

GRENFELL TOWER INQUIRY

OUTLINE OPENING STATEMENT ON BEHALF OF BSR REPRESENTED BY BHATT MURPHY, BINDMANS, HICKMAN & ROSE, HODGE JONES & ALLEN

[A]. THE FIRE

A preventable disaster

1. The basic facts are stark. In the second decade of 21st century London, governed by a regulatory framework designed to ensure fire safety, a local authority instigated the refurbishment of a high rise tower block in such a way as to render it a death trap. RBKC and the TMO did this, and they did so using public funds, paid to an array of professionals, contractors and sub-contractors, none of whom have yet accepted any responsibility for their part in what happened. Residents told them this could happen; but they were met with arrogance, indifference, or worse. Seventy-two people have died. Those who escaped owe their lives primarily to chance, rather than risk assessment and contingency planning by either the council or the fire brigade. The survivors are displaced, many suffering from physical and psychological injury, and grieving for the loss of loved ones, their homes and their community. The scale of the disaster, the failure of regulation, and the inadequacy of the response renders it inevitable that trust in government, industry and firefighting requires restoration. Trust can only begin to be restored through a fearless process of publicly accountable learning that inquiries of this nature are able to achieve.

A floor-by-floor and family-by-family summary

2. We attach a table that indicates the location and movement of those who we act for, both survivors and deceased. The table deals with floors 3 to 23, and represents 69 of the 129 flats. We propose to use the oral opening to describe these people, their personalities, and their devastating experiences on that night. That process will also allow us to introduce some basic reference points as to how their evidence assists in understanding the spread of the fire and the response to it.

[B]. THE BUILDING

The obvious role of design and construction in the fire

3. The parties responsible for the design and construction have yet to provide an explanation for the extraordinary dangers engendered by their work. Inquiry experts tell us as follows: (1) Once any fire inside a flat in Grenfell Tower was close to a window there was a real likelihood that the fire would spread out of the flat and into the cladding, due to a complete lack of cavity barriers at windows and the combustibility of all materials used except the aluminium window frames and glazing.¹ (2) The major accelerator of the fire in all directions was the polyethylene core material between the two sheets of aluminium comprising the cladding panels. As Professor Bisby puts it, *“the overall phenomena were similar to those that would be broadly expected for vertical flame spread up a solid fuel surface”*.² (3) Other materials such as the insulation material,³ and the various materials in the window infill sandwich panels,⁴ may have played a substantial role. (4) The geometry and installation details of the refurbishment created, at least, six separate vertical and horizontal pathways for rapid fire spread.⁵ (5) Of particular significance to spread were (a) the extensive and continuous vertical well ventilated channels (kept so hot by the insulation that every material within them could ignite) which ran uninterrupted over the full building height at every column tip and were unprotected by effective cavity barrier,⁶ and (b) the entire absence of any horizontal cavity barriers between floor 23 and the roof, which could have prevented horizontal spread at the crown and then downward spread.⁷ (6) Other features of the refurbishment that may have contributed, particularly the new and incomplete gas pipe installations and electric wiring, remain under investigation.

Doomed from the start of the refurbishment: the role of the cladding

¹ Lane BLAR00000004_0039-40 [9.7]

² Bisby LBYSR00000001 [674], [685] (upward vertical spread); see further [760] (downward vertical spread), [837] (lateral spread)

³ Bisby [702], with more work required to ascertain the effect on the lateral spread: [845] – [851]

⁴ Bisby [868]

⁵ Lane BLAR00000005_0004: summarised at [10.1.16] (and superimposed on the façade at fig 10.4)

⁶ Bisby [215], [218], [710] and [722] and Lane BLAR00000005_009

⁷ Bisby [858] – [864] and Lane BLAR 00000005_041 [10.8]

4. Compartmentation is the basic tenet of a high-rise building's defence against fire and the foundation for the so-called stay-put strategy. The last Fire Safety Risk Assessment ("FRA") for Grenfell produced by CS Stokes, assumed a high degree of compartmentation, leading to the conclusion that there was only a risk of "slight harm" defined as "unlikely to result in serious injury or death of any occupant" in the event of outbreak of fire.⁸ The reality is that occupants in all flats were not safe to remain, as they would be exposed to heat and smoke, spreading through the cladding system that was connected to every flat in the Tower.⁹ So, from the moment the cladding was installed, it harboured the dangers that led to this disaster. Had Grenfell not been over-clad as it was, a fire of this magnitude would not have occurred, since the original concrete walls are virtually non-combustible.

Failure of foresight: an absence of competent risk analysis of a cladding-based fire

5. The impact of the cladding on Grenfell from a fire safety perspective was never addressed by any appropriately qualified professional. Exova (UK) Ltd was commissioned by Studio E to produce a report on Grenfell, but in the end only produced some outline strategy documents. Of those we have seen (including the last in November 2013¹⁰), Exova stated "it is considered that the proposed changes will have no adverse effect on the building in relation to external fire spread but this will be confirmed by an analysis in a future report" (emphasis added). This document was addressed to Studio E, and made available to RBKC and the TMO (as 'clients'). In the event, the aluminium system installed was never analysed for safety because, after Exova's involvement had ceased, Rydon suggested¹¹ that the specified zinc cladding could be replaced by an aluminium composite system,¹² and the TMO's Position Statement refers to the cladding being changed to reduce costs whilst expressing an understanding that Studio E took fire safety advice from Exova (advice which was rendered manifestly wrong by the cladding change). The assessment of fire risks posed by the cladding was accordingly not delegated by RBKC /TMO to *anyone*.¹³

⁸ CS Stokes LFB00000066_011

⁹ Lane BLAR00000007_003 [12.1.8]

¹⁰ EXO00000582

¹¹ Rydon was formally tasked with preparing an alternative cladding proposal by the Pre-construction Agreement 21.05.14 RBK00018806

¹² RBK00018805

¹³ TMO00867466_0007-9

6. The later assumption by the fire risk inspector (CS Stokes) that Grenfell's compartmentation was adequate was therefore without basis and grossly misrepresented the risk in the post-refurbishment FRA, without considering the underlying information that should have been available to him. The London Fire and Emergency Protection Authority ("LFEPA") had originally required RBKC to carry out a full FRA to ascertain the risks posed by the refurbishment,¹⁴ but it seems this was never properly done insofar as the cladding was concerned. Instead, CS Stokes noted in respect of *"...the new fire rated cladding...[that]...the whole process has been overseen by the RBKC Building Control Department and Officers. They have approved and accepted the fixing system and cladding used. ...There appears to be no hidden voids apart from the normal service duct and sanitary ones, in this building or sandwich panels used [sic]. There are no apparent unusual elements of the building construction that were considered to add a significant additional contribution to the fire risk"*.¹⁵
7. There is a body of opinion,¹⁶ which the Inquiry is invited to reject, that consideration of the cladding does not fall within the ambit of the Fire Safety Order 2005 ("FSO"), because it is not a common part, even though it has the potential to compromise the compartmentation of the whole premises. However, that issue does not apply to this case, since CS Stokes purported to conduct an FRA in accordance with the Local Government Association guidance on fire safety in purpose built flats, which specifically identified the need to consider risks arising from external cladding.¹⁷ Further, CS Stokes claimed to have studied the Coroner's report into the Lakanal House fire,¹⁸ which included a recommendation to the local authority that inspectors should gain access to information concerning construction refurbishment so as to consider its implications for compartmentation.¹⁹ As of October 2016, CS Stokes was still seeking to establish whether the TMO itself had access to fire safety information from the contractor,²⁰ with the implication that CS Stokes had not had such information.

¹⁴ RBK000003002

¹⁵ LFB00000066_0004-5

¹⁶ Todd CTAR00000001_0096 [9.1.13-14] and [10.3.1]

¹⁷ LFB000000066_0003 and 0008 and CTAR00000033_0070, 0114 and 0133

¹⁸ LFB000000066_0008

¹⁹ Letter from Coroner to London Borough of Southwark R43_28 March 2013

²⁰ TMO10045796_0001-2. See also the schedule of outstanding actions in June 2016: TMO100117691_0001. The obligation on the contractor to supply fire safety information to RBKC on

8. RBKC (with other councils) was warned by the LFB in April 2017, in the aftermath of the Shepherd's Court fire, that cladding panels may not be achieving the standard required by the Building Regulations.²¹ That clear warning now stands as eerily prophetic, but appears to have gone unheeded: the TMO's June Final Fire strategy (dated 20.6.17), *Criteria for prioritising RBKC blocks on the basis of Fire risks*, demonstrate that RBKC had not changed its FRA policy or recognised any risk posed by cladding.²² It does not appear that CS Stokes was asked to comment.
9. Both before and after the refurbishment, competent professionals should have anxiously focused on the issue given the notorious cladding fires that took place around the world in the previous decade, including Lakanal House (2009), Mermoz Tower (Roubaix, France, 2013), and Lacrosse Building (Melbourne, Australia, 2014). These were residential blocks, the former two provided social housing. There were also fires in ultra-modern supersize skyscrapers, where cladding is standard: Wooshin Golden Suites (South Korea 2010), Tanweel Tower (2012) and Marina Torch (2015) in Dubai. The astonishing effects of these fires was widely reported and there to study on YouTube and the internet. They put construction and fire engineering professionals on notice of the imperative to develop their risk assessment systems accordingly; and also ought to have informed fire brigade contingency planning (see Part C below).

Non-compliance with the Building Regulations

10. It is manifest that the rapid vertical spread of fire and smoke beyond the flat immediately above flat 16 demonstrates a failure, by RBKC, its advisors, designers and contractors, to ensure compliance with Requirement B4(1) of the Building Regulations 2010: *"The external walls of the building shall adequately resist the spread of fire over the walls and from one building to another, having regard to the height use and position of the building"*.²³ Dr Lane has reached a damning provisional conclusion: the multiple ways in which the construction breached the Building Regulations (not solely the cladding) are such as to suggest *"a culture of non-compliance"*.²⁴

completion of the work or occupation (whichever is earlier) is detailed in Regulation 38 of the Building Regulations 2010.

²¹ LFB00000085

²² TMO10047404_0008 [12] and [14 .1.1]

²³ Todd CTAR00000001_0051 [5.1.62]; Lane BLAR00000001_050 [2.18.2-4]

²⁴ Lane BLAR00000001_0065 [2.23.4]

Principal individual non-compliant components of the cladding system

11. There is no suggestion in the presently available documents that the design team or contractors (Studio E, Rydon, Harley Curtain Wall, CEP and other subcontractors) sought to justify the proposed cladding system.²⁵ The sole compliance document we have seen is the RBKC Completion Certificate²⁶ purporting to certify BR compliance of the refurbishment: “...as far as could be ascertained after taking all reasonable steps, the building work carried out complied with the relevant provisions. This certificate is evidence, but not conclusive evidence that the relevant requirements...have been complied with”. There is no evidence of what the alleged *reasonable steps* were. Further, there is no known large-scale test under BS8414-1 of the Grenfell cladding system, so as to justify it *as a system* rather than the alternative approach in Approved Document B (“ADB”) section B4(1) whereby each component complies with the prescriptive approach in paragraphs 12.6-12.9. For present purposes the BSR make clear their criticism of three elements of the cladding system.
12. First: Reynobond PE 55 Cassette system: There is an issue as to whether the cladding panels were required to be of limited combustibility (Part B4(1) of ADB). Todd and Bisby both consider that ADB B4(1) paragraph 12.7 requires filler material to be of limited combustibility and that filler means the inside or core of the cladding panels.²⁷ Dr Lane’s opinion (not apparently supported by the cladding specialist building industry²⁸) is that it does not.²⁹ In Lane’s analysis, the Reynobond PE 55 cassette panels used at Grenfell are nevertheless non-compliant because ADB requires them to be class 0 *throughout*. The BSR regard Todd’s analysis as correct in law. In order to discharge its functions, the Inquiry will need to determine this issue. In any event, there does not appear to be a class 0 certificate for this product.³⁰ Harley’s manual simply includes Reynobond sales literature stating that Reynobond PE and FR are

²⁵ Lane BLAR00000001_53 [2.19.2]

²⁶ Dated 07.07.16: RBK00018811

²⁷ Todd CTAR00000001_0070 [5.2.58-59]; Bisby LBY00000001_0069 [e.g. 263]

²⁸ Todd cites published technical guidance issued by the BCA and NHBC before the Grenfell fire that supports this view [5.2.59] copied at CTA00000025_0001-4 and CTA00000026_0001.

²⁹ Lane BLAR00000021_009 and BLAR00000021 _052 [App F1.2.16-17, F6.4] and [F6.5 conclusion at F6.5.53].

³⁰ Lane BLAR00000006_0019 [11.6.16].

class 0.³¹ In 2014 the PE 55 cassette panel scored a class E in the European tests³², which indicates its unfitness for purpose. Given the absence of any test data establishing that Reynobond PE is class 0³³, it is inexplicable that Arconic's sales literature (a) asserts it and (b) was accepted without question, by anyone. Confirmation of the panels' flammability could have been gleaned from the CSTB test house result dated 7.01.05 which showed a fail and the test having to be stopped prematurely.³⁴ The Inquiry will note that even a distributor of one of Arconic's products "Renodual" has, shockingly, alluded to the Reynobond PE panels used on Grenfell, as "petrol", in advertising material marketing Arconic's new "non-combustible" product to the Australian market.³⁵

13. Second: the Insulation: Celotex PIR RS500 and Kingspan Kooltherm K15: It is common ground that all insulation materials are required, by virtue of ADB B4(1) paragraph 12.7, to be of limited combustibility. Neither the principal insulation used to insulate the face of the building (Celotex RS5000), nor the product from the Kingspan Kooltherm K15 range are of limited combustibility. The insulation between the original and new window infill panels has no defined performance and is therefore class F; woefully short of the required class A2 or better.³⁶
14. Third: voids, cavity barriers and fire-stopping: By reference to B3(4), "*The building shall be designed and constructed so that the unseen spread of fire and smoke within concealed spaces in its structure and fabric is inhibited*", Lane also finds non-compliance in the use and installation of the cavity barriers and fire-stopping, which assumes critical importance³⁷ given the new design had pushed the windows outwards, bringing within the new wall system voids which allowed the rapid spread of fire and which were unprotected by adequate cavity barriers, vertically or laterally. Lane found no

³¹ RYD00092657_0182

³² ARC00000395_003

³³ The BBA Certificate [[ARC00000368_001] stipulates a cassette fixing system different to that installed at Grenfell and does not relate to PE 55

³⁴ ARC00000360 and photos at ARC00000360_0010

³⁵ See three attached screenshots: (1) an advert for Reynodual, a non-combustible new product by Arconic with the strap line, "*would you want to wrap your building in petrol?*" and a link to a "Four Corners" documentary, (2) a photograph of Grenfell which is a thumbnail photo at the beginning of the Four Corners documentary, and (3) a further Reynodual Advert being a photo of Grenfell and the strap line "*Play it safe...Reynodual*".

³⁶ Lane BLAR00000006_053 [11.16]

³⁷ Lane BLAR00000006_0057 [11.18]

evidence that cavity barriers were incorporated into the window structure.³⁸ The horizontal cavity barriers were not installed in accordance with the manufacturers' test-data.³⁹ The vertical cavity barriers were non-compliant and the installed product was the manufactured model meant for horizontal, not vertical, barriers.⁴⁰ Critically the fourteen well ventilated and insulated columns became effective pathways for vertical flame and smoke spread uninhibited by effective cavity barriers⁴¹. Lane considers that the cavity barriers just beneath the crown of the building were not compliant with B3(4) ABD in that the vertical ones stopped at window level on floor 23, absent a horizontal cavity barrier, flames spread over the top of the cavity barrier.⁴² This accords with Bisby's description of rapid horizontal spread of the fire at the crown of the building. Its devastating effects are evidenced by the 999 calls of those deceased persons who were trapped in flat 201 on the 23rd floor, suffering the rapid, fatal effects of smoke and heat before the end of the first hour of the fire.⁴³

Failures in the building's active and passive fire protection measures

15. Whilst recognising that from the moment Grenfell was over-clad its basic fire defence tenet had been undermined, key active and passive fire protection measures (already outdated, for instance the single stairwell) were further and unnecessarily compromised by the culture of non-compliance. As Lane notes, the more layers of a building's safety which are compromised, the greater the likelihood of a *catastrophic incident*.⁴⁴

Protected stairs and lobbies: flat doors, stair doors and ventilation

16. Even before the fire, RBKC was well aware that in the event of a fire the stairs would become critical: well after Practical Completion of the refurbishment on 17.11.16, LFEPa served a deficiency notice (following an audit under FSO 2005) noting that the "PROTECTED ROUTE" had been compromised by the fitting of flat doors which were not self-closing and shafts and risers permitting the spread of smoke. CS Stokes had

³⁸ Lane BLAR00000006_0063 [11.18.21]

³⁹ Lane BLAR00000006_66-67 [11.18.42-48]

⁴⁰ Lane BLAR00000006_0070-72 [11.18.57-87]

⁴¹ Lane BLAR00000005_009 [10.3]

⁴² Lane BLAR00000005_0044 [10.8.23] – [10.8.25]

⁴³ LFB00000486 (attributable to Debbie Lamprell) and LFB0000507 (attributable to Jessica Urbano Ramirez), both of whom had migrated from lower floors to take refuge in flat 201

⁴⁴ Lane BLAR00000001_0019 [2.8.1]

made the same point (letter 19.10.16): many items identified as high risk, such as the lack of self-closing devices on the staircase doors themselves, had not been remedied.⁴⁵

17. The same letter raised concerns as to whether the automatic smoke ventilation system was being tested. The ventilation was reported as not working only a few days before the fire (see email thread 7.6.17 PSB and JS Wright re the AOV's not opening).⁴⁶ On the night, firefighters were unable to operate the ventilation override which would have enabled them to use the ventilation floor by floor.

The lifts: a further fetter on the rescue and evacuation process

18. Lifts at Grenfell were repeatedly described, both by CS Stokes and TMO, as *firefighter lifts* when in fact they were not⁴⁷; they did not have a separate power supply, an escape hatch, water ingress protection, etc.⁴⁸ Even though the lifts had been replaced by Apex in 2005, those replacements were carried out only to CP3 1971, which applied when the tower was built, and not to the standards of the relevant guidance in 2005.⁴⁹ The 2014 – 2016 refurbishment involved the adaption of lifts to include the adding of two new doors at the two additional floors;⁵⁰ again requiring compliance with up-to-date standards. On the night, the lifts did not even function to the lower 1971 standard: there was no provision of an override switch such that firefighters could call the lift and go to the floor they needed without interruption.⁵¹ Shortly after 1:30 the lift, even when available, was completely compromised by smoke.⁵² The defect constitutes a breach by RBKC, or the TMO, of the duty under article 38 of the FSO to adequately maintain facilities, equipment and devices provided in respect of the premises for the use by or protection of firefighters.

[C]. THE FIRE FIGHTING RESPONSE

⁴⁵ TMO00045796; the FRA on 20 June 2016 is at LFB0000066

⁴⁶ PSB00000103

⁴⁷ The TMO's Fire Safety strategy listed all its lifts at Appendix 8 (TMO00830598_0034) and stated (last sentence of [18] (TMO00830598_0013)) that those in bold were *firefighting lifts* as described at [18.2] of the document; see also CS Stokes FRA 20.6.16 LFB00000066_0024 and 0029

⁴⁸ Lane BLAR00000010_0036 [15.9] and BLAR00000023_0019-20 [H2.5.17-23] and *ibid*_0065 [H.4.8.19]

⁴⁹ Lane BLAR00000001_0119 [4.5]

⁵⁰ Lane BLAR00000001_0126 [4.7.2] and ART00003801_1

⁵¹ Brown MET000010867 and Secrett MET00010105

⁵² CM Gallagher MET00010083_0005

19. The culture of non-compliance pre-determined the fatal risks to which the BSR were exposed; but it also bore direct consequences on the calamitous experience of the firefighters on the night. A full assessment of the firefighting response awaits. The subject adds a further emotional layer to the inquiry. The firefighters were secondary victims of the fire. They have suffered damage to their professional and personal lives, by failing so considerably to save lives, as well as surviving 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 BSR, as the first and foremost victims, are able to ascertain how their bereavement and trauma might have been prevented.

The failure of foresight: the Fire Brigade

20. The repeated view of firefighters was that this was a fire beyond their experience; but it is also clear that it was a fire beyond their training or indeed LFB's strategic contemplation. It ought not to have been. The FBU identified the failure to train for vertical high-rise cladding fires in evidence to the Environmental, Transport and Regional Affairs Committee as long ago as July 1999 (HC 741 – i); and since the turn of the century, fires involving external cladding systems have become almost the archetypal form of mass fire disaster. So it was that the LFB wrote warning letters to councils, including the prescient one identified above, in the wake of the Shepherd's Bush cladding fire; and yet no one from the LFB Commissioner down appears to have trained or planned for this type of fire.⁵³ Neither are cladding fires expressly dealt with in relevant national⁵⁴ or LFB policies⁵⁵ despite LFB's acknowledgement in its London Safety Plan that it was incumbent upon it *"to understand construction methods and possible failure mechanisms"*.⁵⁶

⁵³ Commissioner Dany Cotton MET00012492_0002. This strongly suggests that Babcock International did not properly place the issue on the training curriculum, but we are yet to see the training materials

⁵⁴ GRA 3.2 Fighting Fires in High Rise Buildings (DCLG & CFA, Feb 2014) LFB00001255_0010 is notable for its failure to specify the risk of cladding fires.

⁵⁵ Policy 633 High rise firefighting (26 November 2008, but updated 2011, 2012, 2014, 2015 and 2017) LFB00000178_0029

⁵⁶ London Safety Plan LFB00000225_0026

21. The cladding fires of recent years should have become case studies for firefighters around the world. For example: (1) the Mermoz fire in Roubaix (2013): the fire spread rapidly from the 2nd to the 18th floor but the building was fully evacuated except for a disabled lady who lived on the 15th floor and could not descend in the lift as the electricity was cut by a fireman.⁵⁷ (2) The Lacrosse Docklands (2014) fire in a residential building in Melbourne spread rapidly and penetrated flat balconies on many levels. The sprinkler system appears to have functioned remarkably well, there were two, not one, narrow evacuation staircases, and the air ventilation mechanism in both of them was not compromised. The emergency warning and communication system however failed on the levels affected by the fire such that fire crews were forced to enter every level and alert occupants of each apartment to ensure total rapid evacuation of four hundred people which they did successfully.⁵⁸ The operational key in both cases, and the obvious case study lesson, was an almost immediate recognition of the need for total evacuation given the rapidity of external spread of the fire.
22. This begs the 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 evacuation to save lives? Lane has emphatically queried the logic of maintaining the stay put advice up to 02:47, given that compartmentation had begun to fail by 01:15, had substantially failed by 1:26, and there was a declaration of a 'major incident' by 02:06.⁵⁹ Standing LFB and national policy required consideration of withdrawing stay put advice,⁶⁰ although no Incident Commander appears to have done so until AC Roe⁶¹ and in the event the stay put advice was withdrawn in the control room by DAC Fenton (with only the aid of watching Sky TV) and at the Incident Command Unit at roughly similar times, but without either location communicating with one another.⁶²

Operational matters

⁵⁷ Kate Youde, Grenfell: the French connection, INSIDE HOUSING, 20.12.17

⁵⁸ MFB, Post Incident Analysis Report, Lacrosse Docklands 673-675 La Trobe Street, Docklands 25 November 2014

⁵⁹ Lane BLAR00000001_0053 [2.18.17]; see also [2.11.23] Table C at BLAR00000001_0029-30

⁶⁰ Policy 633 LFB00000178_0014 [7.49] – [7.51] and [7.55]; and GRA 3.2 LFB00001255_0022

⁶¹ AC Roe MET00007520_004

⁶² DAC Fenton MET00080569_7

23. Operational matters that the BSR would wish to be investigated include: (1) the failure to appreciate the futility of firefighting within the 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;⁶³ (3) the haphazard extent to which the narrow staircase was crowded by BA deployments and equipment that obstructed evacuation;⁶⁴ (4) the acute failure of communication at various junctures between the control room, the command units, the firefighting bridgehead and deployed/returning BA units; and (5) the very rudimentary local familiarisation knowledge in breach of s.7(2)(d) of the Fire and Rescue Service Act 2004 and the fundamental breach of standing policy, which mandated rigorous operational intelligence-gathering and contingency planning in relation to at-risk high-rise buildings.⁶⁵

Equipment

24. There are a range of technical and equipment issues arising including: (1) earlier availability and deployment of Extended Duration Breathing Apparatus ('EDBA') trained firefighters; (2) discrete provision of 'flash' masks to assist the breathing of evacuees; (3) higher ladders and pumps; (4) the feasibility, or otherwise, of other aerial responses, including by helicopter;⁶⁶ (5) communication coverage in high rise blocks, and the failure of the communication devices within the BA paraphernalia; and (6) whether the earlier deployment of a positive pressure ventilation system might have made a difference to the smoke compromised stairwell.

The control room

25. The overriding conclusion to be derived from the 999 transcripts is that the control room was deprived of essential operational information about the drama and scale of

⁶³ For example: CM Phillip Turcsi MET00010899_0004; WM Harrison MET00007885_0005, SM Egan MET00007515_0005; GM O'Neill MET00010758_0005. The 999 transcripts show that stay put advice was unilaterally revoked by some operators before the 02:47 instructions; for example: LFB00000329_0004; LFB00000345_0009; LFB00000351_0003-4.

⁶⁴ SM Myatt MET00007783_0012; and Upton MET00007254_0013. See also GRA 3.2 LFB00001255_0014 that warns against congestion of access and egress routes.

⁶⁵ High rise firefighting Policy 688 LFB00000178_007-8 [4], especially [4.8]; and GRA 3.2 LFB00001255_0016-18

⁶⁶ Helicopter water drops and roof top evacuation was provided in the Korean Wooshin Golden Suites in 2010: Young-sun Kim, M.M., Yoshifumi Ohmiya (2011) *Fire Examination of Superhigh-Rise Apartment Building "Wooshin Golden Suites" in Busan, Korea*, Fire Science and Technology 2011; Vol 30(No 3): 81-90

events unfolding on the ground, leaving the operators manifestly ignorant about the advice they were giving,⁶⁷ but unable to sufficiently react to the clear information that they were being given from the residents that smoke and fire had penetrated much of the building in minutes.⁶⁸ The resulting fire survival guidance was therefore confusing, dangerous, and too often fatal. This was despite belated efforts in many of the later calls to implore evacuation in any way possible. Just as there was no Plan B for the stay put policy, there was no training or conception of how to advise on any type of Plan B at the control room level.⁶⁹

Command, control and co-ordination

26. This became a 20 pump fire in 20 minutes and a 40 pump fire in 60 minutes. Ten Fire Rescue Service vehicles had been called out by 02:16. There was a considerable lack of organisation in the first 1.5 - 2 hours, which resulted in (1) the maintenance of stay put, when it should have been amended or withdrawn, and (2) the hindering of evacuation because of the over-deployment of people and equipment into the stairwell. As a matter of justice to both the BSR and the firefighters, how this could have been better achieved must be raised with both the witnesses in Phase 1 and those experts and other witnesses who are to follow in Phase 2.

[D]. THE BROADER CONTEXT: LOOKING TOWARDS PHASE 2

27. The broader context of why this fire was able to occur in 21st century London will be examined in Phase 2, but initial premises arising from the evidence currently available are: (1) The tragedy is peculiarly modern, involving contemporary building industry proclivities, value engineering employed to compromise risk compliance, complex procurement processes, and a diverse tower block community that was once home to an extraordinarily global range of people and cultures. (2) Much of the refurbishment process (regardless of its actual motives) was *done to* the residents, rather than *for* or *with* them, and the contemporary language of social housing based on *self-management*,

⁶⁷ Norman MET000080589_0007

⁶⁸ LFB00000303 (Naomi Li Flat 195 floor 22 reporting at 01:21.24 that she could smell smoke); and LFB00000310 (Mariem Elgawahry from Flat 196 floor 22 reporting at 01:30.00 that multiple families had migrated to the top floors, that the roof doors would not open, and that contrary to the operator's suggestion, her own flat was already on fire)

⁶⁹ Duddy MET00007787_0004

consultation and *clients* was a substitute for genuine recognition by the RBKC/TMO that the residents were their status equals. (3) The failure of foresight was compounded by the lack of transparency and accountability in the use of public funds, caused partly by organisational exclusivity, which allowed RBKC to fob off and manage its critics like Grenfell Action Group, rather than engaging with them. The Inquiry must investigate whether there was more behind the secrecy and the reasons for it. (4) Economic biases are inextricably bound into the tragedy, whether it is the changing politics and culture of the welfare state, value judgments about the *viability* of the construction and property industry if reform is imposed, or the deliberate policy of successive governments to jettison regulations and regulators, instead allowing stakeholders to agree their rules, rather than Government rigorously leading the rule making process.

28. Finally, the circumstances of the disaster included a systemic deficit of effective legal rights and protections. (1) Foremost, are the Building Regulations and FSO: they are designed to protect residents, but neither can be enforced by residents, and their complexity and amenity to qualified or loophole interpretation makes them unfit for purpose. (2) Similarly, housing law presently lacks an effective private law remedy against landlords concerning the safety, as opposed to the disrepair, of premises, in the absence of personal injury or damages.⁷⁰ (3) Likewise the Housing Act 2004 is not tenure neutral; such that the enforcer against fire and other hazards is the local authority, which cannot take action against itself.⁷¹
29. All of the above remedies are in any event dependent on access to information, which would be the condition precedent to mounting a legal challenge, but also to obtaining legal aid. Informational rights in this context are fundamentally inhibited by the fact that the Freedom of Information Act 2000 ("FOIA") does not apply to the TMO, or similar entities, even though it carries out public functions.⁷² Although this TMO had a policy to comply with the FOIA *as if* it did apply, the fact that it did not apply meant

⁷⁰ Landlord and Tenant Act 1985, s.11; Defective Premises Act 1972, s.4; Occupiers' Liability Act 1957, s.2

⁷¹ Housing Act 2004, ss 5 – 7 and see *R v Cardiff City Council ex parte Cross* (1983) 6 HLR 11, CA

⁷² Freedom of Information Act 2000, s.3, s.5, s.6, s.84 and Schedule 1

that an appeal to an Information Commissioner (which would have been automatic, free and speedy) was not available.⁷³

30. The Inquiry in Phase 2 will need to consider features of local authority behaviour including procurement for complex buildings and will necessarily be concerned with the question of how Grenfell could have been designed and constructed by so many organisations in such flagrant breach of Building Regulations, without any real analysis of fire risks posed by the refurbishment. The problems that arose here, of incompetence and lack of proper oversight, and the ways in which safety, in the hands of elected local government, fell victim to value engineering, is essential to a proper understanding of the tragedy.
31. The Inquiry will also need to investigate such matters and the fire response, through the lens of the equality duties of relevant public authorities under s.149 of the Equality Act 2010; particularly in relation to age, disability and race. Yet it should also not neglect the implications of s.1 of the Equality Act not being in force, despite being passed by Parliament. It would have required RBKC, in exercising their functions to *have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage*. Whilst cladding fires affect rich and poor alike, fires in other high-rise buildings have been contained by adequate prevention or suppression systems. Less wealthy socio-economic groups are more vulnerable to the consequences of cladding fires. That has certainly been the case here. The question therefore arises whether the absence of a duty on RBKC and other relevant authorities proactively to consider the need to ameliorate *distributive* inequality for those living under its governance could have made a difference to those who died, lost loved ones and who have been left homeless.
32. The people of Grenfell Tower were a richly diverse predominantly social housing community. Many of them would rightly object to being called poor. Yet they have all suffered poor treatment; and the cause of that lies in the poverty of how they were regarded, as opposed to who they really were. Their poverty – in this sense – lay in the

⁷³ This is not an academic point. Ed Daffarn wrote to the TMO in October 2014 asking for copies of the minutes and communications between the TMO, Rydon, and Studio E at which the progress of the Grenfell Tower improvement works were discussed; as well as documents to the same effect detailing the communications between the TMO, RBKC, the Planning Department and any Scrutiny Committees. All requests were refused: see GTI Statement, 18.5.18, [99] – [100]

lack of concern by local and central Government, and too much of society at large. It is that failure of human accounting, an indifference, both institutional and societal, that renders more explicable the worst housing fire disaster in modern British history.

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