, all batted away attempts to persuade
6 them of the urgency of the situation.
7 By September 2016, then Housing Minister
8 Gavin Barwell confirmed in Parliament that the
9 department had not made formal plans to review the
10 regulations but intended to do so "following the Lakanal
11 fire". By that point, Lakanal had occurred several
12 years previously. The coroner's report was three years
13 old. How long did the department need?
14 In its position statement, the MHCLG has set out the
15 framework of the regulations as they understand them.
16 Elsewhere, the previous ministers made clear that the
17 subsequent testing shows -- correctly, in our view --
18 that the cladding system on the tower did not comply
19 with the existing regulations. But the MHCLG remains
20 silent on its own failings in providing a clear
21 regulatory framework to deal with fire safety. It was
22 their obligation to do so and we call on them to rectify
23 that lack of explanation in their opening. Tell us why
24 you failed to rectify this known problem, even after the
25 coroner's comments about ADB after Lakanal.



1 The bereaved and survivors need to have the
2 acknowledgement and the candour. Tell them why you
3 failed to regulate more generally for a robust testing
4 regime, regulations and testing that should have stopped
5 the Grenfell Tower disaster happening. The failure to
6 have a practical and effective regulatory framework to
7 ensure fire safety is a further breach of article 2.
8 Staying for a moment with the other public
9 authorities, RBKC and the TMO, what was their role in
10 allowing such flammable materials to be used in the
11 cladding system, and was their decision to change the
12 original design intent to more flammable materials based
13 upon cost-cutting, ignoring the obvious and increased
14 fire risks?
15 Can you help the bereaved and survivors by
16 explaining the much publicised communications between
17 the TMO and your agents, Artelia, in 2014 regarding
18 cutting the costs of the cladding system?
19 Did you seek expert fire safety opinion before
20 making those changes?
21 Are RBKC and the TMO able to explain why the
22 firefighters were not able to command their lifts? Why
23 the fire doors were of a substandard fire rating?
24 Where was the database of vulnerable persons to
25 which I've referred that was in the fire risk

1 assessment? Was it available to LFB? Indeed, was the
2 fire risk assessment available to the LFB?
3 Was there an evacuation plan involving TMO staff as
4 referred to in the FRA?
5 How did it happen that the building control signed
6 this building off as safe after the refurbishment via
7 a completion certificate in July 2016 knowing what we
8 now know, notwithstanding that the refurbishment had
9 converted a fire safe tower to one with flammable
10 cladding which would almost inevitably facilitate fire
11 to breach the buildings intended compartmentation?
12 Can they explain why there was no retrofitting of
13 sprinklers or installation of alarm systems given the
14 Lakanal inquest rule 43 report? Sprinklers may have
15 prevented death at Grenfell Tower or at least slowed the
16 progress of the fire to allow more to escape. A general
17 alarm system would have facilitated a full evacuation.
18 You know the answers to these questions. It's time
19 for transparency and candour in public.
20 RBKC note in their written opening that they've
21 signed Bishop James's candour charter and they are
22 anxious to be transparent and helpful. Bishop James was
23 particularly concerned at the failure of authorities to
24 be upfront with the victims of disasters from the outset
25 and that truth was trumped by institutional denial.



1 It's time to live up to that charter and tell us what
2 you accept you failed to do. Was the disaster which
3 occurred in your property really all the fault of
4 others?
5 Both RBKC and the TMO have referred to defective
6 regulations, the involvement of architects, contractors
7 and others, with the implication that it's them that are
8 accountable, not RBKC as owner or TMO as manager. Is
9 that really the position, all somebody else's fault?
10 I've dealt with the position of the LFB, but it
11 would really be some comfort to the victims of Grenfell
12 if the LFB would at least acknowledge that stay put
13 should have given way to full evacuation at an early
14 stage and that it was a serious failing for there to be
15 no contingencies.
16 We reiterate that many firefighters were heroes. We
17 know that the LFB did not start the fire or put up the
18 dangerous materials on the tower. If we're wrong in our
19 assertion that stay put should have given way to full
20 evacuation and that there was a clear requirement for
21 contingency planning, then tell us. Avoiding these
22 issues a year on should not be an option.
23 There's a common theme with public authorities here,
24 we say; they provide documents and policies and
25 explanations of some of their organisational structure,



1 they express condolences and they're not shy to
2 implicate others, but they're all completely silent on
3 what went wrong in the areas for which they were
4 responsible. Now is the time for candour.
5 Moving away from public authorities but staying with
6 fire engineering and fire risk, others have addressed
7 you, sir, regarding Exova. We hear what they say in
8 their position statements, the now familiar mantra of
9 "not our fault", because they dropped out of the
10 equation at a relatively early point. But perhaps
11 they'd like to address which parts of their report
12 warned of the substantial risks involved with cladding
13 systems if the wrong materials are used or the wrong
14 configuration is designed or the build is substandard.
15 I've addressed you already about Mr Stokes and the
16 CS Stokes issues with the fire risk assessment. Can
17 Mr Stokes help us with the matters I've referred to with
18 disabled residents? It's our understanding that
19 Mr Stokes took up issues regarding the cladding with the
20 TMO. Can Mr Stokes help us all at this stage with what
21 response he got and why he took those issues up with
22 them?
23 I move on swiftly to deal with those involved in the
24 refurbishment itself, and I echo, support and adopt what
25 Stephanie Barwise said earlier, that the CPs involved



1 should say now in their openings what they say about
2 compliance. The time is now to help the inquiry with
3 those matters.
4 To Arconic: we note in your opening that you say you
5 wish to do everything possible to avoid exacerbating the
6 suffering. Mr Stein has picked out the phrase that you
7 accept that, at most, the ACM that you supplied was
8 a contributing feature of the fire. But, in fact,
9 there's an even more remarkable proposition in your
10 opening when you say that the panels "did not render
11 inevitable the catastrophe that ensued". If that were
12 the test, we're all lost.
13 The reality is that Arconic are not the only
14 villains of the piece, and, yes, you are correct that
15 others bear responsibility too. But the use of your
16 panels was a key factor in the disaster. Will you
17 acknowledge that now?
18 Likewise, Celotex and likewise, Kingspan. Plainly
19 Celotex knew that their insulation was to be used on the
20 tower, as has been made clear by others. We understand
21 that in the early days of cladding, the default
22 insulation material was mineral wool. We seek answers
23 from Kingspan in particular as to how it came to pass
24 that expanded foams, flammable plastics, came to
25 challenge the much safer A1 non-combustible mineral wool

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1 products. Yes, the new products were a little cheaper,
2 and, yes, they were a little more efficient, but at what
3 cost?
4 It's obvious, isn't it, in high buildings which
5 require compartmentation for fire safety, and in others
6 with vulnerable occupants, such as hospitals and
7 schools, these products were simply not suitable.
8 And what of Artelia, quantity surveyors and the
9 original CDM of the project, referred to as agents by
10 the TMO? What do you say regarding the changes to the
11 design specs? Was cost the primary factor? Was a safer
12 consideration abandoned to cut a few percentage points
13 from the budget? What was your role in that and the
14 choice of contractors? Please tell us.
15 Sir, you've been addressed extensively about
16 Studio E, about Rydon, about Harley -- architect, main
17 contractor, cladding specialists. I won't add to those
18 submissions, save to say that it is a surprise that
19 Studio E has not provided a written opening. It's not
20 acceptable that Rydon asserts that they're not in
21 a position to say very much because there's much
22 disclosure to be made. These companies must make clear
23 the lines of responsibility -- crystal clear -- to
24 assist the inquiry.
25 The subcontractors involved: why were the smoke

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1 ventilation systems in the lifts defective?
2 To Cadent, the gas company: can you explain why it
3 took the digging of three holes to turn the gas supply
4 off? Why wasn't there a simple remote valve to turn
5 a fuel load which the fire service had to deal with for
6 22.5 hours after the fire started?
7 The questions that we posed are not exhaustive.
8 They're intended to highlight but some of the important
9 issues central to the concerns of the bereaved and the
10 survivors.
11 They don't want to hear meaningless condolences or,
12 as I said at the outset, pretences that a company or
13 authority doesn't want to usurp the role of the inquiry,
14 or indeed they haven't had sufficient disclosure. All
15 of those things are a smokescreen. This is not a moment
16 for technicalities; it's a time for candour and
17 frankness.
18 Thank you, sir.
19 SIR MARTIN MOORE-BICK: Thank you very much, Mr Weatherby.
20 Well, this is probably a convenient point to have
21 a short break, so I will break until 3.15 and then I'm
22 going to invite Mr Imran Khan to address us.
23 Thank you.
24 (3.00 pm)
25 (A short break)

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1 (3.16 pm)
2 Opening statement on behalf of BSRs by MR KHAN
3 SIR MARTIN MOORE-BICK: Yes, Mr Khan.
4 MR KHAN: Sir, I start with a question -- perhaps, more
5 accurately, a rhetorical question -- does the colour of
6 a person's skin matter in this country? Does it affect
7 your education? Does it affect whether you get stopped
8 by the police? Does it affect whether you can get
9 a job? In short, does it affect your life chances?
10 For most people from black and minority ethnic
11 communities, Britain is still either a land of denied
12 opportunities or one in which opportunities are
13 grudgingly extended and extremely limited. In places
14 where white people see a lot of idealism, people from
15 BME backgrounds see, at best, idealism mixed heavily
16 with hypocrisy.
17 The fact is skin colour is one of the defining facts
18 of life in the UK. If you don't feel compelled to think
19 about it much, chances are if you look in the mirror,
20 you're white. If you think about it often, and often
21 urgently, you probably fit another demographic
22 description, a description which unerringly affects
23 whether you get a decent education, whether you are
24 stopped or searched by the police or, in the context of
25 this inquiry, whether you live or die.

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1 And that introduction, chair, informs the basis of
2 our submissions today.
3 We are fully aware of the terms of reference of this
4 inquiry and of the contents of your letter, chair, dated
5 10 August 2017 to the Home Secretary, in which you said,
6 and I quote:
7 "As a result of the consultation, it has become
8 clear that many of those who have been affected by the
9 fire and some others feel strongly that the scope of the
10 inquiry should be very broad and should include
11 an examination of social housing policy."
12 You went on to state:
13 "I can well understand why local people considered
14 that these are important questions which require urgent
15 examination. I share their concerns."
16 And then you went on to state that:
17 "The inclusion of such broad questions within the
18 scope of the inquiry would raise questions of a social,
19 economic and political nature which in my view are not
20 suitable for a judge-led inquiry."
21 And so you concluded with stating that the inquiry's
22 terms of reference should not extend to the broader
23 questions to which I have referred.
24 Whilst that letter -- you'll remember it well,
25 sir -- did not specify that these broader questions

1 might encompass the issues of race, religion and social
2 class, these appear to be some of the matters which were
3 being alluded to.
4 As a result, the terms of reference made no mention
5 of whether race, religion or social class had any
6 bearing on what led to the loss of life at
7 Grenfell Tower. Our submission today is that these
8 terms of reference require amendment for the reasons we
9 set out.
10 Of course, that is a decision which is in the gift
11 only of the Home Secretary. But in the same way that
12 you made your previous recommendation as to what the
13 terms of reference should be, we invite you, sir, to do
14 the same now.
15 We invite you to state that, having now heard
16 directly from the bereaved, as you did in the last two
17 weeks, and having read the material disclosed to the
18 inquiry as we have, particularly the witness statements
19 of the core participants, we invite you to recommend
20 a change to the terms of reference along these lines:
21 "To examine whether race, religion or social class
22 played any part in the events surrounding the fire at
23 Grenfell Tower on 14 June 2017."
24 Sir, we should make it clear that, despite the
25 obvious concerns in the immediate aftermath of the fire



1 that these factors might have been at play because of
2 the background of the residents of the tower and its
3 immediate environments, there had not been any intention
4 on our part to make such a submission to you when the
5 inquiry started. It has only been as a result of
6 listening to our clients and reviewing the disclosure
7 that we have been driven to the conclusion that this
8 inquiry must consider this issue, and in our view it
9 would be unconscionable not to do so. Because, chair,
10 there is grave foreboding amongst our clients that the
11 race, religion or social class of the residents may have
12 determined their destiny.
13 We hope you will agree that this is a grave issue,
14 and we consider, despite what you state in your letter
15 to the Home Secretary, it is a perfectly proper one to
16 be examined by a judge-led inquiry. Indeed, if I may
17 say so, and if I may go back, that is exactly what
18 Sir William Macpherson did in the Stephen Lawrence
19 inquiry. He examined whether race played any part in
20 the failure of the police to investigate his murder.
21 Sir William Macpherson's approach of conducting
22 an inquiry is an exemplar model and one which we have
23 adopted with our clients and invite you to do the same.
24 Sir William's starting premise was to unequivocally
25 accept what was being said by the Lawrence family unless



1 and until there was any evidence to undermine or
2 challenge it. And that ultimately led him to define
3 a racist incident as "any incident which is perceived to
4 be racist by the victim or any other person".
5 Sir, this was a sea change to the black and minority
6 ethnic communities in Britain, because from then on it
7 wasn't a matter of having the police exercise their
8 discretion as to whether an incident was racist, the
9 police were obliged to accept it. The reason we raise
10 this issue today is because, having now heard from our
11 clients, they tell us, and we unequivocally accept, as
12 Sir William did in his inquiry, what they are saying,
13 and we invite you, sir, to do the same.
14 Because if we do not, our clients will be in the
15 same position as the Lawrence family were prior to the
16 inquiry when they were saying that the reason the police
17 failed to investigate Stephen's murder was because of
18 racism, and nobody at that time believed them.
19 It would be a travesty if that were to happen again,
20 because if we do not ask the question now as to whether
21 race, religion or social class played any part in the
22 events surrounding the fire at Grenfell and answering it
23 with recommendations for the future, we will be putting
24 at risk the lives of thousands, if not hundreds of
25 thousands, of people from black and minority ethnic



1 communities, who are overrepresented in high-rise blocks
2 throughout Britain. And that was certainly the case as
3 far as Grenfell Tower is concerned.
4 This is what one of our clients says about the
5 residents of the tower. I quote:
6 "It was a very diverse place and I definitely feel
7 like race and religion were a factor in people being
8 housed there."
9 Another client says this:
10 "Had this been Westminster or Knightsbridge, with
11 white, upper middle class people residing in the tower,
12 the fire and the measures taken beforehand would never
13 have happened."
14 Sir, according to a 2011 census, 71 per cent of the
15 population of Kensington and Chelsea were white, and it
16 had a higher proportion of high-earners than anywhere
17 else in the country, with more people working in banking
18 than anywhere else in Britain.
19 Given this, it does not take a genius to work out
20 that the poor and BAME community in Kensington and
21 Chelsea, including those in Grenfell Tower, were not the
22 core constituency of the local council. So it's perhaps
23 not surprising that it was the poor and the BAME
24 community who disproportionately ended up in the tower.
25 We might ask whether this was a product of

1 deliberate ethnic or social cleansing or perhaps of
2 segregation, or part of a policy of ensuring that if you
3 were poor or from a BAME background, you would be placed
4 in the tower. Or was it pure chance and coincidence,
5 just pure bad luck for some of those that died? Or was
6 there something else at play?
7 We submit that what occurred at Grenfell Tower may
8 be explained as a product of institutional racism, and
9 we consider it right and proper that this should be
10 investigated.
11 And to remind those of you, institutional racism is
12 defined by the Stephen Lawrence Inquiry report as
13 follows:
14 "The collective failure of an organisation to
15 provide an appropriate and professional service to
16 people because of their colour, culture or ethnic
17 origin. It can be seen or detected in processes,
18 attitudes and behaviour which amount to discrimination
19 through unwitting prejudice, ignorance, thoughtlessness
20 and racist stereotyping which disadvantages minority
21 ethnic people."
22 Now, chair, there is no evidence thus far disclosed
23 which suggests that any one individual, or indeed any
24 one group of individuals, directly set out to place
25 a disproportionate number of individuals from poor and



1 BAME communities in the tower knowing that they will
2 suffer such a fate. However, what may have occurred and
3 which needs consideration by this inquiry is whether --
4 and taking the quote from institutional racism -- as
5 a result of the unwitting actions and conduct of the
6 individuals that made up RBKC and TMO, there was
7 a racist outcome.
8 In short, the question that we might want to ask and
9 have answered is whether RBKC and TMO and its associates
10 were guilty of institutional racism.
11 Our clients believe that this is a proper issue to
12 explore, and we submit that the evidence that we have
13 seen thus far is overwhelmingly in favour of its
14 inclusion as a term of reference.
15 Race remains a defining characteristic in the
16 nation's housing system. Research by the Human City
17 Institute reveals that the level of housing stress in
18 black and minority ethnic communities is much higher
19 than for whites. Homelessness has grown enormously in
20 BAME communities from 18 per cent to 36 per cent in the
21 last two decades, double the presence of ethnic
22 minorities in the general population. BAME households
23 are far more likely to live in overcrowded, inadequate
24 or fuel-poor housing than whites, which was confirmed by
25 the government's recent race audit, which underscores



1 the endurance of racial discrimination and disadvantage
2 in Britain.
3 What is more, around a quarter of BAME households
4 live in the oldest pre-1919-built homes. One in six
5 ethnic minority families have a home with a category 1
6 hazard under the housing health and safety rating
7 system, and their homes less often include safety
8 features such as fire alarms.
9 More generally, there is an overconcentration of
10 BAME households in the most deprived neighbourhoods in
11 Britain's cities, linked to poor housing conditions and
12 lower economic status, negative impacts on health,
13 culminating in lower life expectancy and higher
14 morbidity.
15 There is an underconcentration in home-ownership
16 generally and outright home-ownership specifically.
17 This of course affects the distribution of wealth
18 between ethnic groups, with the BAME population having
19 much lower levels of asset accumulation.
20 BAME households are more likely to wait longer for
21 a housing offer, to be offered poorer quality homes and
22 flats rather than houses. Some housing officers are
23 seen to be steering BAME applicants away from white
24 neighbourhoods based on judgments about social class as
25 well as racial grounds.



1 And, sir, the Grenfell Tower disaster must be placed
2 in the context of these concerns to determine whether
3 race, religion or social class played any part in it.
4 And it's useful, in our submission, to consider how
5 we might approach such a question. Using a comparison
6 from policing, stop-and-search is often used to operate
7 as a litmus test to measure the institutional racism of
8 the police. It has produced statistics, we suggest,
9 that relative to the numbers in the general population,
10 young black men are up to, in some police forces, eight
11 times more likely to be stopped and searched by the
12 police.
13 Now, I hope everyone accepts, as I do, that in this
14 analysis, it's not suggested that every police officer
15 goes out of their way to deliberately target a young
16 black man. It is the police force as a whole through
17 its conduct and practices which leads to the
18 disproportionate outcome.
19 It might be just worth taking a moment and applying
20 this process to one particular resident, one of the
21 deceased who died, and see whether it provides any
22 assistance to determine whether race, religion or social
23 class played any part in the events that led to her
24 death.
25 Sakineh Afrasiabi was 65 years old when she died in





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1 the tower. She was born in Iran and arrived in the UK
2 in 1997 with her younger daughter, and she arrived as
3 a refugee. Her first language was Farsi. She did not
4 speak or write English particularly well and always
5 needed her children to translate for her. For all
6 intents and purposes, she was a proud Briton, and, as
7 her children would attest, loved the Queen more than
8 most.
9 From 1998 to 2016, Sakineh lived in a two-bedroom
10 flat in Ladbroke Grove. Her daughter Nazanin acted as
11 her primary carer, and, sir, you will recall that last
12 week -- I think it was on Wednesday -- Nazanin gave
13 a moving tribute, as did her brother Shahrokh, to her
14 mother during the commemorations.
15 In the year 2000, because of a deterioration in her
16 health, she applied for a housing transfer. It took an
17 astonishing 16 years before this was granted and it was
18 to Grenfell Tower.
19 The events leading up to her moving to the tower
20 sealed her fate, because despite suffering from, and
21 I list, incontinence, diabetes, osteoarthritis,
22 hypertension, memory loss, asthma, depression and
23 significant mobility issues such that she struggled to
24 walk, and the council knowing that she required
25 step-free accommodation, she was placed on the 18th

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1 floor of the tower.
2 This wasn't of Sakineh's choosing. She hated
3 Grenfell Tower. But she had no choice. She was forced
4 to accept the accommodation because, like
5 a disproportionate number of those from BAME
6 communities, she and her family were put under
7 investigation by the council.
8 Her daughter Nazanin says that they were treated
9 like criminals. Her mother's previous flat was raided
10 by council officers at 7 o'clock in the morning.
11 Sakineh was on her own and extremely distressed and
12 disorientated. And did the investigation lead to any
13 prosecution? Any charges? Any action? No, of course
14 not. Neither Sakineh nor her daughter had done anything
15 wrong, in the same way that none of the young black men
16 who are regularly stopped and searched in our streets by
17 the police because of the colour of their skin have done
18 nothing wrong.
19 In the same way that the police make assumptions
20 that young black men are more likely to be committing
21 a crime than white people, it appears that that was the
22 same here. The council seemed to have made
23 an assumption -- and by that I mean stereotyped and
24 racially profiled Sakineh's family -- and drew the wrong
25 conclusions.

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1 What we now know is that those conclusions
2 probably -- probably -- led to her death on the 18th
3 floor, because once there had been an investigation,
4 Sakineh was suspended from the housing bid system and
5 her right to be rehoused was withdrawn. It took many
6 months and the loss of sight in one of Sakineh's eyes
7 due to the stress of what happened before she was
8 offered flat 151 on the 18th floor of Grenfell Tower.
9 By this time, and because of the investigation, she
10 had no choice but to take it. That, it could be said,
11 led to her death, because the council knew she could not
12 walk unaided. The council knew she should not have been
13 placed in housing that had steps, let alone on the 18th
14 floor of a tower. Indeed, her RBKC housing file records
15 that from as early as 2003, Sakineh should not be housed
16 in a lifted property above the fourth floor. Is it any
17 wonder, then, that when the fire started, she couldn't
18 get out and perished with her sister, who had been
19 visiting her?
20 Her son Shahrokh Aghlani says this, I quote:
21 "I heard every last breath my mother and auntie
22 took. She said to me, 'The floor is hot, it's hot'. My
23 mum kept saying, 'Don't come, don't come, just call the
24 fire people', but I said, 'Mum, I'm coming'. The smoke
25 got them and I could hear them wheezing. My aunt said,

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1 'Forgive us' and I could hear her going into shock as
2 she tried to catch her breath. She couldn't talk
3 anymore. That was the last I heard from them. The
4 phone went dead."
5 We have no evidence, sir, that any one person
6 deliberately set out to place Sakineh on the 18th floor
7 of the tower, but we do have evidence that, as
8 an institution, the council did this "through unwitting
9 prejudice, ignorance, thoughtlessness and racist
10 stereotyping", such that it ultimately led to Sakineh
11 being placed in Grenfell Tower in the apparent knowledge
12 that it was not safe for her to be there and she would
13 not be able to escape in the event of a fire.
14 What our clients want to know is how many other
15 people that were housed at Grenfell Tower were placed
16 there in similar circumstances. Because as Nazanin
17 says:
18 "I think it is striking to look at the faces of
19 those that died. They are predominantly non-white. If
20 my mother had been a wealthier woman with a different
21 skin colour, she would have been alive today."
22 Our clients want to know why it is that those that
23 died were predominantly non-white. Did that particular
24 fact have any part to play in their deaths?
25 Our clients believe that, given the make-up of the

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residents of the tower, one of the first thoughts that the council should have had is: how do we ensure that everyone -- and that means every resident, taking into account their background and needs -- fully understood what to do in the event of a fire? And that meant -- and, chair, this may be an uncommon understanding -- is not treating people equally; it is treating people according to their needs, taking into account their individual backgrounds.

Again, using Sakineh's story as illustrative as the wider issue, this is what her daughter Nazanin says:

"Before she moved into the property she was at no point given any information about fire safety. I would have known about this because I arranged all of her paperwork with the TMO and she would have asked me to translate anything official she received regarding her housing. Whilst she was living there, she also did not receive any information whatsoever about fire safety. She was given no information about how to get out of the building in the event of an emergency. My mother never told me about any fire safety checks being carried out by the London Fire Brigade."

Shahrokh Aghlani, her son, puts the matter in this way:

"I know for sure that my mother was given no



information about fire safety at Grenfell Tower. No one came to her place to talk about it, nor to tell her what should be done in the event of a fire. It was simply that she collected her keys and was told to get on with it. There was no culture of talking about public safety. The culture instead was to get rid of what they saw as a problem: the migrants, those on low incomes and ethnic minorities. It was a form of ghettoisation of minorities in what is an affluent London borough. The tower was a living embodiment of the us-and-them culture. The majority of those who died are of Middle Eastern and/or African descent, and I think this is telling."

Sayeda Ibrahim, who lost her sister Rania and Rania's two daughters Fethia and Hania says this:

"Rania could speak basic English but she could not really read or write in English. My daughter Aiasha spoke with Rania about her concerns and what she would do if there was ever a fire. She and Rania discussed how there was only one stairwell and they would have to use the stairs if there was a fire. Rania just said, 'I don't know', as in 'inshallah', 'God only knows'.

"Outside Rania's flat there was a fire hose in a red box but there were no instructions on it. We knew it was there but none of us knew what exactly it was or how



to use it as I don't think Rania was ever told. So if there was a fire, how could she stop the fire until the fire Fire Brigade could come? I highly doubt that Rania was told anything about fire safety.

"I never saw any fire plans. There was one sign right opposite the lift but it never had images or anything. It just said in English, 'Don't use lifts if there's a fire, use the alternative exit'. Then it said the fire exit was the stairs."

Siar Naqshbandi, who arrived on the scene of the fire in the early hours and lived on the third floor of the tower, states:

"I only remember one fire safety sign downstairs when I moved in. It advised to stay indoors in the event of fire and it was only written in English."

Finally on this issue, 24-year-old Hin, who escaped on the 15th floor, says this:

"In terms of signs, I recall there being a fire safety warning downstairs. I did not see any other leaflets or signs about fire safety in the tower. The signs were in English only, not in any other language."

Again, sir, there is no evidence that we can point to that any one person or any one group of people deliberately set out to ensure that the fire safety signs could not be read or be understood by all the



residents of the tower. But the fact that certain residents could not read them or understand them gives our clients grave cause for concern, and we submit requires investigation by this inquiry. Our clients feel -- believe -- that knowing the make-up of the residents of the tower, RBKC and the TMO appear to have failed in their duty -- and again I'm using the definition of institutional racism -- to provide an appropriate and professional service to some of the residents because of their colour, culture or ethnic origin. This, sir, appears to fit the dictionary definition of institutional racism.

Whilst Dr Barbara Lane in her Phase 1 report considered the fire prevention and safety measures in place at Grenfell Tower, her findings only go so far. They don't deal with the particular difficulties faced by those from BAME communities, especially in terms of language.

Given the known diversity of London's population and the probability that it is disproportionately concentrated in high-rise towers, the necessity to grapple with this issue, sir, in our submission is self-evident. Otherwise, whatever recommendations this inquiry makes, it will not have been made with the BAME community in mind. They will have been ignored. And

1 that will be a tragedy, if not another tragedy in the
2 making.
3 Before I move on, I should say that I certainly had
4 some measure of hope yesterday that this issue might
5 have been within the contemplation of the inquiry team
6 when Mr Millett QC made the following statement, and
7 I take these from the transcript:
8 "In terms of Fire Survival Guidance that was given
9 to residents of Grenfell Tower on the night of the fire,
10 I want to say just a little bit more at this stage. It
11 will be necessary to establish precisely what guidance
12 residents were given both before and during the fire and
13 how that was understood and how it was acted upon. We
14 have evidence of fire action notices being provided in
15 the tower, as is illustrated from this photograph ..."
16 We saw on that on the screen, the written notice
17 taken from Dr Lane's report:
18 "... the essence of the Fire Survival Guidance or
19 the stay-put policy is contained in the middle of that
20 notice. We will turn to the language of the notice in
21 due course. This particular notice was found in the
22 lift lobbies by the lifts.
23 "We want to understand how residents interpreted
24 this sign and other guidance that they were given, and
25 for those who left the tower in the early stages of the



1 fire, why they did so, notwithstanding this advice."
2 However, it appears that the only issue actually
3 being considered by Mr Millett and the inquiry is the
4 interpretation and application of the Fire Survival
5 Guidance, not the more fundamental issue of whether it
6 could be read and understood by all of the residents,
7 which we consider to be essential as part of the
8 inquiry's investigations.
9 It was not only the inability of some residents to
10 read or understand the fire safety signs that might have
11 led to their deaths; there was also the issue of
12 communication on the night. In her report Dr Lane
13 concludes, and I quote:
14 "In my opinion, it is important to understand how
15 LFB could communicate with residents and the extent to
16 which limitations on communications affected rescue
17 operations. I recommend that the inquiry investigates
18 these issues further."
19 Communication with residents. We agree. But whilst
20 Dr Lane refers only to the stay put guidance, we
21 consider that the investigation should be wider than
22 that and include whether race or religion in particular
23 played any part in the evacuation of the tower.
24 Ethnicity is in fact, indeed, one of the features
25 which is to be taken into account in the Fire Survival



1 Guidance in the emergency call management circular
2 54-2004 quoted by Dr Lane, so that when guidance is
3 given by the emergency services, the individual caller's
4 age, gender and mental or physical disability is
5 assessed, as well as their ethnicity.
6 On the face of it, it seems to us, ethnicity is
7 already a consideration in this inquiry, as it is
8 a factor to be assessed in surviving a fire. We invite
9 you, sir, to make it a very clear issue and not just
10 limit it to the emergency calls, but the fire service
11 itself. Because I move on to my next point. Outlines
12 the very concerns about the procedures, conduct and
13 operation of the fire service and its governing
14 authorities on the night. As Shahrokh Aghlani explains:
15 "I have grave concerns about the strategic planning
16 of the London Fire Brigade on the night of the fire.
17 This is not about the efforts of the individual
18 firefighters, but instead my focus is on the
19 institution."
20 Sayeda Ibrahim states:
21 "I did not have any communication with the
22 firefighters, but I believe the firefighters were too
23 calm and relaxed about the situation, as if they were
24 letting the tower burn. It seemed like it was only when
25 the fire got really, really serious that firefighters



1 dressed in full protective outfits started to come and
2 get people out of the tower."
3 She recalls seeing a Somali man from the local
4 mosque going into the tower stating, "I'm going in,
5 I don't care. When I come out you can arrest me."
6 She says this:
7 "He managed to go in and save his family members.
8 I strongly believe that if they let the members of
9 public go in and get people out, they would have saved
10 more people than the firefighters have."
11 Unfortunately, Sayeda's is not a lone voice.
12 Rashad Naqshbandi who escaped from the third floor said
13 when he was on the ground he:
14 "... didn't see any firefighters tackling the fire
15 with water jets. I only saw them on the floor. It
16 didn't seem like they were taking the fire seriously as
17 I hadn't heard any sirens or alarms in the building."
18 For Nadia Yousuf, her encounter with the fire
19 services on that night was one which might have cost her
20 her life and that of her fiance's. She escaped from the
21 15th floor of the tower. She says this:
22 "When we reached the fire door exit, we ran into
23 a fire officer on the other side who told us to return
24 to our flat. I was appalled and shouted at him,
25 questioning why were we being told to go back when the

fire was coming up? The fire officer reiterated his instructions but we refused to return to the flat and instead ran past him down the stairs."

Shahrokh states:

"While I was at the foot of the tower, there were insufficient numbers of firemen and equipment. At approximately 3 am I was asked to help move heavy equipment such as their shields to a different part of the tower. I ran with two others towards the tower. We picked up fire shields from one point and took them to the firefighters."

And he concludes:

"In my opinion, 71 people died believing they would have been rescued. Their horror was beyond comprehension. The inquiry should expose the truth and firefighters should tell the story of what happened on that night. I implore them to do that."

Ibrahim Toukou, who lost his brother, his brother's partner and their 3-year-old daughter in the tower on the 19th floor is particularly aggrieved by the conduct of the fire service that night. He says this:

"I feel angry with the fire service for not rescuing my brother and his family. Even now, if I see a fire engine I blame them and I blame the government."

And he wonders aloud:



"Maybe race had something to do with it, because most of them are foreigners and they are not rich."

Referring to the residents of the tower.

Ibrahim Toukou's statement might appear harsh, but cannot be discounted and requires investigation, in our submission. Did race or religion play any part in the procedure and operation of the fire service on that night? Did race or religion affect how the LFB could communicate with residents? Were they viewed as foreign, as Ibrahim Toukou suggests, in the context that they did not belong here in the UK, in the tower?

It would be of concern, I hope, to anyone if this word "foreigner", "foreign", was used to describe any resident from the tower, because it might suggest, we submit, on the face of it, that the user of that term, having a particular outlook which connotes the other, the outsider, a person who does not belong and, more pejoratively, someone who is undeserving, and might it have affected the person's abilities to communicate with or interact with certain residents on the night?

And there is evidence, sir, to suggest that for at least some of the firefighters who attended on that night, the racial or religious origin of the residents was sufficiently important to them for them to record it in their statements. And we have now read a great many



statements of those firefighters, with interest and with some concern. We are troubled by the way in which they have described many of the residents.

Those from BAME communities have been described not, as one might normally expect, by reference to their physical attributes -- their height, eye colour, hair colour, et cetera -- but by their ethnic origin, and a stereotypical one at that. They were common descriptions of people of "Middle Eastern appearance" of "Arabic descent" and even one reference to a resident with "Tunisian appearance". I ask you rhetorically: what exactly does a person of Tunisian appearance look like, or one of Arabic descent?

The use of such stereotypes, including in one instance referring to someone as "foreign", in the statement of the firefighters on the face of it suggests unconscious or some conscious racism. If that is the case, we simply ask the obvious question: did it have any impact on the way individuals were treated that night? We suggest -- we submit -- that this must be explored by this inquiry.

Especially since communication was an issue raised by the firefighters themselves, because reference is made in their statements -- the ones that we have seen -- of firefighters saying that communication was



difficult as the residents were either too traumatised to speak or unable to understand due to the language barrier. What is perhaps most disturbing is that some firefighters were getting their information as to what was happening on the night from children rather than adults as, to use their words, their English was much better.

So we submit that, having looked at this material, this is a live issue and one which needs to be explored and investigated by this inquiry.

The issue of suspicion that Sakineh encountered with RBKC and TMO is one that reared its head again in relation to our clients in the aftermath of the fire. It appears to be a common thread running through the accounts of our clients as to how they were treated in the days, weeks and months after the fire.

In the same way that Sakineh was wrongly accused of trying to jump the housing ladder, our clients have been treated with contempt and distrust, that they have been trying to, in the words of Sayeda Ibrahim, who is recovering from cancer, to get as much money as possible out of RBKC rather than being treated as a bereaved person.

Sayeda and her daughter Aiasha were treated in an appalling manner by so-called support staff from RBKC,

1 including wrongly being presented with a bill for
2 accommodation, food and travel expenses. Each and
3 every, we submit, bereaved family member and former
4 resident will understand what Sayeda says, as they
5 themselves will have felt it. The treatment from RBKC
6 has been loaded with the implicit assumption that almost
7 everybody who sought assistance, however small, after
8 the fire had some ulterior, probably criminal motive.
9 Karim Khalloufi and his mother, brother and mother
10 of the deceased Khadija Khalloufi, were denied a visa to
11 travel to London to present their pen portrait, despite
12 having made the application in January 2018. They were
13 finally granted the visas last week, but then the
14 council failed to assist with accommodation, again,
15 despite assurances that they would do so. He was
16 heartbroken at having been denied the opportunity to
17 read the pen portrait of his sister, and he says this:
18 "No one seems to care about our history and
19 relationship to this case or to care about our pain,
20 heartache and desire for answers. I am now at a loss as
21 to what I can do to defend my family's rights in this
22 case and to represent my sister, who seems to have no
23 representation."
24 The indication appears to be, sir, from the way that
25 our clients were treated -- and we unequivocally accept

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1 what they say to us -- that RBKC had created, to use
2 a phrase very much now in vogue, a hostile environment.
3 Now is not the time to mince our words, because, of
4 course, what that really means is a racist environment.
5 The attitude is one that says your neighbour may be
6 in the country, but they may not be a part of it. We've
7 already seen that with the Windrush scandal. It's
8 an issue with which this inquiry we submit needs
9 urgently to grapple.
10 As Shahrokh Aghlani notes:
11 "Getting support from the council since the fire has
12 involved a lot of begging and needless waste of energy.
13 The help that we should have had to put back the
14 shattered pieces of our lives has been absent. It has
15 felt -- and I know this is the experience of other
16 bereaved family members -- that we are being accused of
17 lying and trying to get money from the system. It is
18 insulting to be treated like that. It demeans the
19 memory of my father."
20 One family in particular was treated worse than
21 most, the Naqshbandis. The family had left Afghanistan
22 in early 1999 due to the conflict there at the time.
23 Over the following 17 years, the family were
24 accommodated by Westminster Council and RBKC. They
25 lived at nine different addresses in Coventry and across

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1 London, always in temporary accommodation and bed and
2 breakfasts. On 22 July 2016, they moved into flat 8 of
3 the tower.
4 There is no doubt that theirs was a long and
5 complicated history of housing. They were a relatively
6 large family. They'd lived in various places. Some
7 family members had moved out and moved back in and their
8 story might not be out of place on a TV soap, except
9 that rather than seeing it for what it was -- and this
10 is where I get back to assumptions -- rather than seeing
11 it for a complicated and perhaps dysfunctional family,
12 the family were treated as suspects in a fraud, which
13 was apparently leaked to the newspapers, which published
14 the story with apparent relish. The family now receive
15 hate mail on social media and they may have to move as
16 a result of it.
17 The point is, chair, this approach of making
18 negative assumptions about certain sections of our
19 community, and my community, is not new. It is rife in
20 almost every institution. Those from BAME
21 communities -- let's be absolutely clear about it, us,
22 we -- are constantly viewed as fraudsters and criminals
23 without any basis in reality.
24 We don't need to go very far to remember this. Just
25 cast your minds back a week. Just a week ago, a report

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1 came out that showed that applications through UCAS for
2 university places found over a five-year period,
3 52 per cent of applications investigated for potential
4 fraudulent activity were from black candidates, even
5 though they made up only 9 per cent of total
6 applications. This was last week. In contrast, over
7 the same period, between 2013 and 2017, just 19 per cent
8 of all suspicious applications were from white students,
9 even though they made up 75 per cent of all
10 applications. Just look at that statistic. Now, if you
11 don't believe what I'm saying, just have a look at those
12 hard statistics.
13 Now, if you're white, you probably think I'm talking
14 a lot of nonsense. But if you are black, some of this
15 might resonate with you. The fact is, chair, in the UK
16 today, assumptions and inferences are made depending on
17 the colour of your skin. It is, as we have already
18 said, a constant and recurring feature of every single
19 day of every single year.
20 Indeed, chair, we consider this fact to be known and
21 thought by everyone who is aware of the Grenfell
22 disaster, but it's a fact that is barely acknowledged
23 and it's yet unspoken at this inquiry, despite the
24 make-up of the tower. This cannot be allowed to
25 continue.

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1 We know -- I know -- that it would be difficult for
2 some to confront this issue, but we do the deceased
3 a disservice if these issues are left unexamined. As
4 Theresa May noted in 2016, because historical inquiries
5 are not archaeological excavations, they are not purely
6 excising truth and reconciliation. They do not just
7 pursue resolution. They are about ensuring justice is
8 done. That's why difficult truths, however unpalatable
9 they may be, must be confronted head on and we invite
10 you, sir, to do so.
11 Chair, we submit in conclusion that you cannot have
12 left the Millennium Gloucester Hotel over the past two
13 weeks hearing the heartbreaking commemorations, which
14 I'm sure will be etched in your memory forever, and not
15 have considered race to have been a significant factor.
16 Just the make-up of the individuals who attended and
17 gave their pen portraits is enough to suffice.
18 We submit, therefore, even at this late stage, that
19 it is a vital consideration to the work of this inquiry,
20 because if this issue is not considered, it will leave
21 a significant minority of our communities at risk of
22 further harm in the future simply because of their race,
23 religion or social class.
24 Our clients firmly believe that it is absolutely
25 vital that the terms of reference are amended so that



1 the race, religion and social class are considered,
2 because whilst there will be -- and I accept rightly --
3 focus on the construction and refurbishment of the tower
4 which led to the fire, that will not be the full story.
5 That will not explain why it was that these particular
6 people -- these particular people -- were the ones that
7 died and will not explain what led them to their death.
8 After the disaster, there was a profound sadness.
9 But also a sense of national shame. It is only if we
10 look at how and why they ended up in the tower and
11 whether their background played a part in that that
12 we'll truly understand the tragedy of what happened and
13 learn the lessons of what went wrong.
14 Thank you, sir.
15 SIR MARTIN MOORE-BICK: Thank you very much.
16 Well, it's now just after 4 o'clock and I think
17 that's probably a convenient time to break for the day.
18 So we'll stop now and we'll resume at 10 o'clock
19 tomorrow morning.
20 Thank you very much.
21 (4.02 pm)
22 (The hearing adjourned until Wednesday, 6 June 2018
23 at 10.00 am)
24
25



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