Grenfell Tower
Inquiry

GRENFELL TOWER INQUIRY: PHASE 2 REPORT

REPORT of the PUBLIC INQUIRY into the FIRE at GRENFELL TOWER on 14 JUNE 2017

The Panel:
Chairman: The Rt Hon Sir Martin Moore-Bick
Ali Akbor OBE
Thouria Istephan

September 2024

Volume 3
Part 4 - The Tenant Management Organisation
Part 5 - The management of fire safety at Grenfell Tower

HC 19–III

GRENFELL TOWER INQUIRY: PHASE 2 REPORT

REPORT of the PUBLIC INQUIRY into the FIRE at GRENFELL TOWER on 14 JUNE 2017

The Panel:
Chairman: The Rt Hon Sir Martin Moore-Bick
Ali Akbor OBE
Thouria Istephan

September 2024

Presented to Parliament pursuant to section 26 of the Inquiries Act 2005
Ordered by the House of Commons to be printed 4 September 2024

Volume 3
Part 4 - The Tenant Management Organisation
Part 5 - The management of fire safety at Grenfell Tower

HC 19–III

This report contains content which some may find distressing.

This publication is available at www.gov.uk/official-documents.

Any enquiries regarding this publication should be sent to us at contact@grenfelltowerinquiry.org.uk.

ISBN 978-1-5286-5080-9
(Volume 3 of 7)
7 volumes not available separately

E03165832 09/2024

Printed on paper containing 40% recycled fibre content minimum.

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office.

Part 4
The Tenant Management Organisation

Chapter 30
Introduction to Part 4

30.1 The Tenant Management Organisation occupies a central position in the matters we have investigated. As the body appointed by RBKC to manage the whole of its housing stock it was responsible for all aspects of the management of Grenfell Tower in the years leading up to the fire, including responsibility for repairs and maintenance and, most importantly, matters affecting fire safety. Although RBKC provided the funds for the refurbishment, the TMO was responsible for organising and managing it and was the client under the design and build contract with the principal contractor, Rydon. In carrying out its operations it was allowed a large measure of autonomy under the overall supervision of the council.

30.2 In order to provide a context for what follows, we begin this Part of our report by describing the history and structure of the TMO and the agreement with RBKC under which it managed the council's residential properties. We also describe its internal organisation and processes and their effectiveness. At the same time, we identify those responsible for some important aspects of its operations.

30.3 The arrangements made by RBKC for supervising the TMO's operations were of considerable importance, both as to their structure and their implementation, so we have described them and expressed our conclusions on their effectiveness.

30.4 Managing a large housing stock inevitably gives rise to a considerable amount of interaction between managers and tenants and it is difficult to avoid a certain amount of friction from time to time. However, it was accepted by all concerned that for some years before the fire many tenants, including some of those who lived in Grenfell Tower, had expressed considerable dissatisfaction with the way in which they were treated by the TMO and that relationships had deteriorated to the point at which they could be described as hostile.

30.5 We describe the history of the relationship between the residents of the Lancaster West Estate (of which Grenfell Tower formed part) and the TMO in the years leading up to the fire, including the various local residents' associations that were formed in an effort to pursue their members' interests, because it is an important part of the context in which the refurbishment of the tower took place.

Chapter 31
Structure and governance

Background

31.1 In 1991 the government pledged to increase opportunities for tenants of social housing to assume greater powers of management of the properties in which they lived, independent of the local authorities which owned the buildings. That was done by amending the Housing Act 1985 to create a right to manage, so that local authorities would be obliged to transfer their housing management functions to a tenant management organisation, provided that a majority of tenants were in favour of such a transfer and certain other conditions were met. Following a study carried out by RBKC of the feasibility of transferring its housing management functions to a tenant management organisation, a ballot of RBKC tenants was held. The necessary majority voted in favour of the proposal and following preliminary government approval the Kensington and Chelsea Tenant Management Organisation (the TMO) was incorporated on 19 April 1995.

31.2 Following a further ballot in which the majority of tenants again voted in favour of the transfer, the first formal management agreement came

into force on 28 February 1996,[1] under which RBKC appointed the TMO as its agent to carry out some (but not all) of its housing management functions.[2] Those functions were formally delegated on 1 April 1996 when the TMO became operational[3] and 250 officers employed in RBKC's Housing Services Department transferred to the TMO.

Constitution

31.3 The TMO was set up as a company limited by guarantee and was owned by its members, all of whom were tenants or leaseholders of premises owned by RBKC. In April 1996, members of the TMO elected the first tenant and leaseholder members of the board.

31.4 The TMO board had 15 members consisting of eight residents (tenants and leaseholders, in which the former were in the majority), up to four members appointed by the council and three members appointed by the board itself.[4]

1 {RBK00018516}.
2 The TMO's management functions under this first Management Agreement {RBK00018516} included repairs, maintenance and services provision (Chapter 2), the collection of rent and levying of service charges (Chapter 3), the granting and management of tenancies (Chapter 5).
3 RBKC's note on the chronology and history of the TMO {RBK00058262/4} paragraph 14.
4 Amended Memorandum of Association of KCTMO Constitution {RBK00050806/16} Article 15, clause 15.1.

31.5 Throughout its life, the TMO's board comprised tenant, leaseholder, council-appointed and independent board members. Its articles of association were designed to ensure that residents' representatives made up the majority of the board's members.[5] In particular, the chair and the two vice-chairs were required to be residents' representatives.[6]

31.6 The TMO's board was responsible for ensuring that the TMO's objectives were carried out and for ensuring its proper day-to-day management.[7] In particular, the board was responsible for the appointment and dismissal of the chief executive and other senior managers.[8]

31.7 The TMO board operated independently of RBKC except on matters relating to the Housing Revenue Account.[9]

5 Amended Memorandum of Association of KCTMO Constitution {RBK00050806/16} Article 15, clause 15.1.
6 Amended Memorandum of Association of KCTMO Constitution {RBK00050806/21} Article 23, clause 23.2.
7 Amended Memorandum of Association of KCTMO Constitution {RBK00050806/20} Article 22, clause 22.1.
8 Amended Memorandum of Association of KCTMO Constitution {RBK00050806/20} Article 22, clause 22.4.
9 Black {TMO00000888/4} page 4, paragraph 23.

31.8 The TMO's principal object was to manage and maintain RBKC's housing stock and ancillary properties on its behalf[10] and on behalf of its 5,600 members, who were either residents or leaseholders of RBKC properties.[11]

31.9 In 1996 a Management Agreement was entered into with RBKC, under which the TMO agreed to manage the residential properties owned by RBKC.

Arm's Length Management Organisations

31.10 Arm's Length Management Organisations (ALMOs) were introduced by the government in its 2000 Housing Green Paper *Quality and Choice: A decent home for all*.[12]

31.11 In 2002, RBKC applied to the government to allow the TMO to become an ALMO. The application was granted, with the result that strategic control of RBKC's housing capital programme was delegated to the TMO.[13]

10 Amended Memorandum of Association of KCTMO Constitution {RBK00050806/2} Article 4, clause 4.1.
11 Black {TMO00000888/4} page 4, paragraph 21.
12 RBKC's note on the chronology and history of the TMO {RBK00058262/8} paragraph 36.
13 RBKC's note on the chronology and history of the TMO {RBK00058262/8} paragraph 39.

31.12 In April 2002, an extraordinary general meeting of the TMO was held at which the members voted unanimously to amend its constitution to allow it to operate as an ALMO and in September 2002, the Secretary of State formally consented to the delegation of additional responsibilities to it.[14]

31.13 To give effect to the TMO's change of status, the 1996 Management Agreement was varied by a deed executed by RBKC and the TMO which came into effect on 7 November 2002. The deed appointed the TMO as an ALMO and, in particular, made the TMO responsible for developing and undertaking all major work schemes as defined in the Management Agreement as well as for the management of the capital programme.

31.14 In 2006, the 1996 Management Agreement and the 2002 deed were replaced by a Modular Management Agreement with effect from 1 April 2006 (the 2006 Agreement), under which the TMO continued to manage residential properties for RBKC as its managing agent. The text of the 2006 Agreement was based on a template approved by the government for agreements between local authorities and tenant management organisations. It was based on

[14] RBKC's note on the chronology and history of the TMO {RBK00058262/8} paragraph 39.

a standardised form with a chapter on each of the relevant subject areas, such as repairs and payment of rent.

31.15 Over the next decade there were further minor changes to the 2006 Agreement before it was superseded by a new Modular Management Agreement in 2015 which reflected the structure and content of a revised template.[15] Thus, in the period leading up to the fire, the contractual relationship between the TMO and RBKC was contained in the 2006 and 2015 Agreements.[16]

31.16 The effect of the two Agreements was essentially the same. Neither agreement transferred any ownership or rights in RBKC's housing stock to the TMO, except the right to manage and maintain that stock, and neither agreement affected RBKC's legal relationship with its tenants or leaseholders. In particular, RBKC retained its statutory, contractual and common law obligations to its leaseholders and tenants. The TMO undertook to carry out management functions in accordance with RBKC's legal obligations.[17]

---

15 For example, the 2006 Modular Management Agreement was varied in July 2008 to provide for implementation of an improvement plan {RBK00050380} and again in April 2010 to transfer responsibility for allocation of housing from the TMO to RBKC; RBKC's Note on the Chronology and History of the TMO {RBK00058262/11} paragraph 45.

16 Tenant Management Organisation Modular Management Agreement Volume 1, Chapter 1 {RBK00018796/13} clause 5.

17 Tenant Management Organisation Modular Management Agreement Volume 1, Chapter 1 {RBK00018796/13} clause 6.2.

In particular, the TMO was responsible for maintenance and repairs[18] and for proposing major works.[19] If the TMO decided that major works were necessary, it was obliged to prepare and approve works within the level of financial resources made available to it by RBKC.[20]

The board and its committees

31.17 There were three committees of the TMO board: the Operations Committee, the Finance, Audit and Risk Committee and the Appointments and Remuneration Committee. Only the first two are relevant for present purposes.

31.18 The Finance, Audit and Risk Committee was responsible for health and safety (including fire safety). Every March, a Health and Safety report was presented to the Finance, Audit and Risk Committee. The report was also presented to the board and to RBKC's Housing and Property Scrutiny Committee (the Scrutiny Committee) as one means by which the TMO and RBKC monitored compliance with fire safety policies.[21] The Finance, Audit and

18 Tenant Management Organisation Modular Management Agreement Volume 1, Chapter 2 {RBK00018796/33} clause 1.1.
19 Tenant Management Organisation Modular Management Agreement Volume 1, Chapter 2, {RBK00018796/34-35} clause 4.1.
20 Tenant Management Organisation Modular Management Agreement Volume 1, Chapter 2 {RBK00018796/35} clause 4.3.
21 Matthews {TMO00873380/6} page 6, paragraph 20.

Risk committee also monitored the scope and effectiveness of the systems used to identify and assess all material financial and non-financial risks to the TMO.[22]

The executive team

31.19 The TMO's day-to-day operations were carried on by an executive team that reported to the chief executive. From May 2009, that was Robert Black. There were three executive directors at the time of the fire, Sacha Jevans (Operations), Barbara Matthews (Finance and ICT) and Yvonne Birch (People, Performance and Governance).

31.20 Each executive director led a senior management team responsible for the TMO's management functions. In June 2017, the team that reported to Sacha Jevans consisted of Peter Maddison, Director of Assets and Regeneration, Teresa Brown, Director of Housing, Hash Chamchoun, Director of Housing Support Services and Graham Webb, managing director of Repairs Direct Ltd, a subsidiary of the TMO which was responsible for carrying out repairs. For present purposes, it is sufficient to note that

22 TMO Annual Health and Safety Report 2015/16 {TMO00843882/1}.

Janice Wray, who had been the Health and Safety and Facilities Manager since 2011, reported to Barbara Matthews.[23]

The management of health and safety

31.21 The Director of Finance and ICT was responsible for ensuring the health and safety of all TMO residents, employees and contractors.[24] That included responsibility for putting in place arrangements to manage the risk of fire.[25] An important element of her role was to monitor the TMO's health and safety performance at a strategic level.[26] Anthony Parkes was the Director of Finance and ICT between August 2009 and June 2015[27] when he was succeeded by Barbara Matthews.

31.22 Before joining the TMO, Barbara Matthews had not held responsibility at any organisation for health and safety or fire safety management. She had received no training in, or experience of, managing health and safety[28] or fire safety management. She received no training on the requirements of the Fire Safety Order, either

23 Wray {Day140/6:16-17}.
24 Matthews {Day147/103:21-25}.
25 Matthews {Day147/113:8}-{Day147/114:5}.
26 Matthews {TMO10049987/2} page 2, paragraph 7.
27 Parkes {TMO00873400/1} page 1, paragraph 3.
28 Wray {Day147/99:19}-{Day147/100:14}.

before or during her time with the TMO,[29] and was not familiar with its details.[30] She was not aware of the concept of the responsible person under the Fire Safety Order or of the substance of that person's duties,[31] nor did she take any steps to satisfy herself of the adequacy of the TMO's arrangements to discharge its duty to take general fire precautions under Article 8 of the Fire Safety Order.[32]

31.23 Anthony Parkes, Barbara Matthews and the wider executive team relied heavily on Janice Wray for all aspects of health and safety. Although she was not part of the TMO's senior management team, the degree of reliance placed on her by Barbara Matthews and the broad autonomy she was given within her area of operations, meant that Janice Wray was effectively acting at senior management level in relation to health and safety.[33]

31.24 The TMO's Health and Safety Committee, chaired by Barbara Matthews, was the TMO's primary forum for discussion of health and safety matters.[34] It was the body which oversaw health and safety performance and challenged managers

29 Wray {Day147/100:25}-{Day147/101:3}.
30 Matthews {Day147/107:23}-{Day147/108:3}.
31 Matthews {Day147/108:23}-{Day147/109:1}.
32 Matthews {Day147/110:24}-{Day147/111:2}.
33 Matthews {Day147/104:15}-{Day147/105:1}.
34 Matthews {TMO00873380/2} page 2, paragraph 8.

of services on their compliance with health and safety duties.[35] The health and safety committee was a critical element in the management of fire safety.[36]

31.25 Between them Barbara Matthews and Janice Wray identified the matters that they considered should be put forward for discussion at executive team meetings and included in the annual health and safety report.[37] They typically arose out of meetings of the health and safety committee, discussions in the broader housing sector or publications brought to the TMO's attention.[38]

31.26 The TMO maintained a "corporate risk map" that identified the various risks to its operations, the harm that might arise if they occurred and the measures that could be employed to mitigate them.[39] It had identified health and safety as a strategic risk and was aware that the consequences of a failure to manage health and safety duties properly could result in serious injury or death.[40] Health and safety committee meetings,

35 Matthews {TMO00873380/2} page 2, paragraph 8.
36 TMO Health and Safety Committee Terms of Reference dated September 2015 {TMO00873368/1}.
37 Matthews {TMO10049987/2} page 2, paragraph 8.
38 Matthews {Day147/105:7-17}.
39 Matthews {Day147/132:8-14}; Example of Corporate Risk Map {TMO00899699}.
40 Matthews {Day147/135:13-25}; Corporate Risk Map dated 16 March 2016 {TMO00899699/1} Risk 5.

involving executive and senior management teams, were held at regular intervals. At those meetings fire risk assessments and any measures required by them were discussed and remedial work monitored and audited.[41]

Janice Wray

31.27 Janice Wray played a fundamental role in the TMO's performance of its health and safety obligations, including its obligations in relation to fire safety. Although she saw her role as essentially advisory,[42] it is plain from the various versions of the TMO's health and safety policy that it was broader, more substantive and covered a range of matters, including those of the Competent Person for the purposes of the Fire Safety Order that we have set out in Chapter 35.[43] The responsibilities she was given were probably too much for one person to discharge properly without substantial assistance and effective oversight and unfortunately she had neither. Senior managers either did not realise

41 Matthews {Day147/136:5-25}.

42 Wray {Day140/7:22-25}.

43 At paragraph 18. See also TMO Health and Safety Policy 2012 {TMO10031076/3}. This list was reproduced in the 2016 version of the policy {TMO10024402/3}. The 2010 version of the policy {TMO10031078/3} does not include the references at (i) and (j) to the Fire Safety Order.

that there was simply too much for her to do, or, if they did, they were nonetheless willing for her just to get on and do her best.

Annual health and safety reports

31.28 The principal means by which the TMO executive committee reported to the board and to RBKC on health and safety matters was its annual health and safety report. The document was prepared by Janice Wray and reviewed by Barbara Matthews and the executive team before it was submitted to the board.[44] The matters reported to the board were those set out in the annual health and safety report and any exceptional events, such as the Adair Tower fire.[45] The TMO itself reported to RBKC's scrutiny committee[46] and to RBKC at quarterly joint management meetings, principally through Robert Black.[47]

31.29 From time to time Janice Wray met members of RBKC's housing team, such as Amanda Johnson and Celia Caliskan, and in the course of those meetings reported informally on what the TMO was doing.

44 Matthews {TMO10049987/3} page 3, paragraph 15.
45 Matthews {Day147/105:18-25}.
46 Matthews {TMO00873380/6} page 6, paragraph 20.
47 Matthews {TMO00873380/9} page 9, paragraph 31.

31.30 Robert Black told us that Barbara Matthews and Janice Wray raised health and safety matters with him which might then be included in the annual health and safety report.[48] Although other TMO employees contributed to the report, it was substantially the work of Barbara Matthews and Janice Wray.[49] As a result, Mr Black was entirely reliant on their judgement to determine whether a matter concerning fire safety or fire safety management should be drawn to the attention of the board.[50]

Funding health and safety management

31.31 The TMO was funded by RBKC. It maintained three separate accounts: a management account, which covered its costs under the agreement with RBKC, a "Repairs Direct" account, which related to the cost of maintenance and repairs, and a Housing Revenue account into which rents were paid,[51] which it maintained on behalf of RBKC.[52]

48 Black {Day149/56:14-25}.
49 Black {Day149/57:10-19}.
50 Black {Day149/57:2-8}.
51 Black {Day149/21:6-7}.
52 Matthews {TMO00873380/10} page 10, paragraph 33.

31.32 The TMO's annual management fee was paid by RBKC into the TMO's management account. Robert Black thought that the TMO board's decision-making was not independent of RBKC because it depended on RBKC for its income.[53]

31.33 The cost of employing and running the health and safety team, including that of the fire risk assessment programme, was borne by the health and safety team budget, which was one of the departmental budgets within the Financial Services and ICT directorate.[54] That budget did not include the cost of carrying out works required as a result of a fire risk assessment, which was borne by whichever team was responsible for the work in question.

Reporting to the Board and RBKC

31.34 The board of the TMO was the body ultimately responsible for its affairs, including strategic decisions relating to matters affecting fire safety in the buildings it managed. It was therefore important that it be kept informed of developments as they occurred, but regrettably there were many instances in which important information was not drawn to its attention. RBKC was responsible for the oversight of the TMO which reported to

53 Black {Day149/23:23}-{Day149/24:2}.
54 Matthews {TMO00873380/10} page 10, paragraph 35.

its scrutiny committees. Reports to the scrutiny committees did not always contain the information that might reasonably have been expected.

31.35 From the start of Robert Black's tenure as chief executive in May 2009, fire safety and the adequacy of the TMO's fire safety measures were regular subjects of discussion, primarily because of the LFB's concern about the TMO's approach to fire risk assessments.[55] The substance of those matters is discussed in Part 5, Chapter 37. At the outset the LFB was concerned that the TMO was producing its own fire risk assessments and that they were inadequate.[56] The LFB was so troubled that it indicated that it would serve an enforcement notice on both the TMO and RBKC.[57] As a result, the TMO entered into a contract with Salvus Consulting Ltd to carry out fire risk assessments in respect of all its high-risk properties.[58]

31.36 The first fire risk assessments produced by Salvus in 2009 identified a number of risks that Janice Wray wanted to discuss with Robert Black. One concerned flat entrance doors.[59] Mr Black was aware from at least October 2009 that defects in flat entrance doors (in particular, a lack

55 Black {Day149/217:3-8}.
56 {RBK00052528/3}.
57 {RBK00052528/3}.
58 Black {Day149/212:1-4}.
59 {TMO10037375}.

of effective self-closing devices, intumescent strips and cold smoke seals) resulting in ineffective compartmentation had been identified by the fire risk assessments as a problem that required attention across the TMO's estate.[60] Mr Black was also aware of the Fire Safety Management report dated 22 September 2009 produced by Salvus for the TMO,[61] which drew attention to 19 respects in which Salvus considered the TMO to be in breach of the Fire Safety Order.[62]

31.37 In December 2009, Janice Wray prepared a report for a meeting of the TMO board on 10 December 2009.[63] It is likely that a copy was provided to Mr Black.[64] In relation to the Salvus Fire Safety Management report it simply said that a management report had been received from the consultant which set out the fire safety framework within which the TMO and its contractors should be working.[65] It said nothing about the 19 breaches of the Fire Safety Order that had been identified and gave the board no information about the serious defects that Salvus

60 Black {Day150/3:18-25}.
61 Fire Risk Assessment for Fire Safety Policy and Procedures prepared by Salvus Consulting Ltd {SAL00000013}.
62 Black {Day150/4:15-19}.
63 {TMO00873623}.
64 Cover Letter to Board Member dated 4 September 2009 {TMO00881999}; Enclosure 16 {TMO00888764}; Board Action Sheet {TMO00882005/20}.
65 {TMO00873623/2} paragraph 4.5.

had found in the TMO's management of fire safety across its estate. There is no evidence that Mr Black presented the report to the board and no recorded explanation or discussion of its contents. We can only conclude that he and the executive team failed to make even the most basic disclosure to the board of the widespread systemic failings in the TMO's management of fire safety that Salvus had found. Janice Wray was seriously at fault in not writing a candid report for the board; Mr Black was equally at fault in failing to inform the board about the deficiencies in fire safety management.

31.38 Following the board meeting, Mr Black, Laura Johnson and Jean Daintith produced a report for the meeting of RBKC's Housing, Environmental Health and Adult Social Care Scrutiny Committee on 15 March 2010, which included an item on the TMO's fire risk assessment programme.[66] Paragraph 3 of the report said that the increasingly stringent requirements of the LFB had led the TMO and RBKC to agree a new approach to fire risk assessments and carrying out any remedial work required as a result. The report did not mention that the LFB had been so concerned about the adequacy of the fire risk assessments carried out by the TMO itself that it had considered issuing an

66 {RBK00030060}.

enforcement notice.[67] Mr Black could not account for that omission,[68] nor could he recall whether the scrutiny committee had been told of Salvus's recommendations or the TMO's response to them.[69] Robert Black's failure to disclose those matters was part of an emerging pattern of withholding from those to whom he reported the fact that there were serious problems with the management of fire safety by the TMO.

A fire at Grenfell Tower: 30 April 2010

31.39 On 30 April 2010, a fire broke out in the lift lobby on floor 6 of Grenfell Tower. On 5 May 2010 Janice Wray sent an email to Collette O'Hara of the LFB (with a copy to Robert Black) giving her report on it.[70] She said there had been a leakage of smoke from the extraction system into the lobbies of floors 7, 12, 13, 15, 17, 18, 19 and 20 that had led a number of residents to believe that their lobbies were smoke-logged and that they were trapped in their homes. They had therefore telephoned the LFB asking for help.

31.40 When Janice Wray reported the incident to the TMO board in her report of 17 June 2010,[71] she did not say that smoke had leaked into

67 Black {Day150/9:8-14}.
68 Black {Day150/9:21-22}.
69 Black {Day150/9:24}-{Day150/10:5}.
70 {TMO10048221/4}.
71 {TMO10037437/96-97} paragraphs 8.2 and 8.3.

the lobbies on eight floors (as described in the email to Collette O'Hara) nor did she mention the residents' belief that they had been trapped in their flats and had called the LFB. The report gave the impression that the smoke ventilation system had operated substantially as intended, but with some relatively minor leakage.[72] It grossly understated the extent to which smoke had spread within the tower and was seriously misleading. Mr Black accepted that it did not give the board proper information about the operation of the smoke ventilation system or, importantly, the residents' fear that they were trapped. Again, Mr Black could not explain why the board had been given a materially incomplete account.[73] He had seen Janice Wray's original report to Collette O'Hara and should have corrected the false impression that Ms Wray's report gave.

31.41 In March 2014 the LFB issued a deficiency notice to the TMO because of its failure to maintain the smoke ventilation system at Grenfell Tower.[74] The system was finally replaced in 2016 as part of the refurbishment, but between 2010 and 2016 there was no fully functioning smoke ventilation system.[75] We return to this episode later in Chapter 43 because it seems that, as

72 {TMO10037437/97} paragraph 8.3.
73 Black {Day150/31:11}-{Day150/32:4}.
74 {LFB00032101}.
75 Black {Day150/45:5-8}.

Mr Black accepted, the absence of a functioning smoke ventilation system was the subject of repeated complaints by the Grenfell Tower Leaseholders' Association.

31.42 The next TMO board meeting took place on 22 May 2014. Robert Black prepared a report for that meeting which was circulated in advance.[76] It made no mention of the deficiency notice. Although he accepted that it was essential information for the board to receive, Mr Black could not explain why it had not been placed before it.[77] The omission can only have been deliberate. Yet again, Mr Black's failure to provide the board with important information relating to fire safety in the TMO's housing stock deprived it of the ability to take corrective action.

Adair Tower Deficiency Notice

31.43 On 12 October 2015, the LFB issued a deficiency notice in respect of Adair Tower.[78] Some of the contraventions of the Fire Safety Order identified by the LFB resulted from failures to carry out remedial works called for in fire risk assessments.[79] Janice Wray received the notice

76 TMO Board document pack {RBK00051017}; Chief Executive's report {RBK00051017/27-28}.
77 Black {Day150/101:2-24}.
78 {TMO00842271}.
79 Black {Day150/138:6-14}.

on 22 October 2015,[80] but she did not bring it to Robert Black's attention until the morning of 31 October 2015, when a fire occurred at Adair Tower.[81] Mr Black accepted that that had been a serious failing on her part,[82] but it was consistent with a culture of concealment that had started at the top and filtered down to lower layers of management.

31.44 In the evening of 31 October 2015, Robert Black sent an email to the members of the TMO board to tell them about the fire.[83] Although he emphasised the LFB's success in tackling it, he made no mention of the deficiency notice. The issue of such a notice was an obviously important piece of information, given that a fire had broken out only two weeks later in that very building. Yet again, Mr Black was unable to explain why he had not told the board about it.[84] We can only conclude that his failure to do so was deliberate.

31.45 On 4 November 2015, Rebecca Burton of the LFB sent an email to Janice Wray containing a list of questions relating to the Adair Tower fire.[85] The email chain had originated with Janice Wray on 22 October 2015 because she had been told that

80 {LFB00001645}.
81 Black {Day150/139:25}-{Day150/140:5}.
82 Black {Day150/140:6-8}.
83 {TMO00866480/2}.
84 Black {Day150/143:3-7}.
85 {TMO00869184/3}.

the LFB was about to issue five more deficiency notices relating to other properties managed by the TMO.[86] Some of them were based on the absence of effective self-closing devices on doors in buildings that had been inspected.[87]

31.46 Janice Wray forwarded the correspondence between herself and Rebecca Burton to Robert Black and others the same day. Mr Black could not remember whether he had read it or had been made aware that the LFB was about to issue more deficiency notices, but he accepted that it was likely that he had.[88]

31.47 On 5 November 2015, Mr Black attended a meeting of RBKC's Housing and Property Scrutiny Committee. The minutes of that meeting record that he provided a report on the fire at Adair Tower, in which he said that the fire doors had worked well.[89] He did not mention the deficiency notice that had been issued 19 days before the fire. Mr Black could not recall why the committee had not been told about the deficiency notice,[90] but the omission cannot have been accidental.

86 {LFB00003440}.
87 {TMO00869184/6}.
88 Black {Day150/147:10-17}.
89 {RBK00048049/6}.
90 Black {Day150/143:3-7}.

31.48 The fact that a deficiency notice had been issued, not to mention its contents, was clearly a matter of some importance and should have been drawn to the attention of the scrutiny committee.[91] Robert Black's failure to report those matters to the committee was a serious dereliction of duty on his part, but entirely consistent with the pattern of concealment he had established in relation to fire safety matters.

31.49 On 4 December 2015, Barbara Matthews sent an email to the members of the TMO board (including Mr Black) telling them that the LFB intended to serve enforcement notices in relation to Adair Tower and Hazelwood Tower.[92] Again, the email is instructive as much for what is not said as for what is. She did not mention the deficiency notice issued on 12 October 2015, nor did she mention the various enforcement measures available to the LFB, although in a draft message to the board composed only two days earlier Robert Black had identified them.[93] Neither Barbara Matthews[94] nor Robert Black[95] could explain why the fact that a deficiency notice

91 Marshall {Day133/137:5-15}.
92 {TMO00902920}.
93 {TMO00902919}.
94 Matthews {Day148/81:16}-{Day148/82:5}.
95 Black {Day150/164:18}-{Day150/165:22}.

issued on 12 October 2015 had again not been mentioned. Again, the omission can only have been deliberate.

31.50 An enforcement notice dated 23 December 2015 was served by the LFB on the TMO in relation to breaches of the Fire Safety Order identified following the fire at Adair Tower.[96] The enforcement notice required the TMO to take steps to remedy the failures specified in the schedule to the notice by 23 June 2016.[97]

31.51 On 6 July 2016, Janice Wray spoke to Ben Dewis of the LFB. During that call he told her about the current status of the LFB's investigation into the Adair Tower fire and the possibility of enforcement action. Janice Wray sent a note of the call by email to Laura Johnson, Robert Black and Barbara Matthews.[98] In it she said that she was concerned to hear that investigations were continuing.[99] Mr Black accepted that he must have seen and read the note[100] which made it clear that the LFB were considering taking legal action against the TMO in respect of breaches of the Fire Safety Order, including possible criminal proceedings, although, as the note recorded, Mr Dewis felt that was unlikely.

96 {TMO00840703}.
97 {TMO00840703/1-2}.
98 {RBK00001865}.
99 {RBK00001863}.
100 Black {Day150/206:5-7}.

31.52 Robert Black reported to the TMO board on 20 July 2016. His report, which was circulated to the members before the meeting,[101] did not mention the possibility that criminal proceedings might be taken against the TMO. Once more, he was unable to explain why he had not told the board about a potential prosecution for failing to comply with the Fire Safety Order, which was obviously a serious matter.[102] It was his responsibility, as he accepted, to keep the board informed about anything that might affect its legal position,[103] but although he denied that he had deliberately withheld the information from the board, we are unable to accept that it was the result of a mere oversight.[104]

31.53 On 17 November 2016, the LFB issued a deficiency notice to the TMO in respect of Grenfell Tower.[105] It was based on the absence of self-closing devices on some doors in the building, which was a potential breach of the Fire Safety Order. The notice required remedial action to be taken by 18 May 2017.

31.54 The events we have described lead us to conclude that although there was a satisfactory system in place within the TMO for reporting

101 {TMO10014037/68}.
102 Black {Day150/209:19}-{Day150/210:18}.
103 Black {Day150/142:24}-{Day150/143:2}.
104 Black {Day150/201:2-18}.
105 {TMO10017254}.

through senior management to the board and the scrutiny committee, it failed to operate effectively because of an entrenched reluctance on the part of Robert Black to inform the board and RBKC's scrutiny committees of matters that affected fire safety. It was his decision whether to report to the board what he knew about problems with fire safety at the TMO and he consistently chose not to do so. Robert Black consistently failed to tell either the board or RBKC of the LFB's concerns about the TMO's compliance with the Fire Safety Order or the various steps taken by the LFB to enforce it. His persistent failure to provide them with important information denied both the board and RBKC of the ability to exercise effective oversight of the TMO's performance of its obligations under the Fire Safety Order.

Chapter 32
RBKC's oversight of the TMO

Introduction

32.1 This chapter considers the arrangements under which RBKC exercised oversight of the TMO in relation to health and safety matters generally and fire safety in particular.

RBKC's constitutional arrangements

32.2 RBKC carried on its operations partly through executive members of the council, partly through committees, including the scrutiny committees, and partly through the full council made up of 50 elected councillors.

The executive

32.3 The executive was composed of individual councillors each responsible for a particular area of the council's functions. It was referred to as "the cabinet" when it met collectively and individual councillors were known as "cabinet members".[106] The cabinet could comprise up to ten councillors, including the leader, who appointed the members and decided which portfolio each

[106] Part two, article 7 of the RBKC constitution {RBK00035010/1} paragraph 7.01(a).

would hold.[107] The executive carried out all those functions that were not reserved to the full council or otherwise delegated to committees, sub-committees or officers.[108]

32.4 In 2013, Councillor Paget-Brown, the leader of the council, appointed Councillor Feilding-Mellen as the cabinet member for housing, property and regeneration. He served in that role until after the Grenfell Tower fire.[109]

32.5 The leader of the council was responsible for all portfolios and could make any decision that may have been delegated to an individual cabinet member or to the cabinet.[110] Councillor Paget-Brown said that, as leader, his responsibilities included decisions relating to housing, but not to projects such as the refurbishment of Grenfell Tower.[111] However, he accepted that he had been responsible for ensuring that Councillor Feilding-Mellen was properly discharging his responsibilities as the cabinet member for housing, property and regeneration,[112] which included the oversight

107 Paget-Brown {Day132/134:22}-{Day132/135:2}.
108 Part two, article 7 of the RBKC constitution {RBK00035010/1} paragraph 7.01(a).
109 Paget-Brown {Day132/135:3-10}; Feilding-Mellen {Day131/82:23-24}.
110 Part three, article 1 of the RBKC constitution {RBK00035007/4} paragraph 1.7.
111 Paget-Brown {Day132/144:3-20}.
112 Paget-Brown {Day132/145:3-16}.

of fire safety within the TMO's buildings,[113] communicating with the LFB,[114] social housing projects and the proper management of the TMO[115] and the welfare of those who lived in RBKC's properties.[116]

32.6 The responsibilities of the cabinet member for housing, property and regeneration were set out in paragraph 1.8 of part 3A of RBKC's constitution. In relation to housing matters, they included responsibility for leadership, strategic planning and decision-making in respect of all social housing regeneration projects, policies on maintenance of the social housing stock and the TMO management agreement.[117]

The scrutiny committee

32.7 RBKC had a number of scrutiny committees, but for our purposes only the Housing and Property Scrutiny Committee (the scrutiny committee) is relevant. It had 11 members, whose function was to scrutinise the provision, planning, management and performance of all housing services, social housing regeneration,

113 Paget-Brown {Day132/148:3-16}.
114 Paget-Brown {Day132/145:3-16}.
115 Paget-Brown {Day132/149:1-5}.
116 Paget-Brown {Day132/149:6-9}.
117 Part three, article 1 of the RBKC constitution {RBK00035007/5} paragraph 1.8.

the TMO, housing strategy and the financing and development of the council's housing stock,[118] based on the information provided to it.[119]

32.8 Between 13 October 2010 and 11 May 2016, Councillor Quentin Marshall was chairman of the scrutiny committee.[120] He was succeeded by Councillor Sam Mackover, who chaired his first scrutiny committee meeting on 13 July 2016.[121]

Scrutiny of fire safety matters

32.9 Fire safety fell within the scope of responsibility of both the scrutiny committee and the Cabinet and Corporate Services Scrutiny Committee. The scrutiny committee had a responsibility for it because residents of the council's housing stock were affected by arrangements relating to fire safety.[122] The Cabinet and Corporate Services Scrutiny Committee also had a responsibility for it because fire safety was an aspect of community safety and emergency planning.[123] The scrutiny committee received reports from

118 Part two, article 6 of the RBKC constitution {RBK00035012/3-4} paragraph 6.03(a) and (b).
119 Feilding-Mellen {Day131/91:21-24}.
120 Marshall {RBK00033744/2} page 2, paragraph 9; Marshall {RBK00033744/28} page 28, paragraph 118.
121 Mackover {RBK00029923/5} page 5, paragraph 20.
122 Mackover {Day134/3:13-17}.
123 Mackover {RBK00029923/9} page 9, paragraph 40.

RBKC's Housing department on fire safety across the council's estate, including the buildings managed by the TMO.[124]

RBKC's fire safety policy

32.10 RBKC's fire safety policy dated January 2014[125] was produced in conjunction with the London Borough of Hammersmith and Fulham. It set out the strategy and organisational arrangements for the management of fire safety within RBKC[126] and described how RBKC could manage fire safety effectively.[127]

32.11 The fire safety policy applied to any premises in respect of which other parties were the responsible persons by virtue of a contract or tenancy agreement, but in respect of which RBKC retained responsibilities as landlord.[128] Accordingly, the policy applied to the premises managed by the TMO.[129] It required RBKC's health and safety team to have appropriate processes in place to ensure that suitable and sufficient fire safety management systems had

124 Feilding-Mellen {Day131/97:8-15}; {Day131/95:10-13}; Mackover {Day133/95:11-16}; Marshall {Day133/95:11-16}.
125 {RBK00001655}.
126 {RBK00001655/2} final paragraph.
127 {RBK00001655/3}.
128 {RBK00001655/4} paragraph 2.2.
129 Paget-Brown {Day133/7:4-9}.

been established and that suitable protocols had been devised to ensure that compliance with fire safety requirements was assured.[130]

RBKC's arrangements for monitoring the TMO

32.12 Celia Caliskan was the general needs housing commissioning manager in RBKC's Housing Commissioning Team.[131] From 2005, she was directly responsible for managing the agreement between RBKC and the TMO.[132] Between 2011 and 2017 she reported to Amanda Johnson.[133]

32.13 Until 2016 Celia Caliskan was one of two officers in RBKC's housing commissioning team who reported to Ms Johnson on matters relating to general needs commissioning, which had been delegated to the TMO.[134] In 2016, she became the only officer dedicated to that task, because the second officer was made redundant and was

130 {RBK00001655/5} fifth paragraph.
131 RBKC organograms contained within {RBK00000278}.
132 Amanda Johnson {Day130/136:16-18}; {Day130/144:4-6}; Caliskan {RBK00035166/3} page 3, paragraph 11.
133 Amanda Johnson {Day130/137:2}-{Day130/140:7}; RBKC organograms contained within {RBK00000278}.
134 Amanda Johnson {Day130/143:25}-{Day130/144:3}.

not replaced in order to save costs.[135] Much of the work involved in overseeing the agreement was thereafter left to Celia Caliskan.[136]

32.14 Amanda Johnson became the permanent head of the housing commissioning team at around the end of 2010 and was then involved in overseeing the TMO.[137] As Celia Caliskan's line manager, she was responsible for monitoring the performance of the TMO.[138]

Annual performance reviews and performance agreements

32.15 Every July reports on the performance of the TMO were prepared for the scrutiny committee.[139] They incorporated as appendix 1[140] a review of the TMO's performance and (as appendix 2) the performance agreement for the coming year.[141] The annual performance agreement was drawn up in consultation with the TMO. It contained key performance indicators and "actions" for the

135 Amanda Johnson {Day130/144:12-19}.
136 Amanda Johnson {Day130/149:2-4}.
137 Amanda Johnson {Day130/133:10-12}.
138 Amanda Johnson {Day130/139:16-19}.
139 For example {RBK00032466}.
140 {RBK00032466/4}.
141 {RBK00032466/18}.

TMO to take during the coming year. It also set out the annual cycle of auditing of the TMO to be carried out by RBKC.[142]

32.16 The stated purpose of the annual performance agreement was to set out how the performance of the TMO would be monitored by the council over the coming year in accordance with its priorities and national and local requirements.[143] The stated purpose of the annual review was to allow the council to assess the TMO's performance over the past year and to comment on various aspects of its activity in the borough that contributed to the council's strategic priorities.[144]

Absence of fire safety as a key performance indicator

32.17 Although the key performance indicators evolved over the years,[145] none related to fire safety or fire safety management, fire risk assessments, or performance by the TMO of its duties under the Fire Safety Order. Although both RBKC and the TMO were aware of the delay in completing work identified in fire risk assessments, none of the annual performance agreements contained a performance indicator based on their full and

142 Amanda Johnson {RBK00033719/7} page 7, paragraph 38.
143 {RBK00032466/18}.
144 {RBK00032466/4}.
145 Caliskan {RBK00035166/5} page 5, paragraph 24.

prompt completion. Although Laura Johnson conceded that fact, she said that the contents of mid-year and annual reports to the scrutiny committee did provide current information about fire risk assessments.[146] She also made the point that the focus of key performance indicators was on the "big six" matters[147] and that the details of compliance were monitored by the TMO's health and safety committee.[148]

RBKC's oversight

32.18 RBKC's function was to exercise strategic oversight of the TMO's activities, not to monitor its operations on a day-to-day basis.[149] It had monitored fire safety in the same way as it had monitored other areas of activity requiring compliance with its legislative and regulatory obligations, and the TMO reported on its performance in respect of fire safety in the six-monthly and annual reviews.[150] Laura Johnson also discussed matters relating to fire safety at her monthly meetings with Robert Black.[151]

146 Laura Johnson {Day128/220:3-11}.
147 Fire safety, legionella, asbestos, gas, electricity and lifts.
148 Laura Johnson {Day128/220:16-25}.
149 Laura Johnson {Day129/38:3-16}.
150 Laura Johnson {Day129/39:15-21}.
151 Laura Johnson {Day129/59:11}-{Day129/60:19}.

32.19 Janice Wray's understanding was that the management of health and safety at the TMO was monitored primarily by RBKC's Corporate Health and Safety Advisor and its main Health and Safety Co-ordinating Committee.[152] Laura Johnson's understanding was that RBKC's Housing department had not monitored health and safety at the TMO. She admitted that she had not been aware that the annual health and safety report had been presented to the RBKC corporate health and safety manager. She conceded that, in hindsight, that had been a weakness in RBKC's governance arrangements.[153]

32.20 The annual performance agreement required reports on discrete areas, one of which was always health and safety. The health and safety reports were drafted by Janice Wray. The broad purpose of their inclusion was to draw attention to any relevant developments.[154]

32.21 Celia Caliskan said that she received information from Janice Wray, which she used for drafting the performance review.[155] The division of labour between Celia Caliskan and Janice Wray is usefully demonstrated by a draft version of the 2016-17 annual performance review, in which

152 Wray {TMO00000890/37} page 37, paragraph 164.
153 Laura Johnson {Day129/67:1}-{Day129/68:14}.
154 For example {RBK00032466/23-24}.
155 Caliskan {RBK00054409/5} page 5, paragraph 13.

the person responsible for drafting each section appears to be marked in red.[156] The health and safety section of the report is marked "TMO" and ''Janice"[157] Janice Wray confirmed that she had drafted the health and safety sections of the performance reviews.[158] Amanda Johnson said that Celia Caliskan relied heavily on Janice Wray for the information contained in the report.[159] Although Amanda Johnson said that she would scrutinise the contents of Janice Wray's reports, she accepted that they contained no independently verified information about the TMO's performance.[160]

32.22 Laura Johnson also confirmed that the health and safety sections of the annual performance review had been drafted by Janice Wray and Celia Caliskan.[161] Some of them, such as the health and safety section of the annual performance review for 2013/14, contained judgments and assessments that reflected well on how fire safety was being managed by the TMO.[162] In practice, Janice Wray was effectively writing her own reference.

156 {RBK00002395/15}.
157 {RBK00002395/15}.
158 Wray {Day140/84:10-14}.
159 Amanda Johnson {Day130/209:21}.
160 Amanda Johnson {Day130/210:3}-{Day130/211:4}.
161 Laura Johnson {Day129/145:24-25}.
162 {RBK00032466/15-16} paragraph 3.9.

RBKC's audits of the TMO

32.23 The purpose of RBKC's audits on behalf of the TMO was to provide senior management and members of the TMO with assurance about the adequacy and effectiveness of the internal controls in the area being audited. The audits considered each service area and gave an assurance assessment rating ranging from "substantial" to "limited". Where the rating was "limited", a further exercise was usually undertaken within six to nine months to assess the effect of remedial measures.[163]

32.24 RBKC produced an audit plan for the TMO every three to five years in order to ensure that the areas of interest were audited at least once every five years.[164] The plan was approved by the TMO's Finance, Audit and Risk Committee at the beginning of each year.[165] RBKC allocated a maximum of 100 audit days to the TMO a year.[166]

32.25 A list of audits was provided for in the annual performance agreement between the TMO and RBKC.[167] They were carried out by RBKC's internal audit department as part of its corporate

163 Patel {RBK00029884/2} page 2, paragraph 5.
164 Patel {RBK00029884/3} page 3, paragraph 9.
165 Patel {RBK00029884/2} page 2, paragraph 7.
166 Patel {RBK00029884/3} page 3, paragraph 10.
167 {RBK00030149/22}.

function rather than the housing department.[168] At the conclusion of an audit, the auditors would provide the TMO officers in charge of the relevant departments with a draft of their report which would be reviewed by TMO before it was formally issued. The TMO was given two weeks to provide its responses to the report's recommendations together with an indication of the time within which any necessary steps would be implemented.[169]

32.26 The annual performance agreement forming part of the report to the scrutiny committee in July 2012 identified that an audit in relation to fire risk assessments by the TMO was due to take place in 2012.[170] There is no evidence that it did in fact take place.[171]

32.27 RBKC carried out three separate audits of health and safety management at the TMO between 2013 and 2016. The first was undertaken in 2013.[172] Its purpose was to examine how health and safety policies and procedures were being implemented. The TMO received a "limited" assurance rating in respect of that audit.[173] A follow-up audit was carried out in December 2013 when the TMO was given a "satisfactory"

168 Amanda Johnson {RBK00033719/9} page 9, paragraph 50.
169 Patel {RBK00029884/3} page 3, paragraph 10.
170 {RBK00030149/22}.
171 Amanda Johnson {Day131/32:17-25}.
172 {RBK00000313}.
173 Amanda Johnson {Day131/33:3-16}.

rating.[174] The final audit took place in March 2016.[175] It was a high-level audit with a budget of 10 audit days. The TMO received a "substantial" assurance rating.

32.28 Two other significant reviews of the TMO specifically in respect of the management of fire safety were carried out by external parties at the request of the TMO. The first was carried out by Salvus Consulting Ltd in September 2009, which specifically considered fire safety policy and procedures.[176] The second was a safety management review carried out by Matt Hodgson in July 2013.[177] We address these in detail in Chapter 37.

174 {RBK00000320}.
175 {RBK00000531}.
176 {SAL00000013}.
177 {TMO10040497}.

Chapter 33
The TMO's relationship with its residents

Complaints

33.1 In the first part of this chapter, we consider the various mechanisms by which the residents of Grenfell Tower were able to express their views about the quality of the services provided by the TMO. Those mechanisms were not confined to personal representations; they included membership of the various groups that the TMO recognised as representing residents and membership of unofficial organisations set up by residents who were concerned that their views were not being heard, or at least not being heeded, by their landlord.

The Memoli and the Butler reports

33.2 In July 2008, RBKC asked Maria Memoli, a retired solicitor, to investigate longstanding complaints made against the TMO by residents of its properties and to establish whether there were any common themes that could inform a plan for improvement.[178] Her initial report,

[178] {TMO00888711/2} paragraph 1.1.

dated 10 April 2009 (the Memoli report), made serious criticisms of the TMO's relationship with its tenants, leaseholders and some freeholders, particularly as it affected repairs, major works, management charges, service charges, customer care, probity and ethics, communications, performance and monitoring, and trust and confidence. Complaints had not been resolved, it was felt, for some years.[179] The report concluded that the TMO's board should understand better its constitutional and legal role and take collective responsibility to lead the work required by the TMO's improvement plan.[180] It made 34 recommendations.

33.3 Robert Black, who had become the TMO's chief executive officer in May 2009, said that, although he had been made aware of the Memoli report, he could not remember having been given a copy of it.[181] He recalled a report that had made serious criticisms of the TMO's governance and its relationship with its tenants,[182] but his impression had been that RBKC had not been particularly impressed by it.[183]

179 {IWS00001462}.
180 {IWS00001462/3}.
181 Black {Day151/55:2}-{Day151/56:5}.
182 Black {Day151/61:16-22}.
183 Black {Day151/58:16-24}.

33.4 A final report, dated 22 September 2009, was produced by John Butler (the Butler report), also commissioned by RBKC, which made a number of recommendations echoing Maria Memoli's proposals, such as requiring that every complaint be investigated as appropriate.[184] Most importantly for our purposes, the Butler report made a number of observations that are relevant to the difficulties affecting the TMO's relationship with its residents throughout the time with which we are concerned. Although the Butler report noted that governance, customer service, staff attitudes and a poor repairs service were constant themes of the investigation, it is noteworthy that it considered that the residents' lack of trust in the TMO lay at the heart of the troubled relationship.[185]

33.5 RBKC and the TMO responded to the 34 recommendations of the Memoli report and their responses were included in appendix 2 to the Butler report.[186] In the light of how the relationship between the TMO and the Grenfell community evolved in the years between 2010 and 2017, the following recommendations and responses are particularly relevant:

a. In response to the recommendation that there be a process of mediation or conciliation to

184 {TMO00888711/2} paragraph 1.4.
185 {TMO00888711/5-6} paragraphs 4.2 and 4.4.
186 {TMO00894426}.

rebuild relationships with residents of the TMO, RBKC replied that the approach to resident consultation was under review and that it would consider the results.[187]

b. In response to the recommendation that TMO staff should take a more active approach and that the TMO's contractors should share information with residents about prospective work schedules, planned maintenance and emergency works on estates, the response was that the TMO had recently published a five-year capital works programme to residents,[188] one purpose of which was to give leaseholders a chance to plan for their share of the cost.[189]

c. In response to the recommendation that the TMO should be conscious of the diversity of its residents, the response was that it had devised an equality and diversity action plan which was intended to inform all aspects of service improvement plans.[190] Although Robert Black told us that he thought that the plan actively identified those with mental or physical disabilities or disadvantages, he did not appear to know whether in fact it did so.[191]

187 {TMO00894426/2}.
188 {TMO00894426/3}.
189 Black {Day151/67:14}-{Day151/68:10}.
190 {TMO00894426/3}.
191 Black {Day151/70:16-24}.

d. In response to the recommendation that RBKC and the TMO should re-examine their relationship with each other to ensure openness, transparency and trust and to address an historic "them and us" culture,[192] it was said that the problem had been resolved by changes at executive level within RBKC and the TMO. Robert Black explained that it had involved increasing engagement between various people in RBKC and the TMO, as well as other organisational changes within the TMO.[193]

e. In response to the recommendation that RBKC should be more robust in making sure that the TMO's technical services were capable of delivering an effective major works programme and cyclical repairs,[194] RBKC and the TMO said that the TMO had arrangements in place for managing contracts effectively. Laura Johnson told us that Robert Black acted on that recommendation before the Grenfell Tower refurbishment project began.[195]

33.6 Those recommendations are striking, both in their prescience and as a measure of the TMO's failure thereafter. They could just as well have

192 {TMO00894426/4}.
193 Black {Day151/71:3}-{Day151/73:15}.
194 {IWS00001462/4}.
195 Johnson {Day128/190:1-17}.

been contained in this report, given what we have found. It says much about the TMO's character as an organisation that, despite those penetrating reports, eight years later it showed little sign of any change and appeared to have learnt nothing about how to treat, or relate to, its residents.

Complaints procedures and management systems from 2009

33.7 The TMO had a complaints policy that set out the procedure to be followed when a resident made a formal complaint.[196] It was intended to be reviewed every three years and was communicated to residents through leaflets, posters in the housing offices and on the TMO's website.[197] In the event, however, the policy published in 2010 was reviewed only in 2015, when it was revised by broadening the definition of a complaint and by the introduction of a procedural hierarchy for different forms of communication from residents.[198]

196 An earlier version dated May 2010 {TMO00831399} and a revised version dated July 2015 {TMO00879692}.
197 Birch {TMO00879690/2} page 2, paragraphs 8 – 9.
198 {TMO10026197/2}.

33.8 Yvonne Birch was responsible for managing the complaints procedure from 2012. She received reports from Janet Seward, the TMO's policy and improvement manager, who oversaw the administration of the complaints team's work.[199]

Residents' Associations

33.9 Between 2010 and 2017, there were, at various times, four groups and associations representing the residents of Grenfell Tower. They were the Lancaster West Residents' Association, the Grenfell Action Group, the Grenfell Tower Leaseholders' Association and the Grenfell Tower Compact.

Lancaster West Residents' Association

33.10 The Lancaster West Residents' Association was founded in 1977.[200] Before 2015, it was a vehicle for raising residents' concerns with the TMO and providing support to members of the community more generally.[201]

33.11 In September 2015, the TMO called a meeting of the Association which led to the formation of a new committee and a new constitution.[202] The aim was to strengthen the Association, increase

199 Birch {TMO00879690/1} page 1, paragraph 5.
200 Burke {IWS00001544/2} page 2, paragraph 9.
201 Richer {IWS00002345/2-3} pages 2-3, paragraph 9.
202 {MET00049167}.

active participation in its work and provide a more cohesive community by putting on social events and activities.[203]

33.12 Over the next few years, although the Association appears to have had some communication with residents' groups associated with Grenfell Tower, it had little involvement in the disputes that later arose between them and the TMO.

Grenfell Tower Leaseholders' Association

33.13 The Grenfell Tower Leaseholders' Association was founded by Shahid Ahmed in 2010[204] to give Grenfell Tower's leaseholders one voice.[205] By 2010, the leaseholders believed that the heating system was poor and that the building in general was poorly maintained. Mr Ahmed used the Leaseholders' Association to try to improve the management of the building.[206]

33.14 The constitution of the Leaseholders' Association provided that its aims were to look after the leaseholders' interests and to work with RBKC and others to do so.[207] The Association had 12

203 Blanchflower {IWS00002072/4} page 4, paragraph 12.
204 Ahmed {IWS00001335/4} page 4, paragraph 13.
205 Ahmed {IWS00001335/4} page 4, paragraph 13.
206 Ahmed {IWS00001335/4} page 4, paragraph 13.
207 {IWS00001386}.

members. Mr Ahmed was the chairman and Tunde Awoderu the vice-chairman. Keith Mott was secretary and treasurer.[208]

33.15 Mr Ahmed said that he had done almost all the work for the Association after Mr Mott moved away in 2013. Mr Ahmed was worried that raising concerns would lead to reprisals from the TMO, and even the forfeiture of his lease. For that reason, although letters and emails were drafted by Mr Ahmed, they were signed in Tunde Awoderu's name with his permission.[209] Although Mr Awoderu was a leaseholder, he did not live in the tower. He rented his flat to tenants and so, presumably, was thought to be less exposed to any risk of reprisal.

33.16 The Leaseholders' Association held meetings from time to time to which all members were invited. At around the time proposals for the refurbishment were being made there were more frequent meetings which all members attended.

33.17 When problems arose, Mr Ahmed sent emails directly to individuals at RBKC or the TMO; he did not make use of the complaints procedure, in which he said he had no faith.[210] He frequently sent emails first to the local ward councillors

208 Ahmed {IWS00001335/4-5} pages 4-5, paragraph 13.
209 Ahmed {IWS00001335/5} page 5, paragraph 14.
210 Ahmed {IWS00001335/6-7} pages 6-7, paragraph 16.

and often to Councillor Judith Blakeman. He would also copy his correspondence to many, if not all, of the other councillors and officers of RBKC and the TMO.

33.18 Although the concerns of the Leaseholders' Association were initially directed to the reasonableness of the service charge and the quality of services, over time they developed to encompass a broad range of matters affecting the tower, one of which was fire safety. On 30 April 2010, there was a fire on floor 6 of the tower, as a result of which smoke leaked from the smoke ventilation system into the lobbies on a number of floors, in some cases a long way from the seat of the fire.[211] After that, some residents complained about the efficiency of the smoke ventilation system[212] and Mr Ahmed raised concerns about the TMO's attitude to fire safety generally.[213] He said he had never received a proper response from the TMO despite repeating his concerns for several years after the fire.[214] Mr Ahmed said that he had felt that the TMO had misrepresented the seriousness of the fire by,

211 {TMO00847309/1}.
212 Blakeman {RBK00054461/15} page 15, paragraph 76.
213 Burton {IWS00001661/2} page 2, paragraph 8.
214 Ahmed {IWS00002369/3} page 3, paragraph 8.

among other things, understating the number of people who had been injured, among whom had been his wife.[215]

Grenfell Action Group

33.19 Grenfell Action Group was set up in 2010 by Edward Daffarn and Francis O'Connor, both of whom lived in the tower.[216] Mr Daffarn said that he founded the group by putting up a poster in the tower in June 2010.[217] He later met Francis O'Connor and Teresa Miles, whose husband, Keith Miles, was the chair of the Lancaster West Residents' Association. Mr Daffarn told us that the Grenfell Action Group had four members: Francis O'Connor, Teresa Miles, Peter Martindale and himself.[218] Rob Regan had also possibly been a member.[219]

33.20 According to Mr Daffarn, the Group was formed because of dissatisfaction with the Lancaster West Residents' Association and the moribund Estate Management Board.[220] (The Estate Management Board had been created in or about 1993[221] and was the precursor

215 Ahmed {IWS00002369/4} page 4, paragraph 10 c.
216 Daffarn {IWS00000169/7} page 7, paragraph 18.
217 Daffarn {Day118/12:13-20}.
218 Daffarn {Day118/12:1-6}.
219 Daffarn {Day118/12:3-6}.
220 Daffarn {IWS00002109/49} page 49, paragraph 124.
221 Caliskan {RBK00035166/4} page 4, paragraph 19.

of the TMO, to which it later delegated most of its functions.[222] In 2010, RBKC became concerned about its effectiveness and its ability properly to oversee the TMO. Eventually, in 2014 or thereabouts, the Estate Management Board ceased to function.)[223] Mr Daffarn said that the Group intended to speak on behalf of all Lancaster West residents whose lives were to be affected by the KALC project.[224] Indeed, the first poster that Mr Daffarn put up in 2010 concerned information that residents had received from Councillor Blakeman about the KALC project.[225]

33.21 From 2012 onwards, both Mr O'Connor and Mr Daffarn tried to obtain recognition by both RBKC and the TMO of a residents' association called "Grenfell Action Group". In September 2012, Mr Daffarn applied successfully to RBKC for the Group to be added to its list of recognised tenants' and residents' associations.[226] Attempts were also made to register the Group as a residents' association with the TMO, but the TMO refused to give it official recognition. In August 2012, Edward Daffarn told Janet Edwards of the TMO that the Group was in the process of being registered with RBKC as a residents' association

222 Johnson {RBK00033719/23-24} pages 23-24, paragraph 115.
223 Johnson {RBK00033719/24} page 24, paragraphs 116-119.
224 Daffarn {IWS00002109/49} page 49, paragraph 126.
225 Daffarn {Day118/12:13-25}.
226 {IWS00002154}.

and he asked her for the form to apply for similar recognition by the TMO.[227] For some reason it was not forthcoming.

33.22 On 20 August 2012, there was a meeting between Mr Daffarn, Janet Edwards and Teresa Miles,[228] at which the TMO refused to recognise the Group. Following the meeting, Mr Daffarn asked the TMO to give written reasons for its decision. In reply Ms Edwards told him that a residents' association already existed on the Lancaster West Estate and that the TMO could not recognise another one. She then suggested that Grenfell Action Group consider becoming a sub-group of the Lancaster West Residents' Association. Ms Edwards told him that she had sought advice from the Tenancy Participation Advisory Service, which discouraged landlords from supporting and recognising two residents' associations in relation to the same estate because of the risk of conflict.[229]

33.23 On 3 September 2012, Jon Warnock of the Tenancy Participation Advisory Service sent an email to Janet Edwards suggesting that she should seek to find a way to support the Grenfell Action Group and establish a harmonious relationship between it and the Lancaster West

227 {TMO00845472}.
228 {TMO00845472}.
229 {TMO00846422}.

Residents' Association. It was suggested that the TMO consider a tripartite agreement between the two of them and the TMO which set out their respective roles and responsibilities. However, on 8 October 2012 Yvonne Birch confirmed that, having considered that advice, the TMO still would not recognise the Grenfell Action Group.[230] Her principal reason for doing so was that the suggested agreement would require a dispute resolution process which she considered to be unworkable. In an email of 23 October 2012, Yvonne Birch repeated the objection that the Group could not be recognised because there was already a recognised residents' association for the estate as well as an elected estate management board which the TMO had a duty to involve in the estate's management.[231]

33.24 In late June 2012, Mr Daffarn and Francis O'Connor began publishing the Grenfell Action Group blog. Mr Daffarn said that it was intended to publicise issues that had not been picked up by the media and to document what was happening to the community.[232] He told us that at the start he felt that the blog was a means of communicating directly with the TMO, rather than writing to it or using the established processes, and that it gave

230 {TMO00845579}.
231 {TMO00845856}.
232 Daffarn {IWS00000169/7} page 7, paragraph 18.

the community on the Lancaster West estate a voice to express its views about the effect on it of the KALC project.[233] He considered it a necessary response to the TMO's overbearing treatment of the tower's residents.[234]

33.25 Another purpose of the blog was to raise concerns about fire safety.[235] The posts that were concerned with fire safety are discussed more fully in Chapter 42, but one particular incident discussed in the blog usefully illustrates the nature of the concerns expressed by residents about fire safety and their belief that the TMO paid insufficient regard to the risk of fire in its buildings.

33.26 In 2013, power surges occurred at the tower which caused damage to electrical equipment in some residents' flats. The Grenfell Action Group and the Leaseholders' Association were concerned about the incident and communicated their concerns to the TMO by emails and in a petition.[236] They were also the subject of a blog post in September 2013,[237] the thrust of which was that the TMO had played down the seriousness of the surges. Edward Daffarn told us that the residents had asked RBKC's Housing and Property Scrutiny Committee to consider the

233 Daffarn {Day118/150:8}-{Day118/151:2}.
234 Daffarn {Day118/26:1-4}.
235 Daffarn {IWS00000169/8} page 8, paragraph 20.
236 Ahmed {IWS00002369/15} page 15, paragraphs 52 and 54.
237 {IWS00002180}.

problems surrounding the power surges, but he felt that the matter had been covered over,[238] with the result that the residents lost trust in the TMO's ability to take appropriate action in respect of fire safety.[239] Councillor Blakeman told a meeting of the Scrutiny Committee in July 2013 that the TMO would find it difficult to regain residents' trust, since many believed that the TMO had failed to take the power surges seriously.[240]

The Grenfell Compact

33.27 The Grenfell Compact was a residents' group set up during the refurbishment of Grenfell Tower specifically to represent residents' interests. The efforts taken by the residents to obtain recognition are worthy of being recorded as an illustration of the difficulties they faced.

33.28 Mr Daffarn explained that the Grenfell Action Group's early efforts to form an association for the broader community changed over time to an organisation designed specifically for the residents of Grenfell Tower. When the refurbishment works were under way there were around 100 people in the tower who had expressed support for such an initiative. There was a perception that the Lancaster West

238 Edward Daffarn's formal complaint {TMO00838788}.
239 Daffarn {Day118/118:23}-{Day118/120:3}.
240 {TMOH00004598/3}.

Residents' Association was ineffective[241] and Mr Daffarn hoped that an association specifically for residents of the tower would counteract the TMO's perception that the Grenfell Action Group was a small, disgruntled minority.[242]

33.29 On 22 January 2014, Mr Daffarn sent an email to Claire Williams which he copied to the Leaseholders' Association and other residents. He asked for recognition, funds and support so that a Grenfell Tower residents' group could be set up to help tenants during the refurbishment. He explained that such a group would allow leaseholders and tenants to make their views known and ensure that the TMO carried out the refurbishment in co-operation with the residents rather than simply imposing it on them. Mr Daffarn said he had spoken to both the Lancaster West Residents' Association and the Leaseholders' Association, both of which supported the request.[243] The TMO's position, however, was unchanged. It declined to recognise the proposed group because a residents' association covering the area already existed.[244]

241 Daffarn {IWS00002109/50-51} pages 50-51, paragraph 131.
242 Daffarn {IWS00002109/51} page 51, paragraph 134.
243 {TMO00845842}.
244 {TMO00832280}.

33.30 On 10 September 2014, Mr Daffarn sent an email to Fola Kafidiya, the TMO's Head of Governance, to complain that residents of Grenfell Tower were being denied the opportunity to form a representative group to speak on their behalf about matters affecting the refurbishment of the tower. He said that the Lancaster West Residents' Association was moribund and that residents were therefore effectively unrepresented.[245]

33.31 On 17 September 2014, Janet Edwards made it clear that the TMO did not object to the tenants and leaseholders of Grenfell Tower forming a group for the purposes of consultation on matters relating to the building work. She also confirmed that the group would be consulted by the TMO on matters relating to the refurbishment.[246] That ought to have provided an opportunity for matters to be put on a better footing.

33.32 On 17 March 2015, Mr Daffarn and others organised a meeting of Grenfell Tower residents which was attended by over 100 people from more than 55 households.[247] On 26 March 2015, residents from about 20 households held another meeting and agreed to form a group which they

245 {TMOH00004881/3}.
246 {TMOH00004881/1}.
247 Collins {IWS00002334/6} page 6, paragraph 27.

called Grenfell Community Unite.[248] They agreed to ask the TMO and Rydon to meet them to discuss their concerns.

33.33 The meetings on 17 March and 26 March 2015 were both reported on the Grenfell Action Group blog in forthright terms.[249] On 1 April 2015, Peter Maddison sent an email to Fola Kafidiya at RBKC, saying that Mr Daffarn was continuing to agitate, attaching the blog posts and asking Ms Kafidiya to advise at what point his comments would become libellous. Mr Maddison noted that there had been no direct contact from the group and said that the TMO would continue its approach of concentrating on consulting residents individually.[250]

33.34 On 6 April 2015, David Collins asked Claire Williams to arrange a meeting between the group and the TMO, Rydon, Studio E and Max Fordham.[251] He also asked for confirmation that the TMO would acknowledge Grenfell Community Unite as a residents' group.

248 GAG Blog, "A collective voice for residents as 'Grenfell Community Unite' is formed!" {IWS00002239}.

249 GAG Blog "Minutes from the Grenfell Tower Emergency Residents Meeting (17/03/15)" {IWS00002209}; GAG Blog "A collective voice for residents as 'Grenfell Community Unite' is formed!" {IWS00002239}.

250 Email from Peter Maddison to Fola Kafidiya dated 1 April 2015 {TMO00845965}.

251 {TMO10043300}.

33.35 Before responding, Claire Williams consulted other TMO officers.[252] In her response, she deflected the request and suggested that discussion with individual households was more appropriate and that a survey had indicated that residents preferred to receive information by letters, newsletters and notices rather than at public meetings.[253] Siobhan Rumble suggested that the TMO should agree to meet Mr Daffarn and Mr Collins, but make it clear that it would not tolerate abusive language or threatening behaviour.[254]

33.36 On 13 April 2015, Claire Williams sent David Collins' request for a meeting to Peter Maddison with a draft response declining to meet residents.[255] She noted that she had spoken to Robert Black and explained that TMO people preferred not to meet Grenfell Community Unite, since such a meeting would provide a platform for Mr Daffarn.[256] In our view, that internal message is revealing. It suggests that one reason for the TMO's reluctance to recognise the Grenfell Action

252 Email from Claire Williams regarding ''DRAFT Grenfell Community – meeting with TMO/Rydon'' dated 8 April 2015 {TMO10043313} and Draft response to David Collins {TMO10043314}.
253 Response to David Collins {TMO00846124}.
254 Email from Siobhan Rumble to Claire Williams dated 8 April 2015 {TMO10043321}.
255 {TMO00846102}.
256 {TMO00846102}.

Group or any new group to speak for residents about the refurbishment was because of a grave mistrust of Mr Daffarn.

33.37 Edward Daffarn is an intelligent, articulate and motivated individual, who was an impressive witness. Whether he ever spoke for the wider community is debatable and his language and approach in his dealings with the TMO caused resentment among its staff. One thing is clear, however: those in the TMO who were responsible for managing the refurbishment were nervous of him and allowed him to become a barrier to proper communication with the rest of the community.

33.38 Councillor Blakeman also took an interest in the request for a meeting with residents and asked the TMO to copy her and other ward councillors into the response.[257] After receiving Peter Maddison's comments, Claire Williams responded to David Collins and Edward Daffarn on 17 April 2015 refusing their request to recognise the Group or organise a meeting with residents.[258] She referred to the survey citing the residents' preference to be consulted by letter, but she offered Mr Daffarn an opportunity to meet Rydon to discuss the work in his flat.

257 {TMO00845970}.
258 {TMO00846124}; {TMO00846121}.

33.39 Following the involvement of Councillor Blakeman, on 11 July 2015, representatives of the TMO and Rydon met residents in Flat 145[259] and on 17 July 2015 there was a meeting with the local Member of Parliament, Victoria Borwick, at which the TMO agreed to her suggestion that it should recognise the Grenfell Compact as a representative group for the purposes of the refurbishment.[260]

33.40 It had taken the best part of three years and the intervention of the local MP to get to that point, but by July 2015 the refurbishment was only a year from completion. The residents of Grenfell Tower had never before that been given any collective say in relation to it, as required by the agreement between the TMO and RBKC.

33.41 The Grenfell Compact was formally constituted on 23 September 2015.[261] An information sheet sent by the TMO to residents following its formation explained that a residents' compact was an agreement between representatives of a block or estate and the TMO which sets out how residents will be involved in

259 Daffarn {IWS00002109/57} page 57, paragraph 153.
260 {IWS00002194}; Daffarn {IWS00002109/58-59} pages 58-59, paragraphs 156-158; {TMO00846146}.
261 {TMO00846191}.

decisions affecting their homes.[262] It also stated that the compact was a means of influencing decision-making.[263] The signatories to the compact were William Thompson, Edward Daffarn, David Collins, Hanan Wahabi and Marcio Gomes.[264]

Consultation with residents

33.42 We can now examine the extent to which the TMO consulted residents during the course of the refurbishment, its response to residents' complaints and its broader attitude to its relationship with the residents of the buildings it managed.

Consultation between the TMO and residents: 2011 to 2014

33.43 In September 2011, Edward Daffarn had complained to Laura Johnson that the residents of Grenfell Tower had not been consulted about the selection of Studio E as architect for the KALC project. He had felt that the KALC presentation on 13 September 2011, which had been attended by an architect

262 {TMO10009741}.
263 {TMO10009741}.
264 {IWS00001711}.

from Studio E, had been a charade because Studio E had already been appointed without consulting residents.[265]

33.44 At a KALC forum meeting on 28 March 2012, Mr Daffarn asked why Studio E had been selected to undertake the initial work on the refurbishment of Grenfell Tower. He was told by Councillor Coleridge that it was difficult to have two architects undertaking separate projects on a single site and that there was a need for synergy between the KALC and Grenfell Tower projects.[266]

33.45 At a meeting of the TMO's Lancaster West Estate Management Board on 15 May 2012, Edward Daffarn asked if Studio E had experience of tower blocks and, if not, why it had been retained for the refurbishment.[267] He never received an answer to that question.[268]

33.46 Most TMO officers knew little or nothing about schedule 3 to the Modular Management Agreement, which contained detailed provisions about resident engagement in respect of refurbishments such as that of Grenfell Tower. Nevertheless, the TMO did make efforts to consult the residents of Grenfell Tower about its

265 {RBK00030110}.
266 {LBI00000129/3}.
267 {TMO00848807/4}.
268 Daffarn {Day118/21:24}-{Day118/22:1}. See also Part 6 Chapter 66. The Tenant Management Organisation

refurbishment. Consultation began in February 2012 and covered numerous topics, including cladding, heating, gas and the windows.[269] It took a variety of forms, including drop-in sessions, newsletters, telephone communications[270] and two major questionnaires in February and May 2012.[271] The TMO consultation strategy was set out in the Grenfell Tower engagement statement dated 22 August 2012,[272] which contained the responses to the wide range of questions that the residents had been asked in the questionnaires. One of the questions in the May 2012 questionnaire was "Do you wish to be involved in the development proposals for Grenfell Tower?" The responses were "Yes" 13 and "No" 1, but despite that request for involvement, no proposals were developed.

33.47 In July 2012, the TMO's project team for the refurbishment called for a resident focus group to be established by the TMO,[273] but a group was never established. There is also no evidence that the residents, who in May 2012 had indicated that they wanted to be involved in the development proposals for the tower,[274] were ever invited

269 Dunkerton {TMO00000885/11} page 11, paragraph 60.
270 Dunkerton {Day51/94:11-17}.
271 Dunkerton {Day51/95:19-25}.
272 {TMO10001401/4}.
273 {ART00000169/4}.
274 {TMO10001401/10}.

to join a focus group.[275] Indeed the creation of a residents' focus group was not part of the consultation strategy.

33.48 In December 2013, the TMO decided that it would no longer hold public consultations with residents about Grenfell Tower. Councillor Blakeman told Councillor Feilding-Mellen that Edward Daffarn had become too disruptive to continue holding public consultations.[276] Peter Maddison agreed that that had been one of the reasons, but said that poor attendance had been another.[277] At a drop-in session on 12 December 2013, a survey was undertaken and residents were asked to indicate how they would prefer the TMO to consult them.[278] Most people did not want formal meetings.

33.49 The decision to discontinue public meetings was regrettable. Mr Daffarn perhaps should have stood back and questioned whether his preferred methods were the only, or even the most effective, way in which the voice of the community could be heard. A more conciliatory approach on his part might have been reciprocated. On the other hand, for its part the TMO ought to have reacted less defensively and, instead of retreating, should have

275 See, for example, Anderson {Day51/99:16}-{Day51/100:2}.
276 {RBK00003386}.
277 Maddison {Day124/22:1-15}.
278 Williams {TMO00840364/30} page 30, paragraph 170.

made a greater effort to engage with Mr Daffarn, both on a personal and public level. It allowed its fear and personal mistrust of him and his methods to influence the way in which it engaged with the residents more generally. As custodian of the safety and security of its residents, it must take responsibility for the breakdown in trust.

33.50 Some 65 households were recorded as attending the drop-in on 12 December 2013, at which people were asked to identify their preferred methods of consultation and 55 forms were returned.[279] Six methods to choose from were listed but they did not include consultation through a residents' group. They were all directed at giving information to residents, not hearing from them.

33.51 The residents of Grenfell Tower were consulted in respect of the various cladding options for the tower. In August 2012, the preference was said to be for a zinc cladding system[280] but the decision eventually conveyed to residents in the newsletter circulated in October 2014 was that RBKC had approved a smoke silver metallic (grey) colour for the cladding.[281] Claire Williams said that she did not think the residents had ever been told that there had been a change from zinc to aluminium composite material or the reasons for

279 {TMO00828516}.
280 {TMO00838191}; {TMO10049897/3}.
281 {TMO00837599/2}.

the change. She thought that had been because the decision had not been made until after the project had begun.[282]

The petition

33.52 In December 2015, at Councillor Blakeman's suggestion,[283] some 60 residents of Grenfell Tower signed a petition to the Housing and Property Scrutiny Committee of RBKC asserting that residents' views had been ignored or minimised, that their day-to-day concerns had been belittled and brushed aside and that they had been forced to endure intolerable living conditions while the work on the tower was going on.[284] It had been prompted by the frustration felt by residents that their concerns about the refurbishment had been ignored by the TMO.[285] They asked the committee to consider their views and experiences and include them in its report.

33.53 The petition was presented by Councillor Blakeman to RBKC on 2 December 2015 and was then referred to Councillor Marshall and the Housing and Property Scrutiny Committee for its consideration.[286] On the same day, RBKC and

282 Williams {Day121/90:3-25}.
283 Blakeman {RBK00054461/17} page 17, paragraph 91.
284 {RBK00000110}.
285 Blakeman {RBK00054461/17} paragraph 91.
286 {RBK00033519}.

the TMO held a joint management meeting, at which Peter Maddison is recorded as having said that Councillor Blakeman and Mr Daffarn were a negative force at Grenfell and that residents were going to them with problems rather than the TMO.[287] The minutes also record Amanda Johnson as having said that she felt that Councillor Blakeman had a conflict of interest since she was a TMO board member appointed by the council.[288] It is striking that senior officers of the TMO and RBKC appear to have been more interested in silencing Councillor Blakeman than in resolving the residents' grievances.

33.54 In response to the petition, the TMO's board suggested that it conduct an internal review of the refurbishment works. Laura Johnson supported the proposal while emphasising that RBKC had no desire to be involved in it. She said she would relay the proposal to Councillor Mackover so that it was supported by the Scrutiny Committee.[289] Clearly, the TMO hoped by that means to avoid external scrutiny of the way in which the refurbishment had been conducted.

287 {TMO10011523/2}.
288 {TMO10011523/2-3}.
289 {TMO00852704/3}.

33.55 A meeting of the Scrutiny Committee was held on 6 January 2016.[290] Edward Daffarn was given an opportunity to address the committee and the request set out in the petition for a review of the TMO's management of the refurbishment was then discussed. Councillors Mackover, Berrill-Cox, Blakeman and Press proposed that a working group should be set up to investigate the management of the refurbishment and Councillors Blakeman and Press said that the reviewers should be independent of the TMO.[291] However, the Chairman, Councillor Marshall, was reluctant to establish a working group at that time.[292] He suggested that the establishment of a working group should await the conclusion of existing working groups as well as the TMO's suggested review.[293]

33.56 Between January and March 2016 the TMO's board carried out a review of the refurbishment. Robert Black did not know why an independent review had not been suggested rather than one led by the board, but it was never envisaged that the review would fully address the request made in the residents' petition for an independent

290 {RBK00032130}.
291 Blakeman {Day135/135:1-14}.
292 {RBK00032130/5}; Blakeman {Day135/136:1-5}.
293 {RBK00032130/5}.

investigation of the TMO's management of the refurbishment, as opposed to responding to the particular complaints that had been made.[294]

33.57 In January 2016, members of the TMO board were invited to express an interest in joining the review group. No residents of Grenfell Tower joined the group and there is no evidence that any of them were even invited to do so. At an initial meeting in February 2016 it was decided that the review would include, among other things, consultation and engagement with residents and responses to complaints. In March 2016, there was a presentation and a tour of Grenfell Tower and the review group was given a pack of information covering each area of the investigation.[295]

33.58 Although the review did not collect residents' views about how the refurbishment had been carried out, the TMO was required under the Modular Management Agreement to gather them after the work had been completed.[296] Robert Black accepted that, although the plan had been to include their opinions as part of the review,[297] he might have overlooked the need

294 Black {Day151/127:18-19}.
295 {RBK00003513/2}.
296 Tenant Management Organisation Modular Management Agreement Volume 2 {RBK00019006/177} Clause 22.1.
297 Black {Day151/146:19-24}.

to do so.[298] Whether that was deliberate or not, ignoring residents' views was entirely consistent with the TMO's approach to engagement with its residents from at least February 2012, and indeed, on the basis of Maria Memoli's report, from far earlier than that.

The working group's report

33.59 The working group's review culminated in a report dated 31 March 2016.[299] The group found that engagement with and consultation of residents had been comprehensive and had used various methods to obtain their views. It recommended that in future details of those attending public meetings should be recorded, that minutes should be taken and that resident profile surveys should be repeated every six months when projects lasted for longer than 12 months.[300]

33.60 In response to the allegations that the contractor and the TMO had used threats, lies and intimidation, the group noted that the only detailed information was a complaint that had not been upheld at Stage 3 of the complaints procedure. A new procedure was proposed for gaining access

298 Black {Day151/148:14-21}.
299 {RBK00003513}.
300 {RBK00003513/3} section 3.

to flats to carry out work internally which could be sent to unco-operative residents in future to avoid any misunderstanding.[301]

33.61 The group reviewed seven formal complaints and other enquiries received from ward councillors and was satisfied that the TMO had responded adequately to them.[302]

33.62 The report's conclusion acknowledged the disruption and inconvenience caused by the works over an extended period of time,[303] but commended Rydon, Peter Maddison and his team on completing the refurbishment works.

33.63 In our view, the review was flawed in its origins, its process and its conclusions. Given the history of the matter and the lack of trust between the residents of Grenfell Tower and the TMO, the board should have realised that only an independent review of the management of the project with particular reference to the residents' complaints could fairly satisfy the requirements of the moment. As it was, the review was superficial and the group conducting it failed to carry out its investigation in a sufficiently thorough and robust manner. The report lacked balance. It gave the impression that very little, if anything, had gone

301 {RBK00003513/4} section 5.
302 {RBK00003513/4} section 6.
303 {RBK00032438}.

wrong and that there was no substance in any of the complaints made in the petition. The Scrutiny Committee in its turn failed in its task of ensuring that the relationship between the TMO and its residents was rigorously investigated.

33.64 On 4 July 2016, David Collins wrote to Councillor Feilding-Mellen on behalf of Grenfell Compact to express his view that the report failed to address how the refurbishment work and resident consultation had been carried out by the TMO.[304] He thought that the report was not sufficiently critical about the lessons to be learned from the refurbishment and he set out 15 recommendations for the conduct of future refurbishment works.

33.65 Councillor Feilding-Mellen responded on 7 July 2016. He told Mr Collins that, although he was happy to review his recommendations, he considered that many of them had already been addressed in the TMO board's review. He went on to say that he would not advise officers to investigate new allegations which were not submitted in writing and supported by evidence.[305]

304 {RBK00003501/1-2}.

305 {RBK00003466}. See also {RBK00000136} for further emails in the same chain.

Councillor Feilding-Mellen met David Collins later in July 2016,[306] but their meeting took matters little further forward.

33.66 On 6 September 2016, David Collins wrote to Councillor Feilding-Mellen again to thank him for attending the meeting in July and to ask him whether he was minded to reconsider RBKC's approach to regeneration projects or the TMO's operations.[307] Councillor Feilding-Mellen sent the email on to Laura Johnson and asked her if she could think of any "small concession" he could offer David Collins. Although he told us that only a small concession was needed because the differences between them were not great,[308] what he really meant, we think, was that he was looking for something trivial he could give away.

Conclusion

33.67 The overwhelming impression we have gained from the evidence, both that of the witnesses and that contained in the contemporaneous documents, is that between 2011 and 2017 relations between the TMO and many of the residents of the tower were increasingly characterised by distrust, dislike, personal antagonism and anger. Some, perhaps many,

306 {RBK00030865/2}.
307 {RBK00030865/2}.
308 Feilding-Mellen {Day132/95:14}-{Day132/96:7}.

occupants of Grenfell Tower regarded the TMO as an uncaring and bullying overlord, which belittled and marginalised them, regarded them as a nuisance or worse, and simply failed to take their concerns seriously. For its part, the TMO regarded some of the residents as militant troublemakers led on by a handful of vocal activists, principally Edward Daffarn, whose style they found offensive. The result was a toxic atmosphere fuelled by mistrust on both sides.

33.68 In the end, however, responsibility for the maintenance of the relationship between the TMO and the Grenfell community fell not on the members of that community, who had a right to be treated with respect, but on the TMO as a public body exercising control over the building which contained their homes. The TMO lost sight of the fact that the residents were people who depended on it for a safe and decent home and the privacy and dignity that a home should provide. That dependence created an unequal relationship and a corresponding need for the TMO to ensure that, whatever the difficulties, the residents were treated with understanding and respect. We regret to say the TMO failed to recognise that need and therefore failed to take the steps necessary to ensure that it was met.

33.69 However irritating and inconvenient it may at times have found the complaints and demands of some of the residents of Grenfell Tower, for the TMO to have allowed the relationship to deteriorate to such an extent reflects a serious failure on its part to observe its basic responsibilities.

Part 5
The management of fire safety at Grenfell Tower

Chapter 34
Introduction to Part 5

34.1 One of the TMO's most important functions as manager of Grenfell Tower was to take appropriate steps in relation to fire safety. In this Part of our report we examine the nature of the obligations imposed by law on those who manage residential buildings and the steps taken by the TMO to comply with them in the years leading up to the fire.

34.2 The Fire Safety Order prescribes the duties imposed on the person who has control of premises such as Grenfell Tower, known as the "responsible person", and on every other person who has, to any extent, control of the premises so far as the requirements relate to matters within his control. In the case of Grenfell Tower it was accepted that both the TMO and RBKC were subject to those duties but for practical purposes we decided to concentrate on the TMO and examine the way in which it went about discharging its duties and the extent to which it did so effectively.

34.3 In this Part we have therefore considered the systems adopted by the TMO to discharge its obligations, its discussions with the LFB as the

enforcing authority, the steps it took to identify the risks to which the properties it managed were subject and its response to the findings that emerged. RBKC had an important part to play because it was responsible for overseeing all the TMO's arrangements for protecting health and safety. We have therefore also examined the extent to which RBKC fulfilled its responsibility in that respect.

34.4 Fire risk assessments play an important part in ensuring fire safety. We therefore examined the steps taken by the TMO to obtain suitable and sufficient fire risk assessments as required by the Fire Safety Order and the way in which it responded to them.

34.5 Maintenance of fire protections within buildings are an important element in managing fire safety effectively. One of the most important, but often least regarded, protections against the spread of fire within a residential building is the provision and effective maintenance of fire doors at the entrance to individual flats with working self-closing devices. We have therefore examined the steps taken by the TMO to ensure that the flats in Grenfell Tower were fitted with modern fire doors and the measures put in place to ensure regular inspection and maintenance of the doors and self-closing devices.

34.6 When Grenfell Tower was built it included a smoke ventilation system designed to operate in the event of a fire to clear smoke from the lobby of the floor on which the flat affected by the fire was situated. Such systems require regular maintenance as part of managing fire protection, so we examined the extent to which the TMO had maintained the system and whether it was capable of operating effectively. Regrettably, by the time of the refurbishment it was not in working order and could not be renovated. We describe how that situation had come about and, in the next Part, the steps that were taken to replace it as part of the refurbishment.

34.7 Finally, we identify certain other matters relating to fire safety that we consider to be important to comment on, including emergency planning, the provision of fire safety information in public parts of the building and arrangements for safeguarding vulnerable residents.

Chapter 35
The Fire Safety Order

Introduction

35.1 Part of our terms of reference is to investigate the fire prevention and fire safety measures in place at Grenfell Tower on 14 June 2017.[309] The starting point for any investigation of that kind is to understand the obligations of those who were in law responsible for fire safety. Article 8 of the Regulatory Reform (Fire Safety) Order 2005 (the Fire Safety Order) imposes on "the responsible person" an obligation to take such general fire precautions as will ensure, so far as is reasonably practicable, that the premises are safe.[310] The first question we consider, therefore, is who was, for the purposes of article 8 of the Fire Safety Order, the responsible person in relation to Grenfell Tower.

The responsible person

35.2 Under article 3 of the Fire Safety Order, the responsible person in relation to premises that are not a workplace is the person who has control of the premises in connection with the carrying

309 Terms of reference, paragraph (i)(f).
310 The Regulatory Reform (Fire Safety) Order 2005 {INQ00011327/8} Article 8(1).

on of an undertaking of some kind or, where the person in control of the premises does not have control in connection with the carrying on of an undertaking of some kind, the owner of the premises. By article 5(2) the responsible person must ensure that any duty imposed by articles 8 to 22 or by regulations made under article 24 is complied with in respect of those premises, so far as the requirements relate to matters within his control. Article 5(3) imposes on anyone other than the responsible person who has control of the premises the same duties as those imposed on the responsible person, so far as they relate to matters within his control.

35.3 In addition to the duty under article 8 to take general fire precautions, the responsible person and anyone to whom article 5(3) applies are subject to certain specific duties. The most relevant are:

a. to carry out a suitable and sufficient risk assessment for the purpose of identifying what general fire precautions are necessary;[311]

b. to make and give effect to appropriate arrangements for the effective planning, organisation, control, monitoring and review of preventive and protective measures;[312]

311 The Regulatory Reform (Fire Safety) Order 2005 {INQ00011327/8} Article 9(1).

312 The Regulatory Reform (Fire Safety) Order 2005 {INQ00011327/9} Article 11(1).

c. to ensure, where necessary to safeguard the safety of relevant persons, that the premises are appropriately equipped with fire-fighting equipment and fire detectors and alarms and that any non-automatic fire-fighting equipment is easily accessible, simple to use and indicated by signs;[313]

d. to take measures for fire-fighting, nominate competent persons to implement them and ensure that their training and the equipment available to them are adequate;[314]

e. to ensure that routes to emergency exits from premises and the exits themselves are kept clear at all times;[315]

f. to establish and, where necessary, give effect to appropriate procedures, including fire safety drills, to be followed in the event of serious and imminent danger;[316]

g. to ensure that the premises are subject to a suitable system of maintenance and are

313 The Regulatory Reform (Fire Safety) Order 2005 {INQ00011327/9} Article 13(1).
314 The Regulatory Reform (Fire Safety) Order 2005 {INQ00011327/10} Article 13(3).
315 The Regulatory Reform (Fire Safety) Order 2005 {INQ00011327/10} Article 14(1).
316 The Regulatory Reform (Fire Safety) Order 2005 {INQ00011327/10} Article 15(a).

maintained in an efficient state, in efficient working order and in good repair;[317]

h. to appoint one or more competent persons to assist him in undertaking the necessary preventive and protective measures;[318]

i. to ensure that his employees are provided with adequate safety training.[319]

RBKC as the responsible person

35.4 RBKC contended that, between 1 April 2005 (when the Fire Safety Order came into force) and June 2017, the responsible person in relation to Grenfell Tower (outside the period of the refurbishment and excluding the non-residential units) had been the TMO, although it accepted that it had itself fallen within the scope of article 5(3) during that period.[320] It argued that under the Modular Management Agreement (the Agreement) it had delegated to the TMO the vast majority of its housing management functions and that the TMO had been responsible for health and safety arrangements (including arrangements relating to

317 The Regulatory Reform (Fire Safety) Order 2005 {INQ00011327/12} Article 17(1).

318 The Regulatory Reform (Fire Safety) Order 2005 {INQ00011327/12} Article 18(1).

319 The Regulatory Reform (Fire Safety) Order 2005 {INQ00011327/14} Article 21(1).

320 RBKC Module 1 Opening Statement {RBK00055479/8} paragraph 33. This submission is maintained in RBKC Module 3 Opening Statement {RBK00063631/9} paragraph 31.

fire safety) for the housing stock which it managed on behalf of the council. RBKC's position was based on the proposition that, as a matter of law, the Fire Safety Order seeks to identify a single responsible person for each premises.[321] We do not need to resolve that question, however, because RBKC was either the responsible person in relation to Grenfell Tower or was a person to whom article 5(3) applied, as it recognised in its opening statement, and was therefore subject to the same duties.

35.5 Before the fire, the identity of the responsible person appeared to be uncontroversial. For example, officers of the TMO thought that both bodies were responsible persons[322] in relation to Grenfell Tower. Moreover, on 20 February 2012, a joint protocol was agreed between LFEPA and RBKC[323] under which RBKC undertook to discharge certain duties under the Fire Safety Order. The correspondence about the joint protocol between Kevin Thompson, Laura Johnson and Janice Wray demonstrates that there was a mutual understanding between the TMO and RBKC that they both had responsibilities under the Fire Safety Order.[324]

321 RBKC Module 3 Opening Statement {RBK00063631/10} paragraph 34.
322 Black {Day149/37:22}-{Day149/38:1}; Wray {TMO00000890/37} page 37, paragraph 166; TMO Fire Safety Strategy November 2013 {TMO00830598/1}.
323 {LFB00032248}.
324 {RBK00001176}.

35.6 That understanding was reflected in the TMO's Fire Safety Strategy of November 2013, which expressly stated that both RBKC and the TMO were to be considered responsible persons for the purposes of the Fire Safety Order.[325] There is no evidence that that statement was challenged by anyone.

35.7 On the other hand, Laura Johnson thought that the TMO was the only responsible person in relation to RBKC's housing stock but she could not explain why and speculated (incorrectly) that the TMO's responsibility had been set out in the Agreement. She said that, because RBKC took the view that it was not the responsible person, it had not put in place any arrangements to discharge any of the duties of the responsible person under the Fire Safety Order.[326] As far as she knew, nobody in RBKC oversaw the TMO's performance on health and safety matters beyond receiving an annual health and safety report.[327]

35.8 We found Laura Johnson's evidence on this point unconvincing. The evidence shows that while she was RBKC's Director of Housing she took an active interest in matters relating to fire safety. At no time did she say that RBKC was not the responsible person in relation to the housing

325 {TMO00830598/1}.
326 Johnson {Day129/57:21-25}.
327 Johnson {Day129/64:16-20}.

managed by the TMO. We conclude that, before the fire, Laura Johnson understood that RBKC, together with the TMO, was the responsible person for the premises managed by the TMO.

The TMO as the responsible person

35.9 The TMO set out its understanding of the division of responsibilities under the Fire Safety Order in its annual health and safety reports to the TMO Board and to RBKC. As set out in the Annual Health and Safety Report for the year 2009-2010[328] it was:

a. that operational compliance with the Fire Safety Order had been delegated to the TMO;

b. that RBKC was liable for any breach of the Fire Safety Order and subject to enforcement notices or prosecution or both;

c. that RBKC would monitor the TMO's actions on health and safety matters to ensure compliance with relevant statutory responsibilities and adherence to best practice;

d. that RBKC's corporate health and safety adviser and the health and safety adviser for housing, health and adult social care would receive minutes of the meetings of the TMO's health and safety committee and copies of the TMO's annual report on health and safety;

328 {TMO00879745/1}.

e. that the TMO's health and safety adviser would attend RBKC's six-weekly meetings of its Main Co-ordinating Committee dealing with health and safety matters; and

f. that it would notify RBKC of major incidents, accidents, significant near-misses and any current investigations.

35.10 Robert Black understood that RBKC shared the TMO's understanding of their respective responsibilities.[329] He understood that, as a responsible person under the Fire Safety Order, the TMO was responsible for appointing competent people to ensure safety. He understood the distinction, which we explain below, between the responsible person and the competent person under the Fire Safety Order.[330]

35.11 In mid-2015, Barbara Matthews succeeded Anthony Parkes as the TMO's Director of Financial Services and ICT. Although she was unaware of the duties imposed on the responsible person,[331] she believed that RBKC and the TMO were both responsible persons for the premises owned by RBKC but managed by the TMO.[332] She relied on the fact that fire risk assessments and internal audits were carried out to satisfy herself

329 Black {Day149/37:22}-{Day149/38:1}.
330 Black {Day149/38:23-25}.
331 Matthews {Day147/108:23}-{Day147/109:1}.
332 Matthews {Day147/109:2-9}.

that the TMO was discharging its obligations under the Fire Safety Order.[333] She was unaware of RBKC's arrangements for discharging its own duties as a responsible person under the Fire Safety Order.[334]

The competent person

35.12 Article 18(1) of the Fire Safety Order requires the responsible person to appoint one or more competent persons to assist him in undertaking the preventive and protective measures. In particular, article 18(3) obliges the responsible person to ensure that the number of competent persons appointed, the time available for them to fulfil their functions and the means at their disposal are adequate having regard to the size of the premises, the risks to which relevant persons are exposed and the distribution of those risks throughout the premises.

35.13 Article 18(5) provides that a person is to be regarded as competent if he has sufficient training and experience or knowledge and other qualities to enable him properly to assist in undertaking the preventive and protective measures. Janice Wray,

333 Matthews {Day147/110:24}-{Day147/111:2}.
334 Matthews {Day147/112:14-17}.

the TMO's health and safety manager, was familiar with the concept of the competent person and undertook that role for the TMO.[335]

Janice Wray's responsibilities

35.14 Although Ms Wray saw her role as essentially advisory,[336] it is plain from the various versions of the TMO's health and safety policy that it was broader, more substantive and included the following:[337]

a. providing competent advice on health and safety matters as required by the Management of Health & Safety at Work Regulations;

b. formulating health & safety policy and strategy;

c. producing health & safety policy, procedures and guidelines and ensuring that they were regularly reviewed and kept up to date;

d. providing managers and employees with specialist health and safety advice;

e. organising and administering the health & safety committee and communicating with and consulting safety representatives through it;

335 Wray {Day140/43:10-13}.

336 Wray {Day140/7:22-25}.

337 TMO Health and Safety Policy 2012 {TMO10031076/3}. This list was reproduced in the 2016 version of the policy {TMO10024402/3}. The 2010 version of the policy {TMO10031078/3} does not include the references at i and j to the Fire Safety Order.

f. identifying the need for health and safety training;

g. monitoring, reviewing and auditing compliance with the policy;

h. producing an annual Health & Safety Report for presentation to the TMO board and RBKC;

i. advising on compliance with the Fire Safety Order; and

j. attending meetings and committees as necessary to provide information on the TMO's performance in relation to specific areas of health & safety, including compliance with the Fire Safety Order.

35.15 Janice Wray accepted that that was an accurate description of her responsibilities.[338] When asked whether she had primary operational responsibility for the TMO's compliance with the Fire Safety Order, she denied having overall responsibility for it but accepted that she was responsible for overseeing and monitoring the performance by the TMO of its fire safety obligations.[339]

35.16 Although Janice Wray may have had responsibility for monitoring the performance by the TMO of its obligations in relation to fire safety, from mid-2015 primary operational responsibility

338 Wray {Day140/39:18-22}.
339 Wray {Day140/42:11-25}.

lay with Barbara Matthews. An important part of her responsibilities was to monitor the TMO's health and safety performance at a strategic level,[340] which encompassed ensuring the health and safety of all the TMO's residents, employees and contractors.[341]

35.17 In his safety management review produced in September 2013 Matt Hodgson[342] identified Janice Wray as the competent person at the TMO[343] and considered that her qualifications were more than adequate for that role.[344] He noted that the TMO Health and Safety Policy named Adrian Bowman, Janice Wray's assistant, as the competent person and recommended that it be amended to name her.[345]

35.18 In undertaking the responsibilities of a competent person Janice Wray considered that she had access to a fire safety specialist and, if she needed further advice, was able to ask for it.[346] She had regular meetings with the LFB and access to various people to whom she could go

340 Matthews {TMO10049987/2} page 2, paragraph 7.
341 Matthews {Day147/103:21-25}.
342 An independent consultant who was instructed by the TMO to prepare a safety management review in 2013 {RBK00055531}.
343 {RBK00055531/23}.
344 {RBK00055531/23}.
345 {RBK00055531/23-24}.
346 Wray {Day140/44:5-10}.

for advice.[347] She felt that she had had sufficient training, experience and knowledge to carry out the role of competent person for the TMO.[348]

35.19 Janice Wray did not think that a shortage of funds or other resources had hindered her ability to discharge her responsibilities as the competent person.[349] Although she felt that she was often spread very thinly,[350] she felt able to discharge her fire safety responsibilities satisfactorily.[351]

347 Wray {Day140/44:15-18}.
348 Wray {Day140/45:9-12}.
349 Wray {Day140/47:16-25}.
350 Wray {Day140/48:10-20}.
351 Wray {Day140/49:23}-{Day140/50:13}.

Chapter 36
Fire safety management at the TMO

Health and safety policies

36.1 The TMO maintained a policy which described the way in which it sought to comply with its obligations under health and safety legislation. We saw various versions of the policy but the witnesses were asked principally about the versions dated July 2010[352] and February 2016.[353]

36.2 The TMO's senior staff were familiar with the policy. Teresa Brown was familiar with the general principles in the policy, but had no reason to refer to the details.[354] Barbara Matthews helped to review the policy in February 2016[355] and Janice Wray also contributed to it.[356] The policy provided that Robert Black was ultimately responsible for health and safety at the TMO.[357]

36.3 According to the policy, the TMO was required to make sure that staff with key roles in the management of health and safety were

352 {TMO10031078}.
353 {TMO10024402}.
354 Brown {Day126/9:14-22}.
355 Matthews {Day147/140:5-16}.
356 Wray {Day142/152:14-16}.
357 Matthews {Day147/141:3-5}; {TMO10024402} paragraph 1.2.

competent and adequately trained.[358] However, Barbara Matthews told us that there was no document that described standards of competence or the training required for those members of staff.[359]

The TMO's fire safety strategies

36.4 On 18 January 2013, Janice Wray sent Carl Stokes[360] a document entitled "Fire Safety Policy",[361] which she had drafted to address one of the failings identified by Salvus in a report dated September 2009.[362] It was intended to replace the fire safety policy approved by Robert Black in 2009.[363] When drafting the document Janice Wray had consulted her colleagues, Cyril Morris and Adrian Bowman, and the operations division of the TMO. She may also have consulted the LFB with the intention of adopting its standards.[364] On 1 February 2013, Carl Stokes provided some comments.[365]

358 {TMO10024402/1} paragraph 1.4.
359 Matthews {Day147/142:11-25}.
360 {CST00001187}.
361 {CST00002046}.
362 Wray {Day140/141:20-25}.
363 Wray {Day140/142:2-11}.
364 Wray {Day140/142:25}-{Day140/143:13}.
365 {CST00030180}.

36.5 The draft policy was discussed at a meeting of the TMO's Assets & Regeneration and Repairs, Health & Safety Group on 18 April 2013.[366] It was discussed again at a meeting of the Operational Health and Safety Committee on 15 November 2013. The intention was for it to be circulated by Janice Wray in draft for comments before sending it to the LFB by mid-December.[367]

36.6 The version of the document produced in November 2013[368] (entitled "TMO Fire Safety Strategy") was given to the LFB at the bi-monthly meeting in December 2013. Janice Wray said that the LFB had not commented on it.[369] The draft was discussed again at the meeting of the Operational Health and Safety Committee on 17 January 2014, when it was noted that it had already been given to the LFB and that the final version could be approved at the next committee meeting.[370] In fact, there is no record of the document's having been approved at the next or any subsequent Operational Health and Safety Committee meeting. Despite that, it was in its final form, as far as Janice Wray was concerned.[371]

366 Item 7.1 "Fire Safety Policy" {TMO10002648}.
367 TMO Operational Health & Safety Minutes {TMO10004726/6}.
368 {TMO00830598}.
369 Wray {Day140/151:2-3}.
370 TMO Operational Health & Safety Meeting {TMO00840384}.
371 Wray {Day140/155:17-19}.

36.7 The minutes of the meeting on 17 January 2014 recorded that Janice Wray and Michael Lyons (the Health and Safety manager of Repairs Direct) were to meet to discuss any changes to the strategy. In the event, Michael Lyons, who had been sent a copy of the draft, sent back a different document described as a fire safety policy dated January 2014.[372] Janice Wray said that that document had not been adopted, however, as it did not reflect the TMO's working practices.[373]

36.8 There were various versions of that document, the earliest being dated January 2014[374] and the latest May 2014.[375] The former, apparently written solely by Michael Lyons, contemplated the appointment of a fire safety manager,[376] who would be responsible for the strategic management of fire precautions, including the formulation and revision of the TMO's fire safety plan and oversight of the process for obtaining fire risk assessments.[377] When she received that document from Michael Lyons Janice Wray noted the different structure for managing fire safety, including the introduction of a fire safety manager. She sent a copy of the policy to Anthony Parkes,

372 {TMO10040770/1}.
373 Wray {Day140/151:25}-{Day140/152:12}.
374 See Fire Safety Policy, Issue 01, January 2014 {TMO10040770}.
375 {TMO00856458}.
376 {TMO10040770/6}.
377 {TMO10040770/6}.

her then line manager, who confirmed that the TMO did not intend to implement the arrangements described in the draft.[378]

36.9 The draft dated May 2014, jointly written by Janice Wray and (apparently) Michael Lyons, did not contain any reference to a fire safety manager and made it clear that responsibility for fire safety policy lay with the Health & Safety Manager. In any event, it appears that neither the January 2014 nor May 2014 draft was taken any further.[379]

36.10 Another version of a fire safety policy was identified by the RBKC auditor, Alpesh Patel, who carried out an audit of the TMO's health and safety arrangements in March 2016. Janice Wray had provided him with examples of the latest internal policies and procedures, which included a Fire Safety Policy and Strategy.[380] That document was presented in the same way as the January and May 2014 drafts and was in substance a revised version of the fire safety strategy dated November 2013.[381] It was not adopted by the TMO's health and safety committee.[382] Janice Wray did not know why that document

378 Wray {Day140/154:13}-{Day140/155:5}.
379 Wray {Day140/157:13-15}.
380 Patel {RBK00058245/11-12} pages 11-12, paragraph 32; Exhibit AP2/38 – TMO fire safety policy and strategy {RBK00058236}.
381 Wray {Day140/162:9-14}.
382 Wray {Day140/162:19}-{Day140/163:2}.

had been given to the auditor.[383] The current fire safety strategy remained the one that had been approved in November 2013.

36.11 A review of the 2013 strategy began in April 2016.[384] Janice Wray presented a paper[385] at a meeting of the TMO Health and Safety Committee that took place on 12 April 2016.[386] The document was entitled "Review of Fire Safety Strategy" and set out initial points to consider as part of the review. The review is likely to have been prompted by the Adair Tower fire, which had occurred on 31 October 2015.[387]

36.12 The process of reviewing the strategy continued well into 2017. The TMO Health and Safety Committee considered a draft dated June 2017[388] at its meeting on 13 June 2017, the day before the fire. Janice Wray said that the revision had taken so long to complete because the TMO wanted to review many aspects of the draft and make many minor changes and because there were many aspects on which she needed to obtain responses from others.[389] That may be so, but on any view, the delay speaks to an

383 Wray {Day140/163:6-22}.
384 Wray {Day140/164:4-13}.
385 {TMO10024351}.
386 {TMO10012811}.
387 Wray {Day140/167:24}-{Day140/168:10}.
388 {TMO10017036}.
389 Wray {Day140/171:7-20}.

absence of proper expedition to make sure that a policy, which touched on the health and safety of residents, was completed expeditiously and kept up to date to reflect any changes in circumstances or regulatory requirements.

Chapter 37
Development of fire safety strategies and policies

37.1 Before 2008 the TMO's health and safety team comprising Adrian Bowman and Janice Wray carried out fire risk assessments itself in order to save money, rather than using external fire risk assessors.[390] In May 2008, however, Collette O'Hara, a fire safety inspecting officer in the LFB's Kensington & Chelsea fire safety team (the LFB fire safety team), identified certain deficiencies in the TMO's fire risk assessments.[391]

37.2 In January 2009, the LFB fire safety team was not satisfied that the TMO's fire risk assessments had improved. It therefore sent a series of letters to the TMO, each in relation to a property in respect of which it did not consider the fire risk assessment to be suitable and sufficient as required by article 9(1) of the Fire Safety Order. That precipitated a number of meetings and

390 Wray {Day140/85:17-19}; Briefing Note on Fire Safety dated 27 July 2009 by Janice Wray {TMO10037317/1} item 3; Email from Janice Wray to Robert Black and Liam Good copying in various others on 17 June 2009 about the LFB's intention to issue an enforcement notice {RBK00052535/4}.

391 LFEPA (LFB) Report Form on the TMO by Collette O'Hara dated 16 November 2009 {LFB00031977/22}.

discussions between Angus Sangster, the team leader, Collette O'Hara and Janice Wray about the standard expected of fire risk assessments.[392]

37.3 Following a site visit to one of the TMO's properties with Janice Wray on 17 June 2009, Mr Sangster and Ms O'Hara concluded that the TMO was not competent to carry out fire risk assessments itself. Accordingly, Mr Sangster advised Janice Wray that the LFB would issue an enforcement notice against RBKC and the TMO requiring fire risk assessments to be carried out by a competent person.[393]

37.4 Later that day, Janice Wray told Laura Johnson and Jean Daintith, RBKC Executive Director of Housing, what the LFB intended to do.[394] Jean Daintith immediately sought advice from RBKC's building control department, which said that the TMO's fire risk assessments were not sufficiently robust and that a specialist should be engaged to carry them out.[395]

---

392 LFEPA (LFB) Report Form on the TMO by Collette O'Hara dated 16 November 2009 {LFB00031977/22}; Wray {Day140/85:10}-{Day140/86:8}.

393 LFEPA (LFB) Report Form on the TMO by Collette O'Hara dated 16 November 2009 {LFB00031977/22}.

394 Email from Janice Wray to Jean Daintith and Laura Johnson copying in others on 17 June 2009 about the LFB's intention to issue an enforcement notice {RBK00052535/3}.

395 Email from Jean Daintith to Derek Myers cc David Prout on 17 June 2009 about the LFB's intention to issue an enforcement notice {RBK00052535/3}; Email from Jean Daintith to Derek Myers and Robert Black cc others on 18 June 2009 about the TMO's fire risk assessments {RBK00052528/1}.

37.5 As a result, on 18 June 2009, Alexis Correa, RBKC's health and safety advisor for the Housing, Health and Adult Social Care department, contacted Angus Sangster to explain that RBKC would provide funds to allow the TMO to appoint an external fire risk assessor and to carry out all necessary works. He sought an assurance that in those circumstances the LFB would not issue an enforcement notice. Mr Sangster agreed not to do so, subject to receiving from RBKC and the TMO a schedule for the completion of fire risk assessments.[396]

37.6 On 9 July 2009, Janice Wray sent Mr Sangster a schedule of work[397] that had been agreed between RBKC and the TMO,[398] but he did not consider it acceptable and suggested a further meeting to discuss the way forward.[399] The meeting took place on 6 August 2009[400] and was attended by representatives of the LFB fire safety

396 LFEPA (LFB) Report Form on the TMO by Collette O'Hara dated 16 November 2009 {LFB00031977/23}.

397 LFEPA (LFB) Report Form on the TMO by Collette O'Hara dated 16 November 2009 {LFB00031977/23}.

398 Email from Alexis Correa to Pam Sedgwick cc others on 7 July 2009 about providing a schedule of works for fire risk assessments {TMO00866049/2}; Email from Alexis Correa to Janice Wray and others on 8 July 2009 describing the outcome of a meeting that day with Janice Wray, Liam Good and Ann Muchmore about fire risk assessments {TMO00865069/1}.

399 LFEPA (LFB) Report Form on the TMO by Collette O'Hara dated 16 November 2009 {LFB00031977/23}; Briefing Note on Fire Safety dated 27 July 2009 by Janice Wray {TMO10037317/3} item 5.

400 Minutes of meeting between RBKC, TMO and LFB on 6 August 2009 {RBK00018535/1}.

team, RBKC and the TMO. During the meeting Keith Holloway, the TMO's Director of Strategic, Planning, Performance and Compliance, confirmed that fire risk assessments would be carried out by an external consultant. He and Jean Daintith also agreed that RBKC and the TMO would complete fire risk assessments for all their properties within three years, starting with high-risk properties, and carry out any work identified in them within five years.[401]

37.7 Although RBKC and the TMO felt that, in requiring that approach to fire risk assessments, the LFB was treating them unduly harshly, they agreed to comply with its requirements.[402]

37.8 On 7 September 2009, a fire risk consultant, Salvus Consulting Ltd (Salvus), was appointed by the TMO to carry out the first phase of fire risk assessments. It covered 110 properties that were considered to pose a high risk, including Grenfell Tower. Work was due to start on

401 Minutes of meeting between RBKC, TMO and LFB on 6 August 2009 {RBK00018535/2} item 5.

402 Minutes of TMO Executive Team meeting dated 29 July 2009 {TMO00903017/5} item 9; Minutes of TMO Executive Team meeting dated 3 August 2009 {TMO00903019/3} item 2.4; Emails between Laura Johnson and Janice Wray cc Keith Holloway dated 4-5 August 2009 about fire safety {TMO10037329}; Minutes of meeting between RBKC, TMO and LFB on 6 August 2009 {RBK00018535/1} item 1; Minutes of meeting between RBKC, TMO and LFB on 6 August 2009 {RBK00018535/4} item 10.

24 September 2009.[403] There were meetings between Salvus, the LFB fire safety team, the TMO and RBKC on 16 September 2009 and 23 November 2009 to discuss the scope of the fire risk assessment programme and the method to be adopted.[404]

37.9 On 27 January 2010, Robert Black and Laura Johnson wrote to Angus Sangster confirming the joint commitment of RBKC and the TMO to achieving compliance with the Fire Safety Order. In their letter they described what had been agreed in their meetings with the LFB fire safety team in relation to the fire risk assessment programme, which by that time was already under way. The LFB was evidently satisfied with their proposal.[405]

403 Wray {TMO00842341/2} page 2, paragraph 9; Agreement between TMO and Salvus to appoint Salvus to carry out fire risk assessments on high-risk properties dated 7 September 2009 {TMO10037438/42}; TMO spreadsheet of potentially high-risk properties dated 1 July 2009 {TMO00842374}.

404 Minutes of the meeting between Salvus, LFB fire safety team and TMO on 16 September 2009 {SAL00000039}; Minutes of the meeting between Salvus, LFB fire safety team, TMO and RBKC on 23 November 2009 {SAL00000043}.

405 Minutes of meeting between RBKC, TMO and LFB on 6 August 2009 {RBK00018535}; Minutes of the meeting between Salvus, LFB and TMO on 16 September 2009 {SAL00000039}; Minutes of the meeting between Salvus, LFB, RBKC and TMO on 23 November 2009 {SAL00000043}.

The Salvus Management Report

37.10 On 22 September 2009, Steve Wain, a Salvus fire risk assessor, carried out a detailed assessment of the TMO's fire safety management systems at the request of Russell Thompson, the TMO's Head of Assets Strategy and Investment.[406] Steve Wain set out his findings in a report of the same date entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" (known as the Salvus Management Report).[407]

37.11 The Salvus Management Report was divided into two parts. Part 1 identified 25 deficiencies in the TMO's fire safety management arrangements that created hazards. It also identified where there were inadequate control measures in place in relation to those hazards and the level of risk the hazards presented.[408] It based risk on both the likelihood of harm occurring and the likely severity of harm. A high-risk event, for example, was defined as one that was very likely or almost certain to occur and cause major injury or death and a medium-risk event as one that could occur in time and was likely to cause injury and

406 Salvus report entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" dated 22 September 2009 {SAL00000013/2}.
407 Salvus report entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" dated 22 September 2009 {SAL00000013/1}.
408 Salvus report entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" dated 22 September 2009 {SAL00000013/2}.

ill health.[409] All but two of the deficiencies were assessed as presenting a high or medium to high level of fire risk.[410] Hazards included the absence of an overall fire safety policy setting out the TMO's strategic fire safety objectives, which was assessed as a high risk, the lack of policy and supporting arrangements to explain how the TMO would meet its fire safety objectives (for example, in relation to fire risk assessments and the maintenance of fire safety measures), which was also assessed as high risk and the lack of senior managerial audit of the fire safety arrangements to ensure that they were being satisfactorily implemented, which was assessed as medium to high risk.[411]

37.12 Although Janice Wray did not agree with all of Salvus's conclusions, she did accept that the TMO had not adequately recorded its fire safety arrangements.[412] Indeed, the TMO's Health and Safety Policy dated May 2009 was the only policy relevant to fire safety in existence at the time of the Salvus Management Report.[413] It was not, however, a fire safety policy. It referred only briefly

409 Salvus report entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" dated 22 September 2009 {SAL00000013/2}.
410 Salvus report entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" dated 22 September 2009 {SAL00000013/5-12}.
411 Salvus report entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" dated 22 September 2009 {SAL00000013/5}.
412 Wray {Day140/108:18-21}.
413 TMO's Health and Safety Policy dated May 2009 {TMO00870519}.

to fire safety and emergency procedures and made no mention at all of the Fire Safety Order, which had come into force in October 2006 some two and half years earlier.[414]

37.13 Part 2 of the Salvus Management Report was an action plan which set out 49 steps required to reduce the risks that had been identified.[415] Salvus considered that 19 of them were required to remedy statutory breaches.[416] According to the priority ratings, Salvus required that the majority be completed within one or three months or, if a plan had been agreed, within six months.[417] There was, therefore, some urgency attached to the recommendations.

37.14 Salvus strongly recommended that the TMO develop an overall fire safety policy within one month setting out its strategic fire safety objectives. It also strongly advised that the TMO introduce policy and supporting arrangements to

414 TMO's Health and Safety Policy dated May 2009 {TMO00870519/5}.

415 Salvus report entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" dated 22 September 2009 {SAL00000013/13-19}.

416 Salvus report entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" dated 22 September 2009 {SAL00000013/13-19}. The key to colour coding on page 19 shows that red signifies a statutory breach. The statute and statutory instruments Steve Wain probably had in mind are set out in the "Reference Material" on page 4.

417 Salvus report entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" dated 22 September 2009 {SAL00000013/13-19}. The "key to priority rating" on page 19 shows that "3" means "Undertake action within 1 month" and "4" means "Action within 3 months or agree plan within 6 months".

show how it would meet its strategic fire safety objectives (for example, in relation to fire risk assessments and the maintenance of fire safety measures) within three months or, if a plan had been agreed, within six months.[418]

37.15 Although we do not know exactly who received the Salvus Management Report, Janice Wray believed that copies had been sent to all those in the TMO who regularly dealt with Salvus. She mentioned Russell Thompson, Janet Rhymes, the TMO's Consultancy Services Manager, and also Ann Muchmore, RBKC's Performance and Contracts Monitoring Officer.[419]

37.16 Janice Wray did not receive the Salvus Management Report until 20 November 2009.[420] We do not know why there was a delay of two months in her receiving it; on the face of it, it should have reached her much sooner. The delay may explain why she did not mention the report in her fire risk assessment report to the TMO board on 8 October 2009,[421] but it does not explain why, according to her report,

418 Salvus report entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" dated 22 September 2009 {SAL00000013/13}.

419 Wray {Day140/105:7-11}.

420 Minutes of the meeting between Salvus, LFB, RBKC and TMO on 23 November 2009 {SAL00000043/4}. At item 5.4 it is recorded that Janice Wray received the email "late Thursday" which would have been 20 November 2009. See also Wray {Day140/118:4-12}; Wray {Day140/119:7-25}.

421 Janice Wray's report to the TMO Board entitled "Further Update on Fire Risk Assessments" dated 8 October 2009 {RBK00053571/1}.

Salvus had said at its meeting with the TMO on 24 September 2009 that generally the TMO had good fire safety policies and procedures in place, although they had not been consistently documented.[422] That statement is difficult to reconcile with the deficiencies in fire safety policy and arrangements that Salvus had identified in the report it had made only two days before that meeting. Regrettably, we have not seen any minutes of that meeting.

37.17 When Janice Wray received the Salvus Management Report she should have communicated at least the substance of its findings to the executive team, which in turn should have communicated them to the board and to RBKC. We have seen no evidence that that was done and we conclude that she did not do so. That would at least have set the record straight and would have corrected the false impression that Ms Wray had given the board on 8 October 2009.

37.18 Janice Wray may have discussed the report with Lornette Pemberton, the TMO's Head of Human Resources and Organisational Development and her line manager at the time and if so, she probably assumed that Ms Pemberton would report the

422 Janice Wray's report to the TMO Board entitled "Further Update on Fire Risk Assessments" dated 8 October 2009 {RBK00053571/2} item 3.4.

deficiencies to the executive team.[423] Robert Black said that he could not recall the report but was sure that he had seen it.[424]

37.19 In her fire risk assessment report on 10 December 2009, Janice Wray told the board that the TMO had received a report from the consultant that set out the fire safety framework within which it and any contractors should be working.[425] However, she did not mention any of the critical findings or urgent measures that needed to be taken by the TMO in relation to the management of fire safety. She could not explain that omission,[426] nor could she remember having told the executive team or the board about them. We have seen no evidence that she or anyone else did so and are forced to the conclusion that they were not drawn to the attention of either the executive team or the board.[427]

37.20 The report and its findings were, however, discussed by Salvus, the TMO and RBKC at a progress meeting on 26 January 2010. That meeting was attended by Janice Wray, Russell Thompson, Abigail Acosta (a TMO project

423 Wray {Day140/122:16}-{Day140/123:12}; Wray {Day140/127:12-17}.
424 Black {Day149/63:9}-{Day149/67:11}; Wray {Day140/133:6-10}.
425 Janice Wray's report to the TMO Board entitled "Further Update on Fire Risk Assessments" dated 10 December 2009 {TMO00873623/2} item 4.5.
426 Wray {Day140/123:7-12}.
427 Wray {Day140/122:24}-{Day140/123:12}.

manager) and Ann Muchmore.[428] It is clear from the minutes of the discussion of the report that Ann Muchmore was aware of its existence, even if she had not been provided with a copy. However, we have seen no evidence that she ever shared the report more widely within RBKC. Laura Johnson had no recollection of having seen it.[429]

Implementation of the recommendations

37.21 At the meeting on 26 January 2010, Janice Wray raised a number of questions about the Salvus Management Report.[430] It is clear from the minutes of that meeting that many of Salvus's recommendations had yet to be implemented and indeed Janice Wray accepted that some had not been. For example, she said she had not had an opportunity to put in place policy and supporting arrangements to explain how the TMO would meet its strategic fire safety objectives.[431] That was despite a recommendation that it be done within three months.[432]

428 Minutes of the meeting between Salvus, RBKC and TMO on 26 January 2010 {RBK00052572/3-4} item 4.
429 Johnson {Day129/100:25}.
430 Minutes of the meeting between Salvus, RBKC and TMO on 26 January 2010 {RBK00052572/3-4} item 4.
431 Wray {Day140/125:3-20}.
432 Salvus report entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" dated 22 September 2009 {SAL00000013/13} item 1.2.

37.22 It appears that Janice Wray had started to implement that particular recommendation within the required time but had stopped work before it was complete. There is a document headed "TMO Fire Safety Policy", apparently signed by Robert Black and dated December 2009,[433] which appears to be an early draft of the fire safety policy. Although she had little recollection of it, Janice Wray thought she had probably started drafting it in response to Salvus's recommendation and had put it aside because of other work.[434] As it was, the TMO did not produce a fire safety policy in response to that recommendation until November 2013.[435]

37.23 On any view, the pace at which the recommendations were implemented was glacial. Given a high or medium to high assessment of the danger posed by a recommendation's remaining incomplete, the TMO failed to act with the degree of urgency that the subject demanded. It is not clear whether the problem flowed from Janice Wray's failure to prioritise the work or whether she did not have the capacity to undertake it and failed to ask for more resources. Whatever the cause, given their importance,

433 Draft TMO Fire Safety Policy dated December 2009 {TMO00870171}.
434 Wray {Day140/131:5-25}; Wray {Day140/142:6-11}.
435 TMO Fire Safety Strategy dated November 2013 {TMO00830598}.

the TMO should have made sure that the recommendations were promptly implemented and it failed to do so.

37.24 One of the other recommendations made by Salvus was that within three months (or six months if a plan had by then been produced) the TMO should introduce a senior managerial audit of fire safety arrangements. There was also a recommendation that it be reviewed as part of the TMO's Business Plan.[436] We have seen no evidence that the TMO had introduced such an audit before the Grenfell Tower fire on 14 June 2017 and no explanation has been given for its failure to do so.

37.25 The TMO Performance Agreement for 2012/13 contained a draft audit programme for the following year that included a full review of fire risk assessments by Lornette Pemberton.[437] It is evident, however, that the audit was intended to relate to fire risk assessments rather than the fire safety management system as a whole. It would not, therefore, have fully met Salvus's recommendation. In any event, we have seen no evidence that Lornette Pemberton, or anyone else, carried out an audit of that kind and we conclude that no one did. Robert Black

436 Salvus report entitled "Fire Risk Assessment for Fire Safety Policy and Procedures" dated 22 September 2009 {SAL00000013/14} item 1.4.

437 TMO Performance Agreement 2012/13 {TMO00883568/42} paragraph 3.4.

could not explain why it had not been carried out.[438] An audit of fire risk assessments did not appear again in the TMO audit programme before 14 June 2017.[439]

37.26 In June 2013, PAS 7:2013, a publicly available specification concerning fire risk management systems, was published by the British Standards Institution.[440] Paragraph 7.4.3 stated that an organisation should audit the fire risk assessment programme after the delivery of the fire risk assessments and hold review meetings at planned intervals to discuss the results of the audits of fire risk assessments and the efforts made to respond to the findings.[441]

37.27 At paragraph 8.3.1, it provided that senior management should review the organisation's fire risk management system at planned intervals to ensure its continuing suitability, adequacy and effectiveness.[442] That specification bears a striking

438 Black {Day149/211:14-22}.
439 TMO Performance Agreement 2013/14 {TMO10002878/22} item 3.2; TMO Performance Agreement 2014/15 Mid-Year Review {TMO10042117/5-6} item 2; TMO Performance Agreement 2015/16 {TMO10043715/20-21} item 3.2; TMO Performance Agreement 2016/17 {RBK00000589/24-25} item 3.2.
440 BSI Standards Publication PAS 7:2013 "Fire Risk Management System – Specification" {LFB00116924/2}.
441 BSI Standards Publication PAS 7:2013 "Fire Risk Management System" {LFB00116924/23} paragraph 7.4.3.
442 BSI Standards Publication PAS 7:2013 "Fire Risk Management System" {LFB00116924/25} paragraph 8.3.1.

resemblance to the recommendation made by Salvus in September 2009 for a senior managerial audit of fire safety arrangements.

37.28 Janice Wray was aware of PAS 7:2013.[443] Despite that, she made no provision in the TMO fire safety strategy that she prepared in November 2013 for an audit of the fire risk assessment programme or for a review of the fire risk management system.[444]

37.29 We have seen no evidence that RBKC or the TMO incorporated a specific audit of the fire risk assessment programme or a review by senior management of the fire risk management system into its policy. Nor have we seen any evidence that the management of the TMO ever implemented such an audit or review in practice. No explanation has been given for those chronic failings.

RBKC audit of the TMO's health and safety arrangements

37.30 The TMO, in conjunction with RBKC, set annual audit plans, the results of which allowed senior management to assess the adequacy and effectiveness of the internal controls in any particular year.[445] Audits were carried out by

443 Wray {Day145/11:12}-{Day145/12:17}.
444 TMO Fire Safety Strategy dated November 2013 {TMO00830598}.
445 Patel {RBK00029884/2} page 2, paragraph 5.

RBKC's audit department, whose reports gave an overview of the area of service being audited. They also provided an assurance assessment rating, which ranged from "substantial" to "limited", based on the findings and the number of recommendations made in the report. If a "limited" assurance rating was given, there was usually a review within six to nine months to assess the implementation of any recommendations.[446]

37.31 For TMO health and safety audits, each recommendation was given a high, medium or low priority and the overall audit would be given a "limited", "satisfactory" or "substantial" assurance rating. "Limited" assurance meant that there were weaknesses that put the objectives of the system at risk of failure. "Satisfactory" assurance meant that there were some weaknesses or omissions that put the objectives of the system at risk of failure. "Substantial" assurance meant that there was a sound system of control designed to achieve its objectives with few errors of weaknesses found.[447] RBKC's audit team provided an independent audit service for the TMO.[448]

446 Patel {RBK00029884/2} page 2, paragraph 5.
447 Patel {RBK00029884/4} page 4, paragraph 12.
448 Patel {RBK00029884/4} page 4, paragraph 14.

37.32 An audit of the TMO's Health and Safety department was carried out by RBKC in April 2013.[449] The report was circulated, initially in draft, to Sacha Jevans, Janice Wray, Peter Maddison and Anthony Parkes. When completed, copies of the report were sent to Robert Black and Laura Johnson.[450] The audit provided only limited assurance that the TMO had adequate controls and processes in place in relation to health and safety.[451] The report made two relevant recommendations, first, that all high priority remedial work identified in the annual health and safety inspection should be reviewed by the Health and Safety Team to ensure that it was undertaken promptly; and secondly, that appropriate performance indicators relating to health and safety inspections should be developed by management.

37.33 The TMO accepted that some performance indicators would be useful, including indicators relating to fire risk assessments and reviews, the service of enforcement and deficiency notices and the number of fires.[452]

449 {RBK00000313}.
450 {RBK00000313/1}.
451 {RBK00000313/4}.
452 {RBK00000313/21}.

Matt Hodgson's review

37.34 Following the audit in April 2013 and the finding of "limited assurance",[453] the TMO instructed Matt Hodgson, a health and safety professional, to complete a safety management review.

37.35 Mr Hodgson prepared two reports, dated 19 July 2013[454] and September 2013 respectively,[455] both of which were marked for the attention of Robert Black. The reports set out to provide an independent assessment of the implementation of the TMO's health and safety policy and its supporting arrangements.[456]

37.36 In his first report Mr Hodgson identified 39 matters that required attention across the broad range of the TMO's health and safety responsibilities.[457] For example, he recommended a review of the section of the corporate policy dealing with roles and responsibilities to make sure that the management of health and safety was appropriate to the TMO. He also concluded that the designation of RBKC's chief executive as the responsible person for the purposes of the Fire Safety Order was not appropriate. He advised that someone within the TMO should be

453 Black {Day149/135:19}-{Day149/136:13}.
454 Safety management review, July 2013 {TMO10003124}.
455 Safety management review, September 2013{TMO00873398} paragraph 2.
456 Safety management review, September 2013 {TMO00873398/4}.
457 Safety management review, July 2013 {TMO10003124/9}.

designated as the responsible person and should receive the training and resources necessary to allow the role to be performed effectively.[458]

37.37 More fundamentally, Mr Hodgson found that the health and safety policy did not identify the risks to which the TMO was exposed and failed to explain in sufficient detail what arrangements were necessary to satisfy, among other matters, its obligations in relation to fire safety.[459] He observed that many of the fire safety arrangements had been grouped together in a way that lacked the detail required to produce an effective planned preventative maintenance process.

37.38 Matt Hodgson's analysis echoed the criticism made by Salvus in 2009. The maintenance process remained reactive, which defeated the object of effective policy arrangements, namely, the clear definition of planned preventative maintenance arrangements that ensured compliance with the TMO's health and safety obligations.[460] Mr Hodgson therefore recommended a full review of the policy arrangements to ensure that there was a section for each property risk in order to achieve compliance.[461] Robert Black was asked

458 Safety management review, July 2013 {TMO10003124/34} paragraph 1.
459 Safety management review {TMO00873398/19} paragraph 5.
460 Safety management review {TMO00873398/19}.
461 Safety management review {TMO00873398/20} item 4.

whether any new policies had been introduced or any existing policies revised following that recommendation. He could not remember.[462]

37.39 Matt Hodgson also considered the position in relation to fire risk assessments.[463] He found that the TMO's records of fire risk assessments were not up-to-date and that it was therefore not possible to see whether and, if so, to what extent the TMO had complied with its duties. It was clear, however, that there were between 900 and 1,000 outstanding matters arising from previous fire risk assessments.

37.40 Following receipt of the report, Robert Black prepared a report for the meeting of the TMO's board on 5 September 2013. In it he referred to Mr Hodgson's initial report and said that an action plan was being prepared for incorporation into the final report, but he did not mention any of the shortcomings identified by Mr Hodgson, not least the fact that the TMO itself and the members of the board could be exposed to liability if some of the deficiencies that had been identified were not remedied. Nor did he mention the lack of a co-ordinated approach to risk management or a lack of leadership from the executive team. In evidence, Mr Black agreed that they were all

462 Black {Day149/141:13-16}.
463 Safety management review July 2013 {TMO10003124/33}.

important matters for the TMO board to know.[464] He suggested that the reason he had not revealed those findings to the board was that at that stage the report was still in draft.[465] The fact is that the Hodgson report contained a powerful criticism of the TMO's health and safety arrangements and was all the more serious for the fact that four years had passed since the Salvus report and not all of the recommendations had been carried out. If Mr Black had disclosed those matters to the board he would no doubt have been asked some very difficult questions. We can only infer that he chose not to face up to them and hoped instead to keep Mr Hodgson's conclusions away from the board and thereby avoid embarrassment.

37.41 Yet again, Mr Black's decision not to inform the board about those important matters prevented it from exercising effective supervision and control over the development of adequate fire safety management policies and arrangements. That was a very serious failing on his part.

37.42 The result was that by the end of 2013, the TMO's executive team had received two independent reports, four years apart, on its fire safety management arrangements, each of which had made far-reaching criticisms and recommendations. Those reports went to the

464 Black {Day150/87:13-23}.
465 Black {Day150/88:24}.

chief executive but not to the board. They were not acted on in any material way by the TMO, not least because Mr Black's failure to bring them to the attention of the board meant that there was no pressure on him to take action. His own failure to take responsibility for implementing the recommendations and put in place a strategy for solving the myriad of deficiencies in the management system was a further serious failing on his part. It was also a serious failing on the part of Janice Wray, who knew as much as he did and on whom he relied. Clearly neither of them regarded fire safety as a high priority, even though the TMO had gone to the trouble and expense of commissioning the reports.

Further audits

37.43 In December 2013, RBKC carried out a further audit of the TMO's Health and Safety department.[466] The report was circulated in draft to Peter Maddison, Alex Bosman and Janice Wray before the final version was sent to Sacha Jevans and Anthony Parkes. Robert Black also received it.[467] The level of assurance had risen from "limited" to "satisfactory" because of the steps that the TMO said had been taken.[468]

466 Exhibit AP/3 – RBKC, TMO Health and Safety Follow up Audit Report {RBK00000320}.
467 Black {Day150/64:20}-{Day150/65:1}.
468 Exhibit AP/3 – RBKC, TMO Health and Safety Follow up Audit Report {RBK00000320/2}.

37.44 The action said to have been taken on key performance indicators is set out on page 9 of the report.[469] Notwithstanding the clear terms of the TMO's response to the report produced in April 2013, no indicators had been prepared for fire risk assessments or reviews, the service of enforcement or deficiency notices or the number of fires. The TMO did not set up a system to monitor each indicator until January 2016.[470] No explanation was given for that delay.[471] The TMO did not inform RBKC of the contents of the two Hodgson reports, much less provide it with copies.

37.45 Another audit of the TMO's health and safety arrangements was undertaken as part of the 2015/16 audit plan. The final report, dated March 2016, was a "high level audit review". It did not identify any shortcomings in the TMO's management of fire safety. It found that appropriate procedure and guidance documents existed covering fire safety policy and had recently been revised.[472] It said that fire risk assessments were carried out by a specialist consultant and were reviewed by the TMO Assistant Safety Advisor during routine inspections to ensure that any significant findings

469 Exhibit AP/3 – RBKC, TMO Health and Safety Follow up Audit Report {RBK00000320/9}.
470 Black {Day150/63:3-6}.
471 Black {Day150/63:18}-{Day150/64:11}.
472 Exhibit AP/4 – RBKC, TMO Final Internal Audit Report {RBK00000531/6}.

and recommendations were pursued in a timely manner and in accordance with their stated priority. Checks on the electronic database relating to ten estates had confirmed that they were up to date and that all fire equipment had been inspected within the past twelve months.[473]

37.46 That finding failed to take account of the serious backlog of remedial work required by previous fire risk assessments that existed in the months before the final audit report.[474] The TMO failed to correct the auditor's mistake in thinking that all remedial work had been carried out in a timely manner and in accordance with their stated priority. None of the witnesses from the TMO could explain that failure. As a consequence, the audit report gave the misleading impression that there were no deficiencies in the TMO's management of fire safety. Nor, once again, did the TMO take the opportunity to tell RBKC about the contents of Matt Hodgson's reports or the systemic failings in its fire safety management he had identified.

473 Exhibit AP/4 – RBKC, TMO Final Internal Audit Report {RBK00000531/6-7}.

474 See for example minutes from the 11 November 2015 TMO Executive Committee meeting, item 3 "Adair Tower – Responses" {TMO00843593/2}.

Chapter 38
Fire risk assessments

Introduction

38.1 Fire risk assessments lie at the heart of the arrangements by which the responsible person discharges its obligations under the Fire Safety Order. In this chapter, starting with the engagement of Salvus by the TMO in 2009, we consider how the TMO carried out fire risk assessments of the high-rise residential buildings within its housing stock, principally in relation to Grenfell Tower. In particular, we concentrate on the appointment of Carl Stokes as the TMO's preferred fire risk assessor, his qualifications and competence, the adequacy of his fire risk assessments and concerns that emerged about the quality of his work.

Fire risk assessments – background

38.2 Between 24 September 2009 and March 2010, Salvus carried out fire risk assessments of high-risk TMO properties for the TMO and RBKC.[475] The programme was a joint initiative between the RBKC and the TMO for which they

[475] Minutes of Fire Risk Assessments in high rise blocks meeting dated 7 September 2009 {SAL00000040/3}.

had joint responsibility.[476] Janice Wray took responsibility for identifying which blocks should take priority, the procurement, commissioning the fire risk assessments and ensuring that progress met the LFB's requirements.[477] Valerie Sharples, and for a brief period Abigail Acosta, were the TMO's project managers.[478] Ann Muchmore, RBKC's performance and contracts monitoring officer, had responsibility for overseeing the contract.[479]

38.3 At the start of the contract, Angus Sangster and Steve Reade of the LFB's Fire Safety team met Janice Wray, Adrian Bowman and Abigail Acosta and Andrew Furness and Steve Wain of Salvus.[480] Angus Sangster repeated the LFB's requirements for the fire risk assessment programme, namely to have the entire property portfolio assessed within three years and to have the

476 Wray {Day140/101:16-19}; Amanda Johnson {Day130/6:2-14}.
477 Minutes of Fire Risk Assessments in high rise blocks meeting dated 7 September 2009 {SAL00000040/1}; Amanda Johnson {Day130/6:2-14}.
478 Minutes of Fire Risk Assessments in high rise blocks, introductory meeting between Consultant and Fire Brigade dated 16 September 2009 {TMO00842368/1}.
479 Wray {Day140/101:20}-{Day140/102:9}.
480 Minutes of Fire Risk Assessments in high rise blocks, introductory meeting between Consultant and Fire Brigade dated 16 September 2009 {TMO00842368/1}.

remedial work required for properties to be fully compliant with the Fire Safety Order completed within five years.[481]

38.4 Salvus employed four fire risk assessors, including Carl Stokes.[482] Carl Stokes started working for Salvus on 24 September 2009 on a six-month contract as a sub-contractor.[483]

Carl Stokes

38.5 Before he started working for Salvus, Carl Stokes had been an operational firefighter.[484] In 1986, he joined the Royal Berkshire Fire and Rescue Service.[485] During that time, he was seconded to the Fire Safety department and carried out familiarisation visits to high-rise buildings.[486] In 1994, Mr Stokes transferred to the Oxfordshire Fire and Rescue Service where he spent most of his time in the Fire Safety department.[487] Following the introduction of the Fire Safety Order, he received training on it

481 Minutes of Fire Risk Assessments in high rise blocks, introductory meeting between Consultant and Fire Brigade dated 16 September 2009 {TMO00842368/1}.
482 Minutes of Fire Risk Assessments in high rise blocks meeting dated 7 September 2009 {SAL00000040/1}.
483 Stokes {Day136/6:5-8}; {Day136/7:19-21}; {Day136/58:6-18}.
484 Stokes {CST00003063/4} page 4, paragraph 7.
485 Stokes {CST00003063/4} page 4, paragraph 7.
486 Stokes {CST00003063/5} page 5, paragraph 8; Stokes {Day136/4:22}-{Day136/5:5}.
487 Stokes {CST00003063/5} page 5, paragraph 9.

and spent a significant amount of time auditing the findings made by fire risk assessors on behalf of responsible persons pursuant to the Fire Safety Order.[488] However, none of these included residential blocks of flats over 18 metres in height.[489]

38.6 On 12 December 2007, Mr Stokes was awarded a Fire Risk Assessment Certificate by the Northern Ireland Fire Safety Panel, which enabled him to carry out fire risk assessments.[490] He set up C S Stokes and Associates Ltd in February 2009 and retired from the Oxfordshire Fire and Rescue Service in September 2009.[491] Carl Stokes was the sole director of C S Stokes and Associates Ltd and employed no-one else. He was therefore always a "one man band".[492] When he started working for Salvus, he had no experience of carrying out fire risk assessments on highrise residential blocks of flats.[493] He had less than two years' experience as a certified fire risk assessor.[494]

488 Stokes {CST00003063/5} page 5, paragraph 10; Stokes {Day136/10:14-17}.
489 Stokes {Day136/15:24}-{Day136/16:9}.
490 Stokes {CST00003063/5} page 5, paragraph 11; {TMO00880581/12}.
491 Stokes {CST00003063/6} page 6, paragraph 13.
492 Stokes {CST00003063/1} page 1, paragraph 1; Stokes {Day136/5:20}-{Day136/6:3}.
493 Stokes {Day136/19:7-13}.
494 Stokes {Day136/19:25}-{Day136/20:7}.

Salvus's fire risk assessment programme

38.7 Salvus operated a quality control process under which all fire risk assessments were reviewed and discussed by email, when required, before being approved by the managing director, Andrew Furness.[495] Mr Furness attended sites periodically to ensure consistency of assessments.[496] Steve Wain oversaw the team of fire risk assessors.[497]

495 'Background re Carl Stokes employment with Salvus Consulting Limited' dated August 2019 {SAL00000002}.

496 Minutes of Fire Risk Assessments in high rise blocks meeting dated 7 September 2009 {SAL00000040/1}.

497 Minutes of Fire Risk Assessments in high rise blocks meeting dated 7 September 2009 {SAL00000040/1}.

38.8 In the case of the TMO, Andrew Furness held regular monthly meetings with Valerie Sharples and Janice Wray.[498] Ann Muchmore of RBKC and officers of the LFB Fire Safety Team often attended those meetings.[499]

38.9 Over the course of the six months between September 2009 and March 2010 the team at Salvus carried out fire risk assessments in relation to about 110 high-risk properties managed by the TMO, including Grenfell Tower.[500] Carl Stokes believed he had carried out between 20 and 30 of those assessments.[501]

---

498 Minutes of Fire Risk Assessments in high rise blocks meeting dated 7 September 2009 {SAL00000040/3}; Minutes of Fire Risk Assessments in high rise blocks meeting dated 16 September 2009 {TMO00842368/1}; Minutes of Fire Risk Assessments in high rise blocks meeting dated 19 October 2009 {SAL00000044}; Minutes of Fire Risk Assessments in high rise blocks meeting dated 23 November 2009 {SAL00000043}; Minutes of Fire Risk Assessments in high rise blocks meeting dated 26 January 2010 {RBK00052572}; Minutes of Fire Risk Assessments in high rise blocks meeting dated 23 February 2010 {SAL00000042}; Minutes of Fire Risk Assessments in high rise blocks meeting dated 1 April 2010 {SAL00000041}.

499 Minutes of Fire Risk Assessments in high rise blocks meeting dated 19 October 2009 {SAL00000044/1}; Minutes of Fire Risk Assessments in high rise blocks meeting dated 23 November 2009 {SAL00000043/1}; Minutes of Fire Risk Assessments in high rise blocks meeting dated 26 January 2010 {RBK00052572/1}; Minutes of Fire Risk Assessments in high rise blocks meeting dated 1 April 2010 {SAL00000041/1}.

500 Minutes of Fire Risk Assessments in high rise blocks meeting dated 16 September 2009 {TMO00842368/1}; Wray {TMO00842341/2} page 2, paragraph 9; {TMO00842374}; Minutes of the meeting between LFB, RBKC and TMO dated 20 April 2010 {TMO00873670/1}.

501 Stokes {Day136/61:17-25}.

38.10 The fire risk assessment in relation to Grenfell Tower was completed on 30 September 2009 by Carl Stokes under the supervision of Andrew Furness.[502] It identified the chief executive of RBKC and the TMO[503] as the responsible persons for the purposes of the Fire Safety Order, which reflected Carl Stokes's view[504] and presumably also that of Salvus. Janice Wray was consulted during the assessment.[505] The fire risk assessment was subject to a quality control process and was reviewed by Andrew Furness on at least two occasions.[506] It rated the overall risk for the building as "normal", but identified 51 defects requiring remedial measures to reduce the risk.[507] Of those 51 defects, 19 were categorised as involving statutory breaches and were marked in red. Each defect was given a "priority rating"

502 Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128}; Stokes {Day136/70:2-16}.

503 Under General Information the Chief Executive of the Royal Borough of Kensington and Chelsea is listed as a Responsible Person. The Tenant Management Organisation Warden is listed as a Responsible Person/contact on site: Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/5}.

504 Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/5}; Stokes {Day136/69:7-10}.

505 Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/5}.

506 Stokes {Day136/70:2-16}.

507 Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/6}; Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/15-19}.

which identified the length of time within which it was recommended that action be taken to remedy it.[508] Some of the measures required to remedy red defects, such as reviewing the evacuation procedure and confirming the policy and procedures for the operation of the smoke ventilation system, required action to be taken within one week.[509] Other defects requiring remedial measures marked in red required the TMO to take action within three months or to agree a plan within six months.[510] They included recommending that the TMO introduce and implement a system of formal checks on flat front doors to ensure that compartmentation remained fit for purpose.[511] The assessment also recommended that the TMO engage competent engineers to test the smoke ventilation system and the lifts, if testing was not being carried out in accordance with current industry best practice.[512]

508 Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/15-19}.
509 Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/16-19}.
510 Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/19}.
511 Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/16}.
512 Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/18-19}.

38.11 The programme ended in March 2010.[513] In February 2010, Janice Wray and Ann Muchmore evaluated the performance of Salvus in accordance with a commitment they had made to the LFB.[514] Although, as she explained to us, they were not unhappy with Salvus's work, on 11 February 2010 Janice Wray told Ann Muchmore that she had some concerns that Salvus were "very rule-bound" and that they had shown some reluctance to challenge the LFB on behalf of the TMO.[515] She noted that Salvus was not as robust as she had hoped and that Carl Stokes, who had done most of the inspections as a sub-contractor, might be willing to tender for the work in future.[516] Janice Wray felt that Salvus had not given her a clear indication on fire safety issues raised by the LFB and she wanted to know whether the course of action suggested by the LFB was required before she committed the budget.[517] They decided to invite tenders for carrying out fire risk assessments in relation to the medium – and low-risk phases of the programme.[518]

513 Wray {TMO00842341/2} page 2, paragraph 10; Minutes of Fire Risk Assessments in high rise blocks meeting dated 1 April 2010 {SAL00000041/1}.
514 Wray {TMO00000890/30} page 30, paragraph 135; Wray {Day140/172:7}-{Day140/173:14}.
515 {RBK00053588/3}.
516 {RBK00053588/1}.
517 Wray {Day140/175:24}-{Day140/177:5}.
518 Wray {TMO00000890/30} page 30, paragraph 135; Wray {Day140/174:1-5}.

38.12 Janice Wray's message reveals that the TMO wanted a fire risk assessor that would take its side against the LFB when debating its fire safety requirements instead of taking them entirely at face value. Given that the LFB was the enforcing authority under the Fire Safety Order, that was a mistake. It also explains why Carl Stokes, who was ill-qualified to carry out fire risk assessments of buildings on this scale, let alone to hold the entire TMO portfolio, was selected by the TMO as the sole fire risk assessor and allowed to retain that role for the best part of seven years.

Appointment of fire risk assessor for medium – and low-risk properties

38.13 Once the fire risk assessment programme for high-risk buildings had been completed, on 18 October 2010 the TMO started a six-month fire risk assessment programme of its medium risk properties.[519] The fire risk assessment programme for the low-risk properties started later, on 17 August 2011.[520] Carl Stokes was appointed as the sole fire risk assessor for both programmes.[521] He began the reviews of the fire risk assessments for the high-risk properties in about December

519 {TMO00842327}; {CST00030040}.
520 {CST00030041}.
521 {CST00030041}; {CST00030040}; Wray {TMO00842341/3-4} pages 3-4, paragraphs 12-14.

2010.[522] Once the medium – and low-risk programmes had been completed, Carl Stokes was retained as the TMO's sole fire risk assessor indefinitely until his contract was terminated in about November 2017.[523]

38.14 RBKC and TMO made a commitment to the LFB to evaluate the performance of the fire risk assessor at the end of the medium – and low-risk programmes, resources permitting, and to appoint a competent fire risk assessor to complete the assessments.[524] The TMO, with the agreement of RBKC, conducted a procurement process for a fire risk assessor for the medium-risk properties in 2010.[525] It did not carry out a further procurement exercise for the review of the assessments relating to the high-risk properties or for the programme relating to the low-risk properties.[526]

38.15 The procurement process that was carried out in 2010 and the decision to appoint Carl Stokes bears further examination.

---

522 Stokes {CST00003063/9-10} pages 9-10, paragraphs 25 and 26; Stokes {Day136/89:7-15}; Wray {Day140/216:14-20}; {CST00001926}.

523 Wray {TMO00842341/4} page 4, paragraph 15; Stokes {Day136/89:3-6}; {Day136/8:14-17}.

524 {LFB00031977/30-31}.

525 {TMO00842327}; Stokes {Day136/88:10-18}.

526 Wray {Day144/220:12-15}; Stokes {CST00003063/9-10} pages 9-10, paragraphs 25 and 26; Stokes {Day136/89:7-15}; Wray {Day140/216:14-20}.

The decision to appoint Carl Stokes

38.16 On 11 February 2010, Janice Wray sought funding and approval from Ann Muchmore to invite tenders for carrying out fire risk assessments in relation to the medium-risk properties.[527] In May 2010, the TMO Operations Committee was told that it had been agreed between the TMO and RBKC that a new fire risk assessor should be appointed for the medium-risk programme by July 2010.[528]

38.17 On or around 6 August 2010, C S Stokes and Associates Ltd, Salvus, and three other companies were invited to tender for the medium-risk programme.[529] The invitation included a consultants' brief, which set out the proposed terms of the contract.[530] It provided at paragraph 1.10 that the consultant's appointment would be for a one year period with an option for the TMO to extend for a further year, subject to the consultant's satisfactory performance.[531]

38.18 There was evidence to suggest that, even before the tender process had begun, Carl Stokes was undertaking fire risk assessments for the TMO. Invoices show that he had been carrying out fire

527 {RBK00053588/3}.
528 {TMO10037422/2}.
529 Wray {TMO00842341/2-3} pages 2-3, paragraphs 10 and 11.
530 Wray {TMO00842341/2-3} pages 2-3, paragraph 10; {TMO00842371}.
531 {TMO00842371/3}.

risk assessments of areas of the TMO's offices from as early as 22 June 2010 and 2 July 2010.[532] There was no evidence to show that he had formally applied for that work or had taken part in any formal procurement process. Janice Wray could not explain why he had been conducting fire risk assessments for buildings in the TMO stock before the procurement process had started.[533] She was adamant that she had not already decided to appoint him as the fire risk assessor[534] and that it was to be a joint decision with RBKC.[535] That may be so, but the episode does suggest that in some way Carl Stokes had an advantage in the procurement process.

38.19 On 22 June 2010, Carl Stokes met Janice Wray.[536] He sent her a letter the following day setting out the matters they had discussed, including employee fire training, personal emergency evacuation plans (PEEPs) and the lift maintenance policy for buildings over 18 metres in height.[537] When he gave evidence he said that they had discussed the nature of the information that he would include in his fire risk assessments and their discussions were reflected in the

532 {CST00030111}; {CST00030077}.
533 Wray {Day141/15:19}-{Day141/17:8}.
534 Wray {Day141/17:9-21}.
535 Wray {Day141/17:9-21}.
536 {CST00001887}.
537 {CST00001887}.

assessments he subsequently produced.[538] Carl Stokes could not explain the reason for that meeting.[539] Janice Wray suggested that he had only been seeking more information about the organisation and its policies and procedures.[540] She thought he had been trying to create a good impression.[541] Ms Wray did not meet any of the other applicants, nor did she tell any of them that she had provided Carl Stokes with the information set out in the letter.[542]

38.20 On the face of it, it appears that Carl Stokes was the favoured applicant because he had already carried out work for the TMO under its contract with Salvus and had continued to carry out work for it.

38.21 Carl Stokes submitted his tender on 24 August 2010.[543] Thereafter, interviews were held with a panel of two officers of the TMO, Janice Wray and either Janet Rhymes or Valerie Sharples, and one officer of RBKC.[544]

538 Stokes {Day136/118:3-17}; {Day136/122:7-11}; Fire Risk Assessment for Grenfell Tower dated 29 December 2010 {CST00003181}.
539 Stokes {Day136/119:12-15}.
540 Wray {Day141/9:16}-{Day141/10:5}.
541 Wray {Day141/9:16}-{Day141/10:5}.
542 Wray {Day141/10:6-18}.
543 {CST00002368}.
544 {TMO00842327/1}; Wray {Day140/189:5-22}; Carl Stokes's interview was held on 6 September 2010 {CST00003159}.

38.22 Clause 1.5 of the consultants' brief required the consultant to hold a current fire risk assessment qualification.[545] Carl Stokes held a qualification from the Northern Ireland Fire Safety Panel, having gained a Fire Risk Assessment certificate on 12 December 2007.[546] The consultants' brief also required applicants to submit documentary evidence of their competence to undertake the appointment, in particular, their experience in assessing residential blocks.[547] Carl Stokes submitted a pack of certifications but he did not provide any other details of his qualifications and experience.[548] The only document that demonstrated his qualifications and experience was a statement in a pro forma fire risk assessment he submitted[549] that read as follows:

> "**Assessment completed by:**
>
> Mr C Stokes, ACIArb, FPA Dip FP (Europe), Fire Eng (FPA), NEBOSH, FIA BS 5839 System Designer, Competent Engineer BS 5266, IFE Assessor/Auditor (FSO). 19 years Fire Safety experience with

545 {TMO00842371/3} paragraph 1.5.
546 Stokes {CST00003063/5} page 5, paragraph 11; {TMO00880581/12}.
547 {TMO00842371/3} paragraph 1.4.
548 Stokes {Day 136/72:21}-{Day136/73:14}; {TMO00880581}.
549 Stokes {Day136/73:18}-{Day136/74:21}; Stokes {CST00003063/17} page 17, paragraph 50; {CST00003071}.

local Fire Authority, in enforcement and auditing roles, 3 years as an independent fire risk assessor.

Member of the construction industry CPD certification Service. Professional Indemnity insurance cover provided by Hiscox. Enhanced C R B checked."

38.23 Mr Stokes accepted in evidence that he had included that statement to lead the reader to think that he possessed the formal qualifications and professional body memberships set out in it.[550] The purpose of including it was to advance his application to become the TMO's fire risk assessor.[551]

38.24 The statement was false in a number of respects. All but one of the qualifications referred to either did not exist or were irrelevant or meaningless.[552] The only one that was valid and correctly stated was "ACIArb", indicating he was an associate of the Chartered Institute of Arbitrators, which had no bearing on fire safety.[553] Carl Stokes also claimed to hold an "FPA Dip FP (Europe)", which, although incorrect in abbreviation,[554] was intended

550 Stokes {Day136/75:5-21}.
551 Stokes {Day136/74:17-21}.
552 Todd, The Fire Risk Assessments of Carl Stokes Report {CTA00000011/55-58} paragraphs 6.45 and 6.46.
553 Todd, The Fire Risk Assessments of Carl Stokes Report {CTA00000011/55-56} paragraph 6.46.
554 The correct abbreviation is "CFPA(EU) Dip".

to convey that he had completed the Diploma in Fire Prevention awarded by the Confederation of Fire Protection Association, as indeed he had.[555] Carl Stokes was neither registered nor certificated by any professional or certification body as competent to carry out fire risk assessments.[556] He suggested that the post-nominals were meant to evidence qualifications, training and experience required by the Fire Safety Order,[557] but the fire safety training he had completed did not entitle him to invent qualifications and use them as he did in that statement.[558] Mr Stokes accepted that he had known at the time that the statement was thoroughly misleading.[559]

38.25 His claim that at the time he had carried out the fire risk assessment on 21 August 2010 he had been an independent fire risk assessor for three years was also false. In fact, he had begun work as an independent fire risk assessor only

555 Todd {Day167/66:24}-{Day167/67:7}; Todd, The Fire Risk Assessments of Carl Stokes Report {CTA00000011/51} paragraph 6.16; {CTA00000011/56} paragraph 6.46.
556 {CTA00000011/58} paragraph 6.47.
557 Stokes {Day136/77:11-15}.
558 Todd, The Fire Risk Assessments of Carl Stokes Report {CTA00000011/55-58} paragraph 6.46.
559 Stokes {Day136/81:24}-{Day136/82:6}.

11 months earlier on 24 September 2009.[560] He accepted that the statement about the extent of his experience had been misleading.[561]

38.26 Each of the fire risk assessments produced by Carl Stokes stated that he was "a member of the construction industry CPD certification service", which, he explained, meant that he had attended "formal CPD designated training 2 or 3 times a year", usually lasting for one day.[562] As Mr Stokes was not registered or accredited by any professional body, he was under no requirement to undergo continuing professional development, but both Dr Lane and Mr Todd considered that even an unregistered fire risk assessor would be expected to undergo a certain amount of regular training.[563] Mr Todd considered it necessary in order to keep up with new developments and to ensure that competence was maintained.[564] As Dr Lane observed, some regular training is necessary to ensure that a fire risk assessor has sufficient skill and knowledge to do his job.[565]

560 Stokes {Day136/83:9}-{Day136/84:12}.
561 Stokes {Day136/84:13-15}.
562 Stokes {CST00030186/7} page 7, paragraph 25(iii).
563 Lane {Day171/27:20}-{Day171/28:9}; Todd, The Fire Risk Assessments of Carl Stokes Report {CTA00000011/46} paragraph 5.37.
564 {CTA00000011/46} paragraph 5.37.
565 Lane {Day171/27:20}-{Day171/28:9}.

38.27 There was evidence that Mr Stokes did undertake a mixture of formal and informal training which complemented his practice as a fire risk assessor, such as attending training days and lectures held by fire industry bodies, such as the Fire Industry Association.[566] He did not keep a training log or any other written record of the training he had undertaken and was not required to do so.[567] We saw no evidence that Carl Stokes consistently undertook any formal training on an annual basis during the years he was employed as the TMO's fire risk assessor and we conclude that he did not.[568]

38.28 Janice Wray knew that Carl Stokes had elected not to join any professional bodies.[569] When she raised it with him, he told her that he did not feel that he would gain anything from such memberships.[570] On 1 February 2013, the Fire Risk Assessment Competency Council published A *Guide to Choosing a Competent Fire Risk Assessor* (the FRACC Guide) which recommended using fire risk assessment companies, including sole traders, who were "third party certificated to appropriate schemes operated

566 Stokes {CST00030186/7-8} pages 7-8, paragraphs 25-27; Stokes {CST00030186/45-49} pages 45-49, Appendix 1.
567 Stokes {CST00030186/8} page 8, paragraph 26.
568 Stokes {CST00030186/7-8} pages 7-8, paragraphs 25-27; Stokes {CST00030186/45-49} pages 45-49; {CST00030191}.
569 Wray {TMO00000890/31} page 31, paragraph 139; Wray {Day140/197:17-19}.
570 Wray {TMO00000890/31} page 31, paragraph 139.

by Certification Bodies which have been UKAS accredited to certificate against such schemes."[571] but it could not make registration or certification mandatory. The FRACC Guide listed the holders of registers, such as the British Standards Institution, the Institute of Fire Prevention Officers (IFPO), the Institute of Fire Safety Managers, the Institution of Fire Engineers and Warrington Certificated Ltd.[572] Carl Stokes was never registered with or certificated by any of those bodies. Janice Wray was aware of the FRACC Guide and was aware that Mr Stokes had chosen not to join any professional register,[573] but she was not concerned.[574] She thought that, as he had already demonstrated his competence in the work he had done for the TMO, the FRACC Guide did not demand that he be certificated.[575] However, she thought it would apply to the appointment of any future fire risk assessor.[576]

38.29 Ms Wray said that she did not think that the interviewing panel (of which she had been a member) had considered Carl Stokes's statements about his qualifications, but she thought they might have looked at a copy of his

571 {HOM00025548/4}.
572 {HOM00025548/5}.
573 Wray {TMO00000890/31} page 31, paragraph 139; Wray {Day140/197:17-19}.
574 Wray {Day140/199:7-14}.
575 Wray {Day140/200:2-15}.
576 Wray {Day140/197:22}-{Day140/200:16}.

curriculum vitae,[577] in which he had claimed to be a fire risk auditor and assessor accredited by the Institute of Fire Engineers, even though he had not been a member of the institute.[578] She knew at the time that Carl Stokes used post-nominals to describe his qualifications, even though they were not genuine, but she was surprised to be told that some of the qualifications which he claimed to hold did not exist.[579] His deliberately misleading description of his experience and qualifications demonstrate a lack of integrity and reliability on Mr Stokes's part, but it is the failure of the TMO and RBKC to pay any serious attention to his supposed qualifications that represent the more serious failing, since it betrays a fundamental carelessness about fire safety matters in the housing stock for which they were responsible.

38.30 When the TMO evaluated the competing tenders Carl Stokes's was rated first for quality; he also submitted the lowest price for a six-month programme.[580] Overall his tender was just over £2,000 cheaper than that of his nearest competitor.[581] He was thought to have the knowledge, competence, experience and

577 Wray {Day140/190:17}-{Day140/193:22}; {CST00001895}.
578 {CST00001895}; Todd, The Fire Risk Assessments of Carl Stokes Report {CTA00000011/57} paragraph 6.46.
579 Wray {Day140/196:3-9}.
580 {TMO00842327/2}.
581 {TMO00842327/3}.

enthusiasm to be a good partner.[582] The fact that he was already known to the TMO because of his work with Salvus also weighed in his favour.[583]

38.31 The consultants' brief required applicants to demonstrate that they were able to satisfy the provisions of a quality management system in accordance with BS EN ISO 9001,[584] but Carl Stokes was not required to satisfy that provision.[585] He ought to have been. He was to all intents and purposes a sole trader who had no quality management system or arrangements in place for peer reviewing his work.[586] Janice Wray was not concerned about that or about the fact that his work for the TMO would not be supervised.[587] She said that the LFB had still been heavily involved in scrutinising the TMO's fire risk assessments and that she had expected it to raise any problems quickly.[588] Moreover, she claimed to have challenged Mr Stokes's fire risk assessments when she did not agree with them,[589] but that is of little significance, since she had no relevant expertise and was certainly not independent. In the end she was reassured by

582 Wray {TMO00000890/31} page 31, paragraph 137.
583 Wray {TMO00000890/31} page 31, paragraph 137.
584 {TMO00842371/5} paragraph 3.2.
585 Stokes {Day136/86:2-21}.
586 Stokes {Day136/86:2-21}; {Day136/61:9-16}.
587 Wray {Day140/201:10-13}.
588 Wray {Day140/203:11-23}.
589 Wray {Day140/203:11-23}.

the fact that he had been recruited by Salvus and that he had been one of the principal assessors it had used to produce fire risk assessments on its high-risk buildings.[590] She knew that he was familiar with many of the TMO's buildings. She said he appeared to be extremely knowledgeable and she understood that everything he had done appeared to meet the requirements of the LFB.[591]

38.32 Ms Wray's approach was not in itself contrary to the Fire Safety Order, given that there is no requirement under article 9 for the responsible person to commission an independent fire risk assessment, nor for the person carrying out a fire risk assessment to be qualified or competent,[592] but it did create a risk that the resulting fire risk assessment would not meet the statutory requirement of being suitable and sufficient. No good reason was given to justify the failure of the TMO and RBKC to require Mr Stokes to show that he could satisfy the provisions of an appropriate quality management system in accordance with the consultants' brief.

38.33 By the end of September 2010, Amanda Johnson had approved the appointment and confirmed the funding of the medium-risk programme.[593]

590 Wray {Day140/201:10-25}.
591 Wray {Day140/202:12-15}; {Day140/202:20-25}.
592 See Chapter 12 for the examination of the role of government in regulating standards of competence in this area.
593 {TMO00842327/2}.

On 28 October 2010, Robert Black approved the appointment,[594] although Carl Stokes had signed the contract seven days earlier.[595] Laura Johnson was aware that the TMO obtained fire risk assessments because it was required to do so,[596] but neither she nor anyone else in the RBKC Housing department received copies of them.[597] Indeed, no one in the Housing department had the experience needed to analyse them or to challenge the TMO on their contents.[598]

38.34 On 25 November 2010, Janice Wray reported to the Operations Committee the completion of the high-risk programme and the appointment of Carl Stokes as fire risk assessor for the TMO's medium risk properties.[599] She explained that he was willing to challenge the LFB if he considered its requirements to go beyond what it could reasonably require.[600] Clearly, Mr Stokes's willingness to be an advocate for the TMO in disagreements with the LFB was a material factor in the decision to appoint him.

---

594 {TMO00842327/2}.
595 {CST00030040}.
596 Laura Johnson {Day129/79:16-19}.
597 Laura Johnson {Day129/70:16-22}.
598 Laura Johnson {Day129/71:4-15}.
599 Minutes of TMO Operations Committee meeting dated 25 November 2010 {RBK00052563/8}.
600 Minutes of TMO Operations Committee meeting dated 25 November 2010 {RBK00052563/8}.

The expansion of Carl Stokes's retainer in December 2010

38.35 From December 2010 onwards, Carl Stokes carried out fire risk assessments for the TMO on its high-risk buildings.[601] The TMO did not invite tenders for that work.[602] Janice Wray believed she had taken advice from colleagues dealing with procurement, her line manager (Lornette Pemberton) and possibly RBKC before appointing Carl Stokes to review the fire risk assessments carried out the year before on high-risk buildings, but we have seen no evidence to support that.[603] It had not originally been intended to appoint Carl Stokes to carry out that work[604] but the need to review the assessments of the high-risk properties and the pressure of time led to a decision not to invite fresh tenders.[605] Neither the TMO nor RBKC had established a programme for the regular review of the fire risk assessments on high-risk buildings at the conclusion of the first programme in March 2010. As a result, the need for the reviews had been overlooked and there was no proper recruitment

601 Stokes {CST00003063/9-10} pages 9-10, paragraphs 25 and 26; Stokes {Day136/89:7-15}; Wray {Day140/216:14-20}; {CST00001926}.
602 Wray {Day140/216:14-16}.
603 Wray {Day140/215:7-15}; {Day140/216:14-20}; {Day140/217:15}-{Day140/218:14}.
604 Wray {Day140/218:15-20}.
605 Wray {Day140/216:21}-{Day140/217:15}.

or selection process.[606] No written contract was entered into with Carl Stokes, who took over the work on an informal basis.[607] Janice Wray could not recall whether the appointment had been approved by the TMO executive team or RBKC or how the funding for it had been obtained.[608] The TMO simply drifted unthinkingly into a broader retainer of Carl Stokes without any formalities.

38.36 When the programme of fire risk assessments on medium-risk buildings had been completed, the low-risk programme began. Carl Stokes was appointed to carry it out.[609] Sacha Jevans approved his appointment[610] and Mr Stokes signed the contract on 24 August 2011.[611] The programme was completed in May 2012, well before the LFB's deadline of July 2012.[612]

38.37 Once the programmes covering the medium and low-risk buildings had been completed, the TMO continued to retain Carl Stokes as its fire risk assessor but did not enter into any new contracts with him.[613] He became responsible for carrying out fire risk assessments on all

606 Wray {Day140/217:8-18}.
607 Wray {Day140/219:7-10}; Stokes {CST00003063/10} page 10, paragraph 26.
608 Wray {Day140/218:21}-{Day140/219:5}.
609 {TMO00842318}.
610 Wray {TMO00842341/3} page 3, paragraph 14; {TMO00842378}.
611 {CST00030041}.
612 {TMO10031056/2} paragraph 3.2.
613 Stokes {CST00003063/10} page 10, paragraph 26.

650 properties managed by the TMO.[614] He did not work exclusively for the TMO but it was his biggest client, having more buildings under its management than any other.[615] Robert Black was aware that Carl Stokes had been retained but he did not know that his continued appointment had not been subject to a further procurement process.[616] He had assumed that a formal procurement process of some kind had taken place and accepted that the failure to keep him informed pointed to a defect in the reporting processes and governance of the TMO.[617]

38.38 Carl Stokes was allowed, therefore, to drift into his role as the sole fire risk assessor for 650 properties, many of which were high-rise buildings, without any regard to formal selection or contracting processes. That was not a proper or safe way for either the TMO or RBKC to seek to discharge their duties under the Fire Safety Order and it created a risk that the standard of the fire risk assessments produced as a result might not meet the statutory requirement.

614 Wray {Day140/207:20}-{Day140/208:8}.
615 Stokes {Day136/9:8-9}.
616 Black {Day150/17:2-17}.
617 Black {Day150/18:3-16}.

Carl Stokes's work as the TMO's fire risk assessor

38.39 Part 2 of the consultants' brief set out the scope of the work in relation to fire risk assessments that Carl Stokes had undertaken to carry out. Paragraph 1.1 of Part 2 required fire risk assessments to be undertaken and reviewed as regularly as the degree of risk dictated. It also required fire risk assessments to include an examination of each communal fire door.[618]

38.40 Paragraph 1.3 of Part 2 of the brief instructed the fire risk assessor to focus on a building's compartmentation (and any possible shortcomings), the operation and adequacy of fire doors, firefighting equipment and automatic detection and other systems, the means of escape, fire safety management systems and the overall fitness for purpose of the building in relation to fire safety.[619]

38.41 Janice Wray and Carl Stokes operated on the understanding that his work was always governed by the terms of the original contract, including the consultant's brief, even after his formal contracts

618 {TMO00842371/6} paragraph 1.1.
619 {TMO00842371/6} paragraph 1.3.

for the programmes of fire risk assessments in relation to medium and low-risk buildings had come to an end.[620]

38.42 The LGA Guide described four kinds of fire risk assessment: Type 1 – Common parts only (non-destructive); Type 2 – Common parts only (destructive); Type 3 – Common parts and flats (non-destructive); and Type 4 – Common parts and flats (destructive).[621] Mr Stokes told us that he had carried out 'Type 1' assessments with elements of 'Type 3'.[622] (He had carried out that hybrid type of fire risk assessment before the LGA Guide was published in July 2011.)[623] The LGA Guide stated that unless there was reason to expect serious deficiencies in structural fire protection, such as inadequate compartmentation, or poor fire stopping, a Type 1 inspection would normally be sufficient for most purpose-built blocks of flats.[624]

38.43 On one reading of the Fire Safety Order, Carl Stokes was required to consider only the common parts of the building when carrying

620 Stokes {CST00003063/10} page 10, paragraph 26; Stokes {Day136/89:25}-{Day136/90:8}; Wray {Day140/220:1-25}.
621 {HOM00045964/44-46} paragraph 35.1.
622 Stokes {CST00003063/16} page 16, paragraph 47.
623 Stokes {CST00003063/16} page 16, paragraph 47.
624 {HOM00045964/45} paragraph 35.1.

out a fire risk assessment.[625] In the case of purpose-built blocks of flats, like Grenfell Tower, that meant inspecting the lift-lobby areas of each floor, the refuse chute rooms, the staircase enclosure and both sides of the entrance doors to the flats, but not the interiors of individual flats.[626] It was his practice also to report any problems with access to properties.[627] He was not expressly instructed to consider the external walls of the properties he inspected[628] and there was nothing in the LGA Guide to suggest that he should do so, unless there was reason to think that they might affect the compartmentation of the building.

38.44 Carl Stokes's practice in relation to Grenfell Tower was to carry out a primarily visual inspection. He also carried out some additional inspection of the inside of front doors where he could gain access.[629] In those circumstances, he checked the self-closer and whether a domestic fire alarm system was fitted.[630] In 2015, he was also asked to check the heat interface units.[631]

625 Stokes {CST00003063/13} page 13 paragraph 36; Wray {TMO00000890/31} page 31, paragraph 140.
626 Stokes {CST00003063/15-16} pages 15-16, paragraphs 43 and 44; {HOM00045964/44} paragraph 34.1; Stokes {Day136/94:2-18}.
627 Wray {Day140/236:20-25}.
628 Wray {Day141/1:18-22}.
629 Stokes {CST00003063/16} page 16, paragraph 48.
630 Stokes {CST00003063/16} page 16, paragraph 48.
631 Stokes {CST00003063/16} page 16, paragraph 48.

38.45 Mr Stokes agreed that for the purposes of making a Type 1 fire risk assessment he had to gain access to some flats in order to inspect the entirety of the entrance door, including the strips and smoke seals and self-closing device, if fitted.[632]

38.46 PAS 79:2012, published by the British Standards Institution, contained the standards for carrying out fire risk assessments as they existed at the time of the Grenfell Tower fire. Paragraph (i) of the commentary on clause 16 says that fire safety management should be regarded as of equal importance to fire protection measures.[633] Clause 16 of PAS 79 required that, among other matters, any shortcomings in evacuation procedures should be identified.[634] Carl Stokes was familiar with those provisions.

38.47 Mr Stokes assessed the TMO's fire safety management systems as part of his fire risk assessments on a continuing basis and expected Janice Wray to tell him if the TMO had changed its policies or procedures.[635] He was aware

632 Stokes {Day136/94:2-25}.
633 {CTA00000003/50} clause 16, commentary, paragraph (i).
634 {CTA00000003/54} clause 16.3.
635 Stokes {Day136/164:3-15}.

of the need to consider the arrangements for maintaining all the fire prevention measures required under the Fire Safety Order.[636]

38.48 Carl Stokes frequently gave the TMO advice about matters relating to fire safety. For example, he might be asked whether matters he had raised in his fire risk assessment and action plans had been remedied or to provide comments or advice on discrete issues.[637] He gave advice on matters such as the TMO's programme for the replacement of flat doors, potentially non-compliant entrance doors to leaseholder's flats and work on the gas supply and was asked to inspect and assess the front doors of particular flats.[638] In December 2016 and July 2017 he provided training to the Estate Service Assistants.[639]

38.49 Carl Stokes was never appointed to advise on the refurbishment of Grenfell Tower, although he occasionally provided advice to the TMO and Rydon about matters relating to the

636 {HOM00045964/44} paragraph 34.5; Stokes {Day136/101:25} -{Day136/102:10}.
637 Stokes {CST00003063/10} page 10, paragraph 28.
638 Stokes {CST00003063/29-33} pages 29-33, paragraphs 87-94; Stokes {CST00003063/47-48} pages 47-48, paragraphs 137-141; Wray{Day140/223:5-6}; {CST00000932}.
639 Stokes {CST00030186/9} page 9, paragraphs 28-32.

refurbishment.[640] When Janice Wray wanted his advice on a particular matter she usually asked him to produce a report, which she then provided to the Asset Management team.[641] Sometimes Claire Williams instructed him directly,[642] for example, if she wanted a second opinion on a matter or if the project team wanted him to produce a report.[643] During the course of the refurbishment he provided advice in relation to the smoke vents and lifts, rights of way to Grenfell Tower, the heating interface units, floor numbering and premises information boxes.[644]

Frequency of fire risk assessments

38.50 Carl Stokes carried out fire risk assessments on the properties managed by the TMO as instructed by Janice Wray.[645] Initially, she sent him a list of the properties requiring inspection in November each year and he assessed the buildings during the course of the following year.[646]

640 Stokes {CST00003063/11} page 11, paragraph 30(iv); Minutes of Grenfell Tower Progress Meeting No.22 dated 19 April 2016 {TMO10045055/2} Item 2.6.
641 Wray {TMO00000890/9} page 9, paragraph 44.
642 Wray {Day141/2:24}-{Day141/3:6}.
643 Wray {Day141/2:12-20}.
644 Wray {TMO00000890/10-14} pages 10-14, paragraphs 45-64; {CST00000894}; Stokes {CST00030186/43-44} paragraphs 167-172; Stokes {Day136/140:5}-{Day136/162:14}; {CST00003088}; {CST00003173}; {CST00001258}; {TMO10043487}.
645 Stokes {Day136/129:5-9}.
646 Stokes {CST00003063/17} page 17, paragraph 51.

38.51 The TMO's fire safety strategy acknowledged that fire risk assessments could not remain valid indefinitely.[647] It required fire risk assessments to be reviewed periodically in various circumstances.[648] In the case of high-risk buildings, reviews were required annually and a new assessment every three years.[649] In the case of medium or low-risk buildings, the intention was to carry out reviews on a two-yearly basis with a new assessment every four years.[650] In practice, new fire risk assessments of Grenfell Tower, which was a potentially high-risk block, were made at least every two years. Two were carried out in 2016.[651]

38.52 The reviews of the fire risk assessments were carried out by the TMO Health and Safety team, primarily by Adrian Bowman.[652] Their purpose was to monitor whether the measures recommended by Carl Stokes had been completed and to check for obvious changes to the building.

---

647 {TMO00830598/9} paragraph 14.3.1.

648 {TMO00830598/9} paragraph 14.3.1.

649 {TMO00830598/10} paragraph 14.3.4.

650 {TMO00830598/10} paragraph 14.3.5.

651 Fire Risk Assessment of Grenfell Tower dated 29 December 2010 {CST00003181}; Fire Risk Assessment of Grenfell Tower dated 20 November 2012 {CST00003084}; Fire Risk Assessment of Grenfell Tower dated 26 April 2016 {CST00003161}; Fire Risk Assessment of Grenfell Tower dated 20 June 2016 {CST00003145}.

652 {TMO00830598/10} paragraph 14.3.3; Wray {Day140/233:6-16}. Janice Wray's "colleague" in the TMO Health and Safety team was Adrian Bowman: Wray {Day140/212:24}-{Day140/213:2}.

That included anything that would cause an increased level of risk, such as anti-social behaviour or work being carried out on site, of which the TMO was unaware.[653] Adrian Bowman used the Significant Findings and Action Plans that Carl Stokes had submitted with the fire risk assessments to record whether remedial measures had been completed.[654]

Meetings with Carl Stokes

38.53 Before he started work Carl Stokes met Janice Wray on two occasions to obtain information, once on 22 June 2010 and once on 24 September 2010.

38.54 In a letter to Janice Wray following their meeting on 22 June 2010, Carl Stokes asked her to send him a copy of the fire safety report produced by Salvus[655] "to back up any fire related issues that may be raised in some of the reports".[656] On 28 September 2010 Ms Wray sent Mr Stokes a copy of the report and action plan.[657] He told us that he assumed that he had read it, but could not remember having done so.[658] If he did read it, however, it appears to have made

653 Wray {Day140/232:14-23}.
654 Wray {Day140/212:18}-{Day140/213:2}; Wray {Day140/233:6-15}.
655 {CST00001887/2}.
656 {CST00001887/2}.
657 {CST00004383}; {SAL00000013}.
658 Stokes {Day136/176:1}-{Day136/178:18}.

very little impression on him. He did not recall having become aware of the weaknesses in the TMO's fire safety management system or the 19 statutory breaches that had been identified in the Salvus report.[659] Janice Wray, for her part, expected him to read the report and to ask her about any outstanding items and when they would be completed. However, she could not recall any such conversation with him[660] and there is no evidence one ever took place. Carl Stokes does not appear to have taken any steps to find out whether the TMO had resolved, or planned to resolve, the statutory breaches identified in the report. We find that very surprising, given the widespread and significant failings identified by Salvus and the effect they must have had on the risk to the TMO's properties.[661]

38.55 A number of matters were discussed between Carl Stokes and Janice Wray at their meeting on 24 September 2010, some of which had already been covered in the meeting on 22 June 2010.[662] The information Mr Stokes obtained on that occasion did not relate to any particular building,[663] but he used it to fill out the fire risk

659 Stokes {Day136/176:1}-{Day136/178:18}.
660 Wray {Day140/127:18}-{Day140/129:5}.
661 Stokes {Day136/177:11}-{Day136/179:6}.
662 {CST00003061}; {CST00001887}.
663 Stokes {Day136/220:21-25}.

assessments relating to various buildings.[664] Not once during the seven years that he subsequently acted as the TMO's only fire risk assessor did he seek or obtain current information about the matters covered in the letters of 23 and 27 September 2010.

Carl Stokes's methods

38.56 The method adopted by Carl Stokes for carrying out fire risk assessments reflected the Health and Safety Executive's five steps for managing risks and PAS 79[665] He explained that in his fire risk assessments for 2009 and 2010 he had kept in mind the guidance in the government's publication *Fire Safety Risk Assessment – Sleeping Accommodation* and, following its publication in July 2011, LGA Guide.[666]

38.57 When Carl Stokes undertook a fire risk assessment, he obtained information from Janice Wray about the nature of the common parts and the active and passive fire safety measures they contained.[667] He asked for

664 Stokes {Day136/125:14-20}.

665 Stokes {CST00003063/13} page 13, paragraph 35; {CTA00000003}; {RBK00036722/13}; https://www.hse.gov.uk/simple-health-safety/risk/steps-needed-to-manage-risk.htm.

666 Stokes {CST00003063/13} page 13, paragraph 35; {RBK00036722}; {HOM00045964}. He would apply the HM Government Guide for Offices and Shops to the office part of Grenfell Tower: Stokes {CST00003063/13} page 13, paragraph 35(iii).

667 Stokes {CST00003063/18} page 18, paragraph 55(i).

any reports of the testing of dry risers or any other services in the building.[668] He obtained maintenance and servicing records from the TMO's management system, Keystone, or by asking the maintenance department for them.[669] If he could not obtain the information he needed, he drew attention to its absence in the action plan.[670]

38.58 If Mr Stokes had completed a fire risk assessment for a building previously, he usually reviewed the last Action Plan and checked whether the remedial measures had been completed.[671] The check did not go much beyond a tour of the building and a look at the TMO's records (including what he described as "tick sheets") which showed what had been done since his last assessment.[672] Janice Wray did not recall his ever asking her for completed action plans or sending him the action plan sheets and she could not recall a tick sheet at all.[673] We saw no health and safety tick sheets nor any evidence that he was sent completed action plan sheets. We have

668 Stokes {Day136/129:12-20}.
669 Stokes {CST00003063/22} page 22, paragraph 67; {TMO00859318}; Stokes {Day136/131:15}-{Day136/133:19}; Parsons {TMO00870938/2} page 2, paragraph 10.
670 Stokes {Day136/133:21-24}.
671 Stokes {CST00003063/23} page 23, paragraph 68; Stokes {Day136/145:7}-{Day136/146:5}; For an example see: Record of Significant Findings and Action Plan for Grenfell Tower dated 26 April 2016 with handwritten notes {CST00000003}.
672 Stokes {Day136/129:12-20}; {Day136/147:21}-{Day136/148:16}.
673 Wray {Day140/232:25}-{Day140/233:23}.

concluded that when drawing up the latest fire risk assessment he had little information before him about which of the remedial measures he had recommended in his previous fire risk assessment had been completed and which had not and why.

38.59 When he visited a building for a fire risk assessment, Mr Stokes inspected it and spoke to anyone he met, such as residents or contractors.[674] In the assessment he set out the names of those he had consulted, which would often be Janice Wray, one of the Estate Service Assistants or Claire Williams.[675] He asked for certificates and records when the opportunity to do so arose.[676] If work had been carried out by third parties, he would rely on their records.[677] He thought that the first fire risk assessment of a building took about four hours to complete and four hours to write up; it would take him less time to carry out a review of an existing assessment.[678] He then prepared his fire risk assessment and a document entitled “Significant Findings and

674 Stokes {CST00003063/18} page 18, paragraph 55(ii); Stokes {Day136/202:16-24}.

675 For example, see Fire Risk Assessment of Grenfell Tower dated 29 December 2010 {CST00003181/3}; Fire Risk Assessment of Grenfell Tower dated 26 April 2016 {CST00003161/3}.

676 Stokes {Day136/69:11-16}.

677 Stokes {CST00003063/22} page 22, paragraph 67(iii).

678 Stokes {Day136/66:19-20}; {Day136/185:7-15}; {Day136/186:7-10}.

Action Plan".[679] After his inspection he could request additional information but often he would draw attention to any missing information in the Action Plan.[680]

38.60 If he was concerned about a particular matter, Carl Stokes included it in his Action Plan, which identified the risk or hazard and the remedial action to be taken.[681] He categorised the item of the significant findings as of high, medium or low priority. The Action Plan was set up as a checklist for the use of the TMO.[682]

38.61 Carl Stokes set out his findings in a fire risk assessment that followed a standard template approved by the TMO, RBKC and the LFB before the start of work on the medium-risk properties.[683] At the time he entered into the contract on 21 October 2010 to carry out fire risk assessments on the medium risk properties Mr Stokes understood that copies would be provided to the LFB.[684]

679 Stokes {CST00003063/19} page 19, paragraph 55(iv); Stokes {Day136/143:8-16}.
680 Stokes {CST00003063/18} page 18, paragraph 55(iii); Stokes {Day136/143:8-16}.
681 Stokes {CST00003063/23} page 23, paragraph 68.
682 Stokes {CST00003063/23} page 23, paragraph 68. See for example, Record of Significant Findings and Action Plan for Grenfell Tower dated 17 October 2014 {CST00003177}.
683 Stokes {CST00003063/16} page 16, paragraph 45; Stokes {CST00003063/9} page 9, paragraph 24(iii); Stokes {CST00003063/17} page 17, paragraph 50; {TMO00842371/6} section 1.4; {RBK00029052/2}.
684 Stokes {CST00003063/17} page 17, paragraph 50.

Carl Stokes's fire risk assessments for Grenfell Tower

38.62 Carl Stokes carried out fire risk assessments of Grenfell Tower on 29 December 2010,[685] 20 November 2012,[686] 17 October 2014,[687] 26 April 2016[688] and 20 June 2016.[689] In each case he identified the chief executive of RBKC as the responsible person,[690] although he did not provide any of his assessments directly to RBKC.[691] In fact, he had no contact with anyone at RBKC.[692]

38.63 Provided nothing had changed, Mr Stokes's practice was to copy text from one fire risk assessment of Grenfell Tower to the next.[693] He also copied text from fire risk assessments of other buildings. For example, in the fire

685 Fire Risk Assessment of Grenfell Tower dated 29 December 2010 {CST00003181}; Significant Findings and Action Plan dated 29 December 2010 {CST00003165}.
686 Fire Risk Assessment of Grenfell Tower dated 20 November 2012 {CST00003084}; Significant Findings and Action Plan dated 20 November 2012 {CST00003083}.
687 Fire Risk Assessment of Grenfell Tower dated 17 October 2014 {CST00003157}; Significant Findings and Action Plan dated 17 October 2014 {CST00003177}.
688 Fire Risk Assessment of Grenfell Tower dated 26 April 2016 {CST00003161}; Significant Findings and Action Plan dated 26 April 2016 {CST00003098}.
689 Fire Risk Assessment of Grenfell Tower dated 20 June 2016 {CST00003145}; Significant Findings and Action Plan dated 20 June 2016 {CST00003069}.
690 See for example, Fire Risk Assessment of Grenfell Tower dated 17 October 2014 {CST00003157/3}.
691 Stokes {Day136/191:10}-{Day136/193:9}.
692 Stokes {Day136/193:10-13}.
693 Stokes {Day136/187:4-17}.

risk assessment for Grenfell Tower dated 17 October 2014, he included some text referring to balconies taken from the assessment of another building, even though there were no balconies at Grenfell Tower.[694] The passage was then repeated in his fire risk assessment dated 26 April 2016.[695] Similarly, in section 11 of his fire risk assessments, he always included a passage headed "Pest control". In the fire risk assessment for Grenfell Tower dated 17 October 2014 he reported on the condition of pigeon netting on the balconies,[696] although there were no balconies on Grenfell Tower. That was simply lazy and careless and undermined the authority and quality of the fire risk assessment. Thoughtless drafting of that kind was bad enough, but it was aggravated by the fact that the same inapposite information was repeated in the fire risk assessments dated 26 April 2016 and 20 June 2016.[697] Carl Stokes explained that the information had been repeated in those assessments because he knew that nothing had changed in relation to pest control and had not read the section again.[698] He did not

694 Fire Risk Assessment of Grenfell Tower dated 17 October 2014 {CST00003157/1}.
695 Fire Risk Assessment of Grenfell Tower dated 26 April 2016 {CST00003161/1}.
696 Fire Risk Assessment of Grenfell Tower dated 17 October 2014 {CST00003157/18}.
697 Fire Risk Assessment of Grenfell Tower dated 26 April 2016 {CST00003161/19}; Fire Risk Assessment of Grenfell Tower dated 20 June 2016 {CST00003145/20}.
698 Stokes {Day136/190:23}-{Day136/191:4}.

read through those fire risk assessments before sending them to the TMO,[699] which Mr Todd described as very bad practice.[700] We agree.

38.64 What is worse, nobody at the TMO noticed those inapposite observations that had clearly been transposed from fire risk assessments on other buildings. That strongly suggests that Janice Wray did not read the fire risk assessments with any degree of care. If she had too many things on her desk to read and digest, she ought to have asked for help. In her own words, she was "spread very thinly", as she had responsibility for 650 buildings across the whole of the borough.[701] Failing to read such important documents with due care reflected the TMO's casual approach to fire safety.

38.65 Carl Stokes included a section headed "Legal statement" in every fire risk assessment for Grenfell Tower. In it he told the recipient (in this case the TMO), among other things, that it did not have to give a copy to anybody, not even the fire authority, and that, if it did so, the document could be used against it at a later date.[702]

699 Stokes {Day136/191:5-7}.
700 Todd {Day167/78:21-24}.
701 Wray {Day140/48:12-20}.
702 See for example, the Fire Risk Assessment of Grenfell Tower dated 20 June 2016 {CST00003145/2}.

38.66 Mr Stokes explained that he included that statement in his fire risk assessments because it was his understanding that the Fire Safety Order required the responsible person only to record the significant findings and make them available for inspection.[703] As there was no requirement to record the risk assessment itself, he considered that there was no obligation to produce it to the fire service.[704] He considered that a fire risk assessment that was critical of the fire safety arrangements could be used against the responsible person at a later date.[705] Colin Todd thought that the statement was unnecessary, confrontational and wrong in law, given that the local fire and rescue service as the enforcing authority has extensive powers under article 27 of the Fire Safety Order to obtain information and documents relating to compliance with the Order.[706] Again, we agree.

Quality management and auditing

38.67 Carl Stokes did not operate a quality management system or peer review process. A one-man company can implement a quality management system and can also be certificated under

703 Stokes {Day136/199:5-10}; Stokes {CST00003063/24} page 24, paragraph 70.
704 Stokes {CST00003063/24} page 24, paragraph 70(ii).
705 Stokes {CST00003063/24} page 24, paragraph 70(iii).
706 Todd, The Fire Risk Assessments of Carl Stokes Report {CTA00000011/76} paragraph 8.15.

BS EN ISO 9001.[707] The absence of a quality management system was a structural weakness in Carl Stokes's business and the absence of such a system in relation to a company that was the only fire risk assessor for the TMO's entire portfolio of 650 buildings was a structural weakness in the TMO's fire risk management system.[708]

38.68 Janice Wray placed an undue amount of trust and confidence in Mr Stokes's ability to carry out sufficient and suitable fire risk assessments. Although she claimed to have read every fire risk assessment and action plan (which, for reasons explained above, we doubt she did with any care) and although she sometimes challenged Carl Stokes when she did not agree with him, she did not monitor the technical quality of his documents[709] and could not have done so, since she had neither the necessary technical expertise nor the time to do it. As we have already mentioned, she was overworked as it was.[710] However, it was a significant failure on the part

707 Todd {Day167/72:2-10}; Lane {Day171/32:8}-{Day171/33:2}.
708 Todd {Day167/73:16}-{Day167/74:20}.
709 Wray {Day140/47:10-15}; {Day140/203:11-23}; Lane, Fire Safety Investigation Module 3 Report {BLARP20000027/145} paragraph 8.4.5.
710 Wray {Day140/48:12-20}.

of the TMO not to monitor the quality of the work done by Mr Stokes as the sole provider of fire risk assessments for its portfolio of buildings.[711]

38.69 The Publicly Available Specification "PAS 7:2013 entitled *Fire risk management system – Specification*" (PAS 7), published by the British Standards Institution in June 2013, contained guidance on the requirements for establishing a fire risk management system by which an organisation can put in place the practical steps required to carry out its fire safety policy.[712] It suggested that an organisation should audit its fire risk assessment programme after fire risk assessments had been delivered and conduct review meetings at planned intervals to discuss the results of the audits.[713]

38.70 Janice Wray was familiar with the provisions of PAS 7 but she did not arrange for the fire risk assessment programme to be audited.[714] Her excuse was that she could not find the time to do it and that she had received a degree of reassurance from the fact that the LFB had been asking questions about some of the fire risk assessments that had led her to understand that

711 Lane, Fire Safety Investigation Module 3 Report {BLARP20000027/145} paragraphs 8.4.5 and 8.4.6.
712 {LFB00116924/1-7}.
713 {LFB00116924/23} paragraphs 7.4.3 and 7.4.4.
714 Wray {Day145/12:6-21}.

they were of a suitable and sufficient standard.[715] She accepted, however, that she should have arranged an audit and that she could not rely on the enforcement authority to act as an auditor.[716] Ms Wray could not recall ever having raised the question of auditing the fire risk assessment programme with Barbara Matthews, although she admitted that she should have done so.[717] Again, we agree.

38.71 Robert Black never gave any thought to whether a sole trader could properly act as the fire risk assessor for 650 buildings.[718] Nor did he ever consider specifically whether Janice Wray had sufficient resources to carry out her fire safety responsibilities properly.[719] He simply never brought his mind to bear on how the TMO, as the responsible person with statutory obligations, was actually setting out to discharge them. That indicates a lack of interest in matters of fire safety and explains his failure to exercise sufficient control over such matters. It also goes a long way to explain the casual approach to fire safety of the TMO as an organisation.

715 Wray {Day145/14:9}-{Day145/15:25}.
716 Wray {Day145/14:9}-{Day145/16:6}.
717 Wray {Day145/13:15-20}.
718 Black {Day150/19:9-12}.
719 Black {Day150/19:13}-{Day150/21:12}.

External concerns

38.72 In her first witness statement Janice Wray said that, as far as she could remember, the LFB had never commented on fire risk assessments produced by Carl Stokes in such a way as to give the TMO any reason to doubt his competence or the quality of the assessments themselves.[720] In fact, however, that was not the case. There were many occasions when both Mr Stokes's competence and the quality of his fire risk assessments were called into question, not only by the LFB but also by others. In the end, Janice Wray was not only constrained to admit that her statement was incorrect, but was unable to provide any credible explanation of how she had come to make it.[721] On this aspect of our investigations, therefore, we have been able to place little weight on her evidence.

Concerns expressed by the LFB

38.73 During the last quarter of 2015, two of the LFB's fire safety inspecting officers, Julie-Anne Steppings and Michelle McHugh, told Rebecca Burton, the leader of the LFB's Fire Safety Team for Hammersmith, Fulham, Kensington and Chelsea, of the concerns they had about the approach taken in fire risk

720 Wray {TMO00000890/36} page 26, paragraph 158.
721 Wray {Day144/200:3}-{Day144/201:2}.

assessments produced by Carl Stokes for the TMO.[722] As a result, between November 2015 and September 2016, she raised the matter with the TMO on a number of occasions.

38.74 Among the concerns identified by Rebecca Burton were that Carl Stokes would rely on inspections by the LFB and undocumented discussions and agreements with LFB personnel as support for his assessments.[723] She did not think that he was providing the TMO with suitable and sufficient fire risk assessments and considered that the matter needed to be addressed.[724] She also highlighted a tendency on his part when carrying out a fire risk assessment to select the most convenient parts of different documents rather than identify the most suitable guide and apply it in full to the premises in question.[725]

Meeting between Janice Wray and Rebecca Burton on 13 November 2015

38.75 On 13 November 2015, a meeting took place between Janice Wray and Rebecca Burton following the fire that had occurred at Adair Tower on 31 October 2015. Neither of them kept a

722 Burton {Day145/119:1-4}; Burton {LFB00084098/12-13} pages 12-13, paragraph 24.
723 Burton {LFB00032331/4-5} pages 4-5, paragraph 11.
724 Burton {LFB00032331/5} page 5, paragraph 11.
725 Burton {LFB00084098/7-8} pages 7-8, paragraph 11; {LFB00003439/1}.

contemporaneous note of their discussions, but at different times each of them described the substance of them in emails to their respective superiors.

38.76 On 13 November 2015, Janice Wray sent a long email to Robert Black, Barbara Matthews and Sacha Jevans, in which she described the review being carried out by the LFB for the purposes of deciding whether to issue an enforcement notice. She referred to a number of questions that had been raised by Ms Burton, none of which had been critical of the fire risk assessment. She did not mention agreeing to raise any concerns with Carl Stokes.[726]

38.77 On 5 May 2016, Rebecca Burton reported what had transpired in an email to her superior, Spencer Sutcliff, when discussing the review. She said that various areas of concern about fire risk assessments had been discussed with Janice Wray, including the assessor's approach to self-closing devices on flat entrance doors generally, his claim that the LFB had agreed that self-closing devices were not required on flat entrance doors and the failure of his fire risk assessment to reflect an understanding of the strategy for the building and how occupants were to be kept safe in the event of fire.[727] Although he

726 {TMO10011001}.
727 {LFB00003445/1}.

is not mentioned by name, it is obvious that when she referred to the fire risk assessor she was referring to Carl Stokes. She went on to record that Janice Wray had agreed to consider each of those points and discuss with Mr Stokes what improvements could be made.[728]

38.78 The difference between the two accounts no doubt reflects the authors' different interests but is striking, nonetheless. However, any difficulty we might otherwise have had in deciding whether Ms Burton did in fact voice criticisms of the fire risk assessment was resolved by Ms Wray's admission that during the meeting Ms Burton had indeed raised the matters to which she had referred in her email.[729] Ms Wray said that she had raised them with Carl Stokes, but we cannot be confident that she did, since there is no record of any such discussion.[730] That itself is a matter for criticism, since, if the LFB had serious concerns about Carl Stokes, she ought to have made a record of when and how she had raised those matters with him.

38.79 Barbara Matthews was also well aware of the LFB's views about Carl Stokes's fire risk assessments.[731] On 30 November 2015,

728 {LFB00003445/1}.
729 Wray {Day144/204:2-4}.
730 Wray {Day144/204:9-16}.
731 Wray {Day144/206:4-17}.

Barbara Matthews had a telephone conversation with Rebecca Burton, during which they discussed the proposed enforcement notices for Adair and Hazlewood Towers. According to her note of the call, Barbara Matthews was told by Rebecca Burton that the fire risk assessments for Adair and Hazelwood Towers were not suitable and sufficient, that Carl Stokes had not considered the question of smoke ventilation and that his risk assessments were not comprehensive.[732] Barbara Matthews told us that she had thought that Rebecca Burton was criticising only the particular fire risk assessments under discussion and not his overall performance[733] but she had no reason to believe that the defects that the LFB had highlighted were limited to those assessments and certainly should not have assumed that that was the case without further investigation.

38.80 On 4 December 2015, Barbara Matthews wrote to the TMO board to provide a report on the Adair Tower fire.[734] She said that the LFB had confirmed that it would serve enforcement notices in respect of Adair and Hazlewood Towers.[735]

732 Barbara Matthews' notebook, entry date 30 November 2015 {TMO00880324/31}. Rebecca Burton confirmed the note as an accurate record of the discussion: Burton {Day145/126:10-14}.
733 Matthews {Day148/75:23}-{Day148/76:4}.
734 {TMO00902920}.
735 {TMO00902920/1}.

She explained that the LFB had advised the TMO of what she called "key matters of concern", specifically smoke ventilation and the absence of self-closing devices on flat entrance doors, but she made no reference to the direct criticism of Carl Stokes's fire risk assessments that Rebecca Burton had made during their conversation on 30 November 2015, less than a week earlier.[736] Nor, strikingly, did she refer to the service of the deficiency notice in relation to Adair Tower on 12 October 2015, a point which is considered elsewhere in this report.

38.81 Barbara Matthews could not explain why she had failed to include in her report any reference to the criticism of Carl Stokes's fire risk assessments, but in hindsight she accepted that she should have drawn it to the board's attention.[737] Her failure to do so was consistent with the desire of Robert Black and the executive team as a whole to keep any bad news about fire safety away from the board.

38.82 Rebecca Burton again raised her concern about Carl Stokes with the TMO at their bi-monthly meeting on 5 January 2016. The minutes record that she told the meeting that Carl Stokes was prone to making statements that were not justified or supported and that he needed to

736 {TMO00902920/1}; {TMO00880324/31}.
737 Matthews {Day148/81:23}-{Day18/83:2}.

provide support for what he said. If he referred to discussions with the LFB he needed to identify with precision in each case when they had taken place, who had been parties to them and what had been the outcomes.[738] Janice Wray agreed to raise the issues identified by Rebecca Burton with Carl Stokes. Janice Wray told us that she did speak to him,[739] but the outcome is not clear and there is certainly no evidence that Carl Stokes's approach improved or that he absorbed the LFB's criticisms.

38.83 On 31 March 2016 there was a meeting of the TMO board at which Barbara Matthews described the progress of the enforcement notices relating to Adair and Hazlewood Towers.[740] At the meeting, Jeff Zitron, a board member nominated by the council, asked why enforcement notices had been issued, given that at the time of the fire the TMO had valid fire risk assessments.[741] Sacha Jevans responded, telling the board that enforcement notices had been served despite the fact that Carl Stokes had not identified any problems when carrying out his fire risk assessment, and that the LFB had identified none either when it carried out

738 Minutes of bi-monthly meeting between LFB and TMO dated 5 January 2016 {LFB00032330/3} item 8.
739 Wray {Day144/208:9-11}.
740 Minutes of meeting of the TMO Board dated 31 March 2016 {TMO10045103/4} item 9.1.
741 Minutes of meeting of the TMO Board dated 31 March 2016 {TMO10045103/4-5} item 9.2.

its fire audit.[742] That was wrong and misleading. In fact, the LFB had served a deficiency notice relating to Adair Tower on 12 October 2015, about 2 weeks before the Adair Tower fire, which had identified contraventions of Articles 11, 17(1) and 8 of the Fire Safety Order.[743]

38.84 We have already commented on this and other examples of the TMO's executive officers misleading the board or failing to disclose to it material matters relating to fire safety. The result in this particular case was that Mr Zitron did not get a straight answer to his question but it was a question that the TMO ought to have asked itself instead of resorting to deflection and concealment. By this point, however, it seems that the TMO had become so heavily reliant on Carl Stokes that any challenge to his work was disregarded, even in the wake of a serious fire.

742 Minutes of meeting of the TMO Board dated 31 March 2016 {TMO10045103/5} item 9.2.

743 {LFB00084110/3-4}. The contravention of Article 17(1) identified referred expressly to an absence of a self-closing device on a flat entrance door, in contradiction to the statement in the fire risk assessment that flat entrance doors were fitted with a self-closing device: {LFB00084110/4}.

The TMO Health & Safety Report 2015/2016

38.85 In June 2016, Janice Wray and Barbara Matthews produced the TMO's Health & Safety Report for the period 1 April 2015 to 31 March 2016.[744] In the section relating to fire risk assessments, it said that suitable and sufficient fire risk assessments were in place which had been produced in accordance with best practice as set out in PAS 79.[745] No mention was made of the concerns raised by Rebecca Burton in November 2015 and January 2016. Janice Wray was unable to explain that omission,[746] but she accepted that unless she included those criticisms in the report, or the matter had been raised by Barbara Matthews, neither the TMO's executive team nor the board nor RBKC would have been aware of them.[747] Yet again, the board of the TMO was kept in the dark about concerns expressed by the enforcing authority about the quality of the TMO's fire risk assessments. That was a particularly important matter for the board to know because it put the TMO, and indirectly the

744 {TMO10024405/1-22}.
745 {TMO10024405/7} paragraph 7.9.
746 Wray {Day144/217:20-25}.
747 Wray {Day144/219:4-12}.

members of the board, at risk of incurring liability for breach of the Fire Safety Order, which carried serious sanctions.

38.86 The report referred to the TMO's intention to procure a new contract for fire consultancy and fire risk assessment services.[748] Janice Wray and Barbara Matthews both denied that that had been prompted by criticisms of Carl Stokes's work.[749] In the event, the procurement manager apparently did not think that a new contract was required at that time and no steps were taken to obtain one. The subject was not discussed further by the TMO's Health and Safety Committee, the executive team or the board.[750]

748 {TMO10024405/18} paragraph 15.2.
749 Wray {Day144/220:17}-{Day144/221:11}; Matthews {Day148/79:23}-{Day148/80:2}.
750 {TMO10047034/19}.

Chapter 39
Response to fire risk assessments

The duty to record significant findings

39.1 Article 9(6) of the Fire Safety Order requires the responsible person to record certain information, including the significant findings of the assessment and the measures which have been or will be taken by that person pursuant to the order.[751]

39.2 Guidance on carrying out fire risk assessments was published by the British Standards Institution in the form of Publicly Available Specification 79 (PAS 79). It represented current best practice in the industry. The edition of PAS 79 relevant to the fire risk assessments carried out in relation to Grenfell Tower by Carl Stokes (other than that carried out in December 2010) was PAS 79:2012. We therefore refer mainly to that edition in this section of the report.

39.3 Clause 19 of PAS 79:2012 provided guidance on the formulation of an action plan.[752] It recommended that every documented fire risk assessment should incorporate an action plan

751 Fire Safety Order {BEI00001545/8} Article 9(7).

752 PAS 79:2012 {CTA00000003/59-60} clause 19; Similar guidance is provided in PAS 79:2007 {CTA00000001/55-56} clause 18.

such as to ensure that, if implemented, it would reduce the fire risk to, or maintain it at, a tolerable level.[753] The commentary on Clause 19 stated that it was normally appropriate to allocate a priority to each measure recommended and gave an example of a scheme of prioritisation.[754]

39.4 In addition to the guidance, the annexes to PAS 79:2012 contained model documents available for use by fire risk assessors.[755] Annex B contained a template that could be used for an initial fire risk assessment and Annex E provided a shorter template for a review of an existing fire risk assessment.[756] It included prompts for the assessor to record any significant changes in the management of fire safety since the previous fire risk assessment.[757] At the end of each template PAS 79:2012 included a basic pro forma action plan.[758] Both of the PAS 79:2012 action plan templates provided space for recording the

753 PAS 79:2012 {CTA00000003/60} clauses 19.1 and 19.2; PAS 79:2007 {CTA00000001/56} contains identical provisions at clauses 18.1 and 18.2.
754 PAS 79:2012 {CTA00000003/59-60} paragraphs (vii) to (xiv); PAS 79:2007 {CTA00000001/56-57} contains similar provisions.
755 PAS 79:2012 {CTA00000003/77-99}; PAS 79:2012 {CTA00000003/106-113}; Similar templates were included in PAS 79:2007 {CTA00000001/59-80} Annex A; PAS 79:2007 {CTA00000001/85-94} Annex D.
756 PAS 79:2012 {CTA00000003/77-99} Annex B; PAS 79:2012 {CTA00000003/106-113} Annex E; PAS 79:2007 {CTA00000001/59-80} Annex A; PAS 79:2007 {CTA00000001/85-94} Annex D.
757 PAS 79:2012 {CTA00000003/111} Annex E.
758 PAS 79:2012 {CTA00000003/98-99}; PAS 79:2012 {CTA00000003/112-113}; PAS 79:2007 {CTA00000001/80}; PAS 79:2007 {CTA00000001/93-94}.

actions to be taken by the responsible person in a table that contained columns for priority, the identity of the person by whom action was to be taken and the date on which it was taken. They also contained sections for the assessor to indicate the overall level of fire risk that would be achieved once all the actions identified had been completed. In addition, the template for a fire risk assessment review included a section prompting the assessor to enter details of any actions identified on a previous occasion that had not been carried out by the time of the review.[759]

39.5 The TMO's fire safety strategy in force from November 2013 recorded that the LFB's Fire Safety team had been told that the assessment to be produced by the TMO's consultant would be based upon the pro forma in PAS 79.[760]

39.6 In their fire risk assessments produced for the TMO, Salvus and Carl Stokes both included a schedule setting out their significant findings and providing a plan for any necessary remedial work. However, although the purposes of the schedules were the same, the contents and approaches differed.

759 PAS 79:2012 {CTA00000003/113}; PAS 79:2007 {CTA00000001/93}.
760 TMO Fire Safety Strategy dated November 2013 {TMO00830598/9} paragraph 14.1.3.

39.7 Salvus's action plan was incorporated in the risk assessment as part of a single document.[761] That was necessary, because the action plan did not repeat the findings in the assessment that required remedial action. Instead, it referred to them using the item number in the assessment. In addition to setting out the action which needed to be taken, Salvus identified the time within which it should be taken. Space was provided to record the name of the person responsible for carrying it out and the date by which it should be completed. A colour-coded column indicated whether the action related to a statutory breach, was required to conform to best practice or guidance, or was simply recommended by the assessor. A column was available to record the name of the person carrying out a re-assessment. Finally there was a column to record any change in the level of risk.[762] However, the form did not make provision for recording the overall risk to the premises once all the actions had been completed, as suggested by the template in PAS 79:2012. It also did not include a section relating to actions outstanding from previous assessments.

761 Salvus FRA and Action Plan for Grenfell Tower dated 30 September 2009 {CST00003128}.

762 Salvus FRA and Action Plan for Grenfell Tower dated 30 September 2009 {CST00003128/15-19}.

39.8 The format in which Carl Stokes produced his fire risk assessments was different. The schedule of significant findings did not form part of the assessment itself but was contained in a separate document described as a "Record of Significant Findings and Action Plan".[763] His form differed from that used by Salvus in that, as well as cross-referring to the section of the assessment which identified necessary remedial action, it also repeated the description of the risk or hazard that had been identified. It indicated the priority to be given to each action, whether high, medium, or low, with colour-coding, although without a key to explain the classification. At the head of the document there was an indication of the time within which each category of remedial measures needed to be completed. The form also provided sections in which the identity of the person or department responsible for carrying out the work and the date by which it needed to be completed could be recorded.

39.9 In contrast to the pro forma at Annex E of PAS 79:2012, Carl Stokes's form did not contain a section for the assessor to record any actions that had not been completed since the last inspection,

[763] Record of Significant Findings and Action Plan for Grenfell Tower dated 29 December 2010 {CST00003165}.

nor did it contain an indication of the level of risk to the premises once the actions identified had been completed.

39.10 Carl Stokes understood that his form of risk assessment and Record of Significant Findings and Action Plan had been shown to and approved by the LFB.[764]

Carl Stokes's practice

39.11 Carl Stokes said that when he identified concerns in the course of a fire risk assessment, he recorded them in the schedule of significant findings and assigned a priority for their completion.[765] He said that the document had been set out in that way to allow the TMO to use it as a checklist to ensure that all the points raised had been dealt with.[766]

Subsequent inspection of premises

39.12 In his written statement Mr Stokes said that when he made subsequent visits to premises in order to conduct a fire risk assessment he would take with him the schedule of significant findings produced following his previous visit, which he would use

764 Stokes {Day137/36:11-13}; Specimen FRA and Action Plan {CST00003071}; {CST00003089}.
765 Stokes {CST00003063/19} page 19, paragraph 55(iv); Stokes {CST00003063/23} page 23, paragraph 68.
766 Stokes {CST00003063/23} page 23, paragraph 68.

as a starting point to ensure that all the points raised had been dealt with.[767] That approach, had he actually adopted it, would have been in accordance with the guidance in clause 20 of PAS 79:2012, which advises that when a fire risk assessment is reviewed, consideration should be given to the extent to which the original action plan has been implemented and work that has not been completed identified.[768]

39.13 However, we doubt that he did in fact adopt that approach. Although the annotated copies of his significant findings and action plans for Grenfell Tower made in October 2014 and April 2016 contain his manuscript annotations,[769] there is no reference in any of his fire risk assessments or action plans to any outstanding (or indeed, completed) work that he had identified as necessary during a previous assessment.

39.14 When he gave evidence Carl Stokes said that it was his practice to ask Janice Wray to provide him with a printed copy of the previous fire risk assessment from which to work.[770] He said that by comparing the state of the premises during

767 Stokes {CST00003063/23} page 23, paragraph 68.

768 PAS 79:2012 {CTA00000003/61} paragraph 20(v). Carl Stokes confirmed that he was aware of this advice, Stokes {Day137/55:20-23}.

769 Handwritten notes on 2014 FRA Significant Findings Schedule {CST00003151}; Handwritten notes on April 2016 FRA Significant Findings Schedule {CST00000003}.

770 Stokes {Day139/103:22}-{Day139/104:4}.

his inspection with the records of his previous inspection, he could see that recommendations he had made on a previous visit had not always been completed, but he did not have any idea of the total number of recommendations outstanding at any time.[771] Mr Stokes told us that he had raised the importance of completing actions during meetings with Janice Wray, but there is no record of any of those meetings.[772] The TMO therefore had no reliable or comprehensive record of what remedial work Mr Stokes thought it particularly important to complete.

The involvement of the TMO's Health and Safety team

39.15 Once the information had been put on to the relevant TMO system, it could be distributed to the teams whose responsibility it was to carry out the work. It was primarily Janice Wray's responsibility to allocate the remedial work to the appropriate team in the TMO.[773]

39.16 The way in which the information was recorded and processed by the TMO changed over time. From October 2010, the work was recorded in electronic spreadsheets and documents.[774]

771 Stokes {Day139/103:16-21}.
772 Stokes {Day139/104:5-21}.
773 Wray {Day141/33:20}-{Day141/34:8}.
774 Wray {Day141/25:10-18}.

The documents contained information which appeared to have been copied from various different Action Plans and pasted into the document.[775] From August 2013, the TMO began to use a computerised system for logging recommendations. This system, known as "W2", was a database in which recommendations were recorded and by which work could be assigned to the appropriate team for completion within a given time.[776] When a job was assigned to a team, it would appear in that team's general "inbox" on the W2 system, along with any other tasks assigned to it.[777] When a team had completed the work assigned to it, it could mark the tasks as complete and Janice Wray or one of her assistants would then close them.[778] When the W2 system was first introduced, it ran in parallel to Janice Wray's spreadsheet tracker until all the actions recorded in the spreadsheet had been completed. At that point the spreadsheet was closed.[779]

On 25 May 2016, the TMO launched a new system, which took over the electronic processes for recording and monitoring remedial work.

775 See Composite FRA (High Risk) Action Plan Items for response repairs for Grenfell and other TMO stock {TMO10002330}.
776 Wray {TMO00000890/33-34} pages 33-34, paragraph 148.
777 Wray {TMO00873629/17} page 17, paragraph 71.
778 Wray {TMO00000890/33-34} pages 33-34, paragraph 148; Wray {TMO00873629/16} page 16, paragraph 65.
779 Wray {Day141/27:10-20}.

However, the TMO Health and Safety team did not use that system to record remedial work until about a week before the Grenfell Tower fire.[780]

39.17 Where remedial work was assigned to the TMO Health and Safety team, Janice Wray could give instructions herself to Repairs Direct or the relevant contractor to carry it out. Instructions of that kind were given through the Capita Housing Management System.[781]

39.18 The methods of recording and monitoring we have described related only to actions recorded in the schedules of Significant Findings and Action Plan produced in the course of fire risk assessments. Any necessary remedial work identified by other means, for example by the LFB in a deficiency notice, was not recorded in or monitored using the electronic systems. We describe below how they were handled.[782]

Access to data

39.19 Throughout his time as fire risk assessor Carl Stokes was not given full access to relevant fire safety information by the TMO, despite his asking for it. In particular, many of the actions identified in the Significant Findings

780 Wray {TMO00873629/17} paragraph 70.
781 Wray {Day143/197:6-15}; Bowman {TMO00842308/1-2} pages 1-2, paragraph 2.
782 Wray {Day141/222:21}-{Day141/224:11}.

and Action Plans referred to the need for the TMO to confirm the maintenance of certain items of equipment. For example, in the Significant Findings and Action Plan for Grenfell Tower produced in November 2012, Mr Stokes sought confirmation that the smoke ventilation system was being serviced and maintained in accordance with the manufacturer's instructions.[783]

39.20 Between 2010, when he began his assessments for the TMO, and October 2015, Carl Stokes had to rely for information about the maintenance and servicing of equipment on records printed out for him by the TMO Maintenance Department or Janice Wray.[784]

39.21 From 2010, the TMO recorded information on servicing and inspection of plant and machinery on a computer programme known as "Keystone".[785] Although he had been providing fire risk assessments for the TMO since 2010, Carl Stokes did not have access to the data held on Keystone until October 2015. He was eventually given remote access to Keystone in the hope that he could check for himself that servicing had been carried out and thus reduce the number

783 Record of Significant Findings and Action Plan for Grenfell Tower dated 20 November 2012 {CST00003083/5} item 23c.
784 Stokes {Day136/131:15-25}.
785 Parsons {TMO00870938/1-2} pages 1-2, paragraphs 5-6.

of recommendations he made in the future.[786] In any event, Carl Stokes had access to the Keystone system by the time he carried out the fire risk assessment in April 2016, as he recorded in that assessment that he had checked the Keystone records in relation to certain items.[787]

39.22 Even with access to Keystone, Carl Stokes was reliant upon TMO staff for some information because Keystone did not contain maintenance and servicing records for some equipment that was critical to fire safety. In particular, it did not contain maintenance and servicing records for the fire control system, dry rising fire main or emergency lighting system at Grenfell Tower.[788] Carl Stokes told us that if he could not obtain information for himself, he asked the TMO for the information he needed.[789] If he was still unable to obtain the information, he would record in the Significant Findings and Action Plan that he did not have it.[790]

786 TMO Health & Safety Committee Minutes dated 16 April 2015 {TMO10009485/2} item 4.1.

787 Record of Significant Findings and Action Plan for Grenfell Tower dated 26 April 2016 {CST00003098/7-8} item 23a and item 23e.

788 Lane, The Management and Maintanance of Grenfell Tower, Chapter 7, Module 3 Report {BLARP20000033/220} paragraph 11.2.56.

789 Stokes {Day136/133:3-19}.

790 Stokes {Day136/133:21-24}.

39.23 However, we doubt that he was consistently conscientious in doing so and his requests for information were patchy. Paul Steadman, who was the estates services assistant (ESA) for Grenfell Tower at the relevant time, had no recollection of having been consulted by Carl Stokes in relation to a fire risk assessment,[791] despite the fact that Mr Stokes recorded having consulted him by name in connection with the fire risk assessments for Grenfell Tower carried out in 2010, 2012, and 2014.[792] Moreover, Mr Stokes was never given access to the W2 system and was therefore unable to check for himself whether actions which had been identified during his previous visit to a property had been completed. He said that he had been forced to rely on documents printed out by Janice Wray,[793] but if that was so, it is surprising that they were not mentioned in his fire risk assessments.

---

791 Steadman {Day146/84:9-25}.

792 Fire Risk Assessment of Grenfell Tower dated 29 December 2010 {CST00003181/3}; Fire Risk Assessment of Grenfell Tower dated 20 November 2012 {CST00003084/3}; Fire Risk Assessment of Grenfell Tower dated 10 October 2014 {CST00003157/3}.

793 Stokes {Day138/121:5-22}; Wray {Day141/153:9}-{Day141/154:5}. Janice Wray was unable to recall whether she had provided Carl Stokes with spreadsheets from W2. She thought that she had probably done so for blocks in respect of which he had been requesting information, Wray {Day141/153:24}-{Day141/154:5}.

The TMO's management of remedial work

39.24 Within its sections on formulating an action plan, PAS 79 provides guidance on prioritising actions and the time to be allowed for their completion. PAS 79:2007 provided a scheme comprising three priorities: "immediate", "short term" (within three months), and "long term" (to be carried out as and when the opportunity arose).[794] PAS 79:2012 also provided a scheme comprising four priorities, which broadly replicated the 2007 scheme publication with the addition of a "medium term" category for implementation within three to six months.[795] It is clear from the text of both editions of PAS 79 that the intention of the document was that actions were to be completed within the timescales indicated. Both the 2007 and 2012 versions of PAS 79 recognise that other systems of prioritisation could be adopted, including a system which distinguished between items which breach legislation and those which do not.[796]

39.25 There were five categories of priority for implementing the remedial measures identified in the action plan produced by Salvus for

794 PAS 79:2007 {CTA00000001/55-56} clause 18.
795 PAS 79:2012 {CTA00000003/59-60} clause 19(ix).
796 PAS 79:2007 {CTA00000001/56} clause 18; PAS 79:2012 {CTA00000003/60} clause 19(x).

Grenfell Tower.[797] The highest three priorities required action within a short time, ranging from 24 hours to one month. Salvus also included a colour-coded designation, indicating whether an action represented a breach of statute (red), compliance with best practice or guidance (amber) or simply a recommendation (green).[798] As such, the colour-coding was not directly related to the priority rating or the time for completion, but it gave a useful indication of the basis of the advice. The risk presented by each item was assessed separately and the action plan included a column for a revised level of risk once the remedial work had been completed.

39.26 The Record of Significant Findings and Action Plan for Grenfell Tower dated 29 December 2010 resulted from Carl Stokes's first fire risk assessment of the tower.[799] He identified 23 separate risks or hazards, each of which was given a priority rating for completion on the scale "High" (2 – 3 weeks), "Medium" (1 – 2 months) and "Low" (3 – 6 months). He thought that those periods had been agreed between the TMO and the LFB, but Janice Wray

797 Salvus FRA and Action Plan for Grenfell Tower dated 30 September 2009 {CST00003128/19}.

798 Salvus FRA and Action Plan for Grenfell Tower dated 30 September 2009 {CST00003128/19}.

799 Record of Significant Findings and Action Plan for Grenfell Tower dated 29 December 2010 {CST00003165}.

could not confirm that and did not believe that a detailed discussion of that kind had taken place.[800] Mr Stokes confirmed that the document required actions to be completed within the periods indicated.[801]

39.27 Carl Stokes also included a colour-coded designation of priority in his action plans. The TMO's fire safety strategy of November 2013 referred to that colour-coding as a guide to the priority to be accorded to different actions and explained that, like the Salvus colour-coding system, red referred to measures required to comply with legal requirements under the Fire Safety Order and any significant risk to life, amber to recommendations relating to good practice and green to actions that would enhance fire safety based on good practice, but of a lower priority.[802] The fire safety strategy also confirmed that remedial work would be carried out in order of risk, with priority given to items with a red or amber rating.[803] Unlike the Salvus document, in which the colour-coding indicated the basis of the action and a separate system was incorporated to indicate priority, Carl Stokes's system effectively

800 Stokes {Day137/36:11-13}; Wray {Day141/53:8-13}.
801 Stokes {Day137/35:19-25}.
802 TMO Fire Safety Strategy dated November 2013 {TMO00830598/9} paragraph 14.1.3.
803 TMO Fire Safety Strategy dated November 2013 {TMO00830598/9} paragraph 14.1.3.

dealt with both aspects together.[804] By taking such an approach he conflated the gravity of the risk and the urgency of the work. We agree with Colin Todd that it is generally better to deal separately with the degree of risk and the time for completion of remedial measures, because, for example, it may be possible to eliminate a low risk quickly.[805]

39.28 Carl Stokes's form did not include a section for an overall assessment of the risk level once all remedial measures had been carried out, as suggested in Annex E to PAS 79, nor did it include a column for a revised level of risk, as did the Salvus template.

39.29 The next Record of Significant Findings and Action Plan for Grenfell Tower is dated 20 November 2012, reflecting Carl Stokes's fire risk assessment of that date. In that document the time within which high priority items were to be completed remained the same as in the 2010 schedule, but the time allowed to complete medium and low priority actions were both increased. In the case of medium priority actions

804 Under a system of that kind an item identified as a breach of legislation would always be categorised red and be prioritised, regardless of the actual risk it posed.

805 Todd {Day167/26:21-24}; Todd {Day167/27:9-12}.

the period of 1 – 2 months was increased to 2 – 3 months; for low priority actions it was increased from 3 – 6 months to 6 – 12 months.[806]

39.30 Carl Stokes thought that he had extended the periods for medium and low priority actions because of relevant guidance, but he was unable to identify it when he gave evidence[807] and none has come to light in any document we have seen. His extended periods did not accord with either the 2007 or 2012 versions of PAS 79. When pressed during his evidence for the specific source of guidance he had relied on to support the change, he suggested that he had taken them from the LGA Guide,[808] but that document contained no reference to the extended periods he adopted and provides guidance on the prioritisation of remedial measures only in the broadest of terms.[809] No other support for his decision has been identified.

39.31 The time allowed for completing remedial measures was changed again in the Action Plan for Grenfell Tower dated 17 October 2014.[810]

---

806 Record of Significant Findings and Action Plan for Grenfell Tower dated 20 November 2012 {CST00003083/1}.

807 Stokes {Day137/37:19-25}.

808 Referred to elsewhere in this report as the LGA Guide.

809 Local Government Association Guide "Fire safety in purpose-built blocks of flats" {HOM00045964/47} paragraph 37.1.

810 Record of Significant Findings and Action Plan for Grenfell Tower dated 17 October 2014 {CST00003177/1}.

Although the periods allowed for each category remained the same, there was added in parenthesis after the period of 6 – 12 months relating to low priority work the words “to start to action any works”. Carl Stokes confirmed that he intended the qualification to apply to all three priority ratings.[811] The effect of that amendment was that whereas previously the TMO had been required to complete the work within the prescribed periods, it was now required only to have started it within that period. No date for completion was prescribed.

39.32 The TMO had not asked for the action plan to be altered in that way.[812] Carl Stokes’s explanation was that “companies” had told him that they were encountering difficulties in completing work identified in action plans where they required capital investment which could not be provided at short notice.[813] His reference to “companies” suggests that he understood it to be a problem that had either been raised by a number of clients or was widespread and well-known within the industry. However, neither of the experts who considered the matter thought that the change he had made reflected a standard approach in the industry. Colin Todd considered that without any

811 Stokes {Day137/41:1-5}.
812 Stokes {Day137/41:14-15}; Wray {Day141/61:20-23}.
813 Stokes {Day137/39:12-23}.

reference to specific examples of major capital works, it was too broad and was unusual.[814] Dr Lane considered it to be entirely incorrect.[815]

39.33 The main problem created by the change was that it meant that in theory a responsible person could allow remedial measures to remain incomplete indefinitely, provided they had been started within the required time.[816] In practice, however, Janice Wray understood the change to mean that in situations where it was not feasible to complete the work with the prescribed time, for example, because it was necessary to undertake a procurement exercise, the TMO needed to be able to demonstrate only that the necessary process had been put in hand.[817] She explained that the teams to which work was assigned did not see the schedule in its original form, because they received their instructions only after the action had been put onto the W2 system for completion.[818] In those circumstances we think that Carl Stokes's unusual and potentially dangerous approach to the completion of remedial work from 2014 onwards probably had little or no effect on how the TMO dealt with the work in practice.

814 Todd {Day167/31:19-25}.
815 Lane {Day171/2:19}-{Day171/4:6}.
816 Stokes {Day137/41:10-13}.
817 Wray {Day141/62:7-13}.
818 Wray {Day141/63:17-22}.

The TMO's approach

39.34 Although Carl Stokes included priority ratings for the risks identified in his action plans, the TMO did not always accept them uncritically. On the contrary, on occasions, the management team even went so far as to challenge his professional judgement and seek to persuade him to change his findings. That was despite the fact that they had far less experience in matters of fire safety than he did. Other than Janice Wray, senior managers at the TMO were not experienced in matters relating to fire safety management and had not received training on it during their time at the TMO. Barbara Matthews, the director responsible for health and safety had no previous experience in that field and had received no fire safety training before or during her time at the TMO.[819] Similarly, Peter Maddison, the TMO's Director of Assets and Regeneration, had no qualifications or experience in the management of fire safety.[820] Although Robert Black had had some practical experience of health and safety, he had no relevant qualifications[821] and had received no fire safety training.[822]

819 Matthews {TMO10049987/1-2} pages 1-2, paragraphs 4 and 8; Matthews {Day147/103:15-20}; {Day147/100:6}-{Day147/102:23}.
820 Maddison {TMO00000892/14} page 14, paragraph 79.
821 Black {Day149/7:4-17}.
822 Black {Day149/7:18-20}.

Re-categorising actions – discussions between Janice Wray and Peter Maddison

39.35 On at least two occasions in 2014 and 2015, Peter Maddison and Janice Wray discussed the categorisation of deficiencies identified in fire risk assessments. The common factor in their discussions was his wish to divide the remedial measures into categories or sub-categories of priority actions.

The June 2014 intervention

39.36 The minutes of the TMO's Health and Safety Operational Meeting on 20 June 2014 record that during a discussion of statistics relating to fire risk assessments Peter Maddison asked Janice Wray which of the actions could be defined as absolute requirements and which were best practice.[823] Janice Wray's view was that there was nothing to clarify, other than the number of actions and which ones were "red", that is to say, urgent.[824] She was clear that she would not adjust the priorities but she said that she had not thought that Peter Maddison was seeking to treat some

823 TMO Health and Safety Operational Meeting Minutes dated 20 June 2014 {TMO10009784/2}.
824 Wray {Day141/141:17-21}.

red items as having a slightly lower importance.[825] The upshot on that occasion was that she resisted his request. However, he did not give up.

Peter Maddison's next request

39.37 The minutes of the TMO's Health and Safety Operational Meeting on 23 February 2015 record a discussion between Janice Wray and Peter Maddison in which he suggested that it would be useful to have more information about priority levels and the nature of each outstanding action.[826] Janice Wray agreed to "split the outstanding actions into high, medium and low categories with targets".[827]

39.38 Initially Peter Maddison told us that he had been seeking more information about what the different categories of action entailed.[828] He said that his intention had been to get a better means of understanding what the actions were, the risk they presented and the urgency of remedying them.[829] He thought that was the information he had asked for in June 2014 but had not received.[830] However, he later conceded that by February 2015 his team

825 Wray {Day141/142:16-19}; {Day141/142:20}-{Day141/143:3}.
826 Health and Safety Operational Meeting Minutes dated 23 February 2015 {TMO00869479/1-2}.
827 Health and Safety Operational Meeting Minutes dated 23 February 2015 {TMO00869479/2}.
828 Maddison {Day122/206:1-3}.
829 Maddison {Day122/206:4-15}.
830 Maddison {Day122/207:9-23}.

did have access to spreadsheets setting out the actions and suggested that he was looking for a summary overview.[831] We are not sure what Mr Maddison wanted and we are unable to place much reliance on his evidence of his intentions at the time, as it was rather confused. Janice Wray also thought that Peter Maddison, or members of his team, already had the information he wanted, but she nevertheless ran reports and produced high-level information.[832]

39.39 It is unclear why Peter Maddison felt it necessary to ask Janice Wray for information his team already held. He was emphatic that he was not seeking to change the priorities assigned by Carl Stokes, but was seeking to address the backlog of actions as effectively as possible, although he accepted he might have been seeking to understand which of the high priority work was the most urgent.[833]

The Adair Tower fire risk assessment

39.40 The clearest example of the TMO's seeking to challenge Carl Stokes's risk assessments occurred after the fire at Adair Tower on 31 October 2015. Following that fire, Carl Stokes reviewed the fire risk assessment and action

831 Maddison {Day123/20:7-18}.
832 Wray {Day141/146:18}-{Day141/147:4}.
833 Maddison {Day123/24:24}-{Day 123/25:6}; {Day123/16:8-14}.

plan for Adair Tower which were discussed at a meeting between him and the TMO on 19 November 2015.[834] The draft Record of Significant Findings and Action Plan included at item 12e a high priority recommendation that self-closing devices be fitted to all flat entrance doors that did not already have them.[835] Carl Stokes told us that during that meeting he had advised the TMO to undertake the work set out in the action plan.[836] His recollection of the meeting was that, although the TMO had suggested that there was no legal or regulatory requirement to fit self-closing devices, he had told it to fit them.[837]

39.41 The next day, 20 November 2015, Peter Maddison sent an email to Sacha Jevans, Janice Wray, Robert Black, Alex Bosman and Daniel Wood at 07:45 in which he questioned Carl Stokes's assignment of a high priority rating to the recommendation that self-closing devices be fitted.[838] He explained that he did not consider that to be justified because it was not a statutory requirement to install self-closing

834 Stokes {Day138/190:3-12}.
835 Record of Significant Findings and Action Plan for Adair Tower dated 11 November 2015 {CST00026368/3}.
836 Stokes {Day138/190:16-21}.
837 Stokes {Day138/190:22-24}.
838 Correspondence between Janice Wray, Barbara Matthews, Peter Maddison, Sacha Jevans and Robert Black regarding revised FRA for Adair Tower dated 18-20 November 2015 {TMO00866493/3-4}.

devices retrospectively and because the entrance doors of the leasehold flats were demised to the leaseholders. The proposed action plan would therefore require the TMO to carry out work that it could not require the leaseholders to undertake.[839] Peter Maddison could not remember how he had gained the understanding that there was no statutory requirement to fit self-closing devices.[840] In his email he went on to express his concern that committing itself to carrying out work that it did not have the power to undertake would leave the TMO exposed. He suggested that the priority be reduced to "low" or "advice" and that a note be added that the TMO could not enforce the requirement in relation to leasehold properties.[841]

39.42 Peter Maddison's view was supported by Barbara Matthews and Robert Black.[842] In her response, Barbara Matthews said that Janice Wray had been instructed to raise the matter with Carl Stokes and that a revised Record

839 Correspondence between Janice Wray, Barbara Matthews, Peter Maddison, Sacha Jevans and Robert Black regarding revised FRA for Adair Tower dated 18-20 November 2015 {TMO00866493/4}.

840 Maddison {Day123/135:16}-{Day123/136:17}.

841 Correspondence between Janice Wray, Barbara Matthews, Peter Maddison, Sacha Jevans and Robert Black regarding revised FRA for Adair Tower dated 18-20 November 2015 {TMO00866493/4}. Peter Maddison was unable to explain exactly what he was concerned the TMO would be exposed to, other than possible criticism Maddison {Day123/134:9-13}.

842 Correspondence between Janice Wray, Barbara Matthews, Peter Maddison, Sacha Jevans and Robert Black regarding revised FRA for Adair Tower dated 18-20 November 2015 {TMO00866493/1-3}.

of Significant Findings and Action Plan would be provided to the LFB.[843] She later confirmed that Carl Stokes had changed his categorisation to "strong advice" (as he had), which, she said, had "no regulatory requirement or defined timescale" but was "advisory only".[844]

39.43 It is surprising that Barbara Matthews supported Peter Maddison's view, given that she was aware that the LFB was keeping a close eye on this matter. Only a week before those email exchanges, Janice Wray had attended a meeting with Rebecca Burton to seek clarification on its response to the fire at Adair Tower.[845] Following that meeting, she told Barbara Matthews that the LFB was focusing specifically on self-closing devices and smoke ventilation systems and that she thought the LFB might take a kinder view of smoke ventilation if the revised fire risk assessment recognised the need to fit self-closing devices and it was programmed to be completed

843 Correspondence between Janice Wray, Barbara Matthews, Peter Maddison, Sacha Jevans and Robert Black regarding revised FRA for Adair Tower dated 18-20 November 2015 {TMO00866493/3}.

844 Correspondence between Janice Wray, Barbara Matthews, Peter Maddison, Sacha Jevans and Robert Black regarding revised FRA for Adair Tower dated 18-20 November 2015 {TMO00866493/1}.

845 Correspondence between Janice Wray, Robert Black, Barbara Matthews, and Sacha Jevans, regarding Adair Tower meeting with LFB Fire Safety Team Leader dated 13 November 2015 {TMO00840415}.

swiftly.[846] Barbara Matthews therefore decided to support Peter Maddison's suggestion that Carl Stokes be asked to downgrade the urgency of the action on self-closers despite knowing very well that the LFB was considering taking action against the TMO with a particular focus on self-closing devices on flat entrance doors.

Carl Stokes's response to pressure from the TMO to amend his findings

39.44 Carl Stokes had not been included in the email conversation discussed in the previous section. On 20 November 2015, he sent an email to Janice Wray advising that the item in the action plan concerning fitting self-closing devices should continue to be rated high priority,[847] but agreed to alter that to "strong advice", partly to appease the LFB. However, he reiterated that the fitting of self-closing devices to the front doors of flats

846 Correspondence between Janice Wray, Robert Black, Barbara Matthews, and Sacha Jevans, regarding Adair Tower meeting with LFB Fire Safety Team Leader dated 13 November 2015 {TMO00840415/2}.

847 Email correspondence between Carl Stokes, Barbara Matthews and Janice Wray regarding FRA for Adair Tower dated 20 November 2015 {CST00026445/2-3}.

should be given a high priority.[848] As a result, that item was downgraded to “strong advice” and was not colour-coded.[849]

39.45 When Carl Stokes was asked about his decision to alter the action plan, he said he felt able to make the change as the work was in hand.[850] He also said that his reference to “appeasing” the LFB meant helping them, as it was better to be on the right side of the enforcing authority.[851] Perhaps surprisingly, given his email of 20 November 2015 at 09.48, he said he thought it had been appropriate for the TMO to challenge his professional judgement and suggested that he had decided not to oppose it as the work was being undertaken in any event.[852] However, when pressed he accepted that the change appeared to have been the result of pressure put on him by the TMO.[853] That is exactly what had happened. The TMO, in full knowledge of risks involved, persuaded him to downgrade an important aspect of his assessment in relation to a building in

848 Email correspondence between Carl Stokes, Barbara Matthews and Janice Wray regarding FRA for Adair Tower dated 20 November 2015 {CST00026445/3}.
849 Record of Significant Findings and Action Plan for Adair Tower dated 11 November 2015 {CST00009046/5} item 12i.
850 Stokes {Day138/200:17}-{Day138/201:9}.
851 Stokes {Day138/199:4-21}.
852 Stokes {Day138/201:15-25}.
853 Stokes {Day138/201:10-14}.

which a serious fire had already occurred and in respect of which the LFB was already considering enforcement action.

39.46 Dr Lane and Mr Todd agreed that altering a recommendation in that way in response to pressure from a client was not consistent with the standards to be expected of a reasonably competent fire risk assessor[854] and we have no hesitation in saying that in doing so Mr Stokes was not acting professionally or in accordance with those standards.

39.47 We have analysed this episode at length not because it had any direct impact on what occurred at Grenfell Tower 20 months later but because it illuminates so well the TMO's general approach to fire safety. Its behaviour in seeking to challenge and dilute Mr Stokes's risk assessment, not for the first time, suggests that the TMO treated the demands of managing fire safety as an inconvenience rather than an essential aspect of its care for those living in the buildings under its management. It was a betrayal of its statutory obligations to its tenants.

854 Lane {Day171/9:21}-{Day 171/10:5}; Todd {Day167/40:17-24}.

Remedial work

39.48 When she entered remedial work on the W2 system Janice Wray included a time for completion, which she took from the Record of Findings and Significant Actions. The time was treated as running from the date that she received the action plan and entered the work on the system.[855] She understood that the work was to be completed within the time indicated.[856] Janice Wray explained that she treated any work that had not been completed as "outstanding", not merely those items which had not been completed when the time allowed expired.[857] Over time, the number of outstanding items of work increased, but they were broadly unrelated to any particular kind of risk and do not appear to have been taken into account in assessing the overall risk affecting the TMO's properties.

39.49 From early 2012, various committees and groups within the TMO began to identify problems in dealing with the outstanding work. The minutes of a meeting of the TMO Health and Safety Committee on 26 January 2012 recorded that Janice Wray was continuing to chase up work arising from the assessments in relation to high-risk buildings carried out by Salvus in

855 Wray {Day141/59:21-25}.
856 Wray {Day141/60:1-3}.
857 Wray {Day141/86:4-17}.

May 2010.[858] By January 2012, therefore, the TMO was at least 12 months behind in completing some of the remedial work. Although Ms Wray was very concerned about the backlog and took steps to discover its cause,[859] she did not know what it was, other than that there were problems with contractors.[860]

39.50 The arrears of remedial works were discussed at a meeting of the TMO Assets, Investment and Engineering Health and Safety Group on 15 March 2012. The minutes recorded that some work to put right some high – and medium-risk defects had been outstanding for as long as two years.[861] By December 2012 a significant amount of work was outstanding, which was causing concern.[862]

The Hodgson Report (July 2013)

39.51 In July 2013, Matt Hodgson produced the report on his review of the TMO's safety management to which we referred in Chapter 37.[863] In a section

858 TMO Health & Safety Committee Minutes dated 26 January 2012 {TMO10001026/3} item 8.
859 Wray {Day141/88:6-22}.
860 Wray {Day141/91:3-8}
861 TMO Assets, Investment and Engineering Health & Safety Group Minutes dated 15 March 2012 {TMO00869800/2} item 5.2.
862 TMO Assets, Investment and Engineering Health & Safety Group Minutes dated 13 December 2012 {TMO10001903/3} item 6.2.
863 TMO Safety Management Review by Matt Hodgson dated 19 July 2013 {TMO10003124}.

of the report dealing with fire risk assessments he recorded that there were between 900 and 1,000 outstanding items of remedial work waiting to be completed.[864] The figure is significant, first, because Matt Hodgson clearly thought it large enough to justify specific mention and secondly, because it is the earliest record of the amount of outstanding remedial work presented in that form to the TMO's executive team.

39.52 Although Mr Hodgson had drawn attention to the existence of that huge number of outstanding items of remedial work, Robert Black had little recollection of that part of the report and did not remember what he had done about it.[865] He did not take any steps to find out why a backlog of that size had been allowed to accrue, because he regarded that as the responsibility of Anthony Parkes. He could not recall any discussions about it following the receipt of the report.[866] As a result, there was no direction from the top and nothing to indicate that it was a serious problem that needed to be resolved urgently.

---

864 TMO Safety Management Review by Matt Hodgson dated 19 July 2013 {TMO10003124/33}.

865 Black {Day150/81:10-22}.

866 Black {Day150/81:10-15}; Black {Day150/81:20-22}.

39.53 Matt Hodgson's report was discussed by the TMO's executive team on 7 August 2013.[867] The minutes of that meeting do not record a detailed discussion about the number of outstanding items of work as such, but do reflect concern that the Assets and Regeneration department was being bogged down with recommendations addressing the situation.[868] There is nothing to suggest that the number of outstanding items was regarded as a shocking statistic that demanded to be treated as an urgent priority.

39.54 Matt Hodgson produced a further report on 13 September 2013.[869] The reference to the number of remedial items outstanding had been removed from that version of the report, which instead referred only to the number of high priority items completed between 28 February and 17 July 2013.[870] The arrears were now presented as a percentage of the total number of high priority items completed within a six-month period. It is unclear why that measure was chosen because, although the figures identified relatively low percentages of completions, for example,

867 TMO Executive Team Minutes dated 7 August 2013 {TMO00899807/1-2} item 1.4.
868 TMO Executive team Minutes dated 7 August 2013 {TMO00899807/2} item 1.4.
869 TMO Safety Management Review by Matt Hodgson dated 13 September 2013 {TMO00873398} and Chapter 4A more generally.
870 TMO Safety Management Review by Matt Hodgson dated 13 September 2013 {TMO00873398/31-32}.

34% by Assets and Regeneration Building Services and 34% by Response Repairs, the overall number of outstanding actions, and thus the scale of the backlog, was missing from the report.

39.55 Recommendation 16 of Mr Hodgson's report was to take steps to eliminate the backlog of remedial work.[871] Janice Wray was quite glad that he had made that recommendation, because she thought it would force the TMO to take the necessary action.[872] That was a telling admission because it suggested that her efforts to persuade the TMO's senior management to take the backlog seriously had thus far been in vain.

39.56 The final report also stated that the lack of sufficient information provided to the executive team relating to compliance with statutory duties had resulted in a want of leadership in making important changes or decisions needed to manage risk effectively.[873] The completion of outstanding remedial work identified in fire risk assessments was given as a specific example.

871 TMO Safety Management Review by Matt Hodgson dated 13 September 2013 {TMO00873398/12}, recommendation 16.
872 Wray {Day141/118:24}-{Day141/119:3}.
873 TMO Safety Management Review by Matt Hodgson dated 13 September 2013 {TMO00873398/8}.

39.57 In his original report Matt Hodgson had also referred to a breakdown in communication between the Health and Safety department and other departments in relation to remedial work.[874] Janice Wray denied there had been a breakdown in communications, although she accepted that there had been some frustration,[875] but the fact is that Mr Hodgson's view was near enough the mark. It was on any view a clear warning that remedial work and the associated risks were not being effectively managed by the TMO and that one reason for that was structural.

39.58 Between March 2012 and June 2017, the need to clear the arrears of remedial work was a constant topic of discussion by the Health and Safety Committee, but it did not consider detailed statistics until July 2015. Despite Matt Hodgson's reports in 2013 and the discussions in the various committees from 2012, the TMO was unable to keep up with the flow of remedial work. Janice Wray prepared a paper ("Paper 2") for a meeting of the TMO Health and Safety Committee on 31 July 2015 which showed the number of items of remedial work completed, partly completed and outstanding. Of the 1,850 items recorded, only 941, or about 50 percent, had been

874 TMO Safety Management Review by Matt Hodgson dated 19 July 2013 {TMO10003124/8}.

875 Wray {Day141/111:19}-{Day141/112:15}.

completed, leaving 909 outstanding or only partly completed.[876] That was similar to the position in July 2013 when Matt Hodgson produced his first report. At no time does the TMO Health and Safety Committee or the executive team appear to have considered the risk to life presented by the arrears.

39.59 Following the presentation of Janice Wray's paper in July 2015, Barbara Matthews, who had recently taken over executive responsibility for health and safety, asked her to produce a more informative breakdown of outstanding actions so that the committee could see the details better and understand what programme of work would be required to clear them.[877] For the meeting on 29 September 2015, Janice Wray produced statistics which included a breakdown of work by priority for the contract management team and a breakdown of contract management work by category, showing how long they had been outstanding (by year).[878] A further paper including the breakdown of actions by priority and type was produced in November 2015.[879]

876 TMO Health & Safety Committee FRA Action Statistics Paper dated 31 July 2015 {TMO10009662/1}.
877 TMO Health & Safety Committee Minutes dated 31 July 2015 {TMO10010039/3} item 4.1.
878 TMO Health & Safety Committee FRA Action Statistics Paper dated 28 September 2015 {TMO10010066/4-6}.
879 TMO Health & Safety Committee FRA Action Statistics Paper dated 23 November 2015 {TMO10011191}.

However, when statistics were produced for the January 2016 meeting, far less detail was included (only two pages of the document related to fire risk assessment actions) and the paper no longer included information about the priority of actions, although an age profile was included.[880] Janice Wray was unable to explain why some of the detail had been removed, beyond saying that she thought she may have run out of time to prepare the document.[881] Subsequent papers containing statistics on remedial work did not provide the same level of detail as the papers produced in September and November 2015.[882]

39.60 Despite those efforts to monitor the number of items of remedial work and the progress in completing them, the TMO had not been able to bring the arrears under control by the time of the fire at Grenfell Tower. At the meeting of the TMO Health and Safety Committee on 19 January 2017, Barbara Matthews raised concern about the number of items of work that had been outstanding for more than 12 months. She required the various teams to whom the work had been assigned to explain

880 TMO Health & Safety Committee FRA Action Statistics Paper dated 9 January 2016 {TMO10011910}.

881 Wray {Day141/171:14-18}.

882 See TMO Health & Safety Committee FRA Action Statistics Paper dated 6 April 2016 {TMO10012642}; TMO Health & Safety Committee FRA Action Statistics Paper dated 10 March 2017 {TMO10016217}.

their plans to complete it,[883] but explanations were provided by only two of the five teams.[884] The progress made following the meeting of the Health and Safety Committee in March 2017 was evidently insufficient and Barbara Matthews again expressed her concern at the number of outstanding actions at the next meeting of the committee on 13 June 2017, the day before the fire at Grenfell Tower.[885]

Interim measures: paragraph 14.4.2 of the fire safety strategy

39.61 The TMO's fire safety strategy made specific provision for instances where it was not possible to complete remedial work within the required time. Paragraph 14.4.2 provided that if high-priority work could not be completed within the time indicated, interim measures would be implemented to reduce the risk in the short term.[886] That was a sound attempt, in theory at

883 TMO Health & Safety Committee Minutes dated 19 January 2017 {TMO10016020/2} paragraph 4.1.

884 TMO Health & Safety Committee FRA Action Statistics Paper dated 16 March 2017 {TMO10016217/3}. Explanations received from Health & Safety Team and Neighbourhood Management South. Peter Maddison suggested that only teams with actions older than 12 months needed to provide a report, Maddison {Day123/98:14-17} however this was not Janice Wray's understanding, Wray {Day141/189:22}-{Day141/190:3}.

885 TMO Health & Safety Committee Minutes dated 13 June 2017 {TMO10021548/3} item 3.1.

886 TMO Fire Safety Strategy dated November 2013 {TMO00830598/10} paragraph 14.4.2.

least, to render the risk as low as reasonably practicable, but the TMO failed to create suitable plans to ensure that necessary interim measures were identified, documented or completed.[887]

39.62 Janice Wray said that paragraph 14.4.2 had not been intended to apply in all cases in which remedial work had not been completed within the time allowed but only in those where significant delay was expected, such as where a lengthy procurement process was needed.[888] However, whenever it was thought that it might not be possible to complete high-priority remedial work within times indicated in the action plan, consideration should have been given to adopting interim measures, if appropriate.[889] In reality, however, that was only ever an aspiration. Although Ms Wray thought that over the years a number of interim measures had been implemented by the TMO,[890] she could not identify any, other than those relating to the smoke control system at Grenfell Tower.[891]

887 PAS 79:2012 {CTA00000003/59} Clause 19 (ix); Lane, The Management and Maintenance of Grenfell Tower, Module 3 Report, Chapter 8 {BLARP20000027/141} paragraphs 8.2.37 – 8.2.39.
888 Wray {Day141/75:6-10}; {Day141/76:5-10}.
889 Wray {Day141/77:4-12}.
890 Wray {141/78:21-24}.
891 Wray {Day141/78:25}-{Day141/79:8}.

39.63 We have not been able to identify any occasion on which the TMO implemented interim measures. The TMO did not record such measures and although Janice Wray said that she would have put the details into the W2 system if she had known of them,[892] there was in fact no field in which information of that kind could be recorded. Although interim measures were said to have been recorded as an "update", there was no evidence from W2 of that having been done.[893] Indeed, Janice Wray admitted that there had been no system to record the fact that interim measures had been considered in relation to any particular high priority item or that a decision had been taken about it one way or the other.[894] She accepted that it would probably not be possible to find out whether in any particular case interim measures had been considered.[895] There was no formal system for notifying Carl Stokes of any decision to implement interim measures, although it is likely that Janice Wray discussed the matter with him first.[896]

892 Wray {Day141/79:13-16}.
893 Wray {Day141/79:17-24}.
894 Wray {Day141/81:1-8}.
895 Wray {Day141/80:16-19}.
896 Wray {Day141/81:15}-{Day141/82:7}.

Reporting on the progress of remedial measures

39.64 Remedial work was monitored by the TMO's Health and Safety Committee and also, before July 2015, by the TMO's Health and Safety Operational Committee.[897] The minutes of the TMO's Health and Safety Committee were circulated for the consideration of the executive team.[898]

39.65 Janice Wray prepared reports on safety performance which were presented to the executive team and to TMO board meetings by members of the executive team.[899] Anthony Parkes and his successor, Barbara Matthews, reported to the executive team and, to the best of Janice Wray's knowledge, presented her reports to the executive team.[900]

39.66 It appears that the TMO executive team never reported to the board on the need for remedial work or the extent of the delay in carrying it out.

---

897 TMO Health & Safety Committee Meeting Minutes dated 31 July 2015 {TMO00880645/3} item 4.1. At the TMO Health and Safety Committee Meeting on 31 July 2015, Barbara Matthews is recorded in the minutes as stating that she hoped the committee would become the only Health and Safety Committee {TMO00880645/2} item 2.1.

898 See the distribution list at the foot of the minutes of the TMO Health and Safety Committee {TMO00880645/8}.

899 Wray {TMO00000890/37} page 37, paragraph 168.

900 Wray {Day140/38:24}-{Day140/39:6}. During his evidence, Robert Black explained that the TMO's budget was not big enough to have someone with Health and Safety expertise on the executive team, Black {Day149/27:5-9}.

That is consistent with its failure to report to the board other matters of importance to fire safety. Barbara Matthews said that the only health and safety matters referred to the TMO board were those which had been included in the annual health and safety report or exceptional items, such as matters to do with the enforcement notice served following the fire at Adair Tower.[901] As a result, the board lacked the information it needed to perform its function. It did not know whether the TMO was complying with its statutory duties and did not have the information it needed to make decisions that might enable its management to eradicate the arrears of remedial work.

39.67 The TMO's executive team itself does not appear to have been regularly and reliably provided with information about the arrears of remedial work, which, as was plain from the content of the minutes, was a chronic problem. If it had been given that information and had reported properly to the board, the board might have realised that the TMO had long-term difficulty completing remedial work.

901 Matthews {Day147/105:18}-{Day147/106:4}.

Auditing the fire risk assessment programme

39.68 Although Janice Wray and the other members of the Health and Safety Committee gave frequent consideration to the question of remedial work, they never attempted to identify trends and failings in the delivery and implementation of the fire risk assessment programme. Such an audit was advised by clause 7.4 of PAS 7:2013.[902] The failure to undertake such an exercise contributed to the TMO's lack of understanding of the underlying causes of the problem and its inability to overcome the arrears.

Resources

39.69 At many points in her evidence Janice Wray blamed a lack of money for her failure to act in a more efficient and effective way, but the evidence does not enable us to reach any firm conclusion on that question.

39.70 Robert Black was unsure whether the TMO had a specific budget or sub-budget line item for health and safety, and agreed that the TMO "probably" did not have a line item within the general budget to cover remedial work identified in fire risk assessments.[903] However, he said that, if

902 {LFB00116924/23} paragraphs 7.4.3 and 7.4.4.
903 Black {Day150/14:18}-{Day150/15:3}.

Barbara Matthews had asked for additional funds to eliminate the arrears of remedial work, he was sure that he would have been able to provide them, although he noted that as finance director she knew where all the money was.[904]

39.71 Barbara Matthews told us that there had been a specific budget to enable the TMO to meet its health and safety obligations. Although the budget was restricted,[905] if there had been specific demands which could not be managed within the existing budget, it would have approached RBKC for additional funds.[906] She could not recall any occasion on which RBKC had refused a request for additional funds.[907] However, it had not occurred to her to approach RBKC to obtain funding for additional staff to support Janice Wray because she had felt that she might not have been able to make a strong enough case.[908] She thus appears to have adopted a degree of self-restraint when considering whether to ask RBKC for more funds. By contrast, Janice Wray was under the impression that no additional funding was available.

904 Black {Day150/120:2-10}.
905 Matthews {Day147/144:2-12}.
906 Matthews {Day147/144:13-24}.
907 Matthews {Day147/144:25}-{Day147/145:9}.
908 Matthews {Day148/136:5-16}.

39.72 It is difficult to tell why Janice Wray and Barbara Matthews had such divergent understandings of the position, given their shared responsibility to deliver the fire risk assessment programme. Throughout her evidence Janice Wray referred to many instances in the years 2009 until 2017 when she thought that the absence of funds was the reason why work had not been undertaken or why additional resources or assistance had not been sought. An early example of this was when she was asked about emergency plans and the recommendation by Salvus to ensure that all emergency plans were in accordance with government guidance.[909] When asked why the TMO had not followed Salvus's advice, she said that she suspected that resources had not been available, but she could not recall asking for additional resources to enable her to do so.[910] It is interesting to note that neither the minutes of the TMO Health and Safety committee nor those of the regular meetings between the LFB and the TMO in those years contain any reference to difficulties caused by a lack of funds for fire safety matters. That suggests that lack of resources was not a real constraint, but in the end we do not consider that we have enough information about the TMO's finances or

909 Salvus Fire Risk Assessment of TMO Fire Safety Policy and Procedures dated 22 September 2009 {SAL00000013/18} row 9.1.

910 Wray {Day142/30:1-13}.

the extent to which RBKC was willing to make additional funds available to it to be able to reach a reliable conclusion on that question.

Failure to assess the risk posed by the arrears

39.73 None of Carl Stokes's fire risk assessments considered the risk posed to residents by the TMO's longstanding failure to carry out remedial work in a timely manner. As a result, he did not consider the extent to which the risk to the occupants of the building was enhanced by remedial measures not being carried out within the time required. Secondly, he failed properly to assess the effectiveness of the fire safety management system.

39.74 Clause 20.2 of PAS 79:2012 advised that when a fire risk assessment was reviewed, the assessor should confirm whether work previously recommended has been carried out[911] and the template in Annex E relating to a review assessment included a section headed "Action on Previous Action Plan".[912] It thus prompted the assessor to record whether remedial work required by the previous assessment had been carried out.

911 PAS 79:2012 {CTA00000003/62} clause 20.2.
912 PAS 79:2012 {CTA00000003/112}.

39.75 Dr Lane considered that a fire risk assessor could not make a suitable and sufficient assessment of the risks affecting a building without identifying whether previous recommendations had been satisfactorily addressed,[913] and that a failure to include in a fire risk assessment information about whether previously identified remedial work had been carried out fell below the standard of a reasonably competent fire risk assessor.[914] Colin Todd agreed that it was important for a fire risk assessor to document in the assessment or action plan any items from previous assessments that had not been completed.[915] His preference was to identify deficiencies that had been found on the previous occasion and had not been rectified rather than simply treat them as new items,[916] but he said approaches varied and a failure to deal with them in that way did not of itself fall below the standard to be expected of a reasonably competent fire risk assessor.[917] However, we are not sure why, given the standards set by PAS 79 and the self-evident risks arising from not keeping a track on the progress of previous fire risk assessments.

913 Lane {Day171/14:8-13}.
914 Lane {Day171/14:17}-{Day171/15:2}.
915 Todd {Day167/41:20}-{Day167/42:9}.
916 Todd {Day 167/42:6-10}.
917 Todd {Day167/43:4-23}.

39.76 Carl Stokes's fire risk assessments and significant findings and action plans did not contain a section recording the completion or otherwise of recommendations made during a previous assessment. There is some evidence that during his inspections he looked at the previous Schedule of Significant Findings and Action Plan in order to see whether the TMO had complied with his recommendations, but even if he did so, it did not contribute to his overall assessment of the fire risk and he did not record his findings in the documents provided to the TMO. As a result, he could not tell how long individual deficiencies had remained outstanding. That was particularly important when assessing the extent to which the risk to residents was affected by arrears of remedial work.

39.77 However, Carl Stokes was aware that the TMO was not completing remedial work within the recommended times.

a. In each of the Schedules of Significant Findings and Action Plans produced in 2010, 2012 and 2014, he asked for confirmation that the caretakers were checking and testing the installed fire protection systems and

emergency lighting.[918] He said that he had been challenging the absence of a record of that work, but it must have been apparent to him by 2014 that, regardless of whether the checks and tests were in fact being carried out, the TMO had not established a proper system of keeping records over that 4-year period. Mr Stokes believed that he had taken that issue up with Janice Wray but was unable to recall the outcome.[919]

b. On 13 November 2015, Alex Bosman sent Carl Stokes a consolidated spreadsheet containing a number of questions about recommendations that he wanted him to answer.[920] The spreadsheet contained recommendations relating to a range of buildings managed by the TMO drawn from assessments made in 2013, 2014, and 2015. They included recommendations classified as “high priority” which had been outstanding

---

918 Record of Significant Findings and Action Plan for Grenfell Tower dated 29 December 2010 {CST00003165/4-5} items 20, 23b & 23e; Record of Significant Findings and Action Plan for Grenfell Tower dated 20 November 2012 {CST00003083/5-6} items 23b & 23e; Record of Significant Findings and Action Plan for Grenfell Tower dated 17 October 2014 {CST00003177/9} items 23b & 23d.

919 Stokes {Day136/210:18}-{Day136/211:10}.

920 Alex Bosman’s FRA Queries Spreadsheet {CST00002213}. This document also contains entries where Alex Bosman asked Carl Stokes to “justify” the fire risk and classification of the action as “high risk” (Row 9).

for 20 months.[921] Mr Stokes responded a few days later attaching a revised spreadsheet containing his own annotations. It is clear from that document that by 16 November 2015 at the latest he had been aware that the TMO had been routinely and systematically failing to complete remedial work within the recommended times.[922]

c. In October 2016, Carl Stokes was instructed by Janice Wray to inspect Grenfell Tower before an audit scheduled to be undertaken by the LFB.[923] The outcome of that inspection, as recorded in his letter of 19 October 2016, was that he found that 23 of the 46 recommendations he had made following the fire risk assessment on 20 June 2016, 43 of which had been described as being of "high priority", were still outstanding.[924] Indeed, the majority of the recommendations in the June 2016 action plan were themselves outstanding from an earlier assessment

921 Alex Bosman's FRA Queries Spreadsheet {CST00002213}, see in particular Row 9.

922 Email from Carl Stokes to Janice Wray dated 16 November 2015 {CST00002482}; Annotated spreadsheet {CST00002483}.

923 Letter from Carl Stokes to Janice Wray dated 19 October 2016 {CST00003137}.

924 Letter from Carl Stokes to Janice Wray dated 19 October 2016 {CST00003137}; Record of Significant Findings and Action Plan for Grenfell Tower dated 20 June 2016 {CST00003069}.

made in April 2016.[925] Further, 14 of the recommendations described by Carl Stokes in his letter of 19 October 2016 as outstanding appear in both the April and October 2016 action plans and were unresolved, despite having been brought to the TMO's attention six months earlier.

39.78 Accordingly, by October 2016 at the latest, Carl Stokes was aware that the TMO was not carrying out remedial work promptly. He expressed his frustration with the failure to complete work that ought to have been carried out within two or three weeks.[926] He suggested that he had contacted Janice Wray to ask her why the work had not been undertaken but he could not remember what her response had been.[927] He did not record his advice and there is no other evidence to show that he gave it.

925 The Record of Significant Findings and Action Plan for Grenfell Tower dated 26 April 2016 {CST00003098} contained 42 entries; Record of Significant Findings and Action Plan for Grenfell Tower dated 20 June 2016 {CST00003069} contained 46 entries of which 31 were identical or in close terms to a corresponding entry from the April 2016 document.

926 Stokes {Day138/139:25}-{Day138/140:6}.

927 Stokes {Day138/140:18-25}.

Chapter 40
The replacement of entrance doors

40.1 On the night of the fire, 13 of the entrance doors to the flats had been fitted when the tower was built, 104 had had been installed by Manse Masterdor Limited between 2011 and 2012 as part of a comprehensive replacement programme implemented by the TMO, three had been replaced since 2014, either by the leaseholder or by the TMO, and nine had been fitted to new flats on the lower floors of the building. The doors installed by Manse Masterdor were Suredor GPR fire doors.

40.2 Fire risk assessments of high-risk properties carried out in 2009 and 2010 had drawn the TMO's attention to the need to introduce regular inspections of entrance doors to flats to ensure that they complied with regulatory requirements. They had also drawn attention to the fact that many doors did not meet current standards and needed to be modernised or replaced. A survey of fire safety features of entrance doors conducted by Rand Associates across the whole of the TMO's housing stock completed in October 2010[928] found that a significant proportion

[928] {TMO00866665}; Wray {TMO00847305/1-2} pages 1-2, paragraphs 5 and 7.

of entrance doors did not have fire safety features and in particular did not have the necessary 30 minute fire resistance.[929] They could not, therefore, be modernised.[930] The TMO therefore embarked on a programme of replacing entrance doors to flats in many of its buildings. Funding for the replacement programme was agreed with RBKC and various properties were selected for inclusion in it, including all tenanted properties at Grenfell Tower.

40.3 Abigail Acosta was project manager for the replacement programme until her departure from the TMO early in 2012.[931] In the initial phase of the programme, Simon Throp, the TMO's assistant director of the Assets Investment and Engineering team, was also involved.

40.4 The TMO procured replacement doors through the London Housing Consortium,[932] a social housing procurement company with a framework agreement for external doorsets.[933] Following

929 {TMO00847327}.
930 KCTMO Health and Safety Annual Report 2010-2011 {TMO00854890/7} paragraph 8.1.9.
931 Wray {TMO00000890/3} page 3, paragraph 13; Acosta {TMO00862539/1} page 1, paragraph 1.
932 Wray {TMO00847305/2-3} pages 2-3, paragraph 9.
933 External Doorsets Specifiers' Guide {LHC00000006/1}.

a competition, Manse Masterdor's tender was accepted by the TMO's Operations Committee on 22 February 2011.[934]

40.5 A pilot door was fitted by Manse Masterdor at Flat 16, Grenfell Tower on 11 May 2011 and the rest of the work appears to have started soon after. The final doors were installed by February 2012 or thereabouts.

Regulatory requirements

40.6 The standard of performance required of a door in a compartment wall separating a flat from a space in common use, such as the entrance doors to the flats in Grenfell Tower, was set out in Appendix B to Approved Document B. It called for 30 minutes' integrity when tested in accordance with BS 476-22 and an ability to meet the requirements of BS 476-31.1 or BS EN 1634:2004 for cold smoke leakage. It also had to meet those standards when exposed to fire on each side of the door separately as part of the complete assembly of the doorset.[935] If it met those requirements, it was denoted FD30S.

934 Minutes of the Operations Committee meeting on 22 February 2011 {TMO00866724/2} item 3.

935 Dr Lane Phase 1 Report – Appendix I – Flat Entrance and Stair Fire Doors – requirements and provisions {BLAR00000024/30-31} sections I4.3.39 – I4.3.46 and {BLAR00000024/53} section I4.7.4.

40.7 The Inquiry has seen two fire resistance test certificates for Suredor GPR fire doors, both of which confirm 30 minutes' integrity when tested in accordance with BS 476-22.[936] However, it appears that no fire resistance tests were carried out[937] in accordance with the standard because the test certificates show that the doorset was tested on one side only and not, as required, on both sides.[938] There is no evidence that the door was tested for smoke leakage as required by BS 476-31.1.

40.8 Dr Lane and her team examined many of the entrance doors to the flats in Grenfell Tower after the fire for the purposes of Phase 1 of the Inquiry and in Annex I of her report she identified numerous discrepancies between the construction of the doors fitted to the flats and the construction of the door that had been subjected to testing.[939] We accept her evidence, from which it follows that in many, if not all, cases the doors installed

936 Building Test Centre Report on fire resistance test on single leaf composite door BS 476 {MAS00000001}; Chiltern International Fire test report {MAS00000002}.

937 Duncan {MAS00000356/2-4} pages 2-4, paragraphs 8, 9, 11, 14 and 15; Duncan {MET00040071/2}.

938 Building Test Centre Report on fire resistance test on single leaf composite door BS 476 {MAS00000001}; Chiltern International Fire test report {MAS00000002}.

939 Dr Lane Phase 1 Report – Appendix I – Flat Entrance and Stair Fire Doors – requirements and provisions {BLAR00000024/30} sections I4.3.42, {BLAR00000024/40-53} I4.5.29 – I4.5.88 and I4.7.4.

under the replacement programme did not satisfy the requirements of Approved Document B for that reason also.

The specification

40.9 Simon Throp drafted the specification for the doors to be used for the replacement programme.[940] Carl Stokes and Janice Wray[941] were either consulted or provided general advice about the relevant regulatory requirements.[942]

40.10 The tender documents required that the doors be "Security/30 min fire doors",[943] but despite the clear requirements of Approved Document B, they did not specify that the doorsets should be rated FD30S, nor did they expressly require the inclusion of cold smoke seals or confirmation that cold smoke leakage testing had been carried out. The documents did require fire test certification to be provided on request, but there was no similar requirement in relation to cold smoke leakage.[944]

940 Acosta {Day166/7:6-18}; {Day166/16:6-12}; {Day166/18:9-18}; Letter from Carl Stokes to Janice Wray dated 7 March 2011 updated on 10 March 2011 {CST00013074/2}; Wray {Day143/42:8-19}.
941 Stokes {Day138/39:1-5}; {Day138/40:4-15}; Wray {Day143/40:13-15}; Acosta {Day166/17:6-18}; Wray {Day143/39:9-25}.
942 Acosta {Day166/21:13-24}.
943 Manse Masterdor Ltd Tender Documents 2011 {MAS00000035/3}; {MAS00000035/90-91}.
944 Manse Masterdor Ltd Tender Documents 2011 {MAS00000035/93}.

40.11 In its letter of 22 February 2011 conditionally accepting the bid, the TMO said that the schedule of individual door prices provided by Manse Masterdor in the tender documents would be incorporated in the contract.[945] The schedule referred to the doors as being rated FD30S but no further details were provided.[946] That was the only reference to the FD30S rating in the tender documents or product literature seen by Carl Stokes or others at the TMO.

40.12 Carl Stokes referred to three documents which he said had given him some assurance that the doors were available as 30-minute fire doors:[947] the Manse Masterdor "Suredor" brochure,[948] a style guide[949] and a specification sheet.[950] It is true that the style guide indicated that some doors were available as 30-minute fire doors, but none of them was said to be available with an FD30S rating or with appropriate testing for cold smoke leakage. It seems clear to us that the Suredor GPR door was being marketed primarily as an entrance door for ordinary domestic use, for which a fire and smoke rating was not required.

945 Letter from the TMO to Manse Masterdor Ltd dated 10 February 2011 {MAS00000016/1}.
946 Manse Masterdor Ltd Tender Documents 2011{MAS00000035/7}.
947 Stokes {CST00030186/15} page 15, paragraph 59.
948 {CST00000116}.
949 {CST00002070}.
950 Manse Masterdor specification sheet {CST00002306}.

40.13 Although it is unclear whether the TMO received copies of the certificates relating to tests carried out in accordance with BS 476-22, no one took any steps to check whether the doors supplied corresponded to the test certificates available.[951]

Carl Stokes's advice

40.14 Carl Stokes was asked to advise the TMO on the requirements for fire doors in the relevant guidance[952] and gave the TMO written advice on 7 March 2011[953], 23 May 2011[954] and 24 June 2011[955]. Although he correctly identified the test standard for fire resistance, BS 476-22, he made no reference to the requirement for doors to be tested for cold smoke leakage. However, he was consistently clear that self-closing devices and smoke seals were required. He understood that the entrance doors to flats were required to be FD30 doors with the addition of smoke seals[956] and believed that "S"

951 Wray {Day143/57:13}-{Day143/58:3}; Stokes {Day138/66:8-22}, {Day138/67:3-13}; Acosta {Day166/31:15}-{Day166/32:18}; Pollard {MAS00000341/3} page 3, paragraphs 14 and 17 (certificates were provided to the TMO on two occasions).

952 Stokes {CST00030186/15} page 15, paragraph 57.

953 Letter from Carl Stokes to Janice Wray dated 7 March 2011 updated on 10 March 2011 {CST00013074}.

954 Letter from Carl Stokes to Janice Wray dated 23 May 2011 {CST00000991}.

955 Letter from Carl Stokes to Abigail Acosta dated 24 June 2011 {CST00003149}.

956 Stokes {Day138/39:25}-{Day138/40:3}; {Day138/52:12-17}; {Day138/55:7-19}; {Day138/56:3-19}; {Day138/61:5-8}.

indicated that a cold smoke seal was fitted.[957] He was clearly unaware of the requirement for entrance doors to flats on protected corridors to have been tested for cold smoke leakage to the standard set out in BS 476-31.1.

40.15 Following a meeting with Simon Throp and Janice Wray on 10 March 2011, Carl Stokes wrote to Janice Wray[958] asking her to obtain documentation from Manse Masterdor to confirm that the doors to be supplied would be the FD30 version and complied in all respects with the Building Regulations and the "Sleeping Guide". At the same time he pointed out the absence from the information he had seen of any references to self-closing devices or intumescent seals.

40.16 Carl Stokes had originally drafted the letter on 7 March 2011, three days before his meeting with Mr Throp and Ms Wray. In a note added after the meeting he recorded that Mr Throp had confirmed that the doors would have self-closing devices and cold smoke seals.

957 Stokes {Day138/65:18-19}.

958 Letter from Carl Stokes to Janice Wray dated 7 March 2011 updated on 10 March 2011 {CST00013074}.

40.17 Carl Stokes attended the pilot installation of a Suredor GPR fire door by Manse Masterdor on 11 May 2011. He said that he had checked the sticker on the door to confirm that it was rated FD30.[959]

40.18 Following the pilot installation, Carl Stokes wrote to Janice Wray on 23 May 2011 telling her that on the basis of technical sheets she had given him and information provided by the installation team, the door was a fire-rated (FD30) version of the Suredor GRP fire door.[960] It is clear that he had not seen the fire resistance test certificates for himself and that he made his assessment of the doors on the basis of the limited information provided to him[961] and what he saw during the pilot installation. He said that having seen smoke seals fitted to the door frame he was satisfied that the doors were indeed rated FD30S.[962] From his letter of 23 May 2011, it appears that he was satisfied that the doorset met the regulatory requirements.[963] Colin Todd thought it was reasonable to infer from the presence of a seal that a door was rated FD30S.[964]

959 Stokes {Day138/52:11-14}.
960 Letter from Carl Stokes to Janice Wray dated 23 May 2011 {CST00000991/1}.
961 Stokes {Day138/62:10-15}.
962 Stokes {Day138/64:9-25}.
963 Letter from Carl Stokes to Janice Wray dated 23 May 2011 {CST00000991}.
964 Todd {Day167/220:1-9}; {Day167/221:24}-{Day167/222:20}.

40.19 On 24 June 2011, Carl Stokes wrote to Abigail Acosta about the standards required for entrance doors to residential flats. He said that the doors should have a minimum of 30 minutes' integrity when tested in accordance with BS 476-22, be fitted with a self-closing device and intumescent strips and a cold smoke seal, in other words that they should bear the suffix "S".[965]

40.20 Carl Stokes did not tell the TMO that entrance doors to flats should be tested for cold smoke leakage and his advice led Janice Wray to understand that, if doors had been tested for fire resistance for 30 minutes and had self-closing devices and smoke seals, they were FD30S doors.

40.21 The TMO's invitation to tender did not specify, as it should have done, that FD30S doors were required.[966] Responsibility for that omission lies squarely with the TMO, which should have taken effective steps to make sure that it was procuring entrance doors that met the required standards. However, conditions on the night of 14 June 2017 were such that even a door rated FD30S would have provided little protection to the lobbies or the occupants of any of the flats.

---

965 Letter from Carl Stokes to Abigail Acosta dated 24 June 2011 {CST00001388/1}.

966 Manse Masterdor Ltd Tender Documents 2011 {MAS00000035}.

Chapter 41
Inspection and maintenance of entrance doors

41.1 On the night of the Grenfell Tower fire many of the self-closing devices on the front doors of flats in the block failed to work effectively and some were entirely missing. As a result, many doors remained open when the occupants left, allowing smoke to enter the lobbies, which quickly became smoke-logged. The absence of effective self-closing devices was therefore an important cause of the inability of many occupants to escape the tower at a time when the stairs were relatively free of smoke. It represents a serious defect in the management of the building in relation to fire safety.

Legislation and guidance

41.2 Under article 17(1) of the Fire Safety Order the responsible person must ensure that any equipment or devices provided in respect of the premises under the order are subject to a suitable system of maintenance and are maintained in efficient working order and good repair where necessary in order to protect the safety of relevant persons.

41.3 Among the equipment and devices that fall within article 17(1) are fire-resisting doors and self-closing devices. Part G of the LGA Guide, which is entitled "Managing fire risk – ongoing control", indicates that arrangements for managing fire safety in a block of flats should include putting in place programmes for routine inspection, testing, servicing and maintenance of fire safety systems, such as fire-resisting doors and monitoring the common parts, both through formal inspections and informally as part of day-to-day activities by staff.[967] It also recognises that whatever safety equipment is provided, its effectiveness will depend on proper inspection and maintenance.[968]

41.4 Section 82.3 of the LGA Guide advised that it was good practice to inspect timber fire-resisting doorsets every six months with a view to identifying defects, such as missing or ineffective self-closing devices and doors which had been replaced with non-fire-resisting products.

41.5 The Guide also said that entrance doors to flats should be fitted with effective self-closing devices that should be replaced as a matter of urgency

967 {HOM00045964/112}.
968 {HOM00045964/113}.

when found to be missing or damaged. It also warned of the dangers of residents' removing or disconnecting them.[969]

41.6 Before the LGA Guide was published, on 30 April 2011 Carl Stokes wrote to Janice Wray about a draft version dated 18 April 2011[970] quoting certain paragraphs which he considered could affect the programme for the replacement of entrance doors.[971] Janice Wray was therefore aware by 30 April 2011, if not before, that entrance doors needed to be fitted with self-closing devices and that residents might remove or disconnect them.[972]

Problems with self-closing devices

41.7 Shortly after Manse Masterdor began installing new entrance doors in March 2011, two problems began to emerge with the concealed self-closing devices fitted to them. One was a mechanical fault in the self-closing device which prevented the door from closing or which caused it to become stuck in the closed position. That appears to have been caused by a defect in the fixings connecting the self-closing device to the door and the doorframe. The other was that the

969 {HOM00045964/99}; {HOM00045964/105}.
970 {TMO00847318/1}; {CST00012483}.
971 {TMO00847318/1}. Paragraph 68.2 in the draft LGA Guide was materially the same as that in the published version.
972 Wray {Day143/68:7}-{Day143/69:5}.

self-closing devices were too strong for some residents, particularly those who were elderly or frail, who had difficulty opening and closing their doors. The evidence suggests that both problems were inherent in the design or manufacture of the doorsets rather than the result of defective installation. However, whether the problem was one of design, manufacture or installation, doors were proving difficult to open easily and the solution adopted by many, including the TMO's repair staff, was to remove the self-closing devices, even though they were an important fire safety measure.

41.8 Our conclusions about the extent to which one or other of those problems affected the self-closing devices at Grenfell Tower and the extent to which they were remedied before 14 June 2017 depend to a significant extent on evidence provided by residents about their entrance doors and the requests for repairs sent to Manse Masterdor and the TMO. That evidence has its limitations, however. For example, there are many references to doors' not opening or closing properly that do not identify any more clearly the nature of the problem. Moreover, the lapse of six years between the start of the door replacement programme and the fire means that other factors, such as wear and tear, may have contributed to the condition of some of the self-closing devices

on 14 June 2017. We have made findings about the condition of self-closing devices on 14 June 2017 where the evidence gives us sufficient confidence to do so, but it is important to acknowledge at the outset the limited nature of the information available to us.

Early discovery of failings: 2011

41.9 On 17 May 2011, Andy Webster, a project manager for Manse Masterdor, sent an email to fellow employees Paul Birkett and Richard Moore about the entrance doors being installed for the TMO in which he referred to a defect in concealed self-closing devices that prevented doors from closing. He recognised that the doors should not have left the factory in that state.[973]

41.10 It is unclear from Mr Webster's email what the precise nature of the fault was, except that it prevented the doors from shutting. It appears to have arisen during the design or manufacturing process, but it is unclear how. It is not clear what steps Manse Masterdor took to cure the problem, either in relation to doors that were yet to be installed or in relation to doors that had already been fitted. (At Grenfell Tower 17 entrance

973 {MAS00000187/82}.

doors had been fitted by that date.)[974] It is clear, however, that Manse Masterdor did not tell the TMO about the problem.[975]

41.11 On 24 June 2011, Carl Stokes sent an email to Abigail Acosta about problems with two newly installed entrance doors that he had identified during an inspection of King Charles House.[976] He had found that the self-closing device had come out of the door of Flat 13. Abigail Acosta told Natasha Brown, resident liaison officer at Manse Masterdor, about the problem and she arranged for a fitter to repair it.[977]

41.12 On 21 July 2011, Carl Stokes sent another email to Abigail Acosta about the same problem affecting newly installed entrance doors at Grenfell Tower. He said that he had been told that three self-closing devices had been dislodged from the doors. He did not say which flats were affected but he suggested that the screws securing the closer inside the door were too short.[978]

974 {MAS00000003}.
975 Acosta {Day166/86:3-5}. There is no record of the problem being raised and discussed in the progress meetings for the entrance door replacement programme.
976 {TMO00867377/2}.
977 {TMO00867377/1-2}.
978 {TMO00867783/2-3}.

41.13 Abigail Acosta sent the message on to Andy Webster on 26 July 2011.[979] He said that he was aware of the problem and explained that although the factory had used the screws recommended by the manufacturers, they had turned out not to be long enough. As a precautionary measure the size of the screws had been increased.[980] Apparently Mr Webster told Ms Acosta which other properties had also been affected, but she could not remember which ones they were.[981]

41.14 It is clear that from the outset inadequate screws and fixings presented a systemic problem in relation to self-closing devices on the new entrance doors throughout the TMO stock, as the TMO knew. It is also clear that as a result there was a real possibility that self-closing devices would become dislodged from the doors unless the screws and fixings were changed. It is less clear whether the problem was the same as, or related to, the problem with doors not shutting that Mr Webster had referred to in his email of 17 May 2011.

41.15 In his response to Abigail Acosta of 26 July 2011 Mr Webster said that Manse Masterdor had started changing the

979 {TMO00867783/2}.
980 {TMO00867783/1-2}.
981 Acosta {Day166/87:14-18}.

fixings as necessary,[982] but it changed the screws and fixings only of the doors that were affected, not of all doors.[983]

41.16 At Grenfell Tower, the vast majority of the new entrance doors had been installed by the end of June 2011.[984] Unless Manse Masterdor returned to change them, therefore, they retained the original fixings and did not have the larger screws and fixings that the factory apparently used from July 2011 onwards. There is in fact no evidence that Manse Masterdor replaced the fixings of the self-closing devices on any of the new entrance doors.

41.17 We have seen no evidence that Abigail Acosta ever received confirmation that any remedial work had been carried out by Manse Masterdor at either King Charles House or Grenfell Tower. Further, there is no evidence that she, as project manager, carried out any checks herself or that she had a system to record any remedial work that needed to be carried out. She appears to have assumed that Manse Masterdor carried out any necessary remedial work and that the problem had been resolved.[985]

982 {TMO00867783/1-2}.
983 Acosta {Day166/88:1-6}.
984 {MAS00000003}.
985 Acosta {Day166/87:14}-{Day166/89:5}.

41.18 Carl Stokes also assumed that the problem had been cured.[986] He did not carry out any checks at the time or investigate whether the problem had been satisfactorily resolved when he carried out his next fire risk assessment at Grenfell Tower in November 2012.[987]

41.19 Whatever steps Manse Masterdor took to cure the problem, it is reasonably clear that it persisted, at least at Grenfell Tower, which may explain why so many self-closing devices were defective or missing on 14 June 2017.[988]

41.20 There was evidence that during the period from 2011 to 2013 the self-closing devices on the entrance doors of a number of flats at Grenfell Tower had become dislodged or that the doors would either not close at all or else become stuck in the closed position. It is likely that those problems were caused by inadequate screws and fixings, but it is possible that in some cases there were other faults. It is also evident that various repairers, including employees of Manse Masterdor, Morrisons[989] and

986 Stokes {Day138/75:24}-{Day138/76:3}; {Day138/83:5-21}.

987 {CST00003084}; Record of Significant Findings and Action Plan {CST00003083}.

988 {MET00039807/76-80}.

989 Morrisons Facilities Services Ltd provided reactive repair services for the TMO until the termination of their contract in June 2012 when Willmott Dixon was appointed by the TMO to provide those services.

Repairs Direct,[990] as well as Seamus Dunlea (the Lancaster West Estate handyman) and residents themselves removed self-closing devices so that doors could be opened and closed freely. Self-closing devices were removed from the doors of Flat 11,[991] Flat 12,[992] Flat 25,[993] Flat 32,[994] Flat 41,[995] Flat 54,[996] Flat 66,[997] Flat 76,[998] Flat 82,[999] Flat 115,[1000] Flat 133,[1001] Flat 134,[1002] Flat 152[1003] and Flat 205.[1004]

990 Repairs Direct Ltd was a wholly owned subsidiary of the TMO which was established in 2013 to provide reactive repair services for the TMO in place of Willmott Dixon.

991 Alison Moses {IWS00001281/4-5} pages 4-5, paragraphs 21-25

992 Dainton {IWS00000806/6} page 6, paragraph 33; Dainton {IWS00001974/5} page 5, paragraph 25; {RBK00053524} row 3709.

993 Rasoul {IWS00001768/7-8} pages 7-8, paragraphs 34-35; {RBK00053524} rows 3555 and 3052.

994 {MET00045733} row 5303. The flat was identified in that document by cross-checking the factory reference with the document showing the doors installed at Grenfell Tower {MAS00000003} row 15.

995 Kasote {IWS00000768/5} page 5, paragraph 19; Kasote {IWS00001775/7} page 7, paragraph 23; Kasote {Day117/63:17-20}.

996 Rawda Said {IWS00001729/2-3} pages 2-3, paragraph 4(b); Salma Said {IWS00001727/4-5} pages 4-5, paragraph 4(b).

997 Hanan Wahabi {IWS00000074/5} page 5, paragraph 16; {TMO00899663}; {TMO00899664}.

998 Quang {IWS00000080/3} page 3, paragraph 11; Quang {IWS00001821/8-9} pages 8-9, paragraphs 40-42; {RBK00053524} row 2851.

999 {TMO00868337/1}; {RBK00053524} row 3745.

1000 {MET00045733} row 5110. The flat was identified in that document by cross-checking the factory reference with the document showing the doors installed at Grenfell Tower {MAS00000003} row 62.

1001 Hanife Macit {IWS00000904/5} page 5, paragraph 32; Sener Macit {IWS00000069/7} page 7, paragraphs 39 and 40.

1002 Daffarn {IWS00000169/15} page 15, paragraph 47.

1003 Yahya {IWS00000498/3} page 3, paragraph 10; El-Guenuni {IWS00002034/2-3} pages 2-3, paragraph 7.

1004 Neda {IWS00000886/22} page 22, paragraph 132.

41.21 A common feature of all the flats listed above is that the self-closing device on the entrance door was missing on 14 June 2017.[1005] We have seen no evidence that Manse Masterdor, the TMO or anyone else replaced the self-closing devices on those doors before 14 June 2017, except for Flat 32. In the case of that flat there is evidence that Manse Masterdor replaced the self-closing device.

41.22 There is positive evidence that the self-closing devices on the entrance doors of some of the flats listed above had not been replaced by June 2014. On 14 June 2014 Leon Taylor, a fire risk assessor for PSC London Ltd, carried out a fire risk assessment of Grenfell Tower on instructions from Michael Lyons, a health and safety manager employed by Repairs Direct.[1006] Mr Taylor inspected some of the new doors and found that their self-closing mechanisms had been disconnected; he also found that some of the old fire doors did not have self-closing devices.[1007] He took photographs of missing self-closing devices on at least three entrance doors, including

1005 {MET00039807/76-80}.

1006 Emails between Michael Lyons and Amelia Sales on 26-31 March 2014 {TMO00856436/1-2}; Taylor {PSC00000002/1} page 1, paragraph 2; Leon Taylor's fire risk assessment of Grenfell Tower dated 14 June 2014 {TMO10001286}.

1007 Leon Taylor's fire risk assessment of Grenfell Tower dated 14 June 2014 {TMO10001286} "FRA" sheet, Reference L6, rows 231-233.

Flats 25 and 76.[1008] He recommended that the entrance doors to all flats should have fully functioning, positive-action, working, self-closing devices fitted.[1009] We have seen no evidence that Repairs Direct or the TMO took any action in response to that recommendation.

41.23 On 17 December 2015, Janice Wray sent an email to Siobhan Rumble to report Carl Stokes's concern that some residents of Grenfell Tower had told him that Seamus Dunlea had disconnected the self-closers on their entrance doors. Janice Wray asked Ms Rumble to tell him to stop disconnecting or removing self-closing devices, which apparently she did.[1010] On the face of it, that is consistent with Seamus Dunlea's own evidence.[1011] It is not clear when he disconnected self-closing devices or on which doors, but it does indicate that by December 2015 some of the self-closing devices he had removed had not been replaced. There is no evidence that they were replaced at that point or that any investigation was carried out to determine from

1008 Photographs taken by Leon Taylor on 15 June 2014 of missing self-closing device at Flat 76 {PSC00000072}; Flat 25 {PSC00000082}; another flat entrance door where the number is not visible {PSC00000087}.
1009 Leon Taylor's fire risk assessment of Grenfell Tower dated 14 June 2014 {TMO10001286} "Action Plan" sheet, row 9.
1010 {TMO00859693/1}.
1011 Dunlea {MET00019959/6} page 6.

which flats they had been removed.[1012] Moreover, the TMO did not have a system for the regular inspection and maintenance of entrance doors that might have revealed that self-closing devices at Grenfell Tower were missing or defective and prompted their replacement before the fire.

41.24 In those circumstances, the only plausible explanation for the absence of self-closing devices from the entrance doors of the flats on the night of the fire (except Flats 32 and 53) is that they had been removed as a result of problems that had arisen shortly after the doors had been installed and not replaced before the fire. It is unclear how the self-closing devices on the doors of Flats 32 and 53 came to be missing at the time of the fire.[1013]

Excessive strength of the self-closing device

41.25 During the summer of 2011 there were various reports that the strength of the self-closing devices on new doors caused difficulties for

1012 Janice Wray could not remember, but said she would have asked Siobhan Rumble to ask for repairs, Wray {Day143/189:5-15}-{Day143/190:6-12}. Siobhan Rumble said she took no action beyond asking Seamus Dunlea to stop disconnecting and removing the self-closing devices, Rumble {Day120/43:1-5}. Carl Stokes did not investigate whether the issue had been addressed in his subsequent fire risk assessment of Grenfell Tower in April 2016 {CST00003161}.

1013 {MET00039807/76-80}.

residents when opening and closing them. There is evidence that the self-closing devices to Flats 43,[1014] 72,[1015] 183[1016] and 122[1017] were removed or disabled as a result. We have seen no evidence that they had been repaired or replaced before 14 June 2017, but they were all missing on 14 June 2017 except one (Flat 43), which was present but not working.[1018] Again, it is likely that the reason for their absence is because they had been removed or disabled as a result of the problems that had arisen shortly after the doors were installed and were not subsequently repaired or replaced.

Inspection and maintenance of entrance doors

41.26 The TMO was repeatedly advised, both before and after the LGA Guide was published in July 2011, that it needed to put in place a system of regular inspection and maintenance of fire-resisting doors, including the entrance doors to flats.

1014 Sobieszczak {IWS00001539/4} page 4, paragraphs 16 and 17.
1015 Roncolato {IWS00001774/2} page 2, paragraph 8.
1016 Gomes {IWS00001078/12} page 12, paragraphs 59 and 60.
1017 Beadle {IWS00001872/7} page 7, paragraphs 30 and 31.
1018 {MET00039807/76-80}.

41.27 The Salvus Management Report, dated 22 September 2009,[1019] identified the absence of adequate inspection and monitoring of premises and facilities as a hazard. It specifically identified that the monthly safety inspection did not include any formal checks on fire doors[1020] and contained a strong recommendation that the inspection sheet be revised to include formal checks on fire doors. Salvus advised that that needed to be done within a month to remedy what it considered to be a breach of the TMO's statutory obligations.[1021]

41.28 In his fire risk assessment of Grenfell Tower dated 30 September 2009 on behalf of Salvus Carl Stokes recommended that a system of formal checks on the entrance doors to flats and all other fire compartmentation doors be introduced by the TMO to ensure that fire compartments remained fit for their purpose. He made it clear that checks should be made on all fire doors within the building and recommended that a system of inspection be put in place within three months or that a plan for doing so be agreed within six months.[1022]

1019 See Chapter 37.
1020 {SAL00000013/7} item 4.1.
1021 {SAL00000013/15} item 4.1.
1022 {CST00003128/16}.

41.29 Salvus repeated that recommendation in, at least, 12 other fire risk assessments on TMO properties which it carried out between September 2009 and January 2010 under the high-risk programme. In each case, it recommended that a system of inspection be put in place within three months or that a plan for doing so be agreed within six months.[1023]

41.30 On 4 November 2010, Carl Stokes advised Janice Wray that when carrying out the programme of replacing the entrance doors to flats, the TMO ought to consider introducing an inspection system to ensure that the residents did not disconnect or disable the self-closing devices.[1024]

41.31 On 8 November 2012, representatives of the LFB, the TMO, RBKC and the London Borough of Hammersmith and Fulham met to discuss responsibility for enforcing the law against leaseholders whose entrance doors were not

1023 9 Colville Square dated 25 September 2008 {CST00003736/12}; 11 and 12 Colville Square dated 25 September 2008 {CST00003737/12}; Gillray House dated 14 October 2009 {TMO00873667/19}; Salvus fire risk assessments of Dixon House dated 16 November 2009 {CST00002006/21}; Clydesdale House dated 16 November 2009 {CST00003596/15}; Elm Park House dated 9 December 2009 {CST00003744/15}; Whitstable House dated 25 January 2010 {CST00002008/20}; Frinstead House dated 25 January 2010 {CST00003214/22}; Markland House dated 15 January 2010 {CST00003215/22}; Adair Tower dated 28 January 2010 {CST00002623/17}; Hazelwood Tower dated 28 January 2010 {CST00002626/15}.

1024 {CST00001156/1}; {CST00001155}.

adequately fire-resisting.[1025] Andy Jack, the Head of Fire Safety Enforcement at the LFB, Nicolas Comery, team leader of the LFB fire safety team, and Matthew Ramsey, a LFB fire safety inspecting officer, attended on behalf of the LFB. Janice Wray attended on behalf of the TMO. Carl Stokes also attended.[1026] No minutes were made of that meeting.

41.32 A further conversation took place immediately after that meeting involving, at least, Andy Jack, Carl Stokes and Nicolas Comery about the monitoring and maintenance requirements for entrance doors to flats and self-closing devices.[1027] Janice Wray did not stay for the discussion but Carl Stokes told her afterwards what had been said.[1028] Andy Jack made the point that there was a need to maintain doors and self-closing devices in good working order and to carry out sufficient checks of their effectiveness.[1029] He also drew attention to the possibility of carrying out checks on self-closing devices during gas safety inspections.[1030] It

1025 Jack {MET00040001/6} page 6, last paragraph; {LFB00004623}.
1026 Jack {MET00040001/6-7} pages 6-7; Comery {LFB00032144/15} page 15, paragraph 50; Ramsey {LFB00032092/13} page 13, paragraphs 47 and 48.
1027 Jack {MET00040001/15} page 15.
1028 Wray {Day143/116:24}-{Day143/117:1-7}; Stokes {Day138/167:16-25}.
1029 Jack {MET00040001/19} page 19; Jack {Day147/68:19}-{Day147/69:24}.
1030 Jack {MET00040001/19} page 19.

appears, however, that no agreement was reached about what form the TMO maintenance system should take.[1031]

The TMO's policy on inspection and maintenance of flat entrance doors

41.33 From late 2012 to November 2013 Janice Wray drafted the TMO's fire safety strategy with help from Carl Stokes.[1032] As it was the TMO's overarching policy in relation to fire safety, we should have expected it to contain the arrangements for complying with important aspects of the Fire Safety Order, including the inspection and maintenance of entrance doors to flats and self-closing devices. That is particularly so in view of the specific advice which had been given to the TMO between 2009 and 2012 on the need for a system of regular inspection and maintenance of entrance doors and the recommendations in the LGA Guide that had been published in July 2011. Despite that, however, the TMO's fire safety strategy, which was completed in November 2013, did not provide for such a system.

1031 Jack {Day147/75:1-7}.

1032 {CST00001188}; {CST00001187}; {CST00001159}; {CST00002046}; {TMO00830598}.

41.34 Section 5 of the fire safety strategy covered management arrangements for fire safety. Paragraph 5.1 provided for a programme of regular estate inspections, risk assessments and monitoring by neighbourhood and health and safety staff. It said that inspections ensured that fire doors were operating effectively. It also said that repairs to fire doors and self-closing devices were given priority.[1033] However, the inspection checklist covered only communal fire doors and chute room doors, not the entrance doors to flats.[1034]

41.35 The fire safety strategy also provided for the inspection, testing and maintenance of all fire safety systems and equipment in accordance with the requirements of the relevant British Standard,[1035] but did not include the entrance doors to flats or other fire doors.[1036]

41.36 Section 17 specifically dealt with the entrance doors to flats, but although it clearly envisaged that the TMO's fire risk assessor would inspect some entrance doors as part of his fire risk assessments, it made no provision for a system of regular inspection and maintenance of entrance doors and self-closing devices.[1037]

1033 {TMO00830598/2-3} paragraph 5.1, first bullet point.
1034 {TMO00830598/18}.
1035 {TMO00830598/3} paragraph 5.1, second bullet point.
1036 {TMO00830598/4-7} paragraphs 5.1, 6.2, 9.1.3, 9.2, 9.4 and 10.
1037 {TMO00830598/11} paragraph 17.

41.37 We have seen no evidence that before the TMO completed its fire safety strategy it gave any consideration to Mr Jack's suggestion at the meeting on 8 November 2012 that regular inspections of self-closing devices might be combined with the annual gas safety check.

Janice Wray's email to Matthew Ramsey, 18 December 2013

41.38 On 18 December 2013, Janice Wray sent an email to Matthew Ramsey about various fire safety matters affecting Elm Park House.[1038] In response to a concern he had raised about self-closing devices there, Janice Wray described the TMO's approach to entrance doors as follows: first, when replacement doors were fitted they were fire-rated and fitted with self-closing devices; secondly, when properties became vacant self-closing devices were reinstated or installed as necessary; thirdly, at other times when major work was to be undertaken in a dwelling the self-closing device would be reinstated if it had been removed or disconnected.

41.39 We have seen no evidence that Matthew Ramsey or anyone else in the LFB fire safety team replied to that email or otherwise commented on the approach it described. Mr Ramsey said that

1038 {LFB00003534}.

neither he nor Nicolas Comery had approved it.[1039] Andy Jack said that he had not approved it either.[1040] Janice Wray accepted that the LFB had not approved it in the past.[1041] None of that is surprising. The TMO's approach inevitably led to irregular and infrequent inspections of the entrance doors to flats and so was inconsistent with both the LGA Guide's recommendation for six-monthly inspections and the advice given by Andy Jack in November 2012, which Janice Wray had already accepted.[1042]

41.40 The TMO's approach to inspecting self-closing devices, as described by Janice Wray to the LFB, did not appear in the fire safety strategy. It was also absent from the document used by the TMO and Repairs Direct that described the condition that vacant properties were required to attain in order to be ready for letting (known as the "relettable standard") and was not included in the forms for recording inspections of vacant properties.[1043] However, a requirement to carry out a fire risk assessment inspection was added to a new version of the "relettable standard" that was produced in November

1039 Ramsey {Day147/15:12-17}.
1040 Jack {Day147/78:1-8}.
1041 Wray {Day143/123:13-25}.
1042 Wray {Day143/123:24}-{Day143/124:4}.
1043 {TMO00905397}; {TMO00905501}; {TMOH00000805/1}; {TMO00861934}.

2014.[1044] In addition, there is some evidence that the TMO and Repairs Direct were, in practice, inspecting the entrance doors to flats and their self-closing devices when vacant properties were inspected.[1045]

41.41 Quite apart from that, however, the policy was inadequate because it did not ensure that entrance doors were inspected on a regular and systematic basis. It could be many years before a property changed hands and was inspected. Records of repairs show that work was carried out on only 17 of the 120 flats in Grenfell Tower between the end of 2013, when the policy apparently came into existence, and 14 June 2017.[1046] That means that the vast majority of entrance doors in Grenfell Tower had not been inspected before the fire.

41.42 The policy of inspecting the entrance door to a flat when major work was carried out was similarly inadequate, because it did not ensure regular inspection. It was only by coincidence that the flats in Grenfell Tower all underwent major work relatively shortly before 14 June 2017 as result of the refurbishment. Janice Wray conceded that the refurbishment provided a suitable occasion on

1044 {TMO00905400/2}; {TMO00905535/2}.
1045 Brunning {TMO00880533/7} page 7, paragraph 34.
1046 {RBK00053524}; {RBK00053297}.

which to visit the flats and inspect the self-closing devices on the entrance doors,[1047] but in the event, that did not happen.

Other situations in which the TMO inspected entrance doors

41.43 According to Janice Wray there were three other ways in which the TMO monitored entrance doors to ensure that they remained in good condition once the new doors had been installed.[1048] First, Carl Stokes inspected a proportion of doors as part of the fire risk assessment programme. Secondly, flat entrance doors were to an extent monitored by caretakers, known as Estate Services Assistants, during their weekly and monthly inspections of the communal areas. Thirdly, the TMO expected tenants to report any problems with doors to their flats. However, that did not amount to a reliable system of regular inspection. Carl Stokes's inspections during fire risk assessments did not constitute a systematic and regular inspection of all or even a majority of entrance doors. He was required to carry out fire risk assessments at properties deemed to be high-risk only every two or three years and even less frequently at lower-risk properties.[1049]

1047 Wray {Day143/123:3-11}.
1048 Wray {TMO00000890/7} page 7, paragraph 31; Wray {TMO00847305/16-17} pages 16-17, paragraphs 53 and 54.
1049 Wray {Day143/95:2-6}; {CST00030042}.

Moreover, he was expected to look at only a sample of entrance doors as part of his fire risk assessments.[1050] Accordingly, in a building as large as Grenfell Tower, there were likely to be many doors he had not checked even after several cycles of fire risk assessments. Moreover, it is not part of a fire risk assessor's task to inspect the entrance doors to flats as part of the responsible person's system of inspection and maintenance. His job is to assess whether that person has an effective system of inspection and maintenance in place.[1051]

41.44 The inspection of entrance doors to flats was not formally one of the duties of the Estate Services Assistants and was not included in their daily, weekly or monthly inspection checklists.[1052] To

1050 These matters are addressed in detail in Chapter 38. {HOM00045964/43-45} paragraphs 33.2, 34.1 and 35.1; The TMO Consultant's Brief dated July 2009 for fire risk assessments in high-risk blocks, which became the instructions to which Salvus worked, stated at Part 2, section 1.1 that the "FRA and FRA reviews will include an individual examination of each fire door including whether it operates correctly": {TMO00865175/6}; However, at the meeting on 7 September 2009 between Salvus and TMO, Janice Wray agreed that only a random sample of doors needed to be inspected {SAL00000040/1} item 2.1; Wray {TMO00873629/2} page 2, paragraph 9.

1051 Todd {Day168/17:21}-{Day168/18:3}; Lane {Day171/197:14}-{Day171/198:6}.

1052 Daily Estate Staff Inspection Checklist for daily routines appended to TMO Fire Safety Strategy dated November 2013 {TMO00830598/16-19}; Daily Inspections Routine Checklist contained in Estate Staff Quick Reference Handbook {TMO10028449/83-88}; Record of weekly health and safety checks carried out by Estate Service Assistants between 1 January 2016 and 14 June 2017 {CST00000068}; Record of monthly health and safety checks carried out by Estate Service Assistants between 1 January 2016 and 14 June 2017 {CST00000069}.

the extent, therefore, that they did carry out such inspections, they did so irregularly and there was no means for them formally to record any defects that they found. Their inspections were also limited to reporting visible damage on the outside of an entrance door.[1053]

41.45 Paul Steadman, the Estate Services Assistant who carried out the inspections of the communal areas at Grenfell Tower, did not inspect entrance doors to flats otherwise than by making a visual check when passing.[1054] His inspections, therefore, were not systematic nor did they include the internal aspects of the doors, including, critically, the self-closing devices. The TMO's records show that he did not identify the need for a single repair to an entrance door or any other fire door as a result of his inspections of Grenfell Tower between 1 January 2016, when the records for those inspections began, and 14 June 2017.[1055]

1053 Rumble {TMO10050001/2-3} pages 2-3, paragraph 9; Wray {TMO00000890/7} page 7, paragraph 32; Wray {Day143/98:14}-{Day143/106:12}.

1054 Steadman {TMO10049875/3} page 3, paragraph 13; Steadman {Day146/8:20}-{Day146/9:18}.

1055 TMO spreadsheet entitled "ESA002D_Fault Report Repairs" which shows "results for all fault report (repairs) forms completed" by Estate Services Assistants between 1 January 2016 and 14 June 2017 {CST00000067} sheet 2, filter for Paul Steadman in column E and Grenfell Tower in column H.

41.46 Relying on tenants to report problems with their entrance doors did not amount to a system of inspection at all,[1056] but in any case to be effective would depend heavily on the extent to which residents were aware of the importance of their entrance doors, particularly the self-closing device, to fire safety in the building and of the need to report any defects. Residents who had disconnected self-closing devices themselves could not be expected to report the fact. Although the residents received some information about the purpose of fire-resistant entrance doors, they were not specifically told about the purpose and importance of self-closing devices and the need to report defects in them.[1057] The number of self-closing devices found to have been defective or missing on 14 June 2017 (77 out of 120), for which no request for repair had been made, demonstrates the folly of relying on residents to identify and report defects.[1058]

41.47 The TMO's arrangements for the inspection of entrance doors therefore fell far short of the six-monthly inspections recommended by the LGA Guide and the advice received from the LFB in November 2012. By any measure they fell far below acceptable standards.

1056 Wray {Day143/107:1-18}.
1057 Wray {Day143/107:20}-{Day143/110:23}.
1058 {MET00039807/76-80}.

The TMO's reasons for not implementing a programme of regular inspections

41.48 Janice Wray was familiar with the recommendation in the LGA Guide that entrance doors be inspected every six months as part of a programme of planned preventative maintenance.[1059] She put the failure to implement such a programme down to a lack of resources and difficulties in obtaining access to flats.[1060] However, she accepted that the TMO might have been able to fund the programme, but only at the expense of something else.[1061] She was confident that she had discussed resourcing a programme of regular inspections with her line managers, Anthony Parkes and (from June 2015) Barbara Matthews, but could not recall when.[1062] We have seen no evidence of any such discussions until after the Adair Tower fire on 31 October 2015. We consider that her frequent references to budget restrictions as a reason for not taking necessary action across the TMO estate in relation to fire safety were based on an assumption that any request for further funds

1059 Wray {Day143/91:20-23}.
1060 Wray {Day143/92:8-15}; {Day143/143:16-25}.
1061 Wray {Day143/93:24}-{Day143/94:2}.
1062 Wray {Day143/94:5-13}.

would be refused. Neither she nor anyone else appears to have made any serious effort to obtain additional resources.

Adair Tower and the LFB's stance on self-closing devices

41.49 Both before and after the fire at Adair Tower on 31 October 2015 the LFB fire safety team raised concerns with the TMO about its approach and that of Carl Stokes to ensuring that self-closing devices were fitted on entrance doors to flats.

41.50 In early September 2015, the LFB fire safety team identified during an inspection that the entrance door to Flat 41 at Adair Tower, which had not been replaced as part of the replacement programme, did not have a self-closing device.[1063] They also discovered that in his fire risk assessment of Adair Tower dated 20 February 2014 Carl Stokes had advised that self-closing devices were "not applicable" and that, although entrance doors to flats were not fitted with self-closing devices, he had not identified their absence as a concern and had not assessed the consequent risk or recommended remedial action.[1064] On

1063 {LFB00003385/1-2}; {LFB00001613}.

1064 Burton {LFB00084098/5-6} pages 5 and 6, paragraph 10; {LFB00024281/19}; {LFB00084107/1}.

12 October 2015, the LFB issued a deficiency notice to the TMO in respect of Adair Tower based on the absence of self-closing devices.[1065]

41.51 On 14 September and 22 October 2015, Janice Wray sent emails to Julie-Anne Steppings, the LFB fire safety inspecting officer who had conducted the inspection, and Rebecca Burton, the LFB fire safety team leader, respectively. She told them that the TMO's approach to self-closing devices on existing entrance doors reflected advice from Carl Stokes who had himself received clarification of the position from Andy Jack at the meeting on 8 November 2012.[1066] The LGA Guide had introduced the concept of a "nominal" or "notional" fire door to describe an existing door that does not meet current standards for fire-resistance but satisfied the previous standard and therefore did not necessarily need to be replaced.[1067] For the TMO, the concept applied to the doors that had not been replaced under the replacement programme, such as those at Adair Tower.

41.52 Although she did not say so explicitly, Janice Wray suggested that she had understood from Carl Stokes that the LFB accepted that

1065 {LFB00001613/4}.

1066 {LFB00003385/1-2}. The meeting with Andy Jack is incorrectly referred to in that email as having taken place in November 2015. Email from Janice Wray to Rebecca Burton on 22 October 2015 {LFB00003440/1}.

1067 {HOM00045964/98} paragraph 62.17.

self-closing devices were not required on "nominal" doors, despite the fact that the LGA Guide said that all entrance doors to flats and any doors leading onto a protected escape route needed to have a self-closing device.[1068] Janice Wray suggested that the LFB had changed its position in that respect.[1069] On 22 October 2015 Rebecca Burton replied to Janice Wray, telling her that she was unaware of any guidance that allowed fire doors not to be self-closing, especially those leading to the means of escape.[1070]

We do not think that the LFB had changed its position, not least because the LGA Guide is clear on the point.[1071]

LFB advice and enforcement action

41.53 After the fire at Adair Tower, Rebecca Burton sent an email to Andy Jack, Nicholas Coombe and Nicolas Comery on 1 November 2015 asking what had been agreed at the meeting with the TMO on 8 November 2012.[1072] Although none of them could recall the precise details of what had been discussed, each of them effectively denied that they had agreed that entrance doors did not need

1068 {HOM00045964/99} paragraph 62.19.
1069 {LFB00003440/1}.
1070 {LFB00003440/1}.
1071 Burton {Day145/90:4-7}; {HOM00045964/99} paragraph 62.19.
1072 {LFB00003385/1}.

to be self-closing.[1073] Andy Jack said in evidence that he had been shocked by the suggestion. He was also shocked that Carl Stokes, as a former fire safety officer, should have thought that entrance doors did not need to be self-closing.[1074] Nicolas Comery was similarly clear that there had been no such agreement.[1075] We accept their evidence about that.

41.54 On 13 November 2015, Rebecca Burton met Janice Wray to discuss the LFB's concerns about Adair Tower.[1076] They included the suitability and sufficiency of fire risk assessments, especially in relation to self-closing devices, and the claim that the LFB had agreed that entrance doors to flats did not need to be self-closing.[1077] She told Janice Wray that Andy Jack, Nicholas Coombes and Nicolas Comery all denied that they had agreed to that and she told Janice Wray that self-closing devices were required on all entrance doors.[1078] Janice Wray accepted that they had discussed the need for self-closing devices to be checked regularly.[1079]

1073 {LFB00001610}; {LFB00003463/1}.
1074 Jack {Day147/80:7-21}.
1075 Comery {Day145/181:6-10}.
1076 {TMO00869184/3-4}; {TMO00840415}; {LFB00003445}; Burton {Day145/96:13-25}; Burton {LFB00084098/9} page 9, paragraph 16.
1077 {LFB00003445}.
1078 Burton {Day145/97:1-7}; {Day145/97:17}-{Day145/98:2}.
1079 Wray {Day143/139:4-11}.

41.55 On 23 December 2015, the LFB fire safety team served an enforcement notice on the TMO in respect of Adair Tower and sent a copy to RBKC.[1080] It described a number of matters that the LFB fire safety team considered to involve breaches of the Fire Safety Order. They included a failure to carry out a suitable and sufficient fire risk assessment for the purposes of Article 9 because the assessment carried out by Carl Stokes did not give adequate consideration to existing and required standards for self-closing devices. They also included a failure to maintain the fire resistance of the protected route because none of the doors that opened onto it were fitted with positive-action self-closing devices.[1081] The LFB issued another enforcement notice on 18 January 2016 in respect of Hazlewood Tower (Adair Tower's sister block) which included essentially the same alleged breaches in relation to self-closing devices.[1082]

41.56 Rebecca Burton and Janice Wray discussed the LFB's stance on self-closing devices at their regular meeting on 5 January 2016.[1083] The minutes recorded the LFB's view that landlords should ensure that self-closing devices were fitted and that effective procedures were introduced

1080 {LFB00003383}.
1081 {LFB00003383/4-5}.
1082 {RBK00001020}.
1083 {LFB00032330}.

to ensure that the devices remained operational and were not disconnected or removed by residents.[1084] That was, we consider, a clear and unambiguous warning to the TMO.

41.57 Janice Wray's response was that it would be difficult to establish any other sort of maintenance regime due to problems of access and that she would need to speak to her line management to devise a programme.[1085] They discussed ways in which the TMO could maintain self-closing devices, including by using caretakers, Estate Services Assistants and incorporating a check of self-closing devices into the TMO's annual electricity and gas safety checks.[1086] Rebecca Burton in effect said that, rather than pressing for entrance doors to be inspected every six months the LFB thought that it was better that inspections actually be carried out at less frequent intervals than to be scheduled at more frequent intervals that could not be achieved.[1087]

The response of the TMO and RBKC

41.58 After her meeting with Rebecca Burton on 5 January 2016, Janice Wray told Robert Black and Barbara Matthews that Rebecca Burton

1084 {LFB00032330/3} item 7; {LFB00032331/4} page 4, paragraph 10.
1085 Burton {Day145/101:23}-{Day145/102:3}.
1086 Burton {LFB00032331/4} page 4, paragraph 10; Burton {Day145/102:8-24}.
1087 Burton {Day145/103:5-19}.

had stressed that the entrance doors to all flats in the TMO's housing stock needed to be fitted with self-closing devices and that the policy of checking self-closing devices only in vacant properties was insufficient.[1088] She also reported the LFB's view that the TMO should have a procedure in place for carrying out and recording regular checking of the devices as well as her own opinion that that would be virtually impossible to achieve. In response, Barbara Matthews asked Janice Wray whether it was possible to find out what approach other housing providers, including the London Borough of Hammersmith and Fulham, were taking to self-closing devices.[1089]

41.59 Accordingly, later the same day Janice Wray sent an email to a number of housing providers to ask whether they required all entrance doors to flats to be self-closing and, if so, how they achieved it, what procedures they adopted to ensure that self-closing devices were not removed or disconnected, and what approach the relevant fire and rescue service took to them.[1090] All those who replied said that it was their policy to ensure that entrance doors were fitted with self-closing devices. None of them said that they had a formal system of inspection of self-closing devices,

1088 {TMO00840451}.
1089 {TMO00902946/1}.
1090 {TMO00865995/2-3}.

but three of the five who replied had informal approaches to checking self-closing devices, although the methods varied.[1091] None of those who replied had encountered a challenge to their approach by the fire and rescue service, except one that had also received a number of deficiency notices and an enforcement notice.[1092]

41.60 On 8 April 2016, Janice Wray circulated papers for the TMO Health and Safety Committee meeting on 12 April 2016.[1093] They included a paper dated 4 April 2016 entitled "Review of the Fire Safety Strategy",[1094] in which she said that it was time to review the strategy to make sure that the TMO's policies complied with the relevant legislation and the LFB's advice, guidance and requirements.[1095] However, for reasons which are not apparent, she did not invite the committee to consider the matters she had discussed with Rebecca Burton on 5 January 2016, namely, the need to install self-closing devices on all entrance doors and to put in place a system for the regular inspection and maintenance of self-closing devices.

1091 {CST00007708/1-2}; {CST00006634/1}; {TMO00865995/1}; {CST00002902/1}; {CST00002302/1-2}.
1092 {CST00002902/1}.
1093 {TMO10012661}.
1094 {TMO10024351}; {TMO10012811/5} item 6.3.
1095 {TMO10024351}.

James Swindells' email to Janice Wray of 1 August 2016

41.61 On 27 July 2016, James Swindells, an LFB fire safety inspecting officer, reported to Janice Wray, copying in Rebecca Burton, on his inspection of Lonsdale House.[1096] He had found that a number of self-closing devices had been broken or removed by residents. Janice Wray replied on 1 August 2016 saying that the doors had been replaced as part of the entrance door replacement programme in 2012-2013 and had operational self-closing devices at that time. She said that the TMO could not control the action of residents and pointed out that, even if the self-closing devices were repaired or replaced, they could soon be removed or disabled again.[1097]

41.62 In response Mr Swindells emphasised the obligation imposed on the responsible person by Articles 11 and 17 of the Fire Safety Order to monitor and maintain fire safety systems and suggested that residents should be reminded that the device was there to protect both them and their neighbours.[1098]

1096 {CST00009704/2}.
1097 {CST00009704/1-2}.
1098 {CST00009704/1}.

Review of the TMO fire safety strategy: September 2016

41.63 On 9 September 2016, Janice Wray circulated papers for a meeting of the TMO Health and Safety Committee on 13 September 2016.[1099] She again included a paper entitled "Review of the Fire Safety Strategy", in which she invited the committee to comment on various fire safety matters.[1100] On that occasion they included for the first time the need to install and inspect self-closing devices on entrance doors to flats as had been discussed with Rebecca Burton on 5 January 2016. Janice Wray could not explain the delay other than by saying that complying with the enforcement notices for Adair Tower and Hazlewood Tower had been time-consuming work.[1101] Given the obvious importance of the matter, that is scarcely a sufficient explanation.

41.64 Janice Wray invited the committee to consider the requirement for self-closing devices, the LFB's interpretation of the Fire Safety Order and what the TMO could do to advance the installation of self-closers.[1102] She suggested that one option was to create, and give priority to, a programme for installing self-closing devices, which would

1099 {TMO00840649}.
1100 {TMO00840660/1-2}.
1101 Wray {Day143/152:17}-{Day143/153:19}.
1102 {TMO00840660/2}.

need approval and financial support from RBKC. She also asked the committee to consider how the TMO might implement a system of regular inspection and maintenance of self-closing devices, asking a number of questions relating to practical matters, such as the extent to which the TMO's caretakers could assist, when checks might best be carried out and whether the importance of self-closing devices could be emphasised in communications to residents.[1103]

41.65 At its meeting on 13 September 2016 the committee acknowledged the need to have a more active policy on the installation of self-closing devices in order to meet the LFB's requirements. Someone suggested that the work could be included in cyclical redecoration projects but it was decided that further work needed to be done to obtain approval and funding from RBKC.[1104] We have seen no evidence that the ways in which self-closing devices might be inspected were discussed, either at the meeting or subsequently.[1105]

41.66 The possibility of inspecting self-closing devices when carrying out annual gas safety checks had been raised by Andy Jack in November 2012. Janice Wray said that she had instructed

1103 {TMO00840660/2}.
1104 {TMO00840753/5} item 6.1.
1105 {TMO00905766}.

Alex Bosman to discuss that with the TMO's gas safety contractors, but that they had refused to do it.[1106] She was not able to say when that discussion had taken place, only that it had probably occurred before her meeting with Rebecca Burton on 5 January 2016.[1107] However, that is not easy to reconcile with the matter being raised for discussion for the first time in September 2016. We have seen no other evidence that discussions of that kind took place and on balance we do not think that they did.

The involvement of RBKC

41.67 The fitting of self-closing devices was discussed at a meeting of the TMO executive team on 5 October 2016 attended by Robert Black, Sacha Jevans, Barbara Matthews and Yvonne Birch. The meeting was told that the LFB was putting pressure on the TMO to fit self-closing devices to all entrance doors to flats but that that had been resisted by Laura Johnson.[1108] It was also told that the fire strategy was being revised to contain a programme for the work be done over a period of five years, although it was thought likely that the LFB would expect it to be done within a shorter

1106 Wray {Day143/85:20}-{Day143/86:5}; {Day143/120:2}-{Day143/121:16}.
1107 Wray {Day143/120:2}-{Day143/121:16}; {Day143/141:22}-{Day143/142:7}.
1108 {TMO00843861/2} item 3.2.

period. It was agreed that it would be necessary to discuss the matter with RBKC, which would need to provide the necessary funding.[1109]

41.68 Robert Black's view was that RBKC (in particular, Laura Johnson) was in a position to decide whether or not the TMO took the steps required by the LFB because it controlled the budget.[1110] Laura Johnson said that she had suggested that any programme for installing self-closing devices should be spread over five rather than three years for financial and practical reasons.[1111] She said that she had understood that it would probably have to be carried out within a shorter period, but that she had not wanted to set the TMO up to fail.[1112]

41.69 It is clear that Laura Johnson was not persuaded of the need to install self-closing devices over a three-year period. The minutes make that clear. Although she was right to have in mind the need to balance the expense of the proposed programme against the risks involved, her decision failed to give sufficient weight to the advice of the LFB and the nature of the risk that self-closing devices were intended to mitigate.

1109 Jevans {Day127/97:25}-{Day127/98:5}.
1110 Black {Day150/211:17-20}.
1111 Johnson {Day129/200:2}-{Day129/202:7}; Jevans {Day127/96:15}-{Day127/97:5}; Matthews {Day148/108:7-10}.
1112 Johnson {Day129/200:2}-{Day129/202:7}; Jevans {Day127/96:15}-{Day127/97:5}.

The deficiency notice for Grenfell Tower: 17 November 2016

41.70 On 17 November 2016, the LFB issued a deficiency notice to the TMO in respect of Grenfell Tower[1113] on the grounds that the protected escape route (corridors, lobbies and stairs) was compromised by doors that did not have self-closing devices. It also identified the doors to Flats 44 and 153 as having failed to close themselves when inspected.[1114] It recommended that the deficiencies be remedied by 18 May 2017. The deficiency notice thus informed the TMO of its obligations in respect of the installation and maintenance of self-closing devices and the urgency with which they needed to be discharged.

RBKC's decision

41.71 On 28 February 2017, Barbara Matthews sent a report on self-closing devices to members of the RBKC and TMO Joint Management Committee in advance of its meeting on 1 March 2017.[1115] It had been drafted by Janice Wray.[1116] It set out the LFB fire safety team's requirements in relation to the installation and inspection of self-closing devices,

1113 {TMO10017254}.
1114 {TMO10017254/4-5}.
1115 {RBK00000987}.
1116 {RBK00000988}.

which were based on its view of articles 11 and 17 of the Fire Safety Order. The report drew attention to the TMO's concern that even regular inspections and maintenance would not ensure that self-closing devices remained effective. It referred to the email sent by James Swindells on 1 August 2016 voicing that concern, in which he said that the TMO only needed to put in place a reasonable system of inspection to discharge its duty.[1117] The report included an estimate prepared by Graham Webb, the managing director of Repairs Direct, of the cost of carrying out a programme of installation and inspection and the assumptions underlying.[1118] It did not, however, mention the recommendation in the LGA Guide that inspections be carried out every six months. Although it was estimated that 50% of the TMO's properties did not have self-closing devices fitted to the entrance doors and that 40% of those that were present needed to be repaired or replaced, the report did not touch on the effect that self-closing devices have on the safety of residents.[1119]

41.72 At the meeting of the Joint Management Committee concern was expressed at the fact that no other housing provider had a programme for

1117 {TMO00869692}.
1118 {RBK00000988/3}; {TMO00905766}.
1119 {RBK00000988/3}.

the regular inspection of self-closing devices.[1120] There appears to have been no reference to the recommendation in the LGA Guide for six-monthly inspections, the available means of carrying out inspections or the risk to the safety of residents if a programme of installation or regular inspection was delayed or not implemented.

41.73 On 3 March 2017, Barbara Matthews sought to confirm with Laura Johnson and Robert Black what she understood had been agreed at that meeting, namely, that the installation of self-closing devices would be carried out over a period of between three and five years but that regular inspection would not be introduced until legal advice had been obtained about the TMO's right to obtain access if tenants or leaseholders refused it.[1121] Laura Johnson said that she wanted to spread the installation programme over five years because it would make funding more manageable. In respect of the proposed inspection programme, she took an uncompromisingly negative line, saying that it would impose a continuing burden on the Housing Revenue Account without any evidence that it would affect the safety of residents and that she did not think it was necessary.[1122]

1120 {RBK00014072/2} item 5.
1121 {RBK00014053/4}.
1122 {RBK00014053/4}.

41.74 Laura Johnson accepted that her message amounted to, or at least was interpreted by the TMO as, a direction to extend the period over which the installation programme was to be carried out and to not establish an inspection regime.[1123] The TMO did not resist.[1124] In effect, therefore, she alone decided that the installation programme should be extended.[1125] She did so without having taken any advice about the consequences for the safety of residents.[1126] She effectively accepted that financial considerations were the principal, if not sole, basis for her decision.[1127]

41.75 Laura Johnson admitted that she had not taken any steps to understand the risk to safety of not inspecting and maintaining self-closing devices[1128] and she accepted that her decision not to establish an inspection system had been wrong.[1129] She could not recall what her views had been on the LFB's clear advice about the need to inspect and maintain self closing devices, except that she had wanted to understand whether there was a statutory requirement

1123 Johnson {Day129/225:1-5}.
1124 {RBK00014053/3}; {TMO00842281/1} item 3; {TMO00847312/5} item 4.2.
1125 Johnson {Day129/221:20-23}.
1126 Johnson {Day129/221:24}-{Day129/222:2}.
1127 Johnson {Day129/224:4-17}.
1128 Johnson {Day129/225:17-20}.
1129 Johnson {Day129/225:6-16}.

to do so.[1130] She said that she had not been aware of the recommendation in the LGA Guide that landlords should establish a system of inspection and maintenance of self-closing devices.[1131] It is evident from the email she sent to Barbara Matthews on 6 March 2017 that money again was the driving force behind her refusal to introduce a system of inspection and maintenance.[1132]

Revision of the fire safety strategy: June 2017

41.76 Janice Wray revised the TMO's fire safety strategy in June 2017.[1133] In paragraph 18.1.1 there was a reference to the agreement with RBKC to carry out a programme of fitting self-closing devices to the entrance doors of all flats over a period of five years.[1134] In the same paragraph it said that the TMO had a variety of methods of ensuring that self-closing devices remained in place and operational. They included inspections when properties were vacant and sample inspections during fire risk assessments.[1135] In short, little, if anything, in the TMO's approach had changed.

1130 Johnson {Day129/225:6-16}.
1131 Johnson {Day129/226:24}-{Day129/227:3}.
1132 {RBK00014053/4}.
1133 {TMO10017036}.
1134 {TMO10017036/12} section 18.1.1.
1135 {TMO10017036/12} section 18.1.1.

Oversight by RBKC Housing Property and Scrutiny Committee

41.77 The evidence indicates that neither RBKC nor the TMO fully informed the Housing Property and Scrutiny Committee ("the scrutiny committee") about the position in respect of the installation and inspection of self-closing devices after the Adair Tower fire and before the Grenfell Tower fire. The evidence also indicates that, to the extent that the scrutiny committee was made aware of the LFB's concerns about self-closing devices, it did not take adequate steps to investigate why those concerns had arisen or to ensure that RBKC and the TMO had adequately addressed them.

41.78 In her report for the scrutiny committee meeting on 6 January 2016, Laura Johnson warned that the LFB intended to serve enforcement notices in respect of Adair Tower and Hazlewood Tower, in part because of the lack of self-closing devices on entrance doors to flats.[1136] Robert Black reported orally to the meeting that the LFB's requirement to install self-closing devices applied not only to Adair and Hazlewood Towers, but to all the council's properties.[1137] However, he did not mention that the LFB also required a system of

1136 {RBK00032439/5-6} paragraphs 4.6-4.7.
1137 {RBK00014534/11}.

regular inspection to be put in place. We have seen no evidence that the scrutiny committee took steps at that point to find out how the problems with self-closing devices had arisen, particularly in the light of the replacement of entrance doors only a few years earlier and the continuing programme of fire risk assessments. We find that lack of curiosity surprising.

41.79 In her report for the meeting of the scrutiny committee on 13 July 2016 Laura Johnson provided further information about the enforcement notices relating to Adair and Hazlewood Towers.[1138] She said that the TMO and RBKC had agreed to ensure that all entrance doors to flats in both blocks were adequately fire-rated and fitted with self-closing devices.[1139] At the meeting, Councillor Nicholls asked whether RBKC complied at other locations. Ms Johnson told him that self-closing devices were fitted at all properties,[1140] although at that time the TMO was still discussing internally how to remedy the lack of self-closing devices across its properties. There is no record of Robert Black, who was in attendance, correcting her. The scrutiny

1138 {RBK00032476/1-2} paragraphs 1.3 and 1.4.
1139 {RBK00032476/1-2} paragraphs 1.3 and 1.4.
1140 {RBK00032473/5} paragraph A9.

committee did not take any further action to satisfy itself that RBKC and TMO had fully addressed the LFB's concerns in that respect.

41.80 In her report for the scrutiny committee meeting on 16 November 2016, Laura Johnson said that the works required by the Adair Tower and Hazlewood Tower enforcement notices had been completed.[1141] However, she did not refer to the need to install and inspect regularly self-closing devices across the whole of the housing stock, although by that point she had begun discussing that with the TMO.[1142] Nor were they mentioned in the TMO's Mid Year Review of Performance which had been prepared for that meeting.[1143] Laura Johnson and Barbara Matthews attended the meeting. There is no record of any fire safety matters having been raised by either of them.[1144]

41.81 As we have already said,[1145] we have also seen no evidence that the scrutiny committee were ever informed about the deficiency notice the LFB issued in respect of Grenfell Tower dated 17 November 2016 and the concerns it identified in relation to the maintenance of self-closing devices before the Grenfell Tower fire.

1141 {RBK00032461/1} paragraphs 1.1-1.3.
1142 {TMO00843861/2} item 3.2.
1143 {RBK00000731}; {RBK00032475/8} paragraph A16.
1144 Minutes of the meeting of the scrutiny committee meeting on 16 November 2016 {RBK00032475}.
1145 See Chapter 31.

41.82 At the scrutiny committee meeting on 4 May 2017, following the fire at Trellick Tower on 19 April 2017, Councillor Mackover and Councillor Pascall expressed concern about the TMO's approach to the installation of fire doors on properties owned by leaseholders.[1146] The scrutiny committee had not been briefed about the decision only a month or so earlier to spread the installation of self-closing devices over a period of five rather than three years and not to introduce a system of regular inspection and Laura Johnson did not draw it to their attention.

41.83 The minutes of a TMO executive team meeting on 17 May 2017 recorded that at the meeting of the scrutiny committee on 4 May 2017 Councillor Mackover had criticised the TMO's approach to fire doors but that Laura Johnson had made it clear that RBKC did not want the TMO to inspect the front doors of flats.[1147]

41.84 Laura Johnson sent an email to Robert Black the following day in response to a question he had asked about the nature of Councillor Mackover's concern and whether he should contact him.[1148] She said that it related to the entrance doors of

1146 Mackover {RBK00029923/18} page 18, paragraph 67; {RBK00052464/7} paragraph A8; {RBK00002340/1-2}.
1147 Minutes of the TMO executive team meeting on 17 May 2017 {TMO00894337/1-2} item 2.6.
1148 Emails between Laura Johnson and Robert Black on 17-18 May 2017 {RBK00002340/1-2}.

leaseholders' flats and that there was nothing in it. She recommended not contacting him. She thought that a section in the annual report would be sufficient. Robert Black agreed.[1149]

41.85 It is evident, therefore, that the scrutiny committee was not told about the decisions that had been made, principally by Laura Johnson, about the installation and inspection of self-closing devices before the Grenfell Tower fire.

The TMO's approach to the repair of entrance doors

41.86 Section 5.1 of the TMO's fire safety strategy dated November 2013 said that repairs to fire doors and self-closing devices were given priority.[1150] Beyond that, the TMO had no policy or procedure for responding to requests for repairs to fire doors, including entrance doors to flats. For example, they were not included in the TMO's Fire Protections Systems Policy & Procedure drafted in 2017, which set out the procedure for repairing faults in a number of fire protection systems, including sprinklers, fire alarms, fire extinguishers, hose reels and automatic opening vents.[1151]

1149 Email from Robert Black to Laura Johnson on 18 May 2017 {RBK00002340/1}.
1150 TMO fire safety strategy dated November 2013 {TMO00830598/3}.
1151 TMO Fire Protections Systems Policy & Procedure Version 8 dated 10 January 2017 {TMO00899324/2}.

41.87 Despite the terms of section 5.1, the TMO's repair records for Grenfell Tower reveal no discernible system for giving repairs to fire doors priority over other matters.[1152] Where a need to repair a fire door was identified by Carl Stokes in the course of a fire risk assessment, it was marked as "FRA", or something similar, but we saw nothing to suggest that it was given priority.[1153] The repair records suggest that defects of that kind were dealt with in the same way as any other kind of repair. That is consistent with a finding of a "Health Check" audit carried out on Repairs Direct after the Grenfell Tower fire that there was no structured approach to categorising repairs, which made them difficult to manage effectively.[1154]

41.88 Those sent to carry out repairs to self-closing devices at Grenfell Tower between 2011-2013 often simply removed them, so that doors could be opened and closed freely, but did not replace them. In the period up to 14 June 2017 Repairs Direct staff continued on occasions to remove, or offer to remove, self-closing devices or failed to identify the need to replace them

1152 {RBK00053524}; {RBK00053297}.
1153 {RBK00053524}; {RBK00053297}.
1154 {TMO00862541/11}.

when carrying out repairs to entrance doors. That occurred at Flat 26,[1155] Flat 45,[1156] Flat 126,[1157] Flat 131[1158] and Flat 135.[1159]

41.89 At each of those flats the self-closing device was found to be missing on 14 June 2017, apart from Flat 26 where the resident had refused the Repair Direct workman's offer to remove it.[1160] In our view that is indicative of a broader failure by the TMO to ensure that those carrying out repairs fully understood the importance of effective self-closing devices and ensured that repairs did not undermine the protection offered by the doors.

Fire risk assessment and flat entrance doors

41.90 Paragraph 33.2 of the LGA Guide drew attention to the importance of ensuring that the fire resistance between flats and the common

---

1155 Dagnachew {IWS00001742/4} page 4, paragraph 4b; {RBK00053297} row 467.

1156 Email from Glen Duggan to Janice Jones on 22 July 2015 {CST00000989/2}; Carl Stokes's letter to Janice Wray on 28 July 2015 {CST00001448}; Capita repair spreadsheet {RBK00053524} rows 686 and 1227; West {IWS00000021/3} page 3, paragraph 14; Paramasivan {IWS00001003/3} page 3, paragraph 9.

1157 Repair records {RBK00053524} rows 30 and 163.

1158 Gashaw {IWS00001738/2-3} pages 2-3, paragraph 4b; Fletcher {IWS00001797/3} page 3, paragraph 5b; Repair record {RBK00053524} row 847.

1159 Daniels {IWS00000608/6} page 6, paragraph 40; Daniels {IWS00002065/3} page 3, paragraphs 13-15; Open Contractor spreadsheet {RBK00053297} row 82; Repair records {RBK00053297} row 82.

1160 {MET00039807/76-80}.

parts was considered as part of a fire risk assessment by examining at least a sample of the entrance doors to flats to ensure that they were fire-resisting and self-closing.[1161] In a similar vein, Annex D to PAS 79:2012 stated that a fire risk assessor must consider whether all fire-resisting doors are properly self-closing.[1162]

The approach to flat entrance doors to be expected of a fire risk assessor

41.91 We have no doubt that a fire risk assessor considering any building containing a large number of flats should inspect a representative sample of entrance doors.[1163] Although they expressed themselves in slightly different terms the experts agreed that the number of doors that should be expected will be a matter of judgment in each case and depend on the nature and size of the building and the assessor's familiarity with it.[1164] There appears to have been a general understanding at the time among fire risk assessors that 10% of the total number with a minimum of two doors was sufficient.[1165]

1161 The LGA Guide {HOM00045964/43} paragraph 33.2.
1162 PAS 79:2012 {CTA00000003/104}.
1163 Lane {Day171/177:22}-{Day171/178:11}; Todd {Day168/6:5-11}.
1164 Lane {Day171/178:20}-{Day171/179:11}; {Day171/186:19}-{Day171/187:20}.
1165 Todd {Day168/6:12-20}.

41.92 The experts also agreed that a fire risk assessor should inspect both sides of the door, check whether the self-closing device was working effectively,[1166] keep a record of the doors inspected,[1167] record any defects in the fire risk assessment[1168] and assess the adequacy of the arrangements for the inspection and maintenance of entrance doors.[1169]

41.93 Salvus and the TMO had agreed in late 2009 at the start of programme of assessing high-risk buildings that its fire risk assessors would inspect a sample of the entrance doors to flats during each of their assessments, although they did not agree a specific number or percentage of doors to be inspected.[1170] When Carl Stokes was engaged by the TMO to assess medium-risk buildings in September 2010, it does not appear that he and Janice Wray discussed the need to inspect a sample of doors but they both clearly

1166 Lane {Day171/178:6-11}; {Day171/184:3-9}; Todd {Day168/6:7-11}.
1167 Lane {Day171/180:7}-{Day171/182:16}; Todd {Day168/9:9-23}; Todd {Day168/14:20}-{Day168/15:20}.
1168 Lane {Day171/175:19}-{Day171/176:23}; {Day171/188:13}-{Day171/189:11}; Todd {Day168/20:10}-{Day168/24:1}.
1169 Lane {Day171/197:3-12}; Todd {Day168/17:8-19}.
1170 The TMO Consultant's Brief dated July 2009 for fire risk assessments in high-risk blocks, which was the brief for Salvus, states at Part 2 section 1.1 that the "FRA and FRA reviews will include an individual examination of each fire door including whether it operates correctly": {TMO00865175/6}; However, at a meeting on 7 September 2009 between Salvus and TMO, Janice Wray agreed that only a random sample of doors needed to be inspected {SAL00000040/1} item 2.1; Wray {TMO00873629/2} page 2, paragraph 9.

proceeded on understanding that he would.[1171] That expectation was ultimately recorded in the TMO's fire safety strategy dated June 2017.[1172]

Carl Stokes's inspection of entrance doors at Grenfell Tower

41.94 In section 12 of his fire risk assessment template referring to the means of escape Carl Stokes included the questions whether fire doors were fitted with self-closing devices and whether they functioned correctly.[1173] It was his own addition to the model template contained in PAS 79:2012.[1174]

41.95 Carl Stokes said that he did not make appointments to inspect doors but knocked on doors and asked residents whether he could inspect them and, in particular, whether self-closers were fitted.[1175] He said that tried to inspect at least a handful, or about 5%, of entrance doors[1176] and that if the doors in a building were of the same kind, he aimed to inspect a sample. If they differed, he aimed to

1171 Janice Wray said Carl Stokes continued to inspect flat entrance doors as part of his fire risk assessments, Wray {TMO00000890/7} page 7, paragraph 31; Stokes {Day138/84:5-7}; Stokes {Day138/149:11-15}; {CST00002861}.
1172 {TMO10017036/12} section 18.1.
1173 For example, Carl Stokes's fire risk assessment of Grenfell Tower dated 26 April 2016 {CST00003084/18}.
1174 PAS 79:2012, Annex B model proforma fire risk assessment template {LFB00034866/77}.
1175 Stokes {CST00003063/20} page 20, paragraphs 58 and 59.
1176 Stokes {Day136/96:3-12}.

inspect at least one of each kind.[1177] However, even when the doors in a building were all of the same kind, inspecting only 5% of them was barely enough.[1178]

41.96 Notwithstanding what he said about his approach to sample inspections, the evidence suggests that at Grenfell Tower Carl Stokes did not carry out sample inspections of entrance doors which extended to both the external and internal faces of the doors, including self-closing devices. The evidence tends to support the conclusion that he looked only at the outside of doors and that he noted only such damage as he happened to see rather than visiting a number of flats as part of an organised plan. In the course of four fire risk assessments he carried out at Grenfell Tower between November 2012 and June 2016 Carl Stokes identified defects in only four entrance doors.[1179] Only one of them was a defect that affected the inside face of the door: a self-closing device missing from the door to Flat 112. As it happened, the door to Flat 112 was being

1177 Stokes {Day136/95:21}-{Day136/96:2}.

1178 Lane {Day171/179:14}-{Day171/180:6}; Todd {Day168/8:24}-{Day168/9:8}.

1179 Carl Stokes identified holes in the flat entrance doors of flats 166 and 202 in his Record of Significant Findings and Action Plan for Grenfell Tower dated 20 November 2012 {CST00003083/3} item 12b. Carl Stokes identified that the flat entrance door of Flat 24 was damaged and that the door to Flat 112 was being replaced, was not marked as fire rated and did not have a self-closing device, Record of Significant Findings and Action Plan dated 20 June 2016 {CST00003069/4-5} items 12g and 12h.

replaced in June 2016 and had been open at the time he was carrying out his fire risk assessment. His ability to inspect the inside of the door had therefore been fortuitous rather than planned.[1180]

41.97 Carl Stokes's failure to identify defects on the inside of doors, particularly defective and missing self-closing devices, is in stark contrast with what others who carried out sample inspections of entrance doors at Grenfell Tower found. Leon Taylor, who carried out a sample inspection of entrance doors in the course of a fire risk assessment on 14 June 2014 found at least three self-closing devices missing,[1181] whereas Carl Stokes, who carried out a fire risk assessment on 17 October 2014, did not find any self-closing devices missing. Michelle McHugh, of the LFB fire safety team, carried out an inspection of a sample of entrance doors during her audit of Grenfell Tower on 26 October 2016 and found that three self-closing devices were defective,[1182] but Carl Stokes did not find any devices missing during his fire risk assessments in April and June 2016 or during an inspection he carried out on 18 October 2016, only a week or so before Ms McHugh.[1183]

1180 Stokes {Day138/130:17}-{Day138/131:1}.

1181 {TMO10001286} 'FRA' sheet, ref L6, row 232; Taylor {PSC00000002/2} page 2, paragraph 2.d.

1182 {LFB00105489/6} penultimate paragraph under 'Observations'.

1183 {CST00003098}; {CST00003069}; {CST00003137}.

41.98 Given the number of self-closing devices that were found to be missing or broken after the fire (some 77 out of 120), and in the light of Leon Taylor and Michelle McHugh's findings, we think it likely that, if Carl Stokes had inspected both the inside and outside of a representative sample of entrance doors during his fire risk assessments, he would have discovered a significant number of missing or defective self-closing devices.[1184] Accordingly, we think it unlikely that he did routinely inspect the inside of doors.

41.99 Carl Stokes kept no record of which flats he had visited or tried to visit as part of his fire risk assessments or of the results of any such inspections, except in relation to the four defects he identified in his action plans.[1185]

41.100 In each of his fire risk assessments Carl Stokes stated that the entrance doors to the flats had recently been replaced with new self-closing 30-minute fire doors but he did not say that he had inspected a sample of entrance doors.[1186] Further, in his contemporaneous notes of the fire risk assessment he carried out on 20 June 2016, he recorded only the defects that he had identified on the outside of the door to Flat 24 and on the

1184 {MET00039807/76-80}.
1185 For example, {CST00003084/19}.
1186 {CST00003157/19}; {CST00003161/21}; {CST00003145/20}.

open door to Flat 112.[1187] He did not include a note of any other flats he had sought to enter, nor what he had found. That has left us in some doubt whether he did, in fact, inspect a representative sample of entrance doors during any of his fire risk assessments.

41.101 Gaining access to flats clearly posed a problem for Carl Stokes from time to time. In his fire risk assessment of Grenfell Tower dated 30 September 2009 (when he was working for Salvus), he recorded that the entrance to each flat appeared to be a rated fire door to FR30 standard but that without being able to obtain access to all the flats he could not confirm that every door was fitted with an intumescent strip, cold smoke seals and a self-closing device.[1188] He confirmed when he gave evidence that he had not always been able to gain access to flats because, for example, the residents were out at work.[1189] However, he did not tell the TMO that he was having difficulty in inspecting the inside of entrance doors to flats because people were not at home to let him

1187 {CST00000003/10}.
1188 Carl Stokes's fire risk assessment of Grenfell Tower dated 30 September 2009 {CST00003128/9} item 3.4.
1189 Stokes {CST00003063/20} page 20, paragraphs 58 and 59; Stokes {Day138/149:11-15}.

in,[1190] and except for the fire risk assessments he produced in 2009, he did not record that as a problem. If he could not gain access to enough flats to inspect a representative sample of doors, he ought to have told Janice Wray so that she could arrange access for him.[1191]

41.102 Carl Stokes also failed to record in his fire risk assessments for Grenfell Tower problems that he knew existed in relation to self-closing devices. For example, in the assessment he carried out in November 2012, he did not mention the recurring problem of people disconnecting self-closing devices that he had identified in July 2011.[1192] Similarly, in the assessment he carried out in April 2016, he did not mention the missing self-closing device at Flat 45 that he had identified in July 2015, nor the fact that Seamus Dunlea had been removing self-closing devices on entrance doors, something he had discovered in December 2015.[1193] There is nothing to suggest that he had been told that those problems had been satisfactorily resolved and he ought, therefore, to have taken steps as part of his next fire risk

1190 Carl Stokes said that he considered the sample inspections he carried out to be sufficient and that he did not tell the TMO that he had been unable to obtain access to a sufficient number of doors because he was happy with the process that he had adopted. Stokes {Day138/150:11}-{Day138/151:11}.

1191 Lane {Day171/181:19-24}.

1192 {TMO00867783}; {CST00003084/19}.

1193 {CST00001448}; {TMO00859693}; {CST00003161}.

assessment to find out. If they had not, or if he did not get a satisfactory response, he should have taken that into account in assessing the risk.

41.103 We have seen no evidence that Carl Stokes ever considered the TMO's arrangements for the inspection and maintenance of entrance doors to flats, whether as part of his fire risk assessments or otherwise, much less that he advised it that they were inadequate. When he was asked to comment on the draft strategy in early 2013, he did not tell Janice Wray that it needed to include arrangements for the inspection and maintenance of entrance doors, although the LGA Guide recommended inspections every six months and Andy Jack had referred to the need for regular inspection in the course of their conversation on 8 November 2012.[1194]

41.104 We have seen no evidence that Carl Stokes ever drew Janice Wray's attention to the recommendation in the LGA Guide, although she said she had been aware of it.[1195] Nor did he mention it in his letter of 30 April 2011 when he drew her attention to other provisions of the draft LGA Guide which could adversely affect the replacement of doors, including the risk of

1194 {CST00002046}.
1195 Wray {Day143/71:20}-{Day143/72:14}; {Day143/91:20-23}.

residents' removing self-closing devices.[1196] He also failed to draw it to her attention after the Adair Tower fire when there were discussions about the approach the TMO should take to self-closing devices, of which he appears to have been aware.[1197]

41.105 In the fire risk assessment of Grenfell Tower he produced in April 2016, Carl Stokes referred to the TMO's policy of inspecting self-closing devices in vacant properties[1198] but he did not comment on its adequacy. It is not clear what prompted him to refer to the policy for the first time in April 2016.

1196 Note the letter from Carl Stokes to Janice Wray is wrongly dated as 30 April 2010 {TMO00847318/1}.
1197 For example, {CST00007708/1-2}; {CST00006634/1}; {CST00002902/1}; {CST00002302/1-2}.
1198 {CST00003161/21}.

Chapter 42
Fire safety information

42.1 Under the Fire Safety Order the TMO had a duty to take such general fire precautions as would ensure, so far as was reasonably practicable, that Grenfell Tower was safe for those who lived there, their visitors and its own employees.[1199] General fire precautions include measures in relation to the means of escape and the arrangements for action to be taken if a fire occurs.[1200] It also had a duty to establish procedures to be followed in the event of serious and imminent danger to persons present in the parts of the tower to which the Fire Safety Order related.[1201] As part of our investigation into the fire that occurred on 14 June 2017, therefore, we have considered it appropriate to examine the steps taken by the TMO to comply with those duties. In earlier chapters we have examined the steps taken by the TMO to carry out fire risk assessments as required by the Fire Safety Order and we have described the problems that affected the smoke

1199 Article 8.
1200 Article 4(1).
1201 Article 15(1).

ventilation system. In this chapter we consider the information given to residents relating to fire safety.

42.2 Before the refurbishment Grenfell Tower had been constructed entirely of concrete, apart from some internal structures and the usual internal fittings. The structure was therefore not combustible. The front door of each flat was a fire door and had originally been fitted with a self-closing device. Although a fire could spread from one flat to another up the outside of the building or through the lift lobby, that was likely to happen relatively slowly, giving time for the occupants to escape and the fire brigade to gain control before many people were affected. That was the design principle behind the "stay put" strategy for responding to fires in individual flats which had proved effective in the past.

42.3 The existence of a "stay put" strategy was reflected in the advice the TMO gave residents about how to respond to a fire in the building. It also affected the way in which it approached the question of evacuation.

42.4 The TMO provided fire safety advice to residents in letters to new tenants, in magazines distributed to residents (Link magazine and Homeowner newsletter), through fire action notices and in roadshows held by the TMO

Resident Engagement team.[1202] Written materials were produced in the seven major languages identified as being most likely to meet the needs of the residents.

42.5 Before moving into a property, new residents were given a handbook that included some fire safety advice, including instructions not to store items in communal areas or obstruct the means of escape. The TMO did not display fire safety action notices in residential buildings because it considered that it had provided the relevant information in other ways.[1203]

The resident's handbook

42.6 Historically, the resident's handbook had contained some fire safety advice,[1204] such as how to prevent a fire and how to make sure that a smoke detector was installed, but no advice on how to respond to a fire.[1205] The original stock of handbooks ran out in 2008 or 2009. There were no plans to publish any more at that time, but later on a decision was made to produce a new

1202 Wray {TMO00000890/53-55} pages 53-54, paragraphs 245-250.
1203 Letter from Carl Stokes to Janice Wray dated 27 September 2010 {CST00001979}; Stokes {Day136/217: 2}-{Day136/219:8}; Stokes {Day136/220:15-22}.
1204 Tenant's Handbook {IWS00001762} and Rasoul {IWS00001768/3} page 3, paragraph 13.
1205 Tenant's Handbook {IWS00001762} and Rasoul {IWS00001768/3} page 3, paragraph 13.

version.[1206] By January 2010 a first draft was said to be ready for consideration,[1207] but in the event it had not been published by the time the coroner made her recommendations following the Lakanal House inquests in March 2013, four years later. They included a recommendation that information and guidance should be provided to residents about fire procedures.

42.7 In June 2013, Janice Wray told the Health and Safety Committee that residents received fire safety information on the TMO's website, in the resident's handbook, through articles in Link and in letters and LFB leaflets to new tenants. She asked the committee to consider what other opportunities there were to promote fire safety and fire procedures to residents. No one appears to have pointed out that the new resident's handbook had not been finished and so could not be distributed to residents. It is not clear why Janice Wray told the committee that information was given in the handbook. Although she may not have had direct knowledge of the matter, she told us that she had thought that by March 2013 it had been finalised.[1208] However, that seems unlikely.

1206 Jones {TMO00900052/3} page 3, paragraph 9; "Tenant's Handbook" was used interchangeably with "Resident's Handbook". The TMO also produced a "Homeowner's Handbook" which was intended for leaseholders and contained information which was different from that provided to tenants.

1207 {TMO10000641/2}.

1208 Wray {Day142/185:17-23}.

42.8 When the TMO's Fire Safety Strategy was completed in November 2013, it referred to the resident's handbook as one means by which information about fire safety was communicated to residents.[1209] Although the strategy was submitted to the Health and Safety Committee for its views in November 2013, no one mentioned that the resident's handbook had still not been finished.[1210] In 2017, when the Health and Safety Committee's views were sought on the revised fire safety strategy, yet again no one raised the fact that the handbook had not been produced,[1211] even though it was one of the ways of communicating with residents referred to in the fire safety strategy.[1212]

42.9 The delay in the production of the resident's handbook illustrates many aspects of the TMO's attitude to its fire safety obligations. Having rightly identified the need for a revised handbook in 2010, nothing had been produced by June 2017. Although the handbook had been repeatedly relied upon as a way of communicating information to residents about how to respond to a fire, no one at the TMO had noticed that

1209 Fire safety policy dated November 2013 {TMO00830598}.

1210 The meeting was attended by, among others, Sacha Jevans, Janice Wray, Peter Maddison, and Alex Bosman. Minutes of TMO Operational Health & Safety Meeting dated 15 November 2013 {TMO10004726/6}.

1211 The meeting was attended, among others, by Barbara Matthews, Janice Wray, Peter Maddison and Teresa Brown. Minutes of Health and Safety Committee Meeting dated 13 June 2017 {TMO10021549/4}.

1212 Fire safety strategy dated June 2017 {TMO00847324/3}.

supplies of the old handbook had been exhausted in 2008 or 2009 and that the new edition had never been produced. The effectiveness of the TMO's Emergency Plan depended to a great extent on residents being aware of what to do in an emergency, but the TMO's failure over such a long period of time to make it available denied residents one useful means of receiving that information. No reasonable explanation was offered for that failure.

Letters to new residents

42.10 We have seen three draft letters to new residents containing fire safety advice. The first appears to date from December 2010.[1213] It advised new residents, among other things, that:

a. there was a "stay put" strategy in place;

b. they should not prop open fire doors;

c. they must not disconnect the self-closing device on the entrance door to the flat;

d. they should fit a smoke alarm, if one was not already installed;

e. they should not use a lift in the event of a fire;

f. they should refer to the resident's handbook for additional fire safety information; and

[1213] {TMO00870665}.

g. they would be provided with a personal emergency evacuation plan (PEEP) if they had difficulty hearing or responding to a smoke alarm or had special requirements.

The letter we were shown was a draft and we do not know whether it was sent to any new residents.

42.11 The letter was substantially revised in May 2013.[1214] In its new form it advised residents:

a. to ensure that an operational smoke alarm was installed in their flats;

b. that if there was a fire elsewhere in the building, residents were safe to stay in their flats unless they were affected by heat, flames, smoke or the LFB or the TMO instructed them to leave; and

c. that the front door should be self-closing and should not be propped open. Residents were encouraged to report defective doors to the TMO.

Again, it is not clear whether that letter was ever used.

42.12 Some minor changes were made to the letter in September 2016, but the contents remained essentially the same.[1215] We do not know why the

[1214] {TMO00865707}.
[1215] {TMO00865991}.

reference to PEEPs was removed from the 2013 and 2016 drafts.[1216] Janice Wray thought that the housing officers who met residents took them through the induction pack and, if there were any concerns about vulnerability, came back to her so that appropriate action could be taken.[1217]

42.13 The letter was provided to residents as part of an induction pack by Moira MacDonald, the TMO officer who arranged viewings for prospective tenants.[1218] They could ask for a translation, but there is no evidence that they were routinely told that a translation could be provided. There was no system to record whether residents received the letter during the induction process.[1219]

42.14 Daniel Lewis, a TMO Neighbourhood Co-ordinator, said that fire safety advice for new residents had not been included in the documents that formed part of the "Welcome Pack" that he had compiled and that the Neighbourhood Officer provided to new residents.[1220] Janice Jones agreed that the fire safety letter had not been included in the pack,

1216 Wray {Day142/187:13-25}.
1217 Wray {Day142/187:17-25}.
1218 Wray {Day142/187:4-11}.
1219 Wray {Day142/187:1}.
1220 Lewis {TMO00899762/3} page 3, paragraph 10.

but said that Moira MacDonald took her own paperwork to viewings, including a fire safety letter signed by Janice Wray.[1221]

42.15 We have been left with the impression that it was largely a matter of chance whether new tenants, at whom the fire safety letter in its various versions was directed, saw it at their viewings. The point of the letter was to bring home to tenants in clear terms the fire safety arrangements in their buildings. That was important, but the TMO simply failed to ensure that the message always reached its intended recipients.

'Link' magazine

42.16 Link was a quarterly publication for TMO tenants. Originally it was produced only in English, but from 2012 it contained information about how it could be translated into other languages.[1222] TMO leaseholders received the Homeowner newsletter instead of Link.

42.17 Some issues of Link and Homeowner contained fire safety advice. In the Winter 2009 issue of Link the TMO announced that a fire safety consultant would carry out fire risk assessments in the

[1221] Jones {TMO00900052/6} page 6, paragraph 24.

[1222] See, for example, Link Magazine dated Winter 2012 {TMO00873414}; Link magazines from 2009 did not include information about how to translate the newsletter; see, for example, Link Magazine dated Winter 2009 {TMO10048206}.

communal areas and would require access to the front doors of some flats. Residents were reminded not to smoke in communal areas and to keep those areas free of items.[1223]

42.18 Fire safety advice was also included in the June 2013, Summer 2014 and Autumn/Winter 2015 issues.[1224] Only the latter, published after the Adair Tower fire, gave advice about evacuation and what to do if there was a fire.[1225]

42.19 Some editions of Homeowner also contained information about fire safety, including advice about compliance with the requirements relating to flat entrance doors and smoke alarms.[1226] However, only the Summer 2016 issue contained advice about what to do in the event of a fire.[1227] It is clear that, as Janice Wray accepted, there had been no regular programme for the distribution of fire safety advice; it was included as and when it seemed appropriate.[1228] Contrary to the statements made in the fire safety strategies of November 2013 and June 2017, Link and

1223 Link Magazine Winter 2009 {TMO10048206/5}.
1224 Link Magazine Autumn/Winter 2015 {TMO00873549}; Link Magazine Summer 2014 {TMO10031098}; Link Magazine June 2013 {TMO00873438}; Link Magazine Winter 2009 {TMO10048206}.
1225 Link Magazine Autumn/Winter 2015 {TMO00873549/25}.
1226 Homeowner Newsletter December 2013 {TMO00873466}; Homeowner Newsletter June 2015 {TMO00873520}; Homeowner Newsletter Winter 2015 {TMO00873536}.
1227 Homeowner Newsletter Summer 2016 {TMO00873556/4}.
1228 Wray {Day142/189:2-23}.

Homeowner did not regularly contain fire safety information or information about the evacuation strategy in properties managed by the TMO.[1229] In any event, they were distributed to tenants in a wide range of buildings, so it was not possible to include in them advice which related to specific buildings.

Fire safety advice leaflets

42.20 Carl Stokes delivered leaflets on fire safety produced by the LFB to residents of smaller TMO premises.[1230] He did not do that in the larger blocks, as he thought the caretakers would leave them with the concierge instead. Carl Stokes did not deliver any leaflets to the residents of Grenfell Tower because there was a caretaker or handyman who did that.[1231]

Roadshows

42.21 The TMO organised regular "Roadshows" which were used informally to consult or communicate with residents. On one occasion, on 14 May 2016, Janice Wray invited the LFB to attend a roadshow in Lancaster West Green to speak to residents

1229 Fire safety strategy dated September 2013 {TMO00830598/3}; fire safety strategy dated June 2017 {TMO00847324/3}.
1230 Stokes {Day139/ 99:2}-{Day139/100: 20}; Carl Stokes confirmed he distributed the leaflet {CST00017272}.
1231 Stokes {Day139/ 101:9-14}.

about fire safety.[1232] However, that was no substitute for consistent, clear and regular communication of fire safety advice to residents.

Website

42.22 The TMO maintained a website, which included a page containing fire safety advice. A page headed "Fire and smoke alarms" provided advice on fire safety measures. It first appeared on the website on 13 February 2012.[1233] The website set out detailed advice on fire safety, including advice on the evacuation strategy for residential blocks with purpose-built self-contained dwellings.[1234]

42.23 Apart from a minor change to its contents, the "Fire and smoke alarms" page remained available on the TMO's website until 14 June 2017.[1235] Again, it was not a comprehensive statement of the fire safety advice to all residents and its efficacy depended on residents' accessing, and being able to access, the website to find information for themselves. Engagement, therefore, depended on the curiosity or sensitivity to risk of the individual tenant. The disadvantages of the website as a means of communicating fire safety information are obvious.

1232 Wray {TMO00000890/54} page 54, paragraph 250; Email from Janice Wray to LFB dated 13 April 2016 {LFB00001085}.
1233 {TMO00899658/18}.
1234 {TMO00899658}.
1235 {TMO00899658/17}.

Fire Safety Advice during the refurbishment

42.24 From September 2013 to May 2016, the TMO and Rydon distributed newsletters almost monthly to the residents of Grenfell Tower. Two newsletters published in July 2014[1236] and May 2016 respectively[1237] contained fire safety advice.

42.25 The July 2014 newsletter was prompted by complaints made by Edward Daffarn to the LFB that Rydon was occupying a designated evacuation meeting point for Grenfell Tower.[1238] Janice Wray proposed that the TMO write to residents to reiterate that the "stay put" strategy was still in place. The same day she also responded to Ben Dewis of the LFB saying that the "stay put" strategy was still in place and that the July newsletter included confirmation of that.[1239] In relation to communication of fire safety information, that was as far as it went. The May 2016 newsletter included fire safety advice after the LFB had asked how the "stay put" policy was advertised to residents.[1240] On both occasions, fire safety advice to residents was included in the newsletter only as a response to concerns

1236 {CST00001919/2}.
1237 {JRP00000028/4}.
1238 Williams {TMO00840364/38} page 38, paragraph 210.
1239 {TMO10007353/5}.
1240 {TMO00860222/1}.

raised with the TMO by the LFB. But for those expressions of concern, it is doubtful whether the TMO would have done anything.

Fire action notices

42.26 In September 2009, Salvus identified a number of deficiencies in the TMO's management of fire safety across its housing stock, one of which was that adequate information and instruction on fire safety was not provided to employees. It also said that fire action notices were not displayed in properties where there was no fire alarm system and that residents did not receive specific individual emergency plans based upon the layout of their buildings.[1241] It recommended that fire action notices should be displayed in all properties managed by the TMO setting out the fire action procedure for the particular property.[1242]

42.27 On 26 January 2010, fire action notices were considered at a progress meeting with Salvus on fire risk assessments in high-risk blocks.[1243] There was a long discussion about whether to install a notice in the main entrance of each block setting out the emergency procedure in relation to that block. It was agreed that fire action

1241 {SAL00000013/10} section 7.2.
1242 {SAL00000013/17} section 7.2.
1243 {RBK00052572/1} paragraph 2.2.

notices should be put up in each block and that letters should be sent to residents describing the evacuation procedure.[1244]

42.28 On 13 May 2010, the TMO's Operations Committee agreed to put fire action notices in each block,[1245] but the matter was not raised again at any subsequent meetings and in September 2010 Janice Wray presented a report on fire risk assessments which said nothing about fire action notices.[1246] Instead, she reported that the TMO would write to the residents in each block explaining the relevant evacuation procedure and summarising the fire risk assessment's findings. The decision to post fire action notices was seemingly forgotten.

42.29 On 27 September 2010, Carl Stokes wrote to Janice Wray, at her request, about fire safety signage in the TMO's residential buildings.[1247] He told her that, as the TMO provided fire safety information to residents in other ways, fire action notices were not required. Janice Wray accepted that advice, but she did not tell the Operations Committee or the executive team that

1244 {RBK00052572/1} paragraph 2.4.
1245 {TMO10037437/89}; Wray {Day142/211:11-18}.
1246 {TMO00899839/4}; {TMO00888971/1}.
1247 {CST00002701}.

the decision to put up fire action notices would not be carried out, though she believed that she had told her line manager.[1248]

42.30 Janice Wray was of the view that the LGA Guide (which was published after Carl Stokes's advice of 27 September 2010) supported her understanding that fire action notices were not required in high-rise residential blocks.[1249] She told us that she had thought that the passage in which it is stated that it is not always necessary to display fire action notices in blocks of flats with simple layouts was consistent with Carl Stokes's previous advice.[1250] Nonetheless, neither she nor Carl Stokes assessed each block to decide whether a fire action notice was required. On the contrary, the same generic approach was taken by the TMO to all its high-rise residential buildings.[1251] However, the LGA Guide did not say that fire action notices are never required in a purpose-built block; on the contrary, paragraph 79.1 provided in terms that a fire action notice would usually be all that would be needed by

1248 Wray {Day142/212:15}-{Day142/213:20}.

1249 Wray {Day142/212:22}-{Day142/213:4}; {Day142/214:11-25}. The LGA Guide suggested that there would rarely be a need for a more elaborate emergency plan than a simple fire action notice. It also said that it was not universally necessary to display a fire action notice and that it was common to convey the emergency plan to tenants in other ways, for example, through residents' handbooks {HOM00045964}.

1250 {HOM00045964/118}.

1251 Wray {Day142/217:6}-{Day142/219:19}.

way of emergency plan for most purpose-built blocks.[1252] If Janice Wray and Carl Stokes thought that it supported a blanket decision not to put up fire action notices in any of the buildings managed by the TMO, they were mistaken.

42.31 The question of fire safety advice for residents was considered by the TMO again after the coroner published her recommendations following the Lakanal House inquests. The inquests had identified the need to find ways to advise residents about the fire procedure other than by the website, leaflets, magazines and letters. However, no effective alternative had yet been identified and fire action notices do not appear to have been discussed. On 2 May 2013, Janice Wray wrote a report for the Operations Committee about the TMO's fire risk assessments which summarised the coroner's recommendations following both the Lakanal House and Shirley Towers inquests, particularly as they touched upon the "stay put" strategy.[1253] The Lakanal House coroner's recommendations were discussed at a meeting between the LFB Fire Safety team and the TMO Health & Safety team at a meeting on 15 May 2013.[1254]

1252 {HOM00045964/118}.
1253 {TMO10031056/5}.
1254 {TMO00844568/2-3}.

42.32 A further briefing note was circulated to the Health and Safety Committee about the recommendations and the implications for the TMO[1255] which included a reference to the need to provide information and guidance to residents about fire procedures. The coroner's recommendations were discussed again at a meeting of the TMO's Health and Safety Committee on 20 June 2013.[1256] Janice Wray asked the committee to consider other opportunities for promoting fire safety and bringing fire procedures to the attention of residents.[1257] There was no mention of the coroner's recommendation to put up fire action notices, however, and the committee did not identify any new ways of providing fire safety information to residents. Nor was there any discussion at the meeting of the agreement that had been reached by the committee in May 2010 to install fire action notices in each block or why that had not been done. There was no discussion either about whether the coroner's recommendations should lead the committee to reconsider the assumption that it was not necessary to put up fire action notices in any of the buildings managed by the TMO.

1255 {TMO10039112}.
1256 {TMO00880630/4}.
1257 {TMO00880630/4}.

42.33 On 23 December 2015, following the Adair Tower fire on 31 October 2015, the LFB issued enforcement notices against the TMO and RBKC.[1258] One breach of the Fire Safety Order they identified was that the TMO's procedures in the event of serious and imminent danger were inadequate. That was because no instructions about action to be taken in the event of a fire had been displayed in the common parts of the premises where they might be seen by visitors and other relevant persons.[1259]

42.34 Janice Wray and Rebecca Burton discussed the enforcement notice at their next regular meeting on 5 January 2016.[1260] Rebecca Burton confirmed that the LFB required work to be completed within six months from the date the notice had been posted, i.e. by 23 June 2016. She told Janice Wray that, although the notice related to Adair Tower, the LFB expected that the standards required in one block would be applied in others.[1261] Janice Wray told her that the TMO had not put up fire action notices because the buildings were not complex and a "stay put" strategy was in place. Rebecca Burton indicated

1258 {RBK00029298/4}.
1259 {RBK00029298/6}.
1260 {RBK00013997/1}.
1261 {RBK00013997/2}.

that notices were required, but that it was not a priority.[1262] In the light of that Janice Wray did not think the requirement was pressing.[1263]

42.35 Rebecca Burton told us that in her view fire action notices were of limited use.[1264] When shown the wording of the enforcement order which proposed an adequate fire action notice in the common parts, she said that the LFB would suggest action but that it was for the responsible person to decide how to comply with the notice.

42.36 If the TMO had provided its residents with fire safety information, we can see why fire action notices might not have been required, but it did not provide them with such information. The tenancy pack included no fire safety information and had not done so for many years, and the newsletters contained no advice about what to do in the event of a fire until the Autumn/Winter 2015 issue of Link which was published after the Adair Tower fire. There was no resident's handbook.[1265] Nothing said by Rebecca Burton could fairly have led Janice Wray to think that it was acceptable to have no fire action notices in buildings managed by the TMO, let alone that that would be consistent with the LGA Guide.

1262 {RBK00013997/2}.
1263 Wray {Day142/222:10}-{Day142/223:20}.
1264 Burton {Day145/134:3-11}.
1265 {TMO00873549/25}.

Janice Wray can fairly be criticised for seeking to justify doing the minimum in the face of the enforcement notice.

42.37 Shortly afterwards, on 8 January 2016, Councillor Pat Mason sent an email to Councillor Marshall expressing concern about the advice given to residents on fire procedures. The email followed a meeting of the Cabinet and Corporate Services Scrutiny Committee, which had discussed the Adair Tower fire.[1266] On 9 January 2016, Councillor Marshall asked Robert Black to set out the advice that was normally given to residents of high-rise residential buildings.[1267] Robert Black responded on 15 January 2016,[1268] saying that "stay put" advice was given to residents of high-rise buildings and was available on the website, in regular fire safety articles in Link and in LFB leaflets distributed by the fire risk assessor to some dwellings.[1269] In relation to procedures to respond to a major fire breaking out at the weekend when offices were closed, he said that Pinnacle, the out-of-hours call handling service, would activate the emergency plan. Janice Wray and Hash Chamchoun were the

1266 {RBK00053869/5}.
1267 {RBK00053869}.
1268 {RBK00053869/3}.
1269 {RBK00053869/3-4}.

principal contacts and other staff were available. Estate services staff would also be called out to visit and assess the situation.[1270]

42.38 On 14 April 2016, Councillor Pat Mason wrote to Robert Black asking whether fire safety information was provided to residents otherwise than on the TMO's website. He was concerned that not all residents might have access to the internet.[1271] Janice Wray responded on 15 April 2016 saying that such information was provided to residents on the TMO website, in the letter to new tenants and by regular articles in Link and Homeowner.[1272] However, her response tended to gloss over the defects we described earlier in the quality of the information provided by the TMO and its delivery to residents.

42.39 It was not until 13 September 2016 that the Health and Safety Committee considered putting up fire action notices in all buildings managed by the TMO.[1273] The committee expected the LFB to require notices to be placed in all buildings, having seen the position it had taken in the Adair Tower enforcement notice. The TMO therefore decided to adopt a risk-based approach and to start placing fire action notices in high-risk

1270 {RBK00053869/4}.
1271 {TMO00865782/3}.
1272 {TMO00865782/1}.
1273 {TMO00840753/5}.

buildings.[1274] That was a far cry from what Janice Wray had understood to be required as a result of her meeting in early January 2016 with Rebecca Burton, but it was the correct approach. On 13 October 2016, Barbara Matthews asked Janice Wray to develop a programme for putting up fire action notices in all the TMO's buildings and to provide costings.

42.40 A month later, on 17 November 2016, the LFB issued a deficiency notice in relation to Grenfell Tower because there were no fire action notices in the common parts (among other reasons).[1275] The deficiency notice was issued a year after the Adair Tower fire, 11 months after the enforcement notice relating to Adair Tower and two months after Janice Wray had told the Health and Safety Committee that fire action notices would be installed in all properties managed by the TMO. Janice Wray was not able to say why there had been a delay in putting up the fire action notices; she thought they had been on order by that time.[1276] However, the evidence we have seen suggests that a quotation for fire action notices for Grenfell Tower had been requested

1274 {TMO00840753/5}.
1275 {TMO10017254}.
1276 Wray {Day143/3:7-14}; {Day143/6:24}-{Day143/7:8}.

on 23 November 2016 after Edward Daffarn and Councillor Blakeman had complained about the lack of notices.[1277]

The Grenfell Action Group blog – "KCTMO – Playing with fire"

42.41 On 20 November 2016, Edward Daffarn posted an article on the Grenfell Action Group blog entitled "KCTMO – Playing with fire". In it he criticised the TMO for failing to take fire safety seriously. He said that the Grenfell Action Group firmly believed that only a catastrophic event would expose what he described as the "ineptitude and incompetence" of the TMO.[1278] The post contained links to previous blogs on fire safety and referred to the Adair Tower fire in October 2015, saying that the LFB had found that the TMO had not looked after the safety of residents properly and had issued an enforcement notice compelling it to improve fire safety. He said that the residents of Grenfell Tower had received no proper fire safety instructions from the TMO. Residents, he said, had been informed by a temporary notice in a lift and one announcement in a recent regeneration newsletter that they should remain in their flats in the event of fire.[1279]

1277 {TMO00861289/2}.
1278 {TMO00845987}.
1279 {TMO00845987/2}.

42.42 The post has since gained a degree of notoriety for its apparent prescience, but it did not in fact predict the fire at Grenfell Tower, much less what turned out to be its cause. Nonetheless, based on his own experience as a resident of Grenfell Tower, Mr Daffarn was able to put his finger on something very wrong with the TMO's management of fire safety and used his forthright style to make his point. Shorn of the rhetoric, it was a message that the TMO could not afford to ignore.

42.43 On 23 November 2016, Councillor Blakeman saw the blog post and raised its contents with Robert Black. She agreed with Mr Daffarn's point that instructions were not permanently available on noticeboards or in letters to residents (or in appropriate languages, where required) and asked whether that could be rectified.[1280]

42.44 Robert Black asked Janice Wray to prepare a response.[1281] She told him that advice on fire procedures was included in newsletters, on the website, in regular articles in Link and provided to all new tenants. She said the Health and Safety Committee had been considering putting up fire action notices in all the buildings and that, although the LFB had issued a deficiency notice relating to the absence of fire action

1280 {TMO10015228/2}.
1281 {TMO10015214/1}.

notices, its attitude to the need for them had been inconsistent. Janice Wray asked for permission to order notices for Grenfell Tower to address Mr Daffarn's concerns.[1282] She also said that although Mr Daffarn was challenging the "stay put" strategy, none of the professionals with whom she had discussed Grenfell Tower had suggested that there was a need to change it.

42.45 A quotation for the cost of obtaining fire action notices was provided on 23 November 2016, presumably in response to the issue of the deficiency notice, Mr Daffarn's blog post and Councillor Blakeman's concerns.[1283] On 14 December 2016, Janice Wray confirmed that 30 fire action notices had been put up in Grenfell Tower the previous day.[1284] They cost £328.32.[1285]

42.46 In the response that she prepared for Mr Black to send to Councillor Blakeman, Janice Wray failed to mention that on 17 November 2016 the TMO had received a deficiency notice in relation to Grenfell Tower and that one of the deficiencies identified had been the absence of fire action notices. There is no doubt that Councillor Blakeman should have been told about

1282 {TMO10015214/1}.
1283 {TMO00829191}.
1284 {TMO00861381}.
1285 Quote for fire action notices for Grenfell Tower {TMO00829191}.

the notice and its substance. She was a member of the TMO board who had specifically asked about fire safety advice in response to a resident's concerns and she should have been given the full picture. Janice Wray's failure to mention the deficiency notice to Councillor Blakeman mirrored Robert Black's own failure to bring the notice to the attention of the TMO Board, a matter to which we have referred in Chapter 31.

42.47 On 2 December 2016, Peter Maddison asked if any of the allegations in the blog post could be considered libellous.[1286] Barbara Matthews responded indicating that she had spoken to Robert Black and that they agreed to take no action in response to it.[1287] Peter Maddison's reaction, to seek advice about whether Mr Daffarn had libelled the TMO rather than to get to the bottom of the complaint, was telling. By this point, the TMO's defensiveness and hostility towards the Grenfell community, at least as represented by Mr Daffarn, had sunk to a new low.

42.48 The history of fire safety notices illustrates a reluctance on the part of the TMO to take active steps to promote fire safety. Although the need for fire action notices was first raised in 2009 by Salvus, they were not provided until the end of 2016 after the LFB had issued a deficiency

1286 {TMO00865831/3}.
1287 {TMO00865831/1}.

notice and Councillor Blakeman had questioned the position having read Mr Daffarn's blog post. In the end, fire action notices proved a relatively inexpensive means of providing fire safety advice. Their timely installation following Salvus's advice in 2009, or even immediately after the Adair Tower fire in 2015, would have ensured that consistent advice was available to residents. That might have gone some way to reassuring them that fire safety was taken seriously by the TMO. The delay in installing fire action notices should also be understood in the context of enquiries and complaints from residents of Grenfell Tower about the evacuation strategy.

Residents' complaints about fire safety advice

42.49 Mr Daffarn's was not a lone voice. The blog post of 20 November 2016 was the culmination of a long history going back to 2010 of complaints about fire safety by residents of Grenfell Tower.

42.50 On 3 September 2010, the Leaseholders' Association wrote to Robert Black setting out 11 areas of concern that had arisen as a result of the fire on 30 April 2010.[1288] The letter said that no one in the block had been aware of the

[1288] {TMO10037439}.

evacuation procedure and that they had not been given information about what to do in the event of a fire in the previous 36 years.[1289]

42.51 Anthony Parkes responded on Robert Black's behalf on 21 September 2010,[1290] saying that the fire alarm was functioning and the smoke ventilation system had been working at the time (although in fact it had not).[1291] He did not address the complaint that residents had not been informed of the evacuation procedure.

42.52 On 6 October 2010, the Leaseholders' Association sent another letter to the TMO making a number of complaints again.[1292] Anthony Parkes responded on 27 October 2010. Among other things, he said there was a "stay put" strategy in place, which he explained. He also said that information about fire safety was regularly published in Link and that the TMO planned to write to the residents of each block to advise on the action to be taken in response to a fire in that block.[1293] He also expressed the TMO's commitment to working with the Association and invited it to provide some dates when they could meet for a discussion.

1289 {TMO10037439/5}.
1290 {TMO00846320}.
1291 {TMO00846320/4}.
1292 {IWS00001310}.
1293 {TMO00836390}.

42.53 In 2012, the Association made further complaints about the management of fire safety. On 14 November 2012, it sent an email to David Ward, the TMO's Home Ownership Manager, about the plan to replace the entrance doors to tenants' flats,[1294] asking why leaseholders had not been included in the programme if the replacement related to fire safety and complaining about their omission. They also complained about the lack of health and safety training or drills in case of an emergency.[1295] Paul Dunkerton responded on 20 November 2012 reminding the leaseholders that a "stay put" strategy was in place at Grenfell Tower, meaning that if a fire were to break out anywhere other than in their own flats they were safe to remain in their homes.[1296] The existence of the "stay put" strategy was repeated in several subsequent letters responding to various points raised by the Leaseholders' Association.

42.54 On 29 September 2016, the Association sent an email to Councillor Blakeman raising a number of complaints, including the failure of the TMO to organise any fire drill at Grenfell Tower

1294 {TMO00833837}.
1295 {TMO00833837/1}.
1296 {TMOH00027332/2}.

since 2012. They referred to the recent fire at Shepherd's Bush and asked her to investigate their various concerns.[1297]

42.55 Robert Black circulated the email within the TMO and asked for responses.[1298] Janice Wray told him that fire drills were not required in blocks with a "stay put" fire strategy.[1299] The purpose of fire drills, she said, was to test the procedure to be followed in the event of a fire and if that was to stay put, a fire drill would conflict with the way residents were expected to respond.[1300] Peter Maddison prepared a draft response in which he explained that Grenfell Tower maintained a "stay put" fire strategy[1301] and that, if the LFB decided that an evacuation was necessary in response to a particular incident, it would organise it.[1302] It is not clear whether that response was sent to the Leaseholders' Association.

42.56 Grenfell Compact was formed in 2015 to voice residents' concerns during the refurbishment. Councillor Blakeman responded briefly to the Leaseholders' Association's email on 4 October 2016 attaching a list of complaints that had been prepared by Grenfell Compact in

1297 {TMO00846025/35}.
1298 {TMO00847231}.
1299 {TMO10033125}.
1300 {TMO10033125}.
1301 {RBK00000142}.
1302 {RBK00000142}.

May 2016 together with the TMO's responses to them.[1303] They did not include a complaint about the absence of fire action notices, but as mentioned earlier, fire action notices were put up in Grenfell Tower on 13 December 2016.

42.57 The repeated complaints by the Leaseholders' Association about fire safety advice and procedures over the years prompted responses from the TMO but not a review of the fire safety advice provided to residents. Instead, the TMO simply repeated the "stay put" advice in correspondence with the Association and took no further action. It is difficult to know, even with the benefit of hindsight, whether the earlier installation of fire action notices would have made any difference, but it might have addressed some of the concerns of the Association to have had the advice set out in accessible and publicly available notices.

[1303] {TMO00846745}; {TMO00846746}.

Chapter 43
The smoke ventilation system

The system

43.1 Grenfell Tower was equipped with a ventilation system designed to allow the passage of air through the building for ventilation and the extraction of smoke in the event of a fire. Ventilation depended entirely on natural airflow. The extraction of smoke depended on the natural convection of hot smoke but could be boosted by mechanical means. The booster fans were designed to be operated manually by the fire and rescue service.

43.2 The system comprised two pairs of shafts running the full height of the building with openings into each lift lobby controlled by louvred dampers. In the event of a fire the dampers were designed to open on the floor affected by the fire and close on all other floors, thereby allowing smoke to flow up the shaft to the opening at roof level without escaping into lobbies on other floors.

The fire at Grenfell Tower on 30 April 2010

43.3 On 30 April 2010, a fire was started deliberately outside Flat 64 at Grenfell Tower.[1304] During the fire, the smoke ventilation system (sometimes referred to as the automatic opening vent system or AOV) failed to operate properly.[1305] Smoke leaked into the lobbies of eight other floors, which led a number of residents to believe they were trapped and call the LFB.[1306]

43.4 On 5 May 2010, Janice Wray sent the results of her investigation into the fire to Collette O'Hara, an LFB fire safety inspecting officer.[1307] She explained that the system was subject to quarterly inspections by RGE Services (RGE)[1308] and said that the most recent inspection had identified "incomplete sealing" of a number of

1304 Wray {TMO00000890/43} page 43, paragraphs 195-196; LFB notifiable fire report into the fire {LFB00000201/1-2}; LFB report into the fire dated 22 December 2010 {IWS00001463/3}.

1305 Wray {TMO00000890/43} page 43, paragraphs 195-196; LFB notifiable fire report into the fire {LFB00000201/2}; LFB report into the fire dated 22 December 2010 {IWS00001463/3}.

1306 Email from Janice Wray to Collette O'Hara on 5 May 2010 {TMO10048221/4} item 2; TMO spreadsheet of previous fires {TMO00873387} "fires" sheet, row 6; LFB notifiable fire report into the fire {LFB00000201/1-2}; LFB report into the fire dated 22 December 2010 {IWS00001463/3}.

1307 Email from Janice Wray to Collette O'Hara on 5 May 2010 {TMO10048221/4-5}.

1308 Email from Janice Wray to Collette O'Hara on 5 May 2010 {TMO10048221/4} item 3.

dampers.[1309] She said that the remedial work had been delayed and had therefore not been carried out by the time of the fire.[1310] Janice Wray accepted, in retrospect, that the TMO should have implemented interim measures while the system was being repaired.[1311]

43.5 When he replied to Janice Wray on 6 May 2010,[1312] Spencer Sutcliff, the leader of the LFB Fire Safety team, agreed that the TMO should implement interim measures in future.[1313] He also recommended that the TMO introduce a procedure to assess faults in fire safety systems to ensure that any high-priority remedial work was completed to a strict time scale.[1314] He expressed surprise about the amount of smoke leakage caused by defective sealing of the vents[1315] and recommended that the entire system be tested by an engineer because of what he described as a "catastrophic failure of the system".[1316]

1309 Email from Janice Wray to Collette O'Hara on 5 May 2010 {TMO10048221/4} item 3.
1310 Email from Janice Wray to Collette O'Hara on 5 May 2010 {TMO10048221/4} item 3.
1311 Email from Janice Wray to Collette O'Hara on 5 May 2010 {TMO10048221/4-5} items 3-4; TMO spreadsheet of previous fires {TMO00873387} "fires" sheet, row 6.
1312 Email from Spencer Sutcliff to Janice Wray on 6 May 2010 {TMO10048221/2}.
1313 Email from Spencer Sutcliff to Janice Wray on 6 May 2010 {TMO10048221/2}.
1314 Email from Spencer Sutcliff to Janice Wray on 6 May 2010 {TMO10048221/2}.
1315 Email from Spencer Sutcliff to Janice Wray on 6 May 2010 {TMO10048221/3}.
1316 Email from Spencer Sutcliff to Janice Wray on 6 May 2010 {TMO10048221/3}.

43.6 Janice Wray replied to Spencer Sutcliff on 12 May 2010.[1317] She included an earlier response from the TMO's senior electrical engineer, Keith Fifield,[1318] who had explained that the remedial work, which had been agreed before the fire, included a complete overhaul of the system[1319] and that, when the work had been done, the system would be fully operational.[1320] Mr Fifield did not agree that the failure had been catastrophic.[1321] He said that, except for the incomplete sealing, the system was working properly, but that there had been a failure to activate the mechanical extract system manually during the fire.[1322] He said that he had arranged for smoke tests to be carried out on completion of the work.[1323]

43.7 On 7 May 2010, Janice Wray told Spencer Sutcliff that the remedial work had been completed and a smoke test had been successfully undertaken.[1324]

1317 Email from Janice Wray to Spencer Sutcliff on 12 May 2010 {TMO10048221/1}.
1318 Email from Keith Fifield to Janice Wray on 6 May 2010 {TMO10048217/1}.
1319 Email from Keith Fifield to Janice Wray on 6 May 2010 {TMO10048217/1}.
1320 Email from Keith Fifield to Janice Wray on 6 May 2010 {TMO10048217/1}.
1321 Email from Keith Fifield to Janice Wray on 6 May 2010 {TMO10048217/1}.
1322 Email from Keith Fifield to Janice Wray on 6 May 2010 {TMO10048217/1}.
1323 Email from Keith Fifield to Janice Wray on 6 May 2010 {TMO10048217/1}.
1324 Email from Janice Wray to Spencer Sutcliff on 12 May 2010 {TMO10048221/1}.

RGE's inspections of the system 2009 – 2010

43.8 On 28 July 2009, the TMO appointed RGE to carry out maintenance work on the fire safety equipment and systems.[1325] At some time after, but before the fire at Grenfell Tower on 30 April 2010, RGE had carried out its first test on the system.[1326] There is an undated maintenance report that refers to fire damage, suggesting that it was completed after the fire on 30 April 2010,[1327] but it also refers to a "first visit" to test the system, which RGE apparently carried out before the fire. In that report RGE said that all fresh air inlet dampers were in the open position and had been for some years. As a result, most of them were seized open or so contaminated that they were impossible to close and reset.[1328]

43.9 If the dampers were open and unable to close, smoke could spread between lobbies through the system in the event of a fire.[1329] It is a matter of concern that the situation had apparently existed

1325 Letter from Keith Fifield to RGE dated 28 July 2009 {RGE00000003}.
1326 Undated RGE maintenance report on AOV system at Grenfell Tower {MAX00001414/3}.
1327 Undated RGE maintenance report on AOV system at Grenfell Tower {MAX00001414/5}.
1328 Undated RGE maintenance report on AOV system at Grenfell Tower {MAX00001414/5}.
1329 As explained by Dr Lane in her Module 3 report, The Management and Maintenance of Grenfell Tower – Chapter 7 {BLARP20000033/355} paragraph 15.4.14.

for a number of years before RGE's inspection. Although it is not clear precisely when that first visit took place, there are records of RGE having been instructed to carry out repairs on the system on 4 January 2010 and 20 April 2010, so it was probably before then.[1330] A quotation from RGE dated 20 April 2010 refers to stripping down, cleaning and lubricating each vent, which, on the face of it, relates to the problems identified during the "first visit".[1331] They appear to have been the repairs Janice Wray had referred to in her emails to the LFB fire safety team following the fire at Grenfell Tower on 30 April 2010, which she said had been completed on 7 May 2010.[1332]

43.10 RGE produced another maintenance report dated 12 May 2010 that set out the results of its tests on the system after the fire on 30 April 2010.[1333] It concluded that due to the spring force on the inlet dampers the actuators were not reliable and might not operate on every activation, but that the system was otherwise generally in good operational order and capable of being maintained

1330 Capita Repair Spreadsheet {RBK00053524} row 4870 and row 4701; Repair order raised with RGE on 20 April 2010 {RBK00046981}.

1331 Quote from RGE for £2,257.05 to carry out repair work to the system at Grenfell Tower {RBK00013641}.

1332 Email from Janice Wray to Collette O'Hara on 5 May 2010 {TMO10048221/4} item 3; Email from Janice Wray to Spencer Sutcliff on 12 May 2010 {TMO10048221/1}.

1333 RGE maintenance report on smoke ventilation system at Grenfell Tower dated 12 May 2010 {RBK00013637}.

for the next 5 years.[1334] The report included a quotation of £27,280 for work to the inlet dampers to ensure that they automatically opened and closed without manual intervention.[1335]

43.11 Janice Wray said that she had not been made aware of that report, either before she replied to Spencer Sutcliff on 12 May 2010 or after.[1336] She said that the TMO's Contract Management team dealt with RGE,[1337] but that she would have expected Keith Fifield to provide the report to her.[1338] We have not seen any evidence that the remedial work identified by RGE in its report dated 12 May 2010 was ever carried out.[1339]

43.12 An RGE engineer carried out a further test on the smoke ventilation system at Grenfell Tower on 4 June 2010.[1340] The service sheet says that the purpose was to test the fire dampers following the recent fire and remedial works.[1341] It is likely

1334 RGE maintenance report on smoke ventilation system at Grenfell Tower dated 12 May 2010 {RBK00013637/7}.
1335 RGE maintenance report on smoke ventilation system at Grenfell Tower dated 12 May 2010 {RBK00013637/8}.
1336 Wray {Day144/22:14-21}.
1337 Wray {Day144/23:2-20}.
1338 Wray {Day144/24:1-13}.
1339 There is, for example, no record of a repair corresponding with this quote in the Capita Repair Spreadsheet, whereas there are records of the repairs raised on 4 January 2010 and 20 April 2010 {RBK00053524}.
1340 RGE service/maintenance sheet for smoke test to smoke ventilation system at Grenfell Tower dated 4 June 2010 {RBK00046980}.
1341 RGE service/maintenance sheet for smoke test to AOV system at Grenfell Tower dated 4 June 2010 {RBK00046980}.

that the sheet refers to the remedial works for which instructions were given on 20 April 2010 and which were completed on 7 May 2010, given that there is no evidence that the remedial works identified in the report dated 12 May 2010 were carried out. Despite that, the engineer stated that following the test he had left the site in full working order as witnessed by Keith Fifield and others.[1342]

43.13 In about August 2010, the TMO started to consider the need to modernise or replace the smoke ventilation system at Grenfell Tower.[1343] The minutes of the meeting of the Asset Investment and Engineering Health and Safety Group on 26 August 2010 recorded that the feasibility of modernising the smoke extraction system was being examined.[1344] Janice Wray suggested that the need for that had been brought to the TMO's attention by the fire on 30 April 2010, which had brought to light the age of the system, rather than by RGE's report in May 2010 or the failure of the system to operate properly.[1345]

1342 RGE service/maintenance sheet for smoke test to smoke ventilation system at Grenfell Tower dated 4 June 2010 {RBK00046980}; Email from Janice Wray to Collette O'Hara on 7 June 2010 about the smoke test {LFB00000767}.

1343 Minutes of the Asset Investment and Engineering Health and Safety Group meeting on 26 August 2010 {TMO10000725/3} item 2.

1344 Minutes of the Asset Investment and Engineering Health and Safety Group meeting on 26 August 2010 {TMO10000725/3} item 2.

1345 Wray {Day144/26:23}-{Day144/27:11}.

The Leaseholders' Association's complaint

43.14 In July 2010, the Grenfell Tower Leaseholders' Association made a complaint about fire safety which included a specific concern about the operation of the smoke ventilation system. The evidence suggests that the TMO was less than full and frank in its response. In particular, it did not tell the leaseholders or other residents of the tower about the defects in the system which had been found by RGE or the heightened risk to their safety.

43.15 On 28 July 2010, the Leaseholders' Association wrote to Geoff Payne, the TMO's Head of Housing, making various complaints including a complaint that during the fire on 30 April 2010 smoke had entered lobbies on other floors of the tower.[1346] It asked what defects had been found in the system and what action had been taken in response.[1347] Daniel Wood, the TMO's Head of Home Ownership, responded on 20 August 2010,[1348] saying that there had been a "minor fault" in the system that had been identified during the service visit before the fire.[1349] He said that repairs had been put in hand and

1346 Letter from GTLA to Geoff Payne on 28 July 2010 {IWS00001497/2}.
1347 Letter from GTLA to Geoff Payne on 28 July 2010 {IWS00001497/2}.
1348 Letter from Daniel Wood to GTLA on 20 August 2010 {TMO00846311}.
1349 Letter from Daniel Wood to GTLA on 20 August 2010 {TMO00846311/4}.

that, when completed, the system would be fully operational.[1350] He said that the problem with leaking vents had been put right.[1351]

43.16 On 3 September 2010, the Leaseholders' Association wrote to Robert Black about their complaints.[1352] Among other matters it asserted that the recent fire had raised so many health and safety questions that it demanded an independent investigation into the safety of the building.[1353] Later, when dealing with the fire, it said that if the smoke ventilation system was not working it should be considered a major rather than a minor fault as Mr Wood had described it.[1354]

43.17 Anthony Parkes replied on 21 September 2010.[1355] He acknowledged that the seals on some of the vents had leaked, but said that otherwise they had been working at the time of the fire.[1356] He said that the effects of the fire would not have been so serious if the LFB fire fighters had activated the smoke extract fan manually, but that they had not known how to do

1350 Letter from Daniel Wood to GTLA on 20 August 2010 {TMO00846311/4}.
1351 Letter from Daniel Wood to GTLA on 20 August 2010 {TMO00846311/4}.
1352 Letter from GTLA to Robert Black on 30 September 2010 {TMO10037439}.
1353 Letter from GTLA to Robert Black on 30 September 2010 {TMO10037439/2}.
1354 Letter from GTLA to Robert Black on 30 September 2010 {TMO10037439/5}.
1355 Letter from Anthony Parkes to GTLA dated 21 September 2010 {TMO00846320}.
1356 Letter from Anthony Parkes to GTLA dated 21 September 2010 {TMO00846320/4}.

so.[1357] He also said that the system was being upgraded so that it would work automatically when the fire alarm sounded.[1358] Mr Parkes gave an assurance that the system was regularly checked and test reports completed.[1359]

43.18 Neither Daniel Wood nor Anthony Parkes referred to RGE's report of 12 May 2010, which had advised that the inlet dampers might not operate on every activation and recommended significant remedial work.[1360] As set out above, we have seen no evidence that that remedial work was carried out.

RGE's inspection of the system in 2011

43.19 On 9 August 2011, RGE produced a further test report on the system at Grenfell Tower.[1361] In section 3, under the heading "Test Results / Urgent Recommendation", it said that, having maintained the system for over 12 months, it could not guarantee that it would operate as required or that it met the requirements of the

1357 Letter from Anthony Parkes to GTLA dated 21 September 2010 {TMO00846320/4}.
1358 Letter from Anthony Parkes to GTLA dated 21 September 2010 {TMO00846320/4}.
1359 Letter from Anthony Parkes to GTLA dated 21 September 2010 {TMO00846320/4}.
1360 RGE maintenance report on smoke ventilation system at Grenfell Tower dated 12 May 2010 {RBK00013637/7-8}.
1361 RGE maintenance report on smoke ventilation system at Grenfell Tower dated 9 August 2011 {TMO00894311}.

fire regulations. In particular, it reported that the systems for actuating the vents in the lobbies were no longer reliable and were found to have opened at random between maintenance visits. They were no longer fit for purpose and needed to be replaced.[1362]

43.20 Janice Wray said that she had not been made aware of that report either.[1363] Keith Fifield, however, was certainly aware of it. He discussed it at a meeting with RGE on 7 September 2011.[1364] The minutes of that meeting record that he had seen the report and was aware that RGE could not guarantee that the system would work in the event of an emergency.[1365] They also recorded that he had said that the matter was being looked into by the TMO and that RGE and other contractors would be invited to submit tenders for the necessary work.[1366]

43.21 The required improvements to the system at Grenfell Tower were discussed at a meeting of the TMO Asset Investment and Engineering Health and Safety Group on 15 September 2011

1362 RGE maintenance report on smoke ventilation system at Grenfell Tower dated 9 August 2011 {TMO00894311/5}.
1363 Wray {Day144/25:3-11}.
1364 Minutes of RGE Contract Review meeting with the TMO on 7 September 2011 {TMO00848054/1} item 1.7.
1365 Minutes of RGE Contract Review meeting with the TMO on 7 September 2011 {TMO00848054/1} item 1.7.
1366 Minutes of RGE Contract Review meeting with the TMO on 7 September 2011 {TMO00848054/1} item 1.7.

attended by Keith Fifield and Janice Wray.[1367] The minutes of the discussion do not refer to RGE's recent report,[1368] but in our view, given Keith Fifield's knowledge of that report, it is unlikely that the modernisation or replacement of the system was discussed without mentioning the significant findings it contained.

43.22 Despite the reports made by RGE in May 2010 and August 2011, we have seen no evidence that the TMO gave any consideration at that time to implementing measures to mitigate the risk presented by the potential failure of the smoke ventilation system to operate in the event of a fire. That was despite the assurance Janice Wray had given the LFB Fire Safety team after the fire on 30 April 2010 that it would do so.[1369]

Modernisation of the system

43.23 Even if Janice Wray was not aware of the findings made by RGE in August 2011, it is reasonably clear that she was aware of at least some of the concerns about the system that had been identified in the course of the feasibility study for its modernisation.

1367 Minutes of Asset Investment and Engineering Health and Safety Group meeting on 15 September 2011 {TMO00869798/1-2} item 2.2(e).
1368 Minutes of Asset Investment and Engineering Health and Safety Group meeting on 15 September 2011 {TMO00869798/1-2} item 2.2(e).
1369 Email from Janice Wray to Collette O'Hara on 5 May 2010 {TMO10048221/4-5}.

43.24 In October 2011, AECOM, a construction industry consultancy, produced a tender for the modernisation of the system.[1370] In a description of the existing system it noted that some of the dampers leaked, making it possible for smoke from a fire on a lower floor to leak through the closed dampers on an upper floor into the lift lobby. It was also possible that more than one set of dampers would open at any one time, since there was no way of establishing whether dampers were open other than by visual inspection. Although the extractor fans would overcome those problems, they had to be started manually by the fire brigade.[1371]

43.25 Apart from the installation of an autodialler to monitor the system remotely when staff were not on site, we have seen no evidence that Janice Wray or anyone else at the TMO considered measures to mitigate the risk caused by the defects in the system pending its modernisation. Further, although the tender document was produced in October 2011, no work had been carried out by late 2013 when it was included in the refurbishment, and it was not completed until April 2016, some four and a half

1370 AECOM tender for upgrade to fire alarm and smoke extract system dated October 2011 {MAX00017497}.

1371 AECOM tender for upgrade to fire alarm and smoke extract system dated October 2011 {MAX00017497/6-7}.

years later.[1372] Janice Wray told us that the work had been put back so that it could form part of the refurbishment.[1373]

The fire risk assessments 2009-2012

43.26 Having heard the evidence of Dr Lane and Mr Todd, we are satisfied that a fire risk assessor should assess the risk that the means of escape might be compromised by a failure of a smoke ventilation system to work.[1374] He could not reasonably be expected to test the system, but should satisfy himself that the system had been effectively tested and maintained in efficient working order, either by checking the records or by making reasonable enquiries of the competent person.[1375] If the necessary information is not immediately available, the fire risk assessor should make a further effort to acquire it.[1376] There may be occasions when a fire risk assessor might ask to see the equipment tested,[1377] but that would

1372 See, for example, email from Bruce Sounes to John Allen and Paul Hanson (RBKC Building Control) copying in Terry Ashton and Duncan Campbell on 23 October 2013 {TMO10040556}. It was commissioned in April 2016: PSB Above Ground Commissioning Report dated 28 April 2016 {PSB00000224/7}.
1373 Wray {Day144/46:14}-{Day144/47:4}.
1374 Todd {Day168/24:18-22}; Lane {Day172/3:4-11}.
1375 Todd {Day168/24:14}-{Day168/26:14}; {Day172/3:12}-{Day172/4:5}; {Day172/5:4}-{Day172/6:17}; Lane Module 3 Report, The Management and Maintenance of Grenfell Tower, Chapter 8 {BLARP20000027/267} s.12.3.14-15.
1376 Todd {Day168/26:16}-{Day168/27:10}; Lane {Day172/14:14}-{Day172/15:7}; {Day172/15:15}-{Day172/16:1}.
1377 Lane {Day172/6:25}-{Day172/7:20}.

not be normal.[1378] In the absence of satisfactory information about testing and maintenance he should increase the assessment of risk until provided with information to justify reducing it.[1379] We agree that the absence of available information about the testing and maintenance of a system of that kind indicates a shortcoming in the responsible person's management of fire safety in relation to the building in question.[1380]

PAS 79:2012

43.27 The approach of Dr Lane and Colin Todd was, in essence, the same as that set out in PAS 79:2007 and PAS 79:2012.[1381] The guidance in relation to smoke ventilation systems is materially the same in the two versions. Clause 15 of PAS 79:2012, entitled "Assessment of Fire Protection Measures", states that among the systems that should be taken into account are smoke control systems, which, in some premises can be essential for the protection of the means of escape. It is often vital to ensure that there are adequate arrangements for control, testing and maintenance of such systems.[1382]

1378 Todd {Day168/26:12-14}.
1379 Lane {Day172/15:8}-{Day172/16:1}.
1380 Todd {Day168/29:1-7}; Lane {Day172/16:2}-{Day172/17:1}.
1381 PAS 79:2007 {CTA00000001}; PAS 79:2012 {CTA00000003}.
1382 PAS 79:2012 {CTA00000003/45-48}; See Clause 14 in PAS 79:2007 for the equivalent paragraphs {CTA00000001/42-45}.

43.28 Clause 16 says that fire safety management, which includes the testing and maintenance of fire protection systems, and fire protection measures should be regarded as of equal importance.[1383]

The approach of Carl Stokes

43.29 Carl Stokes told us that he never tested or witnessed the testing of the smoke ventilation system at Grenfell Tower during his fire risk assessments.[1384] He said that in order reliably to verify that the system was functioning correctly he used the contractor's service sheets and made certain that he had one that was in date.[1385] He preferred to use that information rather than ask Janice Wray about the condition and operation of the system, because she would have had to go to the same source material.[1386]

The fire risk assessment in September 2009

43.30 In the fire risk assessment of Grenfell Tower he carried out on behalf of Salvus in September 2009, Carl Stokes reported that he could not confirm that the smoke ventilation system had been maintained and tested in accordance with

1383 PAS 79:2012 {CTA00000003/50-53}; See Clause 15 in PAS 79:2007 for the equivalent paragraphs {CTA00000001/46-47}.
1384 Stokes {Day139/4:14-17}.
1385 Stokes {Day139/4:18-21}.
1386 Stokes {Day139/4:22}-{Day139/5:12}.

current guidance and British Standards.[1387] He advised that that presented a medium to high risk and recommended that the TMO confirm within a month whether the system had been tested and, if not, that it engage a competent engineer to do so within three months.[1388]

43.31 The action plan based on that assessment, which was revised by the TMO in October 2009, stated that regular maintenance was being carried out.[1389] It is not clear precisely when RGE carried out its first test of the system.[1390] If it had taken place by the time of Carl Stokes's fire risk assessment, it is not clear why the test results, which had identified defects in the dampers which had existed for possibly five years, were not provided to him or why he was otherwise unable to obtain them.[1391]

1387 Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/14}.
1388 Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/18} item 9.2.
1389 Fire Risk Assessment Action Plan for Grenfell Tower updated in October 2009 {CST00000019} rows 52-54.
1390 Undated RGE maintenance report on AOV system at Grenfell Tower {MAX00001414/5}.
1391 Undated RGE maintenance report on AOV system at Grenfell Tower {MAX00001414/5}.

The fire risk assessment in December 2010

43.32 Carl Stokes completed his next fire risk assessment of Grenfell Tower on 29 December 2010.[1392] In it he referred to the fire on 30 April 2010 (although he incorrectly dated it as July 2010), but he did not mention that the system had not operated as intended.[1393] He told us that he had not been aware that there had been a leakage of smoke during the fire.[1394] He said he would have expected Janice Wray to give him that kind of information or for it to be included in the service reports for the system.[1395] Janice Wray, for her part, could not remember having given him that information.[1396]

43.33 In the Record of Significant Findings and Action Plan dated 29 December 2010, Mr Stokes noted that there were automatic opening vents in each lobby area, but that he did not know whether the system had been serviced and maintained.[1397] He sought confirmation of that

1392 Fire Risk Assessment for Grenfell Tower dated 29 December 2010 {CST00003181}.
1393 Fire Risk Assessment for Grenfell Tower dated 29 December 2010 {CST00003181/5}.
1394 Stokes {Day139/7:3-9}.
1395 Stokes {Day139/7:3-13}.
1396 Wray {Day144/7:1-21}; {Day144/9:11-21}.
1397 Record of Significant Findings and Action Plan for Grenfell Tower dated 29 December 2010 {CST00003165/5} item 23c.

as a matter of high priority.[1398] That essentially repeated the request he had made in the fire risk assessment carried out in 2009.[1399] However, we have seen no evidence either that he sought, or that the TMO provided, the confirmation he had asked for before he completed the assessment. Carl Stokes could not remember whether he had asked for it.[1400]

43.34 The failure to obtain that information as part of the fire risk assessment was significant because, by that stage, RGE had identified defects in the inlet dampers in their maintenance report dated 12 May 2010 and the TMO had begun to consider the need to modernise or replace the system.[1401] Carl Stokes said that he had not been aware of RGE's concerns about the inlet dampers,[1402] and as he did not have that information, he could not take it into account when making his assessment of the risk at Grenfell Tower. Nor could he advise

1398 Record of Significant Findings and Action Plan for Grenfell Tower dated 29 December 2010 {CST00003165/5} item 23c.
1399 Fire Risk Assessment of Grenfell Tower dated 30 September 2009 {CST00003128/18} item 9.2.
1400 Stokes {Day139/11:15-19}.
1401 RGE maintenance report for the smoke ventilation system at Grenfell Tower dated 12 May 2010 {RBK00013637/7}; Minutes of the Asset Investment and Engineering Health and Safety Group meeting on 26 August 2010 {TMO10000725/3} item 2.
1402 Stokes {Day139/8:1-15}.

on the need for measures to mitigate the risk presented by the defects in the system pending its renovation or improvement.

The fire risk assessment in November 2012

43.35 Carl Stokes completed his next fire risk assessment of Grenfell Tower on 20 November 2012.[1403] In section 23, he ticked the box to indicate that there was no record of monthly testing or annual servicing of the smoke ventilation system[1404] but did not provide any comment or observation.[1405] In his Record of Significant Findings and Action Plan, he referred to the presence of automatic opening vents in each lobby and asked for confirmation that they were serviced and maintained. He rated that a matter of high priority.[1406]

43.36 That was the third time that Mr Stokes had said that he did not know whether the system had been routinely tested and maintained, but we

1403 Fire Risk Assessment of Grenfell Tower dated 20 November 2012 {CST00003084}.

1404 Fire Risk Assessment of Grenfell Tower dated 20 November 2012 {CST00003084/28}.

1405 Colin Todd explained that, where "no" was ticked in the fire risk assessment to a proforma question, the fire risk assessor should include commentary explaining the "no" in the fire risk assessment, then there should be a corresponding action in the action plan: Todd {Day168/34:5}-{Day168/36:3}.

1406 Record of Significant Findings and Action Plan dated 20 November 2012 {CST00003083/5} item 23c.

have seen no evidence that he tried to obtain the maintenance records before he completed his assessments.[1407] Moreover, he made no comment about what had become a persistent and, in our view, worrying problem. Nor did he vary his assessment of the fire risk at Grenfell Tower, which he considered "tolerable", to account for the possibility that the system might not have been maintained in efficient working order.[1408]

43.37 Carl Stokes's failure to request that information before he completed his assessment, and the TMO's failure to provide it, was especially significant in November 2012. By that stage, RGE had stated in explicit terms in its report dated 9 August 2011 that it could not guarantee that the system would work.[1409] The AECOM tender of 19 October 2011 also referred to serious defects in the system.[1410] That information should have been taken into account in assessing the risk and measures should have been put in place to mitigate it, pending the completion of remedial

1407 Carl Stokes said it would have been covered in meetings with Janice Wray, but the Inquiry has seen no evidence in support of that assertion, Stokes {Day139/16:1-12}.

1408 Carl Stokes's Fire Risk Assessment of Grenfell Tower dated 20 November 2012 {CST00003084/10}.

1409 RGE maintenance report on the smoke ventilation system at Grenfell Tower dated 9 August 2011 {TMO00894311/5}.

1410 AECOM tender for upgrade to fire alarm and smoke extract system dated October 2011 {MAX00017497/6-7}.

work. However, Mr Stokes did no more than renew his request for confirmation that the system had been tested and maintained.

The Leaseholders' Association's complaints in 2012

43.38 On 14 November 2012, the Leaseholders' Association wrote a further letter to David Ward about the concerns felt by its members about being excluded from the programme to replace flat entrance doors in 2011 to 2012.[1411] It complained that leaseholders had not been told after the fire on 30 April 2010 that their entrance doors might not comply with safety regulations and questioned whether other health and safety equipment was in working condition and fit for its purpose.[1412] It therefore asked for copies of all reports, conclusions or recommendations relating to any investigation into the fire.[1413]

43.39 On 22 November 2012, in preparing a response to that complaint, Janice Wray sent an email to Paul Dunkerton containing information about

1411 Letter/email from GTLA to David Ward on 18 November 2012 {TMO00842270}.
1412 Letter/email from GTLA to David Ward on 18 November 2012 {TMO00842270/2}.
1413 Letter/email from GTLA to David Ward on 18 November 2012 {TMO00842270/2}.

the fire on 30 April 2010.[1414] She said it would be inappropriate to provide the leaseholders with a copy of the email she had sent to the LFB Fire Safety team after the fire.[1415] Instead, she proposed telling them that the smoke ventilation system had removed the smoke from the lift lobby, but had not worked as effectively as it should have because of a need for remedial works that were then pending. All those works had been completed and the system continued to operate effectively.[1416]

43.40 Paul Dunkerton included that information in his reply to the Leaseholders' Association on 14 December 2012.[1417] By that time, however, the TMO had for a long time been in possession of RGE's report dated 9 August 2011, which stated explicitly that it could not guarantee that the system would work, and AECOM's tender, which described its defects.[1418] Even if Janice Wray had not seen those documents, she should have asked Keith Fifield for information about the

1414 Email from Janice Wray to Paul Dunkerton on 22 November 2012 {TMO00848792}.
1415 Email from Janice Wray to Paul Dunkerton on 22 November 2012 {TMO00848792}.
1416 Email from Janice Wray to Paul Dunkerton on 22 November 2012 {TMO00848792}.
1417 Letter from Paul Dunkerton to Tunde Awoderu, GTLA, on 14 December 2012 {TMOH00027328/2}.
1418 AECOM tender for upgrade to fire alarm and smoke extract system dated October 2011 {MAX00017497/6-7}.

maintenance of the system before responding to Paul Dunkerton.[1419] There is no evidence that she did so.

43.41 By omitting that information from its reply, the TMO failed to give the leaseholders a full and accurate account of the investigation carried out into the fire, failed to inform them, and indeed other residents, of the operational status of the system and provided them with false assurances about the protection the system would provide in the event of a fire.

The TMO's review of the action plan dated 20 November 2012

43.42 In April 2013, after receiving the leaseholders' complaint, the TMO reviewed Carl Stokes's Record of Significant Findings and Action Plan dated 20 November 2012.[1420] A version of the Action Plan was produced with an additional column containing comments following a review in April 2013.[1421] In response to his request for confirmation that the smoke ventilation system had been regularly tested and maintained, there is a comment that the TMO had been informed

1419 Wray {Day144/36:1-7}; {Day144/39:15-18}.
1420 TMO review in April 2013 of Carl Stokes's Record of Significant Findings and Action Plan dated 20 November 2012 {MAX00001426}.
1421 TMO review in April 2013 of Carl Stokes's Record of Significant Findings and Action Plan dated 20 November 2012 {MAX00001426/1}.

that the vent needed changing and that RGE had said that it could not guarantee that in the event of an emergency the system would work.[1422] A report was said to have been sent to someone and additional copies were to be provided to Alex Bowman. The action was marked as completed by Ricki Sams.[1423]

43.43 Janice Wray accepted that she had seen that action plan and the findings of the review.[1424] She accepted, therefore, that from at least April 2013 she had known that the system was not sure to work[1425] but she took no steps at that stage to put in place any measures to mitigate the risk it presented.[1426] She accepted that it had been her job to make sure that the relevant department was aware of its responsibility to carry out repairs, but she did not accept that she had been responsible for ensuring that the work was in fact carried out, or that she had had the ability to do so.[1427] That responsibility lay with the contracts management team, which had the expertise needed to

1422 TMO review in April 2013 of Carl Stokes's Record of Significant Findings and Action Plan dated 20 November 2012 {MAX00001426/7} item 23c.
1423 TMO review in April 2013 of Carl Stokes's Record of Significant Findings and Action Plan dated 20 November 2012 {MAX00001426/7} item 23c.
1424 Wray {Day144/65:13-17}. The document metadata for the TMO's review of the action plan also states that it was last modified on 4 June 2013 by Janice Wray: {MAX00001426/1}.
1425 Wray {Day144/67:4-19}.
1426 Wray {Day144/67:20-25}.
1427 Wray {Day144/68:1-25}.

determine what was required.[1428] We disagree. Janice Wray, as the competent person, was responsible for overseeing the TMO's compliance with the Fire Safety Order. In particular, she had a responsibility to make sure that the smoke ventilation system was either repaired or, if that was not viable, replaced and mitigating measures put in place pending its replacement.

RGE's inspection of the system in October 2013

43.44 RGE carried out a further test of the system on 11 October 2013, which identified the same problems as had been described in its report dated 9 August 2011.[1429] The test report stated that the dampers were still not functioning correctly and could not be guaranteed to work correctly in an emergency.[1430] RGE had provided a quotation for remedial work in May 2010, but the work was evidently still outstanding.[1431] It seems that no immediate action was taken to remedy the defects because of the plan to modernise the system as part of the refurbishment. No measures

1428 Wray {Day144/68:1-25}.
1429 RGE engineers' service/maintenance report dated 11 October 2013 {TMO00879757}.
1430 RGE engineers' service/maintenance report dated 11 October 2013 {TMO00879757/3}.
1431 RGE maintenance report on the smoke ventilation system at Grenfell Tower dated 12 May 2010 {RBK00013637/8}.

were put in place to mitigate the increased risk presented by those defects pending the completion of that work.

Maintenance records

43.45 On 23 January 2014, Matt Smith of Max Fordham sent an email to Simon Coleman of RGE asking for the test and maintenance records for the smoke ventilation system to assist in formulating a submission to building control on the designs for the proposed new system.[1432] Later that day, Dil Singh of RGE sent him a maintenance report for the system, which, although undated, was the same as the inspection report dated 12 May 2010.[1433] Dil Singh told Mr Smith that RGE had told the TMO following every service visit that it could not guarantee that the system would work.[1434]

43.46 It is not clear why Dil Singh did not give Max Fordham the test reports dated 9 August 2011 and 11 October 2013, given the more serious and recent concerns that they raised

1432 Email from Matt Smith to Simon Coleman on 23 January 2014 {MAX00004262/3}.
1433 Email from Dil Singh to Matt Smith on 23 January 2014 {MAX00004262/1}; Undated RGE maintenance report for the smoke ventilation system at Grenfell Tower {MAX00018264}.
1434 Email from Dil Singh to Matt Smith on 23 January 2014 {MAX00004262/1}.

about the operation of the system.[1435] Despite a number of further requests from Matt Smith and Claire Williams between January and March 2014 for the test and maintenance records and for clarity about the current condition of the system, RGE did not provide either.[1436] It is not clear why, but there is evidence that the TMO had previously experienced problems obtaining documents from RGE.[1437] As it was, RGE's contract came to an end on 31 March 2014.[1438]

LFB visit to Grenfell Tower on 12 March 2014

43.47 On 12 March 2014, Matthew Ramsey and Ben Dewis, LFB fire safety inspecting officers, and Daniel Hallisey, the local fire station manager, visited Grenfell Tower with Claire Williams and

1435 RGE maintenance report on AOV system at Grenfell Tower dated 9 August 2011 {TMO00894311/5}; RGE engineers service/maintenance report dated 11 October 2013 {TMO00879757/3}.

1436 Email from Matt Smith to Dil Singh on 24 January 2014 {MAX00004266/1}; Email from Matt Smith to Claire Williams on 3 February 2014 {MAX00004281/1}; Email from Dil Singh to Claire Williams on 6 February 2014 {MAX00004293}; Email from Duncan Campbell to Claire Williams on 13 February 2014 {MAX00004306}; Email from Duncan Campbell to Claire Williams on 28 February 2014 {MAX00004329}; Email from Claire Williams to Duncan Campbell on 3 March 2014 {EXO00000644}; Email from Claire Williams to Dil Singh on 3 March 2014 {MAX00004330}.

1437 See, for example, email from Gary Mitchell to Peter Maddison on 21 February 2013 {TMO10002270/1}; Emails between Roger Greene and Gary Mitchell on 14 March 2013 {CST00004790}.

1438 Craig {RGE00000010/1} page 1, paragraph 1; RGE Maintenance Contract {RGE00000004/3} paragraph 3.2.

Bruce Sounes.[1439] During the visit, consistent with RGE's previous findings, Matthew Ramsey identified that about 25-30 percent of the vents on the smoke ventilation system were not in the correct position.[1440] He was sufficiently concerned about the state of the system to turn his visit into a formal audit and threatened to issue an enforcement notice requiring the TMO to demonstrate within four to six weeks that the system was fully operational.[1441]

43.48 After the visit Claire Williams sent an email to Janice Wray, with a copy to Carl Stokes, telling her of the outcome and suggesting that Ms Wray chase up RGE for the servicing records.[1442]

43.49 Carl Stokes replied to Claire Williams' email later that day with a copy to Janice Wray. In relation to Matthew Ramsey's concern about the system, he said that the matter had been raised on numerous occasions, but that RGE had failed to provide servicing and maintenance information.

1439 Email from Bruce Sounes to Claire Williams and Janice Wray on 13 March 2014 {TMO10005515/3}.

1440 Email from Claire Williams to Janice Wray on 12 March 2014 {TMO10005515/4-5}; Ramsey {LFB00032092/6-7} pages 6-7, paragraphs 19 and 23.2.

1441 Ramsey {MET00071003/4} page 4; Ramsey {LFB00032092/6} page 6, paragraphs 19-20; Email from Claire Williams to Janice Wray on 12 March 2014 {TMO10005515/5}; Email from Bruce Sounes to Claire Williams and Janice Wray on 13 March 2014 {TMO10005515/3}.

1442 Email from Claire Williams to Janice Wray on 12 March 2014 {TMO10005515/4-5}.

He suggested that if the LFB issued an enforcement notice, it would be challenged and that the LFB should be asked to serve it on RGE as the maintenance contractor.[1443]

43.50 On 17 March 2014, Carl Stokes visited the tower at the request of Claire Williams to investigate the LFB's concerns.[1444] He set out his findings in a letter to her dated 18 March 2014.[1445] His inspection of the smoke ventilation system appears to have been limited to what he described as the "smoke extract panel", which he said was "showing healthy", and RGE's maintenance logbook, which he appended to his letter.[1446] For reasons which are not clear, the logbook did not contain entries for the tests carried out on 9 August 2011 and 11 October 2013, which Carl Stokes had not seen.[1447] As a result, he

1443 Carl Stokes email to Claire Williams on 12 March 2014 {CST00001426/1}.
1444 Wray {TMO00000890/10} page 10, paragraph 46.
1445 Letter from Carl Stokes to Claire Williams on 18 March 2014 {CST00003100}.
1446 Letter from Carl Stokes to Claire Williams on 18 March 2014 {CST00003100/2}.
1447 The logbook contained only two entries one dated 11/5/2010, which possibly relates to the test report on 12 May 2010, and the other incorrectly dated "15/15/2013", which identified a faulty relay on 15th floor: {CST00003100/14-15}. Carl Stokes interpreted that to mean "15/12/2013" so that the inspection was in date: {CST00003100/2}. There is, however, a separate record of a test to the fire alarm system associated with the smoke ventilation system on 15/05/2013 so, in our view, that is the more likely date: {RGE00000005}. Carl Stokes stated that "the previous loose page in the logbook" was full, but he did not append it: {CST00003100/2}.

concluded that the logbook showed that RGE had found the system to be generally in working order at the last service.[1448]

43.51 Carl Stokes said that he had also inspected those parts of the system that were visible, but he did not refer to that in his letter.[1449] Nor did he refer to Matthew Ramsey's finding that 25-30 percent of the vents were not working, although he said that he thought he had done so.[1450] He recommended that the contractor be asked to service the system sooner rather than later.[1451] Neither Claire Williams nor Janice Wray raised with him the fact that he had not recorded Matthew Ramsey's findings or the fact that his assessment was, on the face of it, at odds with them. Janice Wray did not tell him that RGE had said that it could not guarantee the system would work in the event of the fire, a matter of which she had been aware from at least April 2013.[1452]

1448 Letter from Carl Stokes to Claire Williams on 18 March 2014 {CST00003100/11}; Carl Stokes said that he understood from RGE's servicing records that the system was functional, notwithstanding Matthew Ramsey's findings, Stokes {Day139/22:19}-{Day139/23:8}.

1449 Stokes {Day139/24:18}-{Day139/25:10}.

1450 Stokes {Day139/26:23}-{Day139/27:1}.

1451 Letter from Carl Stokes to Claire Williams on 18 March 2014 {CST00003100/11}.

1452 As discussed earlier in this section, see the TMO's review in April 2013 of the Record of Significant Findings and Action Plan dated 20 November 2012 {MAX00001426/7} item 23c.

Notice of deficiencies

43.52 On 24 March 2014, the LFB served a deficiency notice on the TMO.[1453] In summary, it stated that about a quarter of the dampers in the smoke ventilation system were not working, which indicated that it had not been maintained in effective working order.[1454] It stated that that was a breach of Articles 11(1) and 17(1) of the Fire Safety Order[1455] and that effective monitoring and maintenance of the system was required to remedy the breach.[1456] It said those steps should be taken by 5 May 2014.[1457]

43.53 Matthew Ramsey decided to issue a deficiency notice rather than an enforcement notice because in his experience the TMO, as a responsible person, generally acted on the LFB's advice and could be trusted to take remedial action within the time allowed and because the imminent refurbishment of the building was subject to the oversight of building control.[1458] When they

1453 LFB Deficiency Notice for Grenfell Tower dated 24 March 2014 {LFB00032101/1}.
1454 LFB Deficiency Notice for Grenfell Tower dated 24 March 2014 {LFB00032101/3}.
1455 LFB Deficiency Notice for Grenfell Tower dated 24 March 2014 {LFB00032101/3}.
1456 LFB Deficiency Notice for Grenfell Tower dated 24 March 2014 {LFB00032101/3}.
1457 LFB Deficiency Notice for Grenfell Tower dated 24 March 2014 {LFB00032101/1}.
1458 Ramsey {LFB00083855/7} page 7, paragraph 19.

had spoken after the visit, Janice Wray had satisfied him that there was a plan to replace the system during the refurbishment.[1459] However, he expected the TMO to ensure that the existing system was working by 5 May 2014, which was necessary to protect both residents and firefighters.[1460]

43.54 In the event, that did not happen. Claire Williams said that it had not been possible to produce a temporary solution to the problem in advance of the refurbishment.[1461] There is evidence that she thought about that following the receipt of the deficiency notice. For example, in an email to Matt Smith and Bruce Sounes on the 25 March 2014, she said that she was looking at the possibility of fixing the dampers in the open position,[1462] but Matt Smith advised against that because it would simply allow smoke to spread from floor to floor.[1463] Claire Williams subsequently sent an email to Janice Wray and Alex Bosman on 17 April 2014 suggesting they discuss the options

1459 Ramsey {LFB00032092/7} page 7, paragraph 23.2; Ramsey {Day147/38:16}-{Day147/39:3}.
1460 Ramsey {Day147/38:1-4}; Ramsey {MET00071003/5} page 5.
1461 Williams {Day121/127:15}-{Day121/128:8}.
1462 Email from Claire Williams to Matt Smith on 25 March 2014 {MAX00004366/3-4}.
1463 Email from Matt Smith to Claire Williams on 25 March 2014 {MAX00004366/3}. Claire Williams had also emailed Michael Lyons on 3 April 2014 about a “temporary option” for the smoke ventilation system: {TMO00856447}.

open to the TMO before the time for remedial work allowed by the deficiency notice expired on 5 May 2014. She had already been advised by Max Fordham that the only option available was to carry out the full modernisation work.[1464] It is not clear whether that discussion ever took place.

43.55 Despite the developing recognition that it was not possible to find a temporary solution to the problem, the TMO had the system serviced again, presumably in response to Carl Stokes's recommendation and the deficiency notice.[1465] On 17 March 2014, after the LFB had visited Grenfell Tower, Alex Bosman had instructed Colt International Ltd, a company specialising in the design, supply and maintenance of smoke control systems, which serviced smoke ventilation systems in some of the TMO's other properties, to quote for servicing the system.[1466] However, the proposal for servicing that Colt produced on 28 March 2014 does not appear to have been

1464 Email from Claire Williams to Alex Bosman copying in Janice Wray on 22 April 2014 {TMO00856473}.

1465 Letter from Carl Stokes to Claire Williams on 18 March 2014 {CST00003100/11}; LFB Deficiency Notice for Grenfell Tower dated 24 March 2014 {LFB00032101/3}.

1466 Email from Alex Bosman to Debbie Sanderson on 17 March 2014 {TMO00856389/3}.

pursued, possibly because the inspection on which it had been based had not identified any of the defects noted by the LFB.[1467]

43.56 On 11 September 2014, Simon Lawrence sent an email to Claire Williams asking whether the LFB had returned to check the system after the time allowed in the deficiency notice had expired.[1468] The answer was that it had not. It is evident from that correspondence that almost six months after the deficiency notice, the smoke ventilation system had still not been properly inspected and serviced.

Meeting with Rydon to discuss interim measures

43.57 Also on 11 September 2014, Claire Williams sent an email to Janice Wray inviting her to a discussion about the smoke ventilation system on 16 September 2014.[1469] She explained that Rydon had been working with JS Wright to find an interim solution to the problem. Janice Wray forwarded the email to Carl Stokes and invited

1467 Colt service proposal for the smoke ventilation system at Grenfell Tower dated 28 March 2014 {TMO10005654}.
1468 Email from Simon Lawrence to Claire Williams on 11 September 2014 {TMO00856902/1-2}.
1469 Email from Claire Williams to Janice Wray on 11 September 2014 {CST00003178/1}.

him to the meeting as well.[1470] That appears to have been the first time the TMO had given any consideration to implementing measures to mitigate the risk presented by the defects in the existing system pending the completion of the refurbishment and the installation of a new system. However, we have not seen any minutes of the proposed meeting and neither Carl Stokes[1471] nor Claire Williams[1472] had any recollection of it. It is not clear, therefore, whether the meeting actually took place.

Meeting with the LFB fire safety team on 18 September 2014

43.58 A progress meeting for the Grenfell Tower project, attended by Claire Williams, was held on 16 September 2014.[1473] The minutes of the meeting record that the smoke ventilation system was currently not working. Rydon was asked to try to bring it up to contracted specification as soon as possible. If that was not possible, the system would be returned to the original specification.[1474]

1470 Email from Janice Wray to Carl Stokes on 12 September 2014 {CST00003178/1}.

1471 Stokes {Day139/29:24}-{Day139/30:21}. He also did not mention it in his letter to Janice Wray dated 17 September 2014 {CST00030043/9} item 27-28.

1472 Williams {Day121/138:18}-{Day121/139:8}.

1473 Grenfell Tower project progress meeting no.3 on 16 September 2014 {TMO00830089}.

1474 Grenfell Tower project progress meeting no.3 on 16 September 2014 {TMO00830089/4} item 9.2.

The minutes recorded that Claire Williams would keep the LFB informed about the work,[1475] but she said that Janice Wray was the main point of contact with the LFB.[1476] Janice Wray thought that Claire Williams and the project team were responsible for keeping the LFB informed about the work to the smoke ventilation system.[1477] Neither of them had a clear understanding of their responsibilities in that respect, but they agreed that the bi-monthly meetings, which they both attended, were the time for informing the LFB fire safety team about the refurbishment. Apart from that, Rydon spoke to the local fire crews when they visited the site.[1478]

43.59 On 18 September 2014, Claire Williams and Janice Wray attended one of the regular meetings with the LFB fire safety team.[1479] Ms Williams told them that the smoke ventilation system was to be modernised as a priority. She also drew attention to the fact that while the work

1475 Grenfell Tower project progress meeting no.3 on 16 September {TMO00830089/4} item 9.3.

1476 Williams {Day121/136:3-23}; Williams {Day121/144:9-19}. Claire Williams said that she kept Janice Wray updated as to the progress of the works to the AOV system: Williams {Day121/140:25}-{Day121/141:3}.

1477 Wray {Day144/54:22}-{Day144/55:10}; {Day144/56:1-7}.

1478 Williams {Day121/141:4-20}; {Day121/144:20}-{Day121/145:8}; Wray {Day144/55:2-10}; {Day144/58:21}-{Day144/59:5}.

1479 Minutes of bi-monthly meeting between TMO and LFB fire safety team on 18 September 2014 {TMO10023364}.

was going on the system would not be working at full capacity. That had also been brought to Carl Stokes's attention.[1480]

43.60 According to the minutes of the meeting, neither Claire Williams nor Janice Wray told the LFB that the existing system was not working.[1481] Claire Williams said that the statement that the system "would not be working at full capacity" while the work was going on did not do justice to the state of the existing system, but that the LFB should have known that it was not working because it had issued the deficiency notice.[1482] The minutes also suggest that the TMO thought about putting in place interim measures only during the modernisation work and did not consider taking steps to mitigate the immediate risk presented by the defects in the existing system.[1483]

43.61 Later that day Claire Williams sent an email to Simon Lawrence telling him that the smoke ventilation system would not be fully operational until after Christmas.[1484] It is evident from that

1480 Minutes of bi-monthly meeting between TMO and LFB fire safety team on 18 September 2014 {TMO10023364/3} item 6.
1481 Minutes of bi-monthly meeting between TMO and LFB fire safety team on 18 September 2014 {TMO10023364/2-3} item 6.
1482 Williams {Day121/149:23}-{Day121/150:7}.
1483 Minutes of bi-monthly meeting between TMO and LFB fire safety team on 18 September 2014 {TMO10023364/3} item 6.
1484 Email from Claire Williams to Simon Lawrence on 18 September 2014 {TMO00851824/1}.

email that at the meeting the LFB had also made a specific request, which was not reflected in the minutes, that the unavailability of the system during the period of the work should be taken into account in Rydon's and the TMO's fire risk assessments.

43.62 On 6 October 2014, Claire Williams told Janice Wray that although the ventilation system would be "in some sort of order" by Christmas, the new extractor fans in the roof plant room would probably not have been fitted, as they would be waiting for building control approval.[1485] In her response Janice Wray asked whether any steps could be taken to reinstate the ventilation and extraction system, even partially, before it was refurbished.[1486] We have not seen a direct response to that email, but it is evident from the subsequent correspondence that it was not considered possible to carry out temporary repairs to the system.

Chubb's inspection

43.63 On 29 September 2014, Alex Bosman instructed Chubb Fire and Security to service the smoke ventilation system at Grenfell Tower, which was

1485 Email from Claire Williams to Janice Wray on 6 October 2014 {TMO00851844/1-2}.

1486 Email from Janice Wray to Claire Williams on 6 October 2014 {TMO00851844/1}.

said to be “out of target”.[1487] He also instructed Chubb to contact Carl Stokes, who wished to meet their engineer.[1488] Mr Stokes met Chubb’s engineer at Grenfell Tower on 6 October 2014 to examine the smoke ventilation system, but it seems that he was unable to test it because a fault was showing on the fire alarm panel.[1489] The service certificate, therefore, recorded that further investigation of the system was required.[1490]

43.64 On 9 October 2014, Alex Bosman sent on to Claire Williams, Janice Wray and Carl Stokes an email that he had sent to Chubb that day, in which he had said that the system had been confirmed as beyond repair and scheduled for replacement shortly.[1491] It is not clear whether the description of the system as “beyond repair” came from Chubb’s inspection or from Rydon’s investigations or something else, but, in any case, in our view, it should have been clear to the recipients of

1487 Email from Alex Bosman to Steve Plumridge and Adria Frith copying in Janice Wray and Siobhan Rumble on 29 September 2014 {CST00001451/3}.
1488 Email from Alex Bosman to Adrian Frith copying in Carl Stokes on 29 September 2014 {CST00001451/1}.
1489 Email from Janice Wray to Alex Bosman copying in Carl Stokes on 6 October 2014 {TMO10007591}; Email from Carl Stokes to Alex Bosman on 7 October 2014 {CST00001451/1}.
1490 Email from Janice Wray to Alex Bosman copying in Carl Stokes on 6 October 2014 {TMO10007591}. The Inquiry has not been provided with a copy of Chubb’s service certificate.
1491 Email from Alex Bosman to Claire Williams, Janice Wray and Carl Stokes on 9 October 2014 {CST00001244/1}.

that email that the existing system could neither be temporarily repaired nor maintained pending its modernisation.

43.65 Nonetheless, neither Claire Williams nor Janice Wray told the LFB that the existing system was beyond repair, nor did they pass on the information that the completion of the work was likely to be delayed beyond Christmas.[1492] When it became clear that the work would not be completed by that time, neither of them sought to implement mitigating measures or to inform the residents that the system was not operating.[1493] Claire Williams had suggested that her concern about the risk to residents had been allayed by the plan to have the system in some kind of working order by Christmas.[1494] If it was not possible, as had by then become apparent, further measures were required.

The fire risk assessment in October 2014

43.66 Carl Stokes carried out a fire risk assessment of Grenfell Tower on 17 October 2014.[1495] In the section headed “Any other relevant

1492 Williams {Day121/156:6-18}.
1493 Williams {Day121/139:10}-{Day121/140:1}; {Day121/156:19}-{Day121/159:18}.
1494 Williams {Day121/139:10}-{Day121/140:1}; {Day121/142:2-14}.
1495 Fire Risk Assessment of Grenfell Tower dated 17 October 2014 {CST00003157}.

information on this premises" he summarised the three requirements of the deficiency notice and stated that they had been covered in the assessment and accompanying Record of Significant Findings.[1496] In respect of the smoke ventilation system, he referred to the LFB's requirement that a system of monitoring should be implemented in relation to the equipment in the lobbies and a maintenance schedule put in place so that the system was kept in good working order.[1497]

43.67 Carl Stokes did not refer to the fact that the deficiency notice stated that about a quarter of the dampers were not working and that the system had not been maintained in effective working order.[1498] Although he did state where the notice could be found, the omission of that information meant that his summary failed to convey the seriousness of the LFB's findings.[1499]

43.68 In section 19 of his fire risk assessment, headed "Fixed Fire Systems and Equipment", he described the smoke ventilation system and

1496 Fire Risk Assessment of Grenfell Tower dated 17 October 2014 {CST00003157/7-8}.
1497 Fire Risk Assessment of Grenfell Tower dated 17 October 2014 {CST00003157/8}.
1498 LFB Deficiency Notice for Grenfell Tower dated 24 March 2014 {LFB00032101/3}.
1499 Carl Stokes disputed in his oral evidence that he had downplayed the seriousness of the situation: Stokes {Day139/42:2-6}.

recorded that it had been serviced by RGE Services on the 11 October 2013. He also recorded that it was being modernised as part of the refurbishment. However, he did not mention that RGE had said in its service report that it could not guarantee that the system would work; nor did he refer to Matthew Ramsey's findings on 12 March 2014 that 25-30% of the dampers were not working.[1500] He did not refer either to the fact that Chubb had been unable to carry out a service of the system on 6 October 2014, or to Alex Bosman's email of 9 October 2014 in which he had described the system as "beyond repair".[1501] In short, he failed to address any of the information before him which showed that the system was not working. Despite knowing that, he maintained his assessment that the fire risk at Grenfell Tower was tolerable.[1502] In those respects, his fire risk assessment gave the misleading impression that the system was operational, at least to the extent that it did not affect the overall risk rating for the building.

1500 Email from Claire Williams to Janice Wray on 12 March 2014 {TMO10005515/4}; Email from Bruce Sounes to Claire Williams and Janice Wray on 13 March 2014 {TMO10005515/3}.

1501 Email from Alex Bosman to Claire Williams, Janice Wray and Carl Stokes on 9 October 2014 {CST00001244/1}.

1502 Fire Risk Assessment of Grenfell Tower dated 17 October 2014 {CST00003157/10}.

43.69 Mr Stokes should have recorded in his fire risk assessment that the smoke ventilation system was not working and should have taken account of that in his assessment of the risk.[1503] He said that he had not referred to the fact that the system was considered to be beyond repair because it was being modernised as part of the refurbishment,[1504] but that did not justify ignoring the fact that it was not then working.[1505] He also said that, because there was a "stay put" strategy in place, the fact that the system was defective would increase the risk to residents only slightly.[1506] Whatever the merits of that suggestion, however, he did not deal with it in his fire risk assessment.

43.70 In his accompanying Record of Significant Findings and Action Plan, Carl Stokes stated that Rydon was going to upgrade the existing smoke ventilation system in the lobbies and the refuse chute rooms.[1507] He asked what compensatory measures, if any were being put in place whilst the work was being done, but he did not ask whether any measures had been put in place to mitigate the immediate risk

1503 Todd {Day168/31:7}-{Day168/32:23}; Lane {Day172/19:7-12}.
1504 Stokes {Day139/35:3-16}.
1505 Lane {Day172/19:14}-{Day172/20:17}.
1506 Stokes {Day139/35:17}-{Day139/37:23}.
1507 Record of Significant Findings and Action Plan dated 17 October 2014 {CST00003177/8} item 19d.

presented by the defects in the existing system, nor did he recommend any. He did not include any assessment of the extent to which there were any measures which might adequately mitigate that risk.

43.71 Neither Janice Wray nor Claire Williams pointed out to Carl Stokes that he had not dealt in his risk assessment with the failure of the existing system. That was despite the fact that Matthew Ramsey had specifically asked Ms Wray to ensure that Carl Stokes addressed his concerns about the system,[1508] and despite the LFB's request at the meeting on 18 September 2014 to ensure that the unavailability of the system during the modernisation work was covered in its fire risk assessment.[1509]

43.72 In section 23 of his fire risk assessment, headed "Testing and maintenance", Carl Stokes responded to the question "Is there a monthly testing and annual servicing and maintenance of any automatic opening vents along with any associated equipment/devices, with records kept?" with the answer "No".[1510] He did not include any comment by way of explanation,

1508 Email from Matthew Ramsey to Janice Wray on 14 March 2014 {CST00003115/1}.
1509 Email from Claire Williams to Simon Lawrence on 18 September 2014 {TMO00851824/1}.
1510 Fire Risk Assessment of Grenfell Tower dated 17 October 2014 {CST00003157/29}.

even though good practice requires that in such circumstances the fire risk assessor should explain the answer and make a corresponding entry in the action plan.[1511] Nor did he record that Chubb had been unable to service the system on 6 October 2014,[1512] but he did record that he did not know whether the occupier's tests and inspections of the fire systems within the building were being undertaken.[1513] In his accompanying action plan he recommended that the occupier should carry out weekly tests of the system and record the results.[1514]

43.73 That was the fourth time in as many fire risk assessments that Carl Stokes had said that he did not have any information about the maintenance of the smoke ventilation system and had asked for it to be provided. In our view, even though the system was considered to be beyond repair, that was simply not good enough. He ought to have insisted on being given that information before he completed his assessment.[1515] If in October 2014 he had asked directly what had been done

1511 Todd {Day168/34:5}-{Day168/36:3}.
1512 Email from Carl Stokes to Alex Bosman on 7 October 2014 {CST00001451/1}.
1513 Fire Risk Assessment of Grenfell Tower dated 17 October 2014 {CST00003157/30}.
1514 Record of Significant Findings and Action Plan dated 17 October 2014 {CST00003177/9} item 23c.
1515 Todd {Day168/26:24}-{Day168/27:10}; Lane {Day172/14:14}-{Day172/15:7}; Carl Stokes's Fire Risk Assessment of Grenfell Tower dated 17 October 2014 {CST00003157/8}.

in response to his previous recommendations, he might have discovered the chronic nature of the failure to maintain the system and taken account of it in his assessment.

The meeting with the LFB on 13 November 2014

43.74 On 12 November 2014, in advance of Janice Wray's meeting with the LFB fire safety team the following day, Claire Williams sent an email to Simon O'Connor asking what it was currently thought could be done to put the smoke ventilation system at Grenfell Tower into working order.[1516] Simon Lawrence replied the next day saying that the design team had been trying to find a solution which did not involve carrying out work that would later have to be discarded, but that one was unlikely to be available before Christmas.[1517]

43.75 Claire Williams did not pass that information to Janice Wray until after her meeting with the LFB that morning,[1518] but apparently the subject of the smoke ventilation system had not been

1516 Email from Claire Williams to Simon O'Connor on 12 November 2014 {TMO00852028/3}.
1517 Email from Simon Lawrence to Simon O'Connor and Claire Williams on 13 November 2014 at 08:50 {TMO00852028/1-2}.
1518 Email from Claire Williams to Janice Wray on 13 November 2014 at 13:59 {TMO00852028/1}.

raised.[1519] However, Ms Wray had been aware from early October that the existing system was beyond repair and that it would, at best, only be partly operational by Christmas, but she did not share that information with the LFB .[1520] Nor did she or Claire Williams pass on the information she had been given by Simon Lawrence to the LFB.[1521] There was evidence that the project team was keeping the local LFB operational crew informed, but Janice Wray accepted that she and Claire Williams should have kept the LFB Fire Safety team informed.[1522]

The Leaseholders' Association complaint, January 2015

43.76 On 2 January 2015, the Leaseholders' Association sent an email to Councillor Blakeman and Councillor Dent-Coad seeking confirmation that the smoke ventilation system at Grenfell Tower was going to be replaced as part of the refurbishment.[1523] Later that day, Mr Maddison sent a draft response to Councillor Blakeman,

1519 Email from Janice Wray to Claire Williams on 13 November 2014 {TMO00852028/1}.
1520 Email from Claire Williams to Janice Wray on 6 October 2014 {TMO00851844}; Email from Alex Bosman to Claire Williams, Janice Wray and Carl Stokes on 9 October 2014 {CST00001244/1}.
1521 Wray {Day144/54:15-20}.
1522 Wray {Day144/55:2}-{Day144/57:9}.
1523 Email from Claire Williams to Janice Wray on 5 January 2015 {TMO00846731}.

in which he said that the system was currently beyond economic repair and that the TMO was working with building control to agree a design for a system that would meet current standards.[1524]

Meeting with the LFB, 20 January 2015

43.77 On 13 January 2015, in preparation for a meeting with the LFB on 20 January 2015 Claire Williams asked Matt Smith whether building control had approved the plans for replacing the smoke ventilation system and whether any steps were being taken in the meantime to produce an effective system.[1525] Matt Smith said in reply that a technical submission had been prepared comprising a two-stage scheme under which natural ventilation would be reinstated as an interim measure before new pressure differential controls and fans were added later. However, he was unable to say when the work was likely to begin.[1526]

43.78 The minutes of the meeting on 20 January 2015 suggest that the information obtained from Max Fordham was not passed on to the LFB.[1527]

1524 Email from Peter Maddison to Councillor Blakeman on 5 January 2015 {TMO10008422}.
1525 Email from Claire Williams to Matt Smith on 13 January 2015 {TMO10042871/2}.
1526 Email from Matt Smith to Claire Williams on 13 January 2015 {TMO10042871/1}.
1527 Minutes of the bi-monthly meeting between the TMO and LFB fire safety team on 20 January 2015 {TMO00844037}.

In the event, only Janice Wray attended the meeting on behalf of the TMO[1528] and although Claire Williams thought it likely that she had sent Matt Smith's email on to Janice Wray, she could not remember having done so.[1529] We are satisfied that she did not send it to the LFB herself.[1530] However, even if Janice Wray had not received the email, she was already aware that the work had not been completed and should have drawn that to the attention of the LFB.

43.79 On 21 January 2015, Claire Williams told Janice Wray that the first phase of the work, involving the creation of a passive system, was programmed to start on 16 March 2015 and be completed by 1 May 2015 and that the second phase, involving the installation of fans and controls, was programmed to start on 5 May 2015 and be completed by 19 June 2015.[1531] It does not appear that either Janice Wray or Claire Williams passed that information on to the LFB at the time.[1532]

1528 Minutes of the bi-monthly meeting between the TMO and LFB fire safety team on 20 January 2015 {TMO00844037}.
1529 Williams {Day121/190:3-8}.
1530 Williams {Day121/190:3-8}.
1531 Email from Claire Williams to Janice Wray on 21 January 2015 {TMO10042915/2}.
1532 It was provided at the meeting on 23 March 2015: {RBK00013999/3} item 9.

Rydon Fire Risk Assessment, 20 February 2015

43.80 On 20 February 2015, Simon Camps and Simon O'Connor of Rydon carried out a project fire risk assessment in relation to Grenfell Tower.[1533]

43.81 They identified as a hazard that the detection and alarm systems and the smoke ventilation system did not work.[1534] Each of them was marked as high risk.[1535] Among their recommendations were that the TMO obtain a fire risk assessment that took into account current circumstances.[1536]

43.82 On 18 March 2015, Simon O'Connor sent the fire risk assessment to Claire Williams.[1537] She did not notice that Carl Stokes had not addressed those defects in the system in his own risk assessment, nor did she notice the criticism that was made of his assessment.[1538] Accordingly, she did not ask Carl Stokes to review his assessment to take account of the fact that the smoke ventilation system did not work properly, nor did

1533 Rydon Project Fire Risk Assessment dated 20 February 2015 {RYD00035553/1}.
1534 Rydon Project Fire Risk Assessment dated 20 February 2015 {RYD00035553/10}.
1535 Rydon Project Fire Risk Assessment dated 20 February 2015 {RYD00035553/10}.
1536 Rydon Project Fire Risk Assessment dated 20 February 2015 {RYD00035553/10}.
1537 Email from Simon O'Connor to Claire Williams on 18 March 2015 {RYD00035549}.
1538 Williams {Day122/10:3}-{Day122/12:21}.

she ask Janice Wray to do so.[1539] Indeed, she could not recall having given the document to Janice Wray at all.[1540]

Further updates to the LFB and delays to the upgrade work

43.83 The work to modernise the system did not begin until April 2015[1541] and the new system was not fully commissioned until 28 April 2016.[1542] Janice Wray and Claire Williams kept the LFB informed of the progress of the work during that period.[1543] The TMO also implemented measures during that period intended to mitigate the risk caused by the absence of a smoke ventilation system while it was being installed. That took the form of familiarisation visits by local fire crews, increased and enhanced inspections by estate staff, health and safety visits, additional inspections by Carl Stokes and preventing contractors from carrying out hot work.[1544]

1539 Williams {Day122/12:22}-{Day122/13:4}; {Day122/14:11}-{Day122/15:2}.
1540 Williams {Day122/15:3-4}.
1541 Emails between Simon O'Connor, Claire Williams and Matt Rawlings on 22-23 April 2015 {TMO00858424}.
1542 PSB Above Ground Commissioning Report dated 28 April 2016 {PSB00000224/7}.
1543 Minutes of the bi-monthly meetings between the TMO and LFB fire safety team on 23 March 2015, 19 August 2015 and 4 March 2016: {RBK00013999/3} item 9; {LFB00000063/4} item 9.1; {TMO10014736/3} item 10.1.
1544 Record of Significant Findings and Action Plan dated 17 October 2014 {TMO10017386/9} row 41; Minutes of the bi-monthly meeting between the TMO and LFB fire safety team on 19 August 2015: {LFB00000063/4} item 9.1.

Chapter 44
Lifts

Introduction

44.1 During Phase 1 there was evidence that in the early stages of the fire the firefighters had been unable to secure control over the lifts in Grenfell Tower. That meant that the they had been unable to use the lifts in their firefighting and search and rescue operations; it also meant that some occupants of the tower were able to use the lifts in an attempt to escape.[1545] The inability of the firefighters to bring the lifts under their control is therefore relevant to the circumstances in which some residents died[1546] and it is therefore necessary to consider why the firefighters were not able to bring the lifts under their control on the night of the fire.

Background

44.2 In 2005, the lifts serving Grenfell Tower were substantially refurbished and many of their components were replaced. At that time the lifts served only the ground floor, the walkway floor

[1545] Phase 1 Report Volume IV paragraph 33.13.
[1546] Phase 1 Report Volume IV paragraph 28.11.

(floor 2) and what became floors 4 to 23.[1547] As part of the refurbishment new flats were created on what became floors 1, 2 and 3. To accommodate those new flats it was necessary to extend service of the lifts to floors 1 and 3.[1548] The extent of that work, which was carried out between 2014 and 2015, seems to have been limited to creating two new lift openings and landing entrances and associated work, such as reprogramming of the software.

44.3 Over the course of time there have been developments in the specifications of lifts installed in high-rise buildings. A fireman's lift is one that is designed to enable firefighters to take control of it when responding to a fire in the building. A firefighting lift has a higher specification and is designed to transport firefighters and their equipment to the scene of a fire with the minimum amount of time and effort. It is fitted with a higher level of equipment and structural protection, a communication system and a secondary back-up power supply. Much evidence was heard about whether the lifts at Grenfell Tower were fireman's lifts or firefighting lifts and, if they were fireman's lifts, whether they could or should have been upgraded to firefighting lifts. For present purposes, however, only two points

1547 {TMO00853783/16}.
1548 Phase 1 Report Volume I paragraphs 6.38-6.39.

need to be made: first, at no stage were the lifts firefighting lifts, as they did not possess all the features of firefighting lifts required by the relevant contemporaneous standards;[1549] secondly, there is not enough evidence to enable us to determine whether it was reasonably practicable at any stage to upgrade the lifts so that they had at least those features of firefighting lifts that the physical constraints of the building would allow.

The fire control switch

44.4 There were two fire control switches at Grenfell Tower, one on the ground floor and one on floor 2 (the Walkway floor). The switch on the ground floor appeared older and at the time of the fire was connected, whereas the switch on floor 2 appeared newer but was not connected.[1550]

44.5 Email correspondence between Janice Wray and Claire Williams on 18 August 2014 showed that the entrance to the tower had been moved temporarily from the ground floor to the Walkway level.[1551]

1549 BS 5588-5: 1991, BS EN 81-72: 2003 and BS 5588-5: 2004. The lifts did not have many of the important features of a firefighting lift including, for example, a secondary power supply, water protection or a trap door.
1550 {MET00019973/19-21}.
1551 {CST00001858}.

44.6 In his Record of Significant Findings dated 17 October 2014 Carl Stokes noted that the entrance to the building had been moved to the Walkway level and asked whether the fire service override controls for the lifts had been moved.[1552] In his Record of Significant Findings dated 26 April 2016 he asked whether the controls for the lifts had been moved back down to street level.[1553] A spreadsheet that appears to be dated October 2016 states that he had received confirmation the controls had been moved back down to street level.[1554]

44.7 It is likely, therefore, that a new fire control switch was installed temporarily on floor 2 during the refurbishment in about August 2014. The switch on floor 2 was subsequently disconnected and the switch on the ground floor reconnected when the entrance was moved back to the ground floor. It is likely that that took place after April 2016, but it is difficult to be any more precise.

Maintenance and testing of the lifts

44.8 In the years before the fire the TMO produced various policies relating to lift safety, lift breakdowns and lift trap-ins.[1555] Those published

1552 {CST00001734/7}.
1553 {CST00002206/6}.
1554 {CST00000196/25-27}.
1555 {TMO00899279}; {TMO00899287}; {TMO00880413}; {TMO00880416}; {TMO00880418}; {TMO00880419}.

after 2011 required a lift engineer to carry out periodic visual checks of safety gear and other equipment, such as emergency alarms, emergency car lighting and lift machine room emergency lighting, in accordance with statutory regulations. The policies also required all lifts, hoists, disabled people's hoists and stairlifts to be inspected periodically by a competent engineer as required by statutory regulations, British Standards and manufacturers' instructions, and inspections to be recorded.[1556]

44.9 The policies also required checks to be carried out by staff, including the TMO's senior lift engineer. He was directed to carry out checks on safety gear, emergency alarms, emergency car lighting and lift machine room emergency lighting in accordance with regulations. Monthly checks of all fireman's switches were required.[1557] Responsibility for those checks passed to the TMO's lift maintenance contractor in January 2014.[1558]

44.10 The TMO also published a "Lift Safety (Passenger, Goods, and Fireman's) Policy and Procedure" dated 23 September 2013.[1559] It stated that lifts should be thoroughly examined by a

1556 See, for example, clause 10.0 in {TMO00880416/6}.
1557 {TMO00880421/30}; {TMO00880422/30}; {TMO00880423/30}; {TMO00880430}; {TMO00880430/30}.
1558 {TMO00880432/26}; {TMO00880430}.
1559 {TMO00880431}.

competent person, usually an insurance engineer, every six months and that a lift maintenance contract should be established with a competent lift maintenance company. The policy also required lifts to be checked weekly or monthly to ensure that they were operating correctly.[1560]

44.11 The TMO also produced a "Lift Safety Policy and Procedure" dated February 2014[1561] which dealt with statutory inspections and maintenance. Section 4.1, relating to planned preventative maintenance, stated that the TMO should appoint a competent lift contractor to carry out monthly maintenance checks on all lifts, to record maintenance on the lift log card and to carry out maintenance identified by inspections as soon as practicable. The policy also noted that that was to be supplemented by regular inspections of the lift cars by the estate staff and health and safety staff. Section 4.2 provided that the lifts should be thoroughly examined every 6 months.[1562] Subject to various minor changes, the substance of the policy remained in place until the fire.

1560 TMO Lift Safety (Passenger, Goods and Fireman's) Policy Procedure Clause 3.23 {TMO00880431/3}.
1561 {TMO00880433}.
1562 {TMO00880433/3-4}.

The PDERS maintenance contract

44.12 PDERS (an unincorporated trading division of Otis Ltd) was the TMO's planned preventative maintenance provider from 3 February 2014.[1563]

44.13 Based on the Description of the Works contained in paragraph 2.0 of the document entitled "Service Information and Preambles for the Lift Preventative Planned Maintenance and Repair Contract",[1564] PDERS was expected to provide fully comprehensive servicing of the lifts throughout RBKC's estate, including routine inspection, maintenance and repairs. Breakdown response repairs due to vandalism or misuse were not included. The contract required maintenance visits to take place monthly with a minimum period between visits of not less than 21 days.[1565]

44.14 The contract identified the maintenance tasks and how often they should be carried out. Codes designated the frequency of a task, so, for example, "M1" indicated that a task should be carried out monthly, "M2" that it should be carried out every two months, and so on.[1566] Under the

1563 Fallis-Taylor {PDR00000050/2} page 2, paragraph 9.
1564 {PDR00000049/43} paragraph 2.0.
1565 {PDR00000049/44} paragraph 2.1.1.
1566 {PDR00000049/45} paragrapgh 2.1.9.

heading of “Landing Entrances” the contract expressly provided that fireman’s control switches should be checked monthly.

44.15 The contract listed the lifts at Grenfell Tower (H090 and H091) and provided that a minimum of two hours should be spent each month on the maintenance of each of them.[1567] The evidence of Mark Wallis, a maintenance engineer at PDERS, was that a maintenance visit normally took about two hours for each lift.[1568]

Maintenance by PDERS

44.16 The service visit reports for lift H090 covering the period from February 2014 until the fire[1569] suggest that it suffered no significant defects. The repair visit reports[1570] also reveal no noteworthy problems with it.

44.17 Similarly, the service visit reports for lift H091 covering the period between February 2014 and June 2017[1571] show no significant faults. The repair visit reports for lift H091[1572] also disclose no significant problems.

1567 {PDR00000049/82}.
1568 Wallis {Day163/86:21-25}.
1569 {PDR00000047}.
1570 {PDR00000048}.
1571 {PDR00000041}.
1572 {PDR00000045}.

Testing by Bureau Veritas

44.18 Bureau Veritas is a testing, inspection and certification organisation which tests equipment, including lifting equipment, to assess whether it meets required technical standards.[1573]

44.19 Bureau Veritas was engaged by RBKC from January 2013 to carry out "thorough examinations" of all the lifts in the borough every six months, including those at Grenfell Tower.[1574] A thorough examination is a detailed examination of a lift and its associated equipment. It does not include maintenance or repairs.[1575]

44.20 The reports of the inspections carried out by Bureau Veritas in 2016 and 2017 were available to us. They identified some category A defects (defects that are or could become a danger to users), some category B defects (defects that do not affect safety but usually require some maintenance) and some category C defects (defects that call for observations or recommendations only).[1576]

1573 Veitch {BVL00000006/1} page 1, paragraph 2.
1574 Veitch {BVL00000006/8} page 8, paragraph 29.
1575 Veitch {BVL00000006/2-3} pages 2-3, paragraph 5.
1576 Lasisi {BVL00000015/2-3} pages 2-3, paragraphs 7-10.

44.21 On 7 January 2016, a Bureau Veritas engineer examined lifts H090[1577] and H091.[1578] He found no category A defects but several category B and C defects. On 2 June 2016, Bureau Veritas examined lift H090[1579] and lift H091 again.[1580] Again, no category A defects were found but several category B and C defects were identified.

44.22 On 2 November 2016, Isiaka Lasisi of Bureau Veritas examined lifts H090[1581] and H091.[1582] Although a category A defect was found in the latter, it did not relate to its fire safety features.[1583] The evidence shows that on 2 November 2016 the TMO raised the category A defects with PDERS and on 3 November 2016 an engineer examined the lifts and rectified them.[1584]

44.23 Michael Arnold of Bureau Veritas examined lifts H090 and H091 on 10 April 2017.[1585] Although he identified some category B defects, he found no category A defects. As no category A defects had been identified during the visit on 10 April 2017 and there is nothing to suggest that the inspection

1577 {MET00036488}.
1578 {MET00036489}.
1579 {MET00035852}.
1580 {MET00035853}.
1581 {BVL00000014}.
1582 {BVL00000016}.
1583 Lasisi {BVL00000015/5} page 5, paragraph 19.
1584 {MET00036245}
1585 {BVL00000008}.

was anything other than diligent, we conclude that there were no significant defects in the lifts at the time of the fire.

Maintenance and testing of the fire control switch

44.24 Although until January 2014 the TMO's policies (in draft from August 2011 and approved in June 2012) provided that its own lift engineer would test the fireman's switch each month,[1586] there is no evidence that the TMO did carry out any testing or maintenance of the fire control switch itself. PDERS said that the switch had been tested monthly from 2014 onwards, as the contract required. Although before that date the TMO's policies required it to be tested by its own lift engineer, it was not done regularly or, it seems, at all.[1587]

The lift maintenance contractor – PDERS

44.25 Not all the lifts maintained by PDERS had fire control switches and it was therefore decided not to include the fire control switch in the report forms.[1588] As a result, none of the service visit

1586 {TMO00880421/30}; {TMO00880430/30}.
1587 Cahalarn {Day164/68:12-19}; {Day164/69:1}; {Day164/70:3}.
1588 Fallis-Taylor {PDR00000050/6-7} pages 6-7, paragraph 25; Wallis {PDR00000036/3} page 3, paragraph 12.

reports produced by PDERS[1589] records testing of the fire control switch and there is no other written record of its having tested the switch.

44.26 From September 2016, Dave Smalley was the PDERS lift maintenance engineer for the North Kensington area, which included Grenfell Tower. He said that the fire control switch had been tested on each of his service visits in November and December 2016 and January and March 2017. He did not recall any problems with it.[1590]

44.27 From April 2017, Mark Wallis was the lift maintenance engineer for Grenfell Tower. He carried out service visits on 12 April 2017[1591] and 9 May 2017.[1592] He said he specifically remembered checking that the fire control switch had been in good working order on both occasions.[1593] However, after he had given evidence, a CCTV recording made on 9 May 2017 was obtained which covered his maintenance visit. It showed clearly that, contrary to his evidence, he had not tested the fire control switch on that occasion. In the light of that recording Mr Wallis accepted that he had not tested the

1589 {PDR00000047}; {PDR00000041}.
1590 Smalley {PDR00000029/5} page 5, paragraphs 25-28.
1591 {PDR00000047/34}; {PDR00000041/36}.
1592 {PDR00000047/35}; {PDR00000041/37}.
1593 Wallis {PDR00000036/3} page 3, paragraph 12; {PDR00000036/5-6} pages 5-6, paragraphs 22-23; Wallis {Day163/115:9}-{Day163/116:5}.

switch on that day.[1594] No CCTV recording of his visit on 12 April 2017 or, if he attended, of any previous visit was available, so we cannot be confident that he tested the control switch on that occasion or on any previous visit.

44.28 In the circumstances, there is no reliable evidence of when the fire control switch was last tested by PDERS before the fire. In fact, the weight of the evidence suggests that the fire control switch was not regularly tested before 14 June 2017.

The insurance inspections – Bureau Veritas

44.29 The Bureau Veritas reports from 2016 and 2017[1595] record only defects affecting the lifts, not the testing of the fire control switch.[1596]

44.30 Michael Arnold, the engineer who tested the lifts on 10 April 2017, confirmed that he had tested the fire control switch at Grenfell Tower. The outcome of the test was not separately documented, but we were told that if the switch had been defective, that would have been recorded in the Report

1594 Wallis {PDR00000056/1} page 1, paragraph 2.
1595 {MET00036488}; {MET00036489}; {MET00035852}; {MET00035853}; {BVL00000014}; {BVL00000016}; {BVL00000008}.
1596 Lane, The Management and Maintenance of Grenfell Tower – Chapter 7 – KCTMO's duty to provide a suitable system of maintenance for fire protection measures {BLARP20000033/463} paragraph 19.5.47.

of Thorough Examination.[1597] There is no such record. Accordingly, the insurance inspections found nothing to suggest that the fire control switch was not working effectively.

The London Fire Brigade

44.31 For the sake of completeness, we note that the LFB made a number of visits to Grenfell Tower.[1598] The last took place on 27 March 2017 and was carried out by Dean Ricketts and a crew from North Kensington fire station.[1599] He recalled that he had been told by one of his crew that the lifts had "fireman's lifts" controls but due to the number of people using the lifts they were unable to test them.[1600]

Automatic fire alarm recall

44.32 An automatic fire recall function was installed in about March 2006. Although there is evidence that the system was tested in 2013 and early 2014,[1601] correspondence from September 2015

1597 Arnold {BVL00000017/5} page 5, paragraph 6c; Arnold {BVL00000019/2-3} pages 2-3.

1598 {TMO00855611}; Ramsey {LFB00083855/3} page 3, paragraph 9; Ramsey {MET00071003/10} page 10; Ramsey {Day147/31:7}-{Day147/32:1}; Stokes {Day138/5:20}-{Day138/6:12}; McHugh {LFB00091787/12} page 12, paragraph 28.

1599 Ricketts {LFB00004825/4} page 4.

1600 Ricketts {LFB00004825/5} page 5.

1601 Howkins, Supplementary Report concerning the lifts at Grenfell Tower {RHO00000005/35-36} paragraphs 92-94.

suggests that by then it had been disconnected. We do not know when that happened or who disconnected it.[1602] Investigations carried out after the fire also showed that there was no connection between the fire alarm, the smoke detection system and the lifts.[1603]

The failure of the fire control switch

44.33 As set out in the Phase 1 report, the firefighters who attended Grenfell Tower on the night of the fire were not able to operate the ground floor fire control switch.

44.34 The first person to attempt to use the switch was CM Christopher Secrett. A CCTV recording shows him inserting a drop key into the switch at 01.01.[1604] He put the drop key into the fire control switch and felt the end of it drop down and engage but it did not work. He felt that the key was hitting some sort of stop. He turned the key several times in both directions but it did not operate the switch. He tried to turn it with more force but it made no difference. Eventually he tried

1602 Howkins, Report concerning the lifts at Grenfell Tower {RHO00000003/177-179} paragraphs 437-449.
1603 {MET00018469/11}; {MET00065879/34-35}; {MET00072161/12}; {MET00072161/26}.
1604 {INQ00000138}.

to take the key out of the box but it was stuck. He left the key in place and tried to use the lifts in the normal way.[1605]

44.35 CM Secrett had bought a new drop key on 27 April 2017 on eBay. He kept it in a pocket of his tunic. He wore the tunic on the night of the fire but he could not be sure that the key he had bought on eBay was the key he had used on the night of the fire as the keys all look alike to the naked eye and it is common for keys to be switched and replaced.[1606]

44.36 A CCTV recording shows that at 01.33 CM Ben Gallagher tried to use the fire control switch. A key was already in the box which CM Gallagher tried to use to take control of the lift. However, he was unable to activate the switch and left the key in place.[1607]

Evidence recovered after the fire

44.37 Another CCTV recording showed FF Nuttall removing the drop key from the fire control switch. He was unable to remember doing so and explained that, some two years after the fire, he had been called by a member of the LFB's investigation team and asked if he had any drop

1605 Secrett {MET00039598/3} page 3; Secrett Phase 1 {Day16/192:23}-{Day16/193:6}.
1606 Secrett {MET00056990/2} page 2.
1607 Gallagher {MET00040215}.

keys. FF Nuttall said that he had posted to them the one drop key that he had been able to find, although he had thought he had two. He was not able to say that the key that he had provided to the investigation team was the one that he had removed from the tower.[1608]

44.38 It is not possible to say whether the key sent in by FF Nuttall had been used on the night of the fire. The period between the fire and the posting of the key was very long and FF Nuttall accepted that he might have swapped the key with another firefighter.[1609]

44.39 The Metropolitan Police instructed an engineering consultant, WSP, to visit Grenfell Tower on 15 March 2018 to conduct a visual inspection of the fire control switch on the ground floor. The engineer who attended noted that it had not been damaged by fire or water and therefore recommended that it be removed for examination.[1610] The fire control switch therefore remained in place from the date of the fire until about March 2018.

1608 Nuttall {MET00056991/1} page 1.
1609 Nuttall {MET00056991/2} page 2.
1610 {MET00019973/12} paragraph 6.1.

Why did the switch fail to operate?

Presence of debris

44.40 The first possibility is that the switch was jammed with debris. It was first tested on 18 April 2018 in the presence of professional engineers from WSP, Elan Lifts, the Metropolitan Police, the LFB and an independent lift test engineer.[1611] The report of the test made by WSP recorded that the switch was difficult to operate. The faceplate was removed to determine the reason why the switch could not be operated and the mechanism was found to be seized and deformed.[1612]

44.41 The report also concluded that, as the mechanism of the switch was defective, it had not been examined by the lift service company at regular intervals.[1613]

44.42 The switch was tested again on 15 February 2019 at the Building Research Establishment (BRE). The test is described in two reports: the first written by Arup,[1614] the second by André Horne, an independent expert instructed by the Metropolitan Police.[1615] In both reports the switch is described as Exhibit BJG/74.

1611 {MET00019973}.
1612 {MET00019973/21}.
1613 {MET00019973/43} paragraph 10.1.
1614 {RHO00000001}.
1615 {MET00056700}.

44.43 There is no evidence that the switch was cleaned between the test on 18 April 2018 and that on 15 February 2019. However, it had been moved between locations, so it is possible that any debris that had originally been inside it had moved or had been dislodged.

44.44 Arup's report is dated 1 March 2019. It stated that a visual examination of the switch disclosed a build-up of builders' material on the casing and that the micro-switch was jammed. The author's impression was that the debris was wall plaster. On examination, the micro-switch became free and worked. The cause of the jamming could not be identified, but there were plaster grains on the work bench. The author's view was that the presence of builders' material had not been the result of disturbance when the switch was extracted but from the original works.[1616]

44.45 André Horne's report was based on the same test. He said that the switch frame arms were jammed because of debris on the frame which appeared to be dirt, mortar or sand, possibly from the construction of the building. Mr Horne could not say whether some of the debris had been dislodged during the removal, transportation and storage of the switch, thereby causing the jam, or if it had been jammed before its removal. After

[1616] Howkins, Grenfell Tower Lifts Briefing Note regarding fire control switches {RHO00000001/13}.

some gentle manipulation by hand, it moved freely. In Mr Horne's view, forceful manipulation of a correctly fitting key would have moved the switch frame arms.[1617]

44.46 Mr Howkins was also present at the test on 15 February 2019. He provided a diagram which showed where the debris had been observed.[1618] He originally estimated the quantity of debris removed as about a quarter of a teaspoonful,[1619] but in his evidence he said that it had been half to three-quarters of a teaspoonful.[1620] There was no way of knowing if the switch had become jammed with debris while it was still in place, during its removal, while it had been stored or in the course of transportation before testing.

44.47 During the test a drop key was inserted into the switch. The switch did not immediately operate but after the key had been turned left and right a few times the debris on the micro switch cleared and it was possible to operate the switch.[1621]

1617 {MET00056700/3}.
1618 Howkins, Supplementary Report concerning the lifts at Grenfell Tower {RHO00000005/48}.
1619 Howkins, Supplementary Report concerning the lifts at Grenfell Tower {RHO00000005/48} paragraph 161.
1620 Howkins {Day165/103:5-10}.
1621 Howkins, Supplementary Report concerning the lifts at Grenfell Tower {RHO00000005/48} paragraph 159.

Mr Howkins and Mr Horne agreed that the use of a reasonable amount of force would probably have cleared the debris.[1622]

44.48 Both Mr Horne and Mr Howkins noted another abnormality in the switch, unrelated to the debris, namely that the side wards were bent out of shape. That was not specifically noted in WSP's report, but the reference to the mechanism being "deformed" may have been a reference to the bent side wards.[1623]

44.49 The Arup briefing note also noted the deformation of the side wards and photo 13 in the report showed the damage.[1624] The author concluded (and Mr Horne agreed)[1625] that the damage to the side wards had been caused either by the use of an incorrect drop key, which deformed the side wards, or by a drop key being inserted too far into the barrel with the result that a high twisting force damaged the side wards.[1626]

1622 Howkins, Supplementary Report concerning the lifts at Grenfell Tower {RHO00000005/49} paragraph 163.
1623 {MET00019973} page 21.
1624 Howkins, Grenfell Tower Lifts Briefing Note regarding fire control switches {RHO00000001/8-9}.
1625 {MET00056700/3}.
1626 Howkins, Grenfell Tower Lifts Briefing Note regarding fire control switches {RHO00000001/13}.

Use of an incorrect key

44.50 The second possibility is that the drop key used was not the right one for the fire control switch.

44.51 The LFB purchased drop keys for fire stations which were made available through its internal supply system. The LFB has used the same supplier of lift keys since at least 2011.[1627]

44.52 Drop keys are not issued to individuals but are kept on the pumps with many other keys and are used by all crew members as necessary. If a key is lost and a replacement needs to be ordered using the LFB's internal system, it can take up to four weeks to arrive. For that reason, firefighters often buy their own drop keys from suppliers such as Amazon or through eBay.[1628]

44.53 The drop key obtained from FF Nuttall was labelled LJH/67 by the police. It is not possible to know whether it was the one used on 14 June 2017.[1629] It was tested on 29 July 2019 at BRE Watford. In his subsequent report Andre Horne noted that because of its dimensions it could not be used in the fire control panel at the tower or in the example panel provided by the Metropolitan Police for the purposes of the

1627 Atkinson {LFB00083885/2} page 2, paragraph 6; Atkinson {LFB00083885/8} page 8, paragraph 11.
1628 Secrett {MET00056990}; Secrett {LFB00091726/2-3} pages 2-3, paragraphs 7-8.
1629 Nuttall {MET00056991}.

examination.[1630] The key could be inserted into the opening of the switch but could not be turned and therefore could not have caused the damage to the side wards.

44.54 A key supplied by Jeff Turner, a forensic locksmith, fitted the switch taken from the tower correctly. An example key provided for the purposes of the examination was also tested but did not fit correctly.[1631]

44.55 Further testing took place on 7 February 2020.[1632] For that purpose two more keys were compared. Key DER/22 was one of a set of keys provided by the LFB that had been assembled from keys left over from various appliances no longer in use and included a drop key.[1633] It did not fit very well in the switch taken from the tower and Mr Horne noted that, even if the side wards had been straight, it would still not have fitted correctly. However, Key DER/22 did fit normally in the example panel and could operate the panel taken from the tower if sufficient force was applied.[1634]

1630 {MET00056700/4}.
1631 {MET00056700/3}.
1632 {MET00071006/1}.
1633 Wilson {MET00077769/2}.
1634 {MET00071006/3}.

44.56 Key SJG/01 had been bought on eBay. It fitted both the switch taken from the tower and the example switch.[1635]

44.57 By contrast, the key obtained from FF Nuttall could not be used to operate either switch. The only keys that functioned normally in the switch taken from the tower were the key bought on eBay (SJG/01) and the key provided by Jeff Turner. Neither the example key nor the key provided by the LFB (DER/22) fitted the switch taken from the tower correctly, but, if sufficient force had been applied, they could both have operated it. All the keys other than LJH/67 worked properly in the example fire control panel.

An unidentified fault

44.58 It is possible that some other unidentified cause was responsible for the failure of the fire control switch to work on the night of the fire, but there is no evidence that the switch had been damaged by smoke or fire and no other defects in it were identified.

44.59 We think that the use of the wrong size of drop key is the most likely reason for the failure of the fire control switch to operate properly on the night of the fire.[1636]

1635 {MET00071006/4}.
1636 Howkins {Day165/112:5-7}.

Conclusions

44.60 Two important matters emerge from this aspect of our investigations. The first is the need for regular maintenance of fire control switches. Whether debris in the switch box interfered to any significant extent with the operation of the switch on the night of the fire, the likelihood is that more foreign material was present than should have been allowed to accumulate in a piece of equipment that was supposed to be checked at regular intervals. We cannot say that a failure of regular maintenance was the cause of the switch becoming inoperable, but we can say that the evidence strongly suggests that it was not given the attention it deserved.

44.61 The second concerns the significant variation in the dimensions of the drop keys tested and their compatibility with different fire control switches. One might have expected fire control switches to conform to a specified pattern and that drop keys would likewise conform to a pattern known to be capable of operating the standard switch. That appears not to have been the case. As a result, it appears to have been largely a matter of chance whether the key carried by the first firefighter who tried to take control of a lift enabled the switch to be operated. That is a recipe for disaster. Part of the reason for that unsatisfactory state of affairs lies in the practice of firefighters'

obtaining drop keys from various sources without appropriate guarantees of their suitability. Standardisation and control of equipment by fire and rescue services are necessary to avoid incompatibility. On 8 August 2019, the LFB notified all watch managers and crew managers that keys purchased from external sources were in circulation and instructed them to carry out an immediate physical check of all drop keys to ensure that keys of the correct pattern were stowed on all firefighting appliances at all stations.[1637] We hope that as a result the substantial variation in the keys used by firefighters has now been eliminated.

[1637] Atkinson {LFB00083885}; also see {LFB00083895}.

Chapter 45
Emergency planning

Legislative framework and guidance

45.1 Save for the purposes of article 30 (which is not relevant for present purposes), the Fire Safety Order does not apply to domestic premises. Each flat in Grenfell Tower was occupied under a separate lease or tenancy agreement and so constituted domestic premises for the purposes of the Order. Accordingly, as far as the residents were concerned, the duties imposed by articles 8 to 22 applied only in relation to the common parts of the building, namely, the lobbies, lifts and staircase.

45.2 Article 14 imposes a duty to ensure that routes to emergency exits and the exits themselves are kept clear at all times; emergency routes and exits must be indicated by signs and be adequately lit (including, where necessary, by emergency lighting). Article 15(1)(a) requires the responsible person to establish, and where necessary give effect to, appropriate procedures to be followed in the event of serious and imminent danger from fire and to nominate a sufficient number of competent persons to implement those procedures in so far as they relate to the

evacuation of relevant persons from the premises. The procedures must, so far as is practicable, require any relevant persons exposed to a serious and imminent danger to be informed of the nature of the hazard and of the steps taken or to be taken to protect them from it (article 15(2)(a)).

45.3 In practical terms the Fire Safety Order required the TMO to ensure that the lift lobbies, the lifts themselves and the staircase were kept free of obstructions, were properly lit (including by emergency lighting when necessary) and displayed appropriate signs to indicate the escape route. It appears to assume that the occupants of any flat in which a fire occurred, or which was affected by heat or smoke from a fire in a neighbouring flat, could escape into the lobby and from there make their way to safety using the stairs. It did not, however, impose a duty on either of them to devise a plan to evacuate residents from within their flats, much less a plan to evacuate the building as a whole. A “stay put” or “defend in place” strategy for responding to a fire is better viewed as a response strategy rather than an evacuation plan.

45.4 Publicly available guidance, in particular the guidance published by the Local Government Association specifically in relation to purpose-built blocks of flats (the LGA Guide), emphasised the

need to ensure that that information about the procedure to be followed in the event of a fire should be disseminated to all residents.[1638]

45.5 Section 79 of the LGA Guide, under the heading "Preparing for emergencies", advised that there must be a suitable emergency plan for the premises, but that, in the case of purpose-built blocks of flats, that would rarely require more than a fire action notice, which in most cases would be sufficient as an emergency plan. It also recognised that it was common to communicate the emergency plan to tenants in other ways, so that it was not always necessary to display a fire action notice in the building.[1639]

45.6 With the approval of the LFB, both before and after the refurbishment Grenfell Tower was subject to a "stay put" strategy, under which residents were encouraged to remain in their flats unless they were directly affected by fire or smoke because that was considered to be the safest course for them to take. Any more general evacuation of the building was expected to be directed and supervised by the fire and rescue service. There was therefore no need for the responsible person to create an evacuation plan for the building as a whole. We consider below

1638 {HOM00045964/115-117} paragraphs 77.1 to 77.6; {HOM00045964/133} Appendix 1.
1639 LGA Guide {HOM00045964/118} paragraph 79.1.

the steps taken by the TMO to inform residents of the steps to be taken in the event of a fire in the building.

The TMO Emergency Plan

45.7 The TMO maintained an Emergency Plan. It had been drafted in August 2004 and revised in October 2006, May 2009, November 2009 and February 2016.[1640] Adrian Bowman was responsible for maintaining, and when necessary revising, it under the general supervision of Janice Wray.[1641] She was unable to say what had given rise to the various revisions, but accepted that there had been no system for reviewing it at regular intervals and making any necessary changes.[1642] That, of itself, was a serious failing, because, if a plan is not reviewed regularly, it may not be fully effective when an emergency occurs.

45.8 The chairman considered the TMO Emergency Plan in the Phase 1 report and found that it was far from adequate.[1643] The evidence we have heard at Phase 2 only reinforces that conclusion. The TMO Emergency Plan was in two

1640 TMO Emergency Plan – Version 1 August 2004 {TMO10013898}; TMO Emergency Plan – Revised October 2006 {TMO10048195}; TMO Emergency Plan – Revised November 2009 {TMO00841015}; TMO Emergency Plan – Revised 2016 {TMO10013898}. The 2016 version referred to revisions in May 2009 and May 2015, but these have not been disclosed to the Inquiry.

1641 Wray {Day142/34:23-25}.

1642 Wray {Day142/36:20}-{Day142/38:3}.

1643 Phase 1 Report, Volume IV, paragraph 30.93.

parts: the first was the generic plan; the second contained separate sections relating to the various properties managed by the TMO, each containing a description of a particular property.

45.9 The section relating to Grenfell Tower was dated 25 February 2002.[1644] It contained estimates of the number of residents and vulnerable persons; it identified places where the emergency services could gather and identified a nearby place of shelter. There was information about the electricity, gas and water supplies and the dry riser. The location of the keys was also recorded and the means of escape. The "stay put" strategy was recorded as was the existence of automatic fire alarm and smoke extract systems, but no further information was provided about them.[1645]

45.10 The version of the Emergency Plan dated February 2016 was current at the date of the fire. The sub-section relating to Grenfell Tower was largely the same as that which had been created on 25 February 2002, 15 years earlier. Janice Wray was unable to explain why that was the case. The number of dwellings had not been changed to reflect the new flats created in the lower floors as a result of the refurbishment, but the place of shelter had been changed to North Kensington Resource Centre. The means of

1644 November 2009 TMO Emergency Plan {TMO00841015/147}.
1645 November 2009 TMO Emergency Plan {TMO00841015/147-148}.

escape were still described as through the stairs and onto the walkway level, which did not reflect the fact that the door to the walkway had been blocked up during the refurbishment. The section containing “other information” had only partly been brought up to date. Information about the reception desk, the creche and the boxing club had been removed as well as information about the hydraulic lift to social services on the first floor. A description of the bin stores was included and a note recorded about a fire that had affected them in 1997. However, the plan still recorded that there was an automatic fire alarm and smoke extract system, even though the former no longer existed. The plan noted that in case of fire residents were advised to remain in their homes unless affected by heat or smoke.[1646]

45.11 The piecemeal and inconsistent revision of the information in the Emergency Plan meant that that part of the plan could not safely be relied on in an emergency at Grenfell Tower.

45.12 Janice Wray told us that the Emergency Plan had been intended to deal with only minor emergencies, such as a fire, a power failure, a leak or a flood.[1647] That was because the TMO lacked the resources to respond to a major emergency. RBKC had a more comprehensive

[1646] February 2016 TMO Emergency Plan {TMO10013898/145-146}.
[1647] Wray {Day142/38:5-19}; {Day142/40:22}-{Day142/41:19}.

emergency plan and greater resources. The plan itself, however, said that it set out the roles and responsibilities of the TMO in the event of a major incident, which it defined as an incident or natural disaster resulting in death, injury or serious disruption to normal life of a magnitude that would acutely stretch the TMO's resources.[1648]

45.13 Ms Wray said that the section on Grenfell Tower had been intended to collate information that the emergency services or anybody else might require for the purposes of emergency planning,[1649] but she appears not to have given any thought to whether it contained all the information recommended by the guidance. They referred only to the requirement to communicate the emergency plan (that is, the "stay put" strategy) which they did through the residents' handbook, Link magazine and in documents provided to residents when they signed the tenancy agreement with the TMO.[1650]

1648 February 2016 TMO Emergency Plan {TMO10013898/13}.
1649 Wray {Day142/43:22}-{Day142/44:2}.
1650 Wray {Day142/45:5}-{Day142/46:1}.

The fire safety strategy

45.14 The TMO's fire safety strategies of 2013 and 2016 did not refer to the Emergency Plan,[1651] but that may have been because it was understood that the Emergency Plan was intended as a response to a wide range of emergencies.

45.15 The 2013 fire safety strategy asserted that a "stay put" or "defend in place" strategy was "overwhelmingly" appropriate for the TMO's housing blocks. That was because compartmentation, both between flats and also between flats and the common parts, was considered to be sufficient to withstand fire for long enough to enable the fire and rescue service to attend and extinguish it. That message was said to have been communicated to residents in various ways, including in the resident's handbook, on the TMO's website and in Link magazine.[1652]

Evacuation planning in the fire risk assessments

45.16 A fire risk assessment should set out in detail the fire management procedures required to respond to a fire so that they can provide the

1651 2013 TMO Fire Safety Strategy {TMO00830598}; 2017 TMO Fire Safety Strategy {TMO00847324}.
1652 {TMO00830598/10-11}, paragraph 15.1; {TMO00847324/10}, paragraph 15.2.

basis of an appropriate response plan.[1653] Clause 16 of PAS 79:2012 also required a fire risk assessor to undertake an assessment of fire safety management, which included procedures for people to follow in the event of fire, including people with special responsibilities, the nomination of people to respond to fire and, where appropriate, to assist with evacuation and arrangements for liaison with the fire and rescue service, both in respect of planning for fire and at the time of any fire.[1654] The commentary to clause 16 said that in making a fire risk assessment there was a need to ensure that there were formal, documented procedures of an adequate kind for people to follow in the event of fire. A list of procedures considered to be adequate was included.[1655]

45.17 Carl Stokes did, in the main, take PAS 79:2012 as his guide for making fire risk assessments, although his adherence to it was patchy and inconsistent. Each of his fire risk assessments for Grenfell Tower had a section headed "The Evacuation Strategy for this building" in which he noted that there was a "stay put" strategy in place and that the fire and rescue

1653 Lane, Chapter 8 – The adequacy of the advice provided by the fire risk assessor Carl Stokes of CS Stokes & Associates Ltd to KCTMO Report {BLARP20000027/373}.
1654 PAS 79:2012 {CTA00000003/50}, paragraph ii.c-e.
1655 PAS 79:2012 {CTA00000003/51}, paragraph viii.

service or the TMO would organise a general evacuation of the building, if appropriate. He also noted that the TMO had provided information to all residents in a tenant's handbook, letters and briefing sheets and in articles in Link.[1656] Once the refurbishment of the tower was under way, he recorded that the contractors had an evacuation policy and procedure relating to areas under their control and that the nursery and boxing club had their own fire risk assessments and evacuation procedures. He did not record whether there was an emergency plan specifically for Grenfell Tower that described how the TMO would contact the LFB, residents or the nursery or boxing club in the event of a fire. Nor did he record whether there was a plan which contained relevant information specific to the tower. That part of the fire risk assessment remained substantially the same between 2010 and 2016 with minor and immaterial variations.[1657]

45.18 Carl Stokes told us that in the case of Grenfell Tower the evacuation plan had been a "stay put" strategy,[1658] information that he admitted he had obtained at a meeting with Janice Wray

1656 Grenfell Tower Fire Risk Assessment – 20 June 2016 {CST00003145/6}.
1657 Lane, Chapter 8 – The adequacy of the advice provided by the fire risk assessor Carl Stokes of CS Stokes & Associates Ltd to KCTMO Report {BLARP20000027/376}.
1658 Stokes {Day136/223:3-6}; Letter from Carl Stokes to Janice Wray of 27 September 2010 {CST00003061}.

on 24 September 2010.[1659] In his view, that explained why his fire risk assessments for many other high-rise residential blocks contained similar language. He had been responsible for the inclusion in his fire risk assessments of the statement that the Fire and Rescue Service or the TMO would organise a general evacuation of the building. He had not been told by Janice Wray that the TMO (either alone or in conjunction with the Fire and Rescue Service) would organise a general evacuation.[1660] He had based it on the knowledge that under GRA 3.2 it was something for which the fire and rescue service should have contingency plans and that the TMO was aware of the needs of individual residents.[1661] He thought that it was always possible that a situation might arise in which the fire and rescue service would have to evacuate the building. He said that he had not contemplated that the TMO would organise an evacuation in response to an emergency; in such cases it would act under the direction of the Fire and Rescue Service.[1662] It would do so only in cases where it had other reasons for evacuating the building and could do so in its own time.[1663] However, those qualifications were not recorded

1659 Stokes {Day137/16:6-11}.
1660 Stokes {Day136/221:15}-{Day136/222:3}; {Day137/4:3}-{Day137/5:18}; Wray {Day142/54:10}-{Day142/55:4}; {Day142/59:2-7}.
1661 Stokes {CST00003063/51} page 51, paragraph 150 (i).
1662 Stokes {Day137/9:19-23}.
1663 Stokes {Day137/6:1-7}.

in the fire risk assessment itself, nor were they readily apparent to anyone reading the document, which gives a quite different impression.[1664]

45.19 It was the TMO's responsibility to check the accuracy of the statements in Mr Stokes's fire risk assessments, since, under article 9 of the Fire Safety Order, they were its own assessments. We therefore find it difficult to understand why no one at the TMO took issue with an erroneous statement on a matter of such importance, particularly since it was repeated in fire risk assessments made in respect of other high-rise buildings, including Adair Tower, Gillray House, Hazlewood Tower and Markland House. However, as we have noted elsewhere, at no point during the seven years in which Carl Stokes carried out fire risk assessments for the TMO did Janice Wray seek to question any of his assessments whether in relation to Grenfell Tower or any other building.[1665] She was clear in her own mind that the TMO had no formal role in organising an evacuation in the event of a fire, but she did not make that clear to Carl Stokes.[1666]

1664 Stokes {Day137/9:24}-{Day137/10:4}.

1665 Apart from a disagreement about whether the lifts at Grenfell Tower were fire-fighting lifts (see Chapter 44); and on his grading of remedial actions (see Chapter 39).

1666 Wray {Day142/63:8-16}.

The fires at Adair Tower and Trellick Tower

45.20 In the two years before the Grenfell Tower fire there were two fires in high-rise residential buildings managed by the TMO. On 31 October 2015, a fire occurred in Adair Tower and on 27 April 2017 there was a fire in Trellick Tower.[1667] On both occasions, the LFB carried out a partial evacuation of the building.[1668]

45.21 Janice Wray was aware that on each occasion part of the building had been evacuated and knew that the "stay put" strategy had sometimes been departed from.[1669] On 23 November 2015, she drafted a note to the Health and Safety team about the Adair Tower fire in which she reported that there was a "stay put" strategy at Adair Tower, in common with most of the TMO's high-rise residential blocks. She said that the LFB would decide whether an evacuation was required and, if so, would carry it out. She also said that the LFB would be assisted by any TMO staff who

1667 LFB FSR Post Fire Review Report {LFB00054910}; LFB Senior Fire Safety Officers Report {LFB00001626}; Paper 3 – Adair Tower fire – 31 October (2015) dated 23 November 2015 {TMO00840431}.

1668 Paper 3 – Adair Tower fire – 31 October (2015) dated 23 November 2015 {TMO00840431}.

1669 Wray {Day142/52:2-19}; {Day142/53:2-7}.

were present.[1670] She described that as merely an observation on the response at Adair Tower rather than a plan.[1671]

The response of senior management to the fires

45.22 After the fire at Adair Tower on 31 October 2015, Robert Black asked Janice Wray and Sacha Jevans to explain the building's fire procedures and processes.[1672] In response Janice Wray described the "stay put" strategy and explained that, if a fire occurred, the LFB would decide whether an evacuation was necessary and, if so, whether it should be partial or total.[1673]

45.23 On 1 November 2015, Robert Black sent Peter Griffiths, Teresa Brown, Sacha Jevans and Yvonne Birch some complaints that Councillor Mason had received from the press and residents. They included the absence of an evacuation plan.[1674]

1670 Paper 3 – Adair Tower fire – 31 October (2015) dated 23 November 2015 {TMO00840431}.
1671 Wray {Day142/63:2-7}.
1672 Email from Robert Black "re Fire Adair Tower" dated 31 October 2015 {TMO00869147}.
1673 Email from Janice Wray to Robert Black dated 31 October 2015 {TMO00869159}.
1674 Email from Robert Black dated 1 November 2015 {TMO00866475}.

45.24 On 2 November 2015, Robert Black told the board that the TMO had responded to the fire rapidly,[1675] and following an inspection of Adair Tower on 3 November 2015 Carl Stokes expressed the view that the TMO's management procedures had worked well.[1676] Robert Black told the Housing and Property Scrutiny Committee on 5 November 2015 that the emergency planning had worked and that the fire doors had also worked well,[1677] but that was not quite the message that was conveyed in internal meetings of the TMO that followed. The incident was discussed at an executive meeting on 11 November 2015.[1678] Barbara Matthews, who was co-ordinating the response to the fire, said that although RBKC had been supportive, the TMO should be more involved in RBKC's emergency planning strategy so that everyone was aware of contact numbers and roles and responsibilities. The TMO's own Emergency Plan was discussed and it was agreed that the executive team should meet Janice Wray and Hash Chamchoun to gain a better understanding

1675 Email from Robert Black dated 2 November 2015 {TMO00866480}; {TMO10050075}.
1676 Initial views of the fire risk assessor following his inspection of Adair Tower on 3 November 2015 {CST00025017}.
1677 Minutes of the Housing and Property Scrutiny Committee, 5 November 2015 {RBK00048049/6}.
1678 TMO executive team meeting {TMO00843593/2}.

of who was responsible for keeping it up to date and for applying any lessons learnt from the fire at Adair Tower.[1679]

45.25 As a result of the Adair Tower fire, it had become apparent to the TMO that its role in an emergency was unclear and that its Emergency Plan should be reviewed in conjunction with RBKC's emergency plan and revised as necessary.[1680] Barbara Matthews may have looked at the plan,[1681] but she did not take any steps herself to make sure that it was brought up to date; instead, she relied on Janice Wray to do that.[1682]

1679 TMO executive team meeting {TMO00843593/2}.
1680 Matthews {Day148/122:9-15}.
1681 Matthews {Day148/122:16-18}.
1682 Matthews {Day148/122:9}-{Day148/123:5}.

Chapter 46
Vulnerable residents

The Fire Safety Order

46.1 Articles 14 and 15 of the Fire Safety Order set out the duties of the responsible person to ensure that there are effective emergency exits and to establish and give effect to procedures to be followed in the event of serious and imminent danger. We need not set them out in detail here. However, we make two general observations at the outset. First, the expression "relevant persons" includes anyone who is lawfully on the premises.[1683] That clearly includes all occupants of the building and any visitors, regardless of their physical or mental capabilities, who are in those parts of the building to which the Fire Safety Order applies. The Order extends to the common parts but not to individual flats. Secondly, whatever the origins of the Fire Safety Order, it cannot be read as applying only to premises where there are employees of the responsible person present at all times to provide assistance with evacuation.

[1683] DCLG regulatory reform (fire safety) order 2005 {CLG00000094/12}, Article 2

46.2 Between 2005 and 2017 there was much guidance available to assist those who had responsibility under the Fire Safety Order for managing fire safety to understand their duties to those with disabilities.

DCLG Guidance Note No. 1: Enforcement

46.3 DCLG Guidance Note No.1 published in October 2007 gave general guidance to enforcing authorities on the need to ensure that the means of escape were suitable and sufficient to allow safe escape from the premises. In relation to the duties under article 14, paragraph 77 of the guidance advised that all emergency routes and exits should lead as directly as possible to a place of safety and be adequate for everyone to escape quickly and safely. It also advised that the risk assessment should identify any person for whom special evacuation arrangements might need to be made because of their age, state of health, physical or mental abilities or, in some circumstances, their location on the premises.[1684] However, no specific guidance was available in relation to different types of premises, such as high-rise residential buildings, and no distinction was made between residential and commercial premises.

[1684] DCLG regulatory reform (fire safety) order 2005 {CLG00000094/20}.

The Sleeping Guide (2007)

46.4 The guidance entitled *Fire Safety Risk Assessments: Sleeping Accommodation*, commonly known as the "Sleeping Guide", published by the government in 2007, was intended to assist in carrying out fire risk assessments in relation to the common parts of buildings containing flats and maisonettes, as well as premises of other kinds.[1685] It was not intended to apply to domestic premises occupied as a single private dwelling, including private flats or rooms. It recommended that when carrying out a fire risk assessment steps should be taken to identify people who may be particularly at risk, such as children and people with disabilities or with a sensory impairment.[1686] In particular, it advised that the means of escape should be assessed to make sure that they are suitable for the evacuation of everyone from the premises, including vulnerable residents. It suggested that, in evaluating the risk to people with disabilities, the responsible person might need to discuss their individual needs with them.

1685 HM Government Fire Risk Assessment (Sleeping Accommodations) Guidance 2015 {RBK00036722/6}. 12 bullet points which state that the guide will address the common areas of flats and maisonettes.

1686 HM Government Fire Risk Assessment (Sleeping Accommodations) Guidance 2015 {RBK00036722/16-17}.

46.5 The Sleeping Guide drew attention to the Disability Discrimination Act 1995 and advised that if a disabled person could realistically be expected to use the premises, the responsible person must make any reasonable adjustments that will make it easier for that person to use and, if necessary, escape from the premises.[1687] In particular, it advised that the concept of "reasonable adjustments" applied equally to fire safety, although its precise application would depend on the circumstances of each case.[1688] As in other aspects, the Sleeping Guide also advised that if people with special needs used the premises, their needs should so far as practicable be discussed with them.[1689] It recommended that effective management arrangements be put in place for those who need help to escape.[1690]

1687 HM Government Fire Risk Assessment (Sleeping Accommodations) Guidance 2015 {RBK00036722/54}, paragraph 1.15.
1688 HM Government Fire Risk Assessment (Sleeping Accommodations) Guidance 2015 {RBK00036722/54}.
1689 HM Government Fire Risk Assessment (Sleeping Accommodations) Guidance 2015 {RBK00036722/54}.
1690 HM Government Fire Risk Assessment (Sleeping Accommodations) Guidance 2015{RBK00036722/69}.

DCLG supplementary guide "Means of Escape for Disabled People"

46.6 In 2007, DCLG published a supplementary guide which considered accessibility and the means of escape for disabled people.[1691] It was intended to be read with its other guides on fire risk assessment. The supplementary guide contains a "Legal Overview" in paragraph 1.1, in which it states that there should be adequate means of escape for all people, including disabled people, which do not depend on the fire and rescue service. It also points out that if an employer or a service provider does not make provision for the safe evacuation of disabled people, that may be discriminatory and a breach of the Fire Safety Order.[1692]

46.7 The guide draws attention to the disability equality duty which, since 2006, had required all public bodies to promote the equality of disabled people.[1693] It also sets out guidance on preparing emergency evacuation plans for disabled people who are likely to be in the building or visiting it.

1691 Fire Safety Risk Assessment Supplementary Guide, Means of escape for disabled people {INQ00014732}.
1692 Fire Safety Risk Assessment Supplementary Guide, Means of escape for disabled people {INQ00014732/6}.
1693 Fire Safety Risk Assessment Supplementary Guide, Means of escape for disabled people {INQ00014732/6}.

The LGA Guide 2011

46.8 The LGA Guide was drafted following the Lakanal House fire in July 2009 specifically to provide guidance on fire safety in purpose-built blocks of flats.[1694] It recognises that there is likely to be a diverse range of physical and mental capabilities among the occupants of a general needs block. The needs of vulnerable occupants are addressed in paragraphs 16.11-16.13 which recognise that older people and people with certain disabilities may have particular needs in responding to a fire. The guide also recognises, however, that in many circumstances it will be impracticable in existing blocks of flats to make special provision for such occupants.[1695]

46.9 Section 79 is concerned with "Preparing for Emergencies". Paragraph 79.9 provides that in "general needs" blocks of flats the physical and mental abilities of the residents are likely to vary but suggests that it is usually unrealistic to expect the responsible person to plan for that or to have in place special arrangements, such as personal emergency evacuation plans. We assume that is intended to reflect the fact that the responsible person's duty under the Fire Safety Order is circumscribed by what is reasonably practicable.

1694 LGA Guide, Fire safety in purpose-built blocks of flats {HOM00045964/11} paragraph 2.1.
1695 LGA Guide, Fire safety in purpose-built blocks of flats {HOM00045964/25}.

In our view, those whose ability to evacuate the building without assistance should be provided with personal emergency evacuation plans (see the chairman's recommendations in paragraph 33.22 of the Phase 1 report), although the content of such a plan will depend in each case on what is practicable. It is difficult to see what additional measures the TMO could have taken to assist the evacuation of disabled residents once they had entered the common parts of Grenfell Tower.

46.10 Paragraph 79.11, on the other hand, states that the case of a "general needs" block it is not realistic to expect the responsible person to hold information relating to residents with mobility or other conditions affecting their ability to escape in a way that enables it to be made available to the fire and rescue services, for example, in a premises information box. The justification offered is the difficulty of keeping that information up to date and the risk that inaccurate information could be more harmful than no information. However, although we understand the risks involved, we do not think it is impracticable for the responsible person to make available to the fire and rescue services by digital or other means reliable information about those with chronic disabilities whose ability to evacuate the building without assistance in an emergency is known to be compromised. Again, that was the subject of

a recommendation in the chairman's Phase 1 report. In our view, therefore, this paragraph of the Guide should be reconsidered.

PAS 79:2012

46.11 We have considered some of the provisions of PAS 79:2012 in Chapter 39. For present purposes we note that it contained very detailed guidance on how to go about ensuring that a fire risk assessment took due account of the specific needs of vulnerable persons in the relevant building. It stated in terms that it applied to blocks of flats,[1696] and indeed Carl Stokes himself rightly considered that it applied to his work for the TMO generally and to Grenfell Tower in particular. Although Colin Todd, who played an important part in drafting PAS 79 in 2005, and its revisions in 2007 and 2012, said that its focus was on commercial premises, he was constrained to accept that it (or at least the 2012 edition) applied to purpose-built blocks of flats.[1697] He also told us that in his view a fire risk assessor would have sufficient training and experience to know that some parts of PAS 79:2012 were not intended to apply to high-rise blocks of flats and other parts were.[1698] We see no overt support in PAS 79 2012 itself for that view, but in any event it was not an

1696 {CTAR00000003/9}.
1697 Todd {Day166/132:23}-{Day166/133:5}; {Day166/133:24}-{Day166/134:19}.
1698 Todd {Day167/106:5-10}.

approach actually adopted by Carl Stokes, who did, albeit idiosyncratically and unevenly, follow the guidance it contained.

46.12 PAS 79:2012 recommended that a fire risk assessment should consider factors that have a major effect on the risk of fire.[1699] They included the approximate number of occupants of the premises, the maximum number of members of the public likely to be present (unless small in number), the nature of the occupants (e.g. young or old, disabled or able-bodied), the familiarity of the occupants with the premises (e.g. fully familiar, slightly familiar or totally unfamiliar) and the state (or likely state) of the occupants (e.g. awake or asleep, alert or under the influence of alcohol or drugs). It recommended a 9-step approach to fire risk assessments. Step 1 was to obtain relevant information about the premises and their occupants, including those particularly at risk in the event of fire.[1700] Step 6 was to make an assessment of the likely consequences to the occupants of a fire. Step 8 was to formulate a plan, if necessary, to address shortcomings in the fire precautions.[1701]

1699 {CTA00000003/19}.
1700 {CTA00000003/34} paragraph i.1.
1701 {CTA00000003/34} paragraphs i.6 and i.8.

46.13 The commentary on clauses 12 and 15 contains guidance about assessing the risks to vulnerable persons in order to ensure that the fire risk assessment is suitable and sufficient. We draw particular attention to paragraphs viii, ix, xi, xiv and xv of the commentary on clause 12, and to paragraphs xx and xxviii of the commentary on clause 15.[1702] Tellingly, paragraph xxix of the commentary on clause 15 provides that "Disabled evacuation strategy should not rely on rescue of disabled people by the fire and rescue service",[1703] but then goes on to say that "assistance with their evacuation is provided by persons within the premises".

46.14 Standing back from the detail, PAS 79:2012 envisages that the fire risk assessment will first assess whether there are persons particularly at risk because of their personal characteristics and consider whether adequate provisions are or can be put in place to ensure their safety. That approach is necessary to ensure that as far as is reasonably practicable those who are vulnerable have a means of escape which is as good as that available to those who do not share their particular vulnerability.

1702 {CTA00000003/36-44}.
1703 {CTA00000003/44}.

BS 9991:2015 Fire Safety Code of Practice

46.15 The Code of Practice BS 9991:2015 considered the means of escape for disabled occupants at various points. It advised on the need to be aware of the types of people in the building (such as disabled people, elderly people, children, pregnant women, etc) and any special risks or needs they might have.[1704] Paragraphs 4.6 and 54, and Annex E, in particular, advised that fire safety management of a residential building needed to take account of the needs of disabled persons with permanent or temporary impairment. High-rise residential premises and premises with a "stay put" strategy in place are not excluded.

The TMO's fire safety planning for vulnerable residents

46.16 The TMO had a duty in relation to each building in respect of which it was a responsible person to identify and record the presence of residents with disabilities and the nature of those disabilities. That was necessary both for the purposes of carrying out a suitable and sufficient fire risk assessment and to enable it to take all such steps as were reasonably practicable to ensure their safety in the event of a fire. The "stay put"

[1704] {BSI00000059/20} paragraph d.

strategy assumed that residents would leave their flats only if they were affected by fire, heat or smoke but that in those circumstances they would escape into the lobby from where they could reach the stairs, which were in a protected area. Any resident who needed help to negotiate the stairs could telephone for assistance but ultimately would have to rely on another resident or the fire and rescue service to escape from the building. The TMO was entitled to assume that if a total or partial evacuation of the building was required it would be carried out under the direction and control of the LFB.

46.17 With that in mind we consider what steps the TMO took to discharge its duty to vulnerable residents.

Concern about vulnerable residents: June 2009

46.18 By June 2009 the LFB had become concerned about the failure of the TMO to make adequate provision for disabled people to escape from some of its buildings. On 17 June 2009, it told Janice Wray that it intended to serve an enforcement notice on the TMO and RBKC due to their failure to make suitable and sufficient fire risk assessments of the communal areas of some of their blocks.[1705] In particular, the LFB considered

[1705] {RBK00053539}.

that the fire risk assessment for Gillray House was not suitable and sufficient because there were no procedures to enable occupants with reduced mobility to escape.

46.19 Janice Wray sent an email to Robert Black advising him of the LFB's intention and at his request she sent it to Jean Daintith and Laura Johnson at RBKC.[1706] It eventually reached Alexis Correa, Health and Safety Advisor in RBKC's Housing, Health and Adult Social Care Services department, and Claire Wise (then a member of the Housing Policy Team).

46.20 On 18 June 2009 Claire Wise sent an email to Janice Wray in which she said that there was little information on the application of the Fire Safety Order to dwellings, but that there might be duties under the Disability Discrimination Act 1995 not to treat disabled people less favourably than people without a disability. She advised Ms Wray that if an evacuation plan was in place that was unsuitable for a person with a disability, alternative provision for disabled people should be provided.[1707] She went on to say that she thought that provision for disabled people in domestic premises and communal areas had slipped through the net in legislation and guidance.[1708]

1706 {TMO00901459}.
1707 {RBK00052528/1-2}.
1708 {RBK00052528/2}.

She asked Janice Wray for a meeting to discuss progress and an action plan. She also suggested it would be an opportunity for collaborative working with the fire brigade to develop a model to be applied across the remaining TMO buildings.

46.21 Jean Daintith forwarded that exchange to Robert Black later that day. She told him that Alexis Correa had confirmed that the fire risk assessments were not robust enough and that a specialist would need to be engaged.[1709]

46.22 Janice Wray accepted that the LFB had recommended there should be a procedure in place to enable residents with reduced mobility to escape,[1710] but admitted that she had not sought advice about the TMO's duties under the Fire Safety Order or the Disability Discrimination Act 1995.[1711]

46.23 Two points emerge from this exchange. First, that the TMO at the highest level was aware from as early as 2009 of the need to consider the arrangements for the safe evacuation of disabled people and, secondly, that RBKC was itself fully aware of the fact.

1709 {RBK00052528/1}.
1710 Wray {Day142/82:6-9}.
1711 Wray {Day142/84:15}-{Day 142/85:24}.

Salvus's Advice: September 2009

46.24 In its report entitled "Fire Risk Assessment for Fire Safety policy and procedures" dated 22 September 2009, Salvus identified a need for the TMO to establish procedures to ensure the safety of disabled or vulnerable persons in the event of a fire.[1712] The absence of such procedures was described as constituting a breach of the statutory requirements. In the enclosed action plan, it recommended that as a high priority the TMO consider developing formal procedures to deal effectively with fire safety concerns associated with disabled or vulnerable tenants and leaseholders and also any employees.[1713] It marked the item as needing to be completed within three months or a plan to be agreed within six months.

46.25 Following receipt of the report, a progress meeting was held on 19 October 2009 attended by Salvus, the TMO and RBKC.[1714] Paragraph 4.3 of the minutes records that Salvus had been unable to confirm whether any residents had sensory impairments at the time of the fire risk assessment and the TMO was advised to tell tenants to contact it if they had a disability

1712 {SAL00000013}.
1713 {SAL00000013/18}.
1714 Minutes of Progress Meeting dated 19 October 2009 {RBK00047771/1}.

affecting their ability to react to an alarm.[1715] The minutes also record that the TMO had attempted to identify and record vulnerable residents. Andrew Furness of Salvus said that if the fire risk assessor had been informed about the location of vulnerable residents and the nature of their vulnerabilities in advance, the assessment would have been more comprehensive. It was agreed that an attempt would be made to obtain that information in relation to one of the TMO properties, the World's End Estate.[1716]

46.26 It seems that the effort was to some extent successful. On 19 October 2009 (the same day as the meeting), two spreadsheets were produced containing data about vulnerable persons.[1717] That is the only documentary evidence we have seen of TMO officials' attempting to gather information about vulnerable residents for the purposes of a fire risk assessment. Janice Wray confirmed that as a result of that meeting, she was aware of the need to provide fire risk assessors with information about vulnerable residents.[1718]

46.27 On 5 January 2010, Andrew Furness complained to Nicholas Coombe of the LFB that the TMO and RBKC had little or no knowledge of the

1715 Minutes of Progress Meeting dated 19 October 2009 {RBK00047771/2}.
1716 Minutes of Progress Meeting dated 19 October 2009 {RBK00047771/2-3}.
1717 {TMO00866618}.
1718 Wray {Day142/87:1}-{Day142/88:10}.

occupiers of their premises and that Salvus had advised them to gather better information about their residents in order to take appropriate steps in respect of disabled or vulnerable people and, specifically, to help them prepare PEEPs.[1719]

46.28 It is not clear what Mr Furness based his report on. Janice Wray told us that he had not spoken to the Housing team at the TMO, but she did not take any steps herself to obtain information about vulnerable residents. She regarded that as a matter for the Housing team.[1720]

46.29 On 21 January 2010, there was another progress meeting attended by Salvus, the TMO and RBKC to discuss fire risk assessments for high-rise buildings at which procedures for vulnerable residents were again discussed. Andrew Furness said that a formal documented system needed to be implemented to address the needs of disabled and vulnerable people in the event of a fire.[1721] Although the recommendation was clear and well made, it was not implemented by the TMO in relation to its general needs housing stock.[1722]

1719 {SAL00000047/2}.
1720 Wray {Day142/89:3}-{Day142/90:22}.
1721 Minutes of Progress Meeting dated 26 January 2010 {RBK00052572/5}.
1722 In 2012, TMO prepared a paper on fire safety and housing which addressed fire safety in sheltered housing. This was limited to sheltered housing only and had no application to general housing {CST00005799}.

Carl Stokes's advice to the TMO: 2010 onwards

46.30 Carl Stokes met Janice Wray on 22 June 2010 and on 23 June 2010 he sent her a letter confirming his advice.[1723] He told her that the PEEPs she had shown him accorded with those described as best practice in the government's guidance on risk assessments. She confirmed that the intention had been to use the PEEPs documents annexed to DCLG's 2007 guide entitled "Means of Escape for Disabled People"[1724] for TMO residents as well as staff.[1725]

46.31 Carl Stokes and Janice Wray had a further meeting on 24 September 2010, the substance of which was reflected in a letter he wrote to her on 27 September 2010.[1726] In it he noted that the TMO had recently introduced a comprehensive programme to gather information about residents, including any disabilities or restrictions on their ability to respond to an emergency. The information would be held on the "TP Tracker system" and used to assess whether residents required any additional devices to provide them

1723 {CST00001887}.
1724 HM Government Fire safety risk assessment supplementary guide, means of escape for disabled people {INQ00014732/46-49}.
1725 Wray {Day142/91:23}-{Day142/93:11}.
1726 {CST00003061/1}.

with early warning of smoke or fire in their homes. It would also be used to inform the development of a personal emergency evacuation plan.[1727]

46.32 Carl Stokes did not check the TMO's systems for recording vulnerable residents as he thought that was beyond what was expected of him as a fire risk assessor.[1728] He did say, however, that Janice Wray had agreed that when carrying out fire risk assessments she would provide him with information about residents who were especially at risk.[1729] She, on the other hand, could not recall whether she had agreed to provide him with that information. At all events, given that he had noted that they had discussed the identification of vulnerable residents for the purposes of preparing PEEPs and that Salvus had advised her of the need to provide fire risk assessors with information about individuals especially at risk, we think it likely that Janice Wray did agree to provide that information to him. However, there is no evidence that she did so.

46.33 Janice Wray thought that Carl Stokes's reference in his fire risk assessments to the residents' newsletters was a reference to the Link magazine, but no edition of Link between 2009 to 2017 made any reference to PEEPs. Janice Wray explained

1727 {CST00003061/3}.
1728 Stokes {Day137/81:10}-{Day137/85:20}.
1729 Stokes {Day137/70:19}-{Day137/74:18}.

that she was reluctant to use the term "PEEP" because it was not generally understood; she invited those with concerns about being able to leave their homes in the event of fire to contact her or the fire brigade.[1730] No editions of Link from Autumn 2009 to Spring 2017 carried any article inviting residents who were worried about their ability to evacuate their homes in an emergency to contact the TMO.[1731]

RBKC's oversight of the TMO's preparation of PEEPs

46.34 On 28 September 2010, Jean Daintith sent Robert Black a copy of an article written by Claire Wise about fire safety and the requirements of housing legislation relating to people living in flats in tall buildings. She invited Robert Black to respond with his observations about what lessons could be learnt.[1732] His response on 30 September 2010 was to reassure her that the TMO had completed fire risk assessments for all its high-risk buildings, including high-rise blocks, and that the evacuation strategy was "stay put – defend in place". He told her that the TMO

1730 Wray {Day142/98:11-22}.

1731 None of the Link or Homeowner magazines disclosed to the Inquiry invited residents to contact the TMO to be evaluated for a PEEP. Fire safety advice was contained in the following Link Magazines: Autumn 2009 {TMO00901358}; Winter 2009 {TMO10048206}; June 2013 {TMO00873438}; Summer 2014 {TMO10031098}; Autumn/Winter 2015 {TMO00873549}.

1732 {RBK00026862}; {RBK00030073}.

intended to produce PEEPs for disabled residents but had so far done so only in a small number of cases with advice from the LFB. However, fire risk assessments had identified the need to extend the work to residents known to have disabilities and that the TMO planned to work with Carl Stokes to produce generic PEEPs for larger blocks which could then be adapted to individual needs.

46.35 Robert Black's assurances were, however, misleading. The first of only two PEEPs to be prepared for TMO residents was still in preparation and was not completed until 18 October 2010, nearly three weeks later.[1733] Plans to produce generic and individual PEEPs were not fulfilled. Even so, at a joint meeting of RBKC, TMO executives and the LFB on 20 July 2011, Janice Wray gave similar assurances that the TMO intended to identify vulnerable and disabled residents who required PEEPs.[1734]

46.36 Despite having been made aware in late 2010 and July 2011 of the TMO's supposed plans, neither Laura Johnson nor Amanda Johnson asked Robert Black whether any PEEPs had been prepared.[1735] Indeed, nobody from RBKC

1733 {CST00005610}.

1734 Minutes of RBKC, KCTMO and LFB Meeting dated 20 July 2011 {RBK00053638/6}; Wray {Day142/119:4}-{Day142/120:3}.

1735 Laura Johnson {Day129/117:5-17}; Amanda Johnson {Day131/44:25}-{Day131/45:12}.

asked whether the TMO had completed any PEEPs. In its written submissions, RBKC rightly acknowledged that fact and admitted that it had been a failure of oversight on its part.[1736]

46.37 Contrary to what had been said by Robert Black and Janice Wray, the TMO did not regularly identify vulnerable residents. Only two residents were assessed for PEEPs between 2010 to 2017,[1737] one in Markland House and one in Gillray house.[1738] Although Janice Wray said that the Health and Safety team were prepared to receive requests for PEEPs from residents in general needs housing,[1739] as far as we can see, none was ever prepared by Janice Wray or her team.

The TMO's assurances to the LFB

46.38 The LFB, like RBKC, received assurances from the TMO about the identification and treatment of vulnerable people. At a meeting on 20 July 2011, Janice Wray told the LFB that the TMO was gathering information about vulnerable and

1736 RBKC Module 3 Closing submissions {RBK00068069/29-30} pages 29-30, paragraph 103; Laura Johnson {Day129/117:5-17}; Amanda Johnson {Day131/44:25}-{Day131/45:12}.
1737 Stokes {CST00030186/38} page 38, paragraph142.
1738 {CST00005610}; {CST00020896}.
1739 Stokes {CST00030186/38} page 38, paragraph 143; Wray {TMO00862589/2} page 2, paragraphs 6-7.

disabled residents in the council's properties with the intention of preparing PEEPs for those who needed them.[1740]

46.39 On 26 September 2012, Nicolas Comery, Nick Coombe and Andy Jack of the LFB met Janice Wray and Claire Wise.[1741] The LFB team asked the TMO to prepare a list of residents with additional needs to be kept close to the fire alarm control panel. They told Janice Wray and Claire Wise that the LFB's view was that the person or organisation managing a building had a duty to develop a plan to be followed in the event of a fire and to collect information on residents with additional needs. A risk assessment would also need to be reviewed if a resident's needs changed significantly or became permanent. Although the discussion was focused on sheltered housing, the LFB's advice related to general needs accommodation as well.[1742] The LFB's views were passed to RBKC's Housing department.[1743]

46.40 Notwithstanding that prompt from the LFB, the TMO did not create a system to collect information about residents with additional needs that could be made available to the LFB in the

1740 Minutes of RBKC, KCTMO and LFB Meeting dated 20 July 2011 {RBK00053638/6}; Wray {Day142/119:4}-{Day142/120:3}.
1741 {TMO00863422}.
1742 Wray {Day142/119:4}-{Day142/120:3}.
1743 {TMO00863422}.

event of a fire. According to Janice Wray, that was because it was concerned about its ability to keep documents held in a premises information box up to date. It was not discussed with the LFB again.[1744] Critically, it does not appear that the TMO told the LFB why it was difficult to comply with its request.

Correspondence with the LFB

46.41 On 30 November 2012, Nick Comery asked Janice Wray for help in identifying vulnerable persons in local authority premises who might be suitable for an LFB initiative promoting sprinklers. Janice Wray passed the request to Carl Stokes who advised her to say that she was not aware of anyone. He did so in order to avoid any questions being asked about why anyone who might qualify had not been identified in the fire risk assessments or received a PEEP.[1745]

46.42 Carl Stokes thought he had spoken to Janice Wray before responding to her email, although he could not be sure about that.[1746] He said that he had not been suggesting that there were no vulnerable residents in the properties managed by the TMO, but that there were no heavy smokers. His evidence was that he had

1744 Wray {Day142/122:16}-{Day142/123:8}.
1745 {CST00016416}.
1746 Stokes {Day137/128:10}-{Day137/129:4}.

thought that the LFB were asking for people who were vulnerable because they were heavy smokers. Although automatic fire suppression systems may have been particularly suitable for use by those who were heavy smokers, we do not accept that explanation. Carl Stokes had no information about the smoking habits of TMO residents and had never sought any. The truth is that he knew that PEEPs were required for vulnerable residents, that the TMO had produced only two, and that his fire risk assessments had not recommended any additional fire safety measures for vulnerable people. His advice amounted to a suggestion that she should lie to the LFB.

46.43 Janice Wray agreed that it was not possible to say that there were no vulnerable residents in the properties managed by the TMO,[1747] but although she said she would not lie to the LFB, she does not appear to have been unduly concerned about Mr Stokes's suggestion that she should.[1748]

46.44 Carl Stokes's reaction to the LFB's request for information about vulnerable people ought to have acted as a spur to him and Janice Wray to correct the position quickly. The TMO should have initiated a process of collecting information and

[1747] Wray {Day142/128:14-23}.
[1748] Wray {Day142/128:24}-{Day142/130:1}.

should have asked him to carry out a proper risk assessment, taking into account the vulnerable people in each building.

46.45 Neither Carl Stokes nor Janice Wray was able to provide a clear explanation for their failure to ascertain the number of vulnerable people living in properties managed by the TMO. Janice Wray had been aware of the need to collect and maintain that information since receiving the advice from Salvus in 2009 and 2010. However, she did not take any steps to review the fire risk assessments or take any action to check whether any of them should contain any reference to vulnerable residents. She said she had had no concerns about Mr Stokes's response, and that if she had, she would have done something about it.[1749]

Carl Stokes's fire risk assessments of Grenfell Tower

46.46 As we have said in Chapter 38, Carl Stokes carried out six fire risk assessments in relation to Grenfell Tower between 30 September 2009

[1749] Wray {Day142/131:5-9}.

and 20 June 2016.[1750] The first, dated 30 September 2009, was carried out as a sub-contractor of Salvus and follows the Salvus template.[1751]

46.47 In section 5 on page 11 of that fire risk assessment, Carl Stokes described the measures in place to counter the risk that people on the premises might not be aware of the fire. In section 5.4 he identified as a hazard the possibility that if tenants and others within the building suffered from a hearing impairment they might not receive adequate warning. In relation to control measures he recorded that there was no evidence that any resident or member of staff on the premises suffered from a sensory impairment that would prevent them from hearing a shouted warning of fire. However, he also recorded that he could not confirm that that was the case or whether the TMO had any personal emergency evacuation plans available or policies in place if they were needed.

1750 Fire risk assessment for Grenfell Tower dated 30 September 2009 {CST00003128}; Fire risk assessment for Grenfell Tower dated 29 December 2010 {CST00003181}; Fire risk assessment for Grenfell Tower dated 20 November 2012 {CST00003084}; Fire risk assessment and schedule of significant findings for Grenfell Tower dated 17 October 2014 {CST00003177}; Fire risk assessment for Grenfell Tower dated 26 April 2016 {CST00003161}; Fire risk assessment for Grenfell Tower dated 20 June 2016 {CST00003145}.

1751 Fire risk assessment for Grenfell Tower dated 30 September 2009 {CST00003128/11}.

46.48 Mr Stokes said that he had focused on hearing impairments to the exclusion of other disabilities, including mobility and visual impairments, because there had been no communal fire alarm in Grenfell tower so residents would be affected if they could not hear someone trying to warn them of a fire.[1752] However, he failed to consider the full range of impairments that could affect residents who might be required to evacuate.

Fire risk assessments: 29 December 2010 and later

46.49 After Carl Stokes had been appointed by the TMO to carry out its fire risk assessments he used his own templates that were partly, but not consistently, based on PAS 79. Section 13 of his form referred to “Disabled People”.

46.50 The 2010 fire risk assessment for Grenfell Tower stated that there was no evidence that any residents suffered from a hearing impairment that would prevent them hearing a shouted warning of fire or a warning in the form of a loud knocking.[1753] It also recorded that the TMO had introduced a programme to gather information about tenants, including any disabilities and their ability to respond to emergency situations. The information

1752 Stokes {Day137/94:7-20}.

1753 Fire risk assessment for Grenfell Tower dated 29 December 2010 {CST00003181/16}.

was to be recorded in the TP Tracker system and used to decide whether any residents required additional devices or PEEPs.[1754]

46.51 Aside from minor variations, the text remained substantively the same between 2010 and 2016.[1755] Janice Wray could not recall speaking to Carl Stokes about the variations in the text. She admitted that she had probably noticed that he had repeatedly used the same information in section 13 of his fire risk assessments, but she never asked him why. She did not remember being concerned that the information in section 13 might have become out of date, but she admitted that she should have been.[1756]

46.52 Although the TP Tracker was discontinued in 2013, the fire risk assessments in relation to Grenfell Tower continued to refer to its being used to identify residents in need.[1757] Janice Wray could not say why Carl Stokes had not been told that it had been discontinued in 2013. She accepted that it had been part of her responsibility to identify vulnerable residents, but she said that

1754 Fire risk assessment for Grenfell Tower dated 29 December 2010 {CST00003181/16}.
1755 Fire risk assessment for Grenfell Tower dated 29 December 2010 {CST00003181/16}; Fire risk assessment dated for Grenfell tower dated 20 November 2012 {CST00003084/20-21}; Fire risk assessment for Grenfell Tower dated 17 October 2014 {CST00003157/21}; Fire risk assessment for Grenfell Tower dated 26 April 2016 {CST00003161/22}.
1756 Wray {Day142/133:7-20}.
1757 {RBK00057527}.

she had not been aware of how the Housing department was recording them. She failed to ask Carl Stokes whether he had that information when he was preparing the fire risk assessments, but she did try to clarify what information was held by the TMO when she reviewed the fire strategy in December 2016.[1758] We return to her attempt to do so below.

Leon Taylor's fire risk assessment: June 2014

46.53 Leon Taylor, an independent fire risk assessor, carried out a fire risk assessment in respect of Grenfell Tower on 14 June 2014. He noted that the vulnerabilities of the occupants were unknown, but that as the building was designated as "general needs" he assumed that the occupants were typical of the general population.[1759]

46.54 In section K13 of his fire risk assessment Mr Taylor noted that the TMO Housing department should have a record of all those who had special needs in relation to evacuation and should make arrangements in accordance with the Housing Act 2004 for evacuation plans and any PEEPs that

[1758] Wray {Day142/135:24}-{Day142/137:13}; {TMO00865834/2}.
[1759] {TMO10001286}, Cell E39.

might be required. No action appears to have been taken by the TMO in response to that fire risk assessment.

Carl Stokes's fire risk assessments relating to other TMO properties

46.55 A sample of Carl Stokes's fire risk assessments for other high-rise buildings managed by the TMO revealed that it was his practice not to identify vulnerable residents.[1760] Only the fire risk assessment carried out in relation to Gillray House in 2010 recorded that there was a resident with impaired mobility.[1761] Moreover, as he accepted, the first three paragraphs of the text in section 13 of each of his fire risk assessments

1760 Fire risk assessment for Adair Tower dated 28 October 2010 {CST00004307}; Fire risk assessment for Adair Tower dated 20 February dated 2014 {LFB00027631}; Fire risk assessment for Adair Tower dated 11 November 2015 {CST00025478}; Fire risk assessment for Adair Tower dated 28 September 2016 {TMO00843943}; Fire risk assessment for Gillray House dated 19 November 2012 {TMO00854930}; Fire risk assessment for Gillray House dated 28 January 2016 {CST00025186}; Fire risk assessment for Hazlewood Tower dated 20 February 2014 {TMO10043804}; Fire risk assessment for Hazlewood Tower dated 25 November 2015 {TMO10044598}; Fire risk assessment for Hazlewood Tower dated 3 October 2016 {TMO10048023}; Fire risk assessment for Markland House dated 16 November 2010 {CST00009754}; Fire risk assessment for Markland House dated 29 November 2012 {CST00017016}; Fire risk assessment for Markland House dated 21 January 2016 {TMO10047159}; Fire risk assessment for Trellick Tower dated 11 June 2012 {CST00017807}; Fire risk assessment for Trellick Tower dated 6 March 2014 {TMO00842081}; Fire risk assessment for Trellick Tower dated 26 April 2017 {TMO00842255}.

1761 Fire risk assessment for Gillray House dated 8 October 2010 {CST00012048/15}.

for Adair Tower (2011), Gillray House (2012), Hazlewood Tower (2014), Markland House (2016) and Trellick Tower (2017) were identical to each other and to that section of the assessment carried out in relation to Grenfell Tower in 2010.

46.56 Carl Stokes drew up a PEEP for a resident of Gillray House on 18 October 2010.[1762] The same resident asked for a copy of the PEEP in November 2013, indicating that she was still living in the property.[1763] Her presence in Gillray House was reflected in the 2010 fire risk assessment but not in the assessment prepared in 2012. He also drew up a PEEP for a resident of Markland House on 8 March 2014,[1764] but it was not noted in the 2016 fire risk assessment.[1765] He was unable to explain why those two fire risk assessments did not record that PEEPs had been produced for residents of those properties.[1766]

46.57 Janice Wray did sometimes comment on fire risk assessments,[1767] but she does not appear to have questioned the inclusion of identical text in section 13 of the fire risk assessments relating to those

1762 {CST00005610}.
1763 {CST00005609}.
1764 {CST00020896}.
1765 Fire risk assessment for Markland House dated 21 January 2016 {TMO10047159/21}.
1766 Stokes {Day137/117:3}-{Day137/122:5}.
1767 On 2 December 2015, Janice Wray asked Carl Stokes to correct a sentence on page 5 of the Hazlewood fire risk assessment: email from Janice Wray to Carl Stokes dated 2 December 2015 {CST00006647}.

five different buildings at different times over the course of some six years. It is difficult to believe that she failed to notice the fact or the fact that he continued to refer to the system used to record information on vulnerable residents years after it had been discontinued.

46.58 We are bound to conclude that the fire risk assessments carried out by Mr Stokes that we examined, including those relating to Grenfell Tower, were inaccurate and out of date in relation to the presence of vulnerable persons and were not suitable and sufficient for the purposes of Article 9 of the Fire Safety Order.

TMO Policies relevant to vulnerable persons

The TMO fire safety strategy

46.59 The TMO had no formal fire safety strategy at all until November 2013. The strategy was later reviewed in 2016 and approved in June 2017.[1768]

46.60 Although the original fire safety strategy made express provision for PEEPs for the TMO's staff,[1769] it contained no reference to PEEPs for vulnerable residents. Similarly, the TMO's Health

[1768] {TMO10004485}; {TMO00832724}.
[1769] {TMO10004485/14} section 24.1 ("Fire Procedures").

and Safety Policy (dated February 2016 and in force in June 2017) referred to PEEPs only in relation to staff.[1770]

46.61 The 2017 version of the fire safety strategy also referred to PEEPs in relation to staff, but not in relation to residents.[1771] A new section (paragraph 28) was added, to cover both hoarders and vulnerable residents. Paragraph 28.3 stated that efforts were made to collect information about a resident's vulnerability when the tenancy was signed and thereafter as part of the TMO's continuing contact with residents. The purpose of the exercise was said to be providing a service which better met the resident's needs, including fire safety. The new paragraph therefore acknowledged to some extent the TMO's obligation to identify vulnerable residents in order to meet their needs in respect of fire safety, but it did not extend to the provision of PEEPs.

46.62 Janice Wray was unable to explain why the 2013 and 2017 fire safety strategies did not refer to PEEPs being produced for residents and accepted that they should have done so.[1772] Robert Black could not remember why there had been no reference in the fire safety strategies or the Health and Safety policy to producing

1770 {TMO10024402/6} sections 7-10.
1771 {TMO00832724/15} section 25.1.
1772 Wray {Day142/149:23}-{Day142/152:1}.

PEEPs for residents, but thought the TMO had probably decided not to follow Salvus's advice about that.[1773] We agree that that is the most likely explanation.

46.63 Given Salvus's clear advice in 2009 about the need for procedures to ensure the safety of disabled or vulnerable persons in the event of a fire it is difficult to understand why none were ever included by the TMO in any of its policies.[1774]

The "Supporting Residents" policy and procedure

46.64 The TMO recognised the need to identify vulnerable residents living in its properties and to make them known to the appropriate support services. David Noble and Teresa Brown started preparing a policy for vulnerable residents in December 2014.[1775] The first draft of the Vulnerability Policy adopted the definitions of vulnerable persons already used by the TMO. It recorded that the process for identifying residents who required PEEPs depended on chance or a request from the relevant resident.[1776] In that regard, the document reflects Janice Wray's evidence, but the position was not recorded in any of the later drafts of the Vulnerability Policy

1773 Black {Day149/169:22}-{Day149/170:1-14}.
1774 {SAL00000013/18}.
1775 {TMO00880460}; {TMO00880458}; {TMO00880463}.
1776 {TMO00880461/2}.

or the "Supporting Residents"' policy. None of the draft policies relating to vulnerable residents dealt with fire safety.

46.65 The final version of the "Supporting Residents" policy was drafted by David Noble and dated April 2016 .[1777] Neither he nor Teresa Brown was able to explain why it had taken nearly two years to complete.[1778] The purpose of the policy was to provide an agreed approach to recognising vulnerable residents and referring them to the neighbourhood teams who could provide them with support.[1779] It was accompanied by the "Supporting Residents" procedure dated April 2016.[1780] The policy and procedure described certain potential indicators of vulnerability and identified steps that might be taken to provide assistance to those who required it. There was no mention of fire safety in either the policy or the procedure.

46.66 The senior management team discussed the "Supporting Residents" policy at a team meeting on 18 February 2016.[1781] Teresa Brown did not recall having discussed it with the Health and Safety team, but she noted that

1777 {TMO00880481}.
1778 Noble {Day119/69:12}-{Day119/70:4}; Brown {Day126/89:25}-{Day126/91:22}.
1779 Brown {Day126/77:5-13}.
1780 {TMO00880482}.
1781 Minutes of Senior Management Team Meeting dated 18 February 2016 {TMO00866011}.

Barbara Matthews, who had overall responsibility for health and safety, had been present at the meeting and had not raised any concerns.[1782] Apparently, no one asked how fire safety procedures might apply to vulnerable residents. Although the revised policy was presented to the senior management team on 17 March 2016,[1783] it was not presented to the executive team for approval.

46.67 In December 2016, before the final version of the policy had been circulated to the senior management team, Janice Wray asked David Noble how the TMO obtained and stored information on vulnerability, as she was reviewing the fire safety strategy.[1784] Although the review of the fire safety strategy (which culminated in the 2017 version) took place when the "Supporting Residents" policy was being completed, neither the TMO's senior management team nor Janice Wray nor David Noble thought that there were matters, such as fire safety, that ought to be covered in both documents.

1782 Brown {Day126/94:12}-{Day126/95:1}.
1783 Minutes of Senior Management Team Meeting on 17 March 2016 {TMO00880549/1}.
1784 {TMO00865834}.

Gathering information about vulnerable residents

46.68 The TMO's regular means of gathering information about residents' vulnerability was by talking to them at the time of granting a tenancy and during a tenancy audit. When registering a new tenant, the TMO recorded whether that person or anyone in the household suffered from any disability. Any disabilities were recorded in the tenancy agreement, Tenancy Information forms and in a data entry form that all new tenants were required to complete. The forms were all stored on the W2 system. The way in which the information was recorded was not consistent and in most cases the Neighbourhood Officers that helped to complete the forms recorded that no support was required, even if a vulnerability of some kind was recorded.[1785]

46.69 On 29 April 2014, David Noble and Teresa Brown told the executive team that there were gaps in some of the information held on tenants, particularly relating to disabilities.[1786] They suggested that the collection of information could be improved by the use of a detailed

[1785] Lane, Module 3 Report {BLARP20000034/173} Table 10-1.
[1786] Noble {Day119/51:11-23}.

questionnaire.[1787] The proposal was approved; a new tenancy questionnaire was introduced and a programme of tenancy audits was put in place.

46.70 From 2015 onwards, housing officers were required to carry out about 30 tenancy audits a month.[1788] Janice Jones carried out tenancy audits at Grenfell Tower.[1789] She collected information about residents, such as their names, contact details, ethnicity, vulnerabilities or disabilities, support needs and whether any repairs needed to be carried out to their properties.[1790] Information gathered in tenancy audits was entered on the W2 system.[1791] A spreadsheet dated 13 April 2016 recorded that 547 audits of TMO properties had been completed between 1 April 2015 and 1 April 2016.[1792]

46.71 The TMO gathered information on vulnerable residents in Grenfell Tower during the refurbishment. Rydon spoke to tenants to ask them, among other things, whether any member of the household had any health problems. The information was recorded in a report

1787 Minutes of Executive Team Meeting dated 29 April 2014 {TMO00851128/1}.
1788 Jones {TMO00873924/3} page 3, paragraph 11.
1789 Jones {TMO00873924/3} page 3, paragraph 11.
1790 Jones {TMO00873924/3-4} pages 3-4, paragraphs 13-15.
1791 Jones {TMO00873924/3} page 3, paragraph 13.
1792 {TMO00860130}.

dated November 2014[1793] which identified 57 residents as having a sensory, cognitive or mobility impairment.[1794]

46.72 The report was discussed with Rydon at Housing Management Liaison Meetings and there is some evidence that it was sent to Siobhan Rumble at the TMO.[1795] There is no evidence, however, that it was used to revise any of the TMO's records. Most importantly, the information was not included in the spreadsheet from which attempts were made on the night of the fire to extract information about vulnerable residents.

Premises information box

46.73 During a visit to Grenfell Tower on 12 March 2014, representatives of the LFB fire safety team and a local fire station crew asked for a premises information box to be installed.[1796] The intention was that it should contain fire safety information specific to Grenfell Tower, such as floor plans, that would assist the LFB in the event of a fire.[1797]

1793 {RYD00024466}.
1794 Lane, Module 3 Report {BLARP20000034/177} paragraph 10.6.10.
1795 Minutes of Housing Management Liaison Meeting with Rydon dated 28 January 2015 {TMO00852169}.
1796 {CST00000178/2-3}.
1797 {CST00000178/2-3}; {TMO10013186/1}.

46.74 On 18 March 2014, Carl Stokes strongly advised Claire Williams against installing a premises information box, in essence, because he thought that the onus was on the LFB to gather the information themselves during section 7(2)d and familiarisation visits.[1798] According to Colin Todd, it was not common at the time for premises information boxes to be installed in general needs blocks of flats, but both he[1799] and Dr Lane[1800] thought that they could be of assistance to fire and rescue services.[1801] We agree. In the face of a request from the LFB we can see no good reason for Carl Stokes to oppose the suggestion.

46.75 Following a demonstration of the smoke ventilation system at Grenfell Tower on 28 April 2016, the LFB renewed its request for a premises information box or other secure information box to be installed in the foyer of the tower,[1802] but on 4 May 2016 Carl Stokes again told Janice Wray that the TMO had no obligation to provide an information box.[1803] He may have

1798 {CST00003100/4}; Stokes {CST00030186/42} page 42, paragraph 160.
1799 Todd, The Fire Risk Assessments of Carl Stokes Report {CTA00000011/102-103} paragraph 10.3.
1800 Lane, Module 3 Report {BLARP20000027/346-347} paragraphs 15.2.31-15.2.42.
1801 Lane, Module 3 Report {BLARP20000027/347} paragraphs 15.2.39-15.2.41; LGA Guide, Fire safety in purpose-built blocks of flats {HOM00045964/120} paragraph 79.12.
1802 {CST00001131/2}.
1803 {CST00001131/1-2}.

been right, but there was no obvious reason to refuse the LFB's request and in our view his advice was foolish.[1804]

46.76 At the regular meeting between the TMO and the LFB fire safety team on 5 May 2016, Nick Davis, the local station manager, asked Janice Wray again for a premises information box to be installed at Grenfell Tower. He agreed to confirm what information the LFB wanted to have stored in it but said that it would include at least information about the operation of the smoke ventilation system.[1805] On 6 May 2016, he sent her a list of the information that he wanted to see made available.[1806]

46.77 At the next meeting on 13 July 2016, which was attended by Janice Wray and Rebecca Burton, the TMO told the LFB that arrangements had been made to store the documents to which the LFB needed access in a secure box in the lobby, the key to which would held in a key safe secured by a padlock in the bin room.[1807] Despite that assurance, however, by the time of the fire no premises information box or any other secure box containing the relevant fire safety information

1804 Wray {Day144/198:19-22}.
1805 Minutes of the Bi-Monthly Meeting dated 5 May 2016 {TMO10013185/3} item 8.
1806 {TMO10013186/1}.
1807 Minutes of the Bi-Monthly Meeting dated 13 July 2016 {LFB00032335/3} item 7.

had been installed at Grenfell Tower. Janice Wray thought that was because Claire Williams had made arrangements for the information to be kept in an existing secure box in the lobby, as contemplated by the minutes of the meeting on 13 July 2016,[1808] but she did not check whether the box did in fact exist or, if it did, what information it contained.[1809] Claire Williams said that there had been a "fire panel" at Grenfell Tower which described how to operate the smoke ventilation system, but she could not identify anything else.[1810] There was nothing else. The TMO simply never complied with the LFB's request for a secure box containing information about the building. There was no good reason for its failure to do so.

TMO's systems for recording data about vulnerable residents

46.78 Between 2010 and 2017 Carl Stokes's fire risk assessments for Grenfell Tower stated that the TMO used the TP Tracker for recording information about vulnerable residents. An entry dated 8 June 2013 recorded that one resident of Grenfell Tower had visual and hearing impairments, three had impaired mobility and

1808 Wray {TMO00000890/13} page 13, paragraph 60; Wray {Day144/195:20}-{Day144/198:1}.
1809 Wray {Day144/195:20}-{Day144/198:1}.
1810 Williams {Day122/33:13-21}.

one had a mental health illness, but none of those residents was recorded in the fire risk assessment made in October 2014.[1811] That tends to show that, although Carl Stokes was aware of the TP Tracker, he did not take into account the information it contained when making his assessments.

46.79 In 2013, there were proposals for replacing the TP Tracker with the Civica W2 electronic document management system[1812] that held electronic copies of documents relating to residents. The information could then be entered manually into Capita, the housing management system maintained by the TMO.[1813] In 2016 the Customer Relationship Management platform (CRM) was introduced with the intention of replacing W2. By 14 June 2017, therefore, information about vulnerable residents was recorded in three different places: on documents held in W2, on the Capita housing management system and on the CRM database.[1814]

46.80 There was some confusion about how information recorded on Capita was transferred to CRM. However, it appears that, although some of the information was transferred to CRM, most of

1811 Fire Risk Assessment for Grenfell tower dated 17 October 2014 {CST00003157}.
1812 {TMO00862586}.
1813 Noble {Day119/54:11-18}.
1814 Noble {TMO00899669/1} page 1, paragraph 2 (a) and (b).

it was not.[1815] That turned out to be significant, because on the night of the fire there was some uncertainty about the reliability of the information held by the TMO about the number of vulnerable residents in the tower.

46.81 Of the 297 people present in Grenfell Tower on the night of the fire, 67 were children and 37 were adults with sensory, mobility or cognitive impairments.[1816] There were a further 17 residents who had a sensory, mobility or cognitive impairment that was not recorded in the tenancy records, tenancy audit documents or David Noble's spreadsheet. The TMO ought to have had a readily accessible system for collecting and maintaining information about its residents' vulnerabilities which would not only have enabled it to decide whether in any case a PEEP was necessary but would also have assisted in responding to emergencies.

PEEPs for Vulnerable Residents

46.82 Janice Wray said that the Health and Safety team would prepare PEEPs for residents in general needs housing if it were asked to do so, but that there was no established procedure for identifying circumstances that would result in consideration of the need for a PEEP and residents were not

1815 Noble {Day119/54:19}-{Day119/55:8}; {TMO00899673}.
1816 Lane, Module 3 Report {BLARP20000034/237} paragraph 14.2.3.

told that they could ask for one.[1817] For its part, the members of the Housing team did not know that they could refer a resident to the Health and Safety team to be assessed for a PEEP.[1818]

46.83 Neither Siobhan Rumble nor Nicola Bartholomew was aware that she could ask for residents to be given PEEPs. Janice Wray said that was because she did not use the expression "PEEP" with the Housing team. She told them that if residents were concerned about fire safety generally, they could be referred to the Health and Safety team.[1819] If the Health and Safety team expected to have residents referred to them by the Housing team for assessment for a PEEP, even if described in other terms, the Housing team should have been aware of that and it should have been covered in one of the policies, such as the fire safety strategy or the "Supporting Residents" policy.

46.84 Residents were not told that they could ask to be assessed for a PEEP and the possibility was not drawn to their attention in any of the literature they were given. Janice Wray could

1817 Wray {TMO00862589/2} page 2, paragraph 6; Wray {Day142/32:4-21}; {Day142/66:5}-{Day142/67:4}; {Day142/69:1}-{Day142/71:11}; {Day142/71:12-18}.

1818 Brown {Day126/65:9}-{Day126/67:3}; Rumble {Day120/70:8-24}; Bartholomew {Day120/163:3-10}; Williams {TMO00879804/11} page 11, paragraphs 79-80; Jones {TMO00873924/6} page 6, paragraph 27.

1819 Wray {Day142/72:7-17}.

not say why that was and we cannot see any reasonable explanation for it. The first draft version of the fire safety letter to new tenants dated December 2010 did include the offer of a personal emergency evacuation plan for those who were not able-bodied or had special requirements,[1820] but it is unclear whether the letter was ever finished and distributed to residents between 2010 and 2013.

46.85 Janice Wray did not prepare a PEEP for any resident while working at the TMO,[1821] perhaps because no one in the Housing team knew that a resident could be referred to the Health and Safety team for a PEEP. Nonetheless, there is evidence that even when Janice Wray was made aware of a resident in Grenfell Tower with a particular vulnerability, she took no steps to ascertain whether that resident needed a PEEP. That was Elpidio Bonifacio in Flat 83.

46.86 On 4 February 2016, Charles Batterbee of the LFB and Janice Wray exchanged emails about a resident of Flat 83, Elpidio Bonifacio, whom the LFB had met during a home fire safety visit and believed to be blind.[1822] Janice Wray said that she should have asked whether he needed a PEEP or some other form of

---

1820 {TMO00870665}.
1821 Wray {Day142/72:18-24}.
1822 {LFB00001057}.

assistance in the event of a fire and could not explain why she had not done so.[1823] Moreover, Mr Bonifacio's disabilities were not recorded on the spreadsheet produced by David Noble on 14 June 2017.[1824]

46.87 Elpidio Bonifacio was the last person to escape from Grenfell Tower at 08.07 on 14 June 2017. Although he had been encouraged by his family to leave his flat from about 02.00, he had had to wait for more than six hours to be rescued by firefighters because he was blind, elderly and unable to escape without help.[1825] There is no reason to think that he was an isolated example or that Grenfell Tower was different from the other buildings managed by the TMO, given the deficiencies in the TMO's system of creating and maintaining accurate records of vulnerable residents.

Vulnerable residents in Grenfell Tower on 14 June 2017

46.88 The list of residents that David Noble produced on 14 June 2017 identified only ten residents of Grenfell Tower as having mental or physical impairments. That was only half the number recorded as vulnerable by the TMO in the tenancy

1823 Wray {Day142/163:4}-{Day142/165:24}.
1824 {TMO00866002}.
1825 Bonifacio {IWS00001085/5-6} pages 5-6, paragraphs 31-32.

creation and tenancy audit documents.[1826] A result of its failure to maintain an adequate record of residents' vulnerabilities was that the TMO was unable to provide the LFB with an accurate list of vulnerable residents,[1827] although by the time the list reached the LFB all those who died in the tower had already lost their lives.[1828]

46.89 Of the ten residents recorded in the spreadsheet as vulnerable, three, Sakina Afrasehabi, Majorie Vital and Alexandra Atala, died in the fire.[1829] They lived on the top floors of the tower. The remaining seven lived on floors 2 and 3. They were able to escape as their flats were below the fire line. It is impossible to say what effect an accurate list of vulnerable residents would have had on the outcome of the tragedy, but it might have provided the LFB with valuable information about the locations and numbers of vulnerable residents when considering the deployment of crews.

46.90 On any view, the Grenfell Tower fire revealed the importance of ensuring that the responsible person collects sufficient information about any vulnerable occupants to enable PEEPs to be prepared, when appropriate, and, in the event

1826 Lane, Module 3 Report {BLARP20000034/188-189} paragraphs 10.8.32-10.8.34.
1827 Phase 1 Report Volume III paragraphs 20.65-20.66.
1828 Phase 1 Report Volume III paragraphs 20.67-20.68.
1829 {TMO00866002}.

of a fire, appropriate measures to be taken to assist their escape. The TMO's failure to collect such information illustrates a basic neglect of its obligations in relation to fire safety.

ISBN 978-1-5286-5080-9
(Volume 3 of 7)
7 volumes not available separately