Grenfell Tower Inquiry: Phase 2 Report

Implications for the Council

Preface

The publication of the Grenfell Tower Inquiry report on 4 September 2024 was a significant moment for the Council.

But its significance for the Council is nothing compared to its importance for the families whose loved ones died in the fire at Grenfell Tower.

The 72 people named below lost their lives that night in the most horrific circumstances imaginable. Their families will forever have to live with that loss.

Among its many pages, the Inquiry report includes a detailed account of the circumstances in which 54 adults and 18 children lost their lives on 14 June 2017.[1]

It is difficult to fathom the grief and anguish that bereaved family members must experience in having to hear or read those accounts, or how it must feel for their deeply personal loss to be the centre of such a public tragedy.

But any analysis of the Inquiry report and its findings must somehow confront the awful reality of that night. The individual and systemic failures that the Inquiry has identified in the report must be seen through the prism of their catastrophic consequences for those affected.

We record the names of the 72 here both to honour their memory and to remember each individual life lost because of the failings of the Council and other organisations responsible for keeping them safe.

We must always remember the human consequence of these failings.

The Council cannot undo the harm it has done, but we owe it to their families, their neighbours and our communities to drive lasting change at the Council in their memory.

[1] *Grenfell Tower Inquiry: Phase 2 Report*, Volume 6, Part 9: The deceased.

Abdeslam Sebbar

Ali Yawar Jafari

Denis Murphy

Mohammad Alhajali

Jeremiah Deen

Zainab Deen

Steven (Steve) Power

Sheila

Joseph Daniels

Husna Begum

Kamru Miah

Mohammed Hamid

Mohammed Hanif

Rabeya Begum

Ernie Vital

Majorie Vital

Maria del Pilar (Pily) Burton

Amal Ahmedin

Amaya Tuccu Ahmedin

Amna Mahmud Idris

Mohamednur Tuccu

Victoria King

Alexandra Atala

Mary Mendy

Khadija Saye

Khadija Khalloufi

Vincent Chiejina

Fatemeh Afrasiabi

Sakina Afrasehabi

Isaac Paulos

Hamid Kani

Berkti Haftom

Biruk Haftom

Gary Maunders

Debbie Lamprell

Farah Hamdan

Leena Belkadi

Malak Belkadi

Omar Belkadi

Jessica Urbano Ramirez

Ligaya Moore

Abdulaziz El Wahabi

Faouzia El Wahabi

Mehdi El Wahabi

Nur Huda El Wahabi

Yasin El Wahabi

Anthony (Tony) Disson

Mariem Elgwahry

Eslah Elgwahry

Raymond (Moses) Bernard

Gloria Trevisan

Marco Gottardi

Fethia Hassan

Hania Hassan

Rania Ibrahim

Hesham Rahman

Mohammed Amied (Saber) Neda

Abufras Ibrahim

Isra Ibrahim

Fathia Ahmed Elsanousi

Logan Gomes

Firdaws Hashim

Hashim Kedir

Nura Jemal

Yahya Hashim

Yaqub Hashim

Fatima Choucair

Mierna Choucair

Nadia Choucair

Sirria Choucair

Zainab Choucair

Bassem Choukair

1. Introduction

1.1 A public inquiry into the fire at Grenfell Tower on 14 June 2017 was announced by the then Prime Minister, Theresa May MP, on 15 June 2017. She appointed Sir Martin Moore-Bick as Chairman of the Inquiry on 28 June 2017, and formally established the Grenfell Tower Inquiry and set its terms of reference on 15 August 2017.

1.2 The Inquiry was conducted in two phases. Phase 1 focussed on the factual narrative of the events on the night of 14 June 2017. Phase 2 examined the causes of these events, including how Grenfell Tower came to be in a condition which allowed the fire to spread in the way identified by Phase 1. The Inquiry's final Phase 2 report was published on 4 September 2024.

1.3 The introduction to the report states plainly its central question: *How was it possible in 21st century London for a reinforced concrete building, itself structurally impervious to fire, to be turned into a death trap that would enable fire to sweep through it in an uncontrollable way in a matter of a few hours despite what was thought to be effective regulations designed to prevent such an event?* The report goes on to describe *the many failings of a wide range of institutions, entities and individuals over many years that together brought about that situation* (Paragraph 1.3).

1.4 After the report was published, the Leader of the Council wrote an open letter to the bereaved and survivors of Grenfell, apologising unreservedly on behalf of the Council, fully accepting the findings of the Inquiry and committing to a full and formal response by the end of November. A small project team of officers has been instructed by the Chief Executive to plan this response.

1.5 The Council's full and formal response must be informed by a thorough understanding of the report and its implications for us as an organisation. As a first step, that team has read the report in detail, analysed the findings with a focus on those most relevant to the Council and suggested possible lines of enquiry that should be considered before the Council responds. This report therefore sets out key considerations for further discussion with officers, elected members and, most importantly, bereaved, survivors and residents.

2. Guiding Principles

2.1 In approaching this task, the team has adopted certain principles and assumptions to shape its work. It is worth setting these out explicitly:

2.2 **We accept the Inquiry's findings as the truth.** The Inquiry's work has taken seven years, gathering millions of documents, receiving written evidence and hearing oral testimony from hundreds of witnesses. The resulting analysis is

rigorous, authoritative and independent. Our position is therefore that any findings about the Council should be accepted without question and acted upon accordingly.

2.3 The Inquiry acknowledges, and we accept, that there are issues of deep significance to those affected that fell outside the Inquiry's terms of reference, such as issues of social housing policy and wider issues of inequality and discrimination. These issues featured in submissions and evidence given to the Inquiry, and the Council recognises those concerns and hears them. It is therefore important to the Council that it continues honest and open conversation and engagement with our communities on these issues.

2.4 **We are committed to the Hillsborough Charter.** In 2017 the Council adopted the Hillsborough Charter. The Charter commits the Council to becoming an organisation which strives to 'place the public interest above [its] own reputation' and 'approach forms of public scrutiny - including public inquiries and inquests - with candour, in an open, honest and transparent way', especially in matters relating to families bereaved by public tragedy.

2.5 This commitment shaped the Council's approach to the Inquiry, with the Council assisting the search for truth by making full disclosure of relevant documents, material and facts, and by admitting openly where the Council had, in its own view, failed.

2.6 The commitments we have made under the Charter do not end with the Inquiry. The Inquiry finds at least one area where in its view our *admissions did not cover the full extent of [the Council's] failure* (62.64). That is a finding that we must reflect on in this next phase of work.

2.7 In planning our response, we intend to honour our commitments under the Charter and are determined to make an open and honest assessment of the Council's failures. In doing so we recognise we are accountable and open to challenge, both from elected members and our communities.

2.8 **We will focus on the Council.** The Inquiry details the failings of a web of public bodies, companies and regulators, with differing relationships and interdependencies. This report focuses specifically on the failings that pertain to the Council. Whatever the report says about others, we must remain focused on what it means for us as an organisation and, just as importantly, what it means for our relationship with our communities.

2.9 Our focus includes not only those failings directly attributable to the Council, but also those by the Tenant Management Organisation (TMO), which managed

the Council's housing stock on its behalf. We have included these criticisms for two reasons: first, despite the arrangements with the TMO, the Council retained the ultimate responsibilities for its tenants and leaseholders; and second, housing services were handed back to the Council in 2018. Any criticisms levelled at the TMO then are therefore criticisms that could be levelled at the Council now and are therefore a benchmark against which to consider what has changed.

2.10 In the coming weeks, we will also examine failures of other organisations that may have lessons or implications for the Council.

2.11 **We are aware that the publication of the Inquiry report is a pivotal opportunity.** Many residents feel that they have told the Council and other organisations about the failings identified in the report many times over the past seven years. Many people have lost trust in the Council and some have given up altogether on the prospect of seeing change.

2.12 Over the past seven years, the Council has sought to make its own assessments of our weaknesses as an organisation and taken steps to address them. With the help of our residents, we are working in new ways and have made some important changes. However, we know that not enough people feel the reality of those changes.

2.13 The conclusion of the Inquiry therefore marks an important moment, with the report offering an authoritative account of failings that is broadly accepted by Council and community alike. It is a moment for the Council to seize, building on the changes we have already made and reflecting with humility and openness on what is left to do. If we do not take this opportunity, we may lose yet more trust and cause further harm.

2.14 **We know this process must be a contribution to truth, justice and change.** Bereaved, survivors and residents have said clearly that after Grenfell they want to see truth, justice and change.

2.15 We recognise the fundamental importance of justice and accountability through the criminal process for bereaved, survivors and residents. We agree that the Council must cooperate fully with the investigation and that justice must run its course.

2.16 The criminal justice process is not within our gift. But what we can influence, particularly at this critical juncture, is change. It will be for others ultimately to assess the extent of change in public policy, corporate behaviour and service provision. But we intend this work to contribute to lasting change at the Council

and to a fundamental reconfiguration of our relationship with our communities. As such, we feel it has a contribution to make to processes of recovery, restoration and accountability.

3. The Findings

3.1 To prepare a full and formal response to the Inquiry, we must assess the current position of the Council in relation to specific failings identified in the report and consider how these failings may have happened, assessing whether necessary reforms and improvements have been made to address them, whether such failures could occur again, and what further action is necessary.

3.2 Before we can establish this, it is vital to understand the Inquiry findings in detail, especially the criticisms of the Council, to analyse them as a whole and to discuss them further with our communities.

3.3 To assist this process, the following sections of the report summarise the findings of the report as they pertain to the Council. Our account seeks to use the words of the Inquiry report itself wherever possible. Each extract has a paragraph reference to allow the reader to consult the full reference in the Inquiry report. This is the team's initial reading of the report's findings. We are aware it is unlikely to be comprehensive and we would welcome further suggestions of areas to consider.

3.4 The following sections of this report detail four key areas of direct relevance to the Council:

- Section 4 covers the **Tenant Management Organisation and the relationship with the Council** (Volume 3, Part 4 of the Inquiry report).
- Section 5 deals with **the management of fire safety at Grenfell Tower** (Volume 3, Part 5).
- Section 6 covers the **refurbishment of the Tower**, and in particular the role of the **Council's Building Control department** (Volume 4, Part 6).
- Section 7 deals with **the aftermath of the fire**, including the emergency response by the Council (Volume 7, Part 10).

3.5 For consistency's sake, we have covered these areas in the same order that they appear in the Inquiry report.

3.6 This report does not comment on the fifty-eight recommendations for change made by the Inquiry, which can be read in Volume 7, Part 14 of the Inquiry report. Many are directed at central Government and some to local authorities

in general. None are addressed directly to this Council, but most have far-reaching implications for us as an organisation.

3.7 The Council has committed to looking carefully at all of the recommendations, and a full account of actions which have, or will be, taken to implement those that are relevant to the Council will be included in the final response to be published and agreed by Full Council in November.

4. The Tenant Management Organisation and the relationship with the Council

4.1 Part 4 of the report deals specifically with the Tenant Management Organisation (TMO) and the arrangements put in place by the Council to monitor and oversee the work of the TMO.

4.2 As the report sets out, the TMO was responsible for delivering specific services on the Council's behalf (namely, managing and maintaining its housing stock) under the terms of a modular management agreement first concluded in 2006 and superseded by a new agreement in 2015.

4.3 The report is trenchant in its criticism of the TMO and the arrangements put in place by the Council to monitor its activities. In particular, Part 4 focuses on three key failings:

i) The TMO's failure to address the complete breakdown of the relationship with tenants and leaseholders.
ii) Individual and systemic failings in the senior management of the TMO.
iii) Failure by the Council effectively to oversee and monitor the activities of the TMO and to address the issues that arose in relation to Grenfell Tower and its residents.

4.4 As noted briefly in the introduction, we have taken the view that it is vital to study both the criticisms directly levelled at the Council *and* the specific criticisms of the TMO for two key reasons:

- First, as the Inquiry report says, despite the agreement with the TMO, the Council retained the ultimate (statutory) responsibilities to its tenants and leaseholders (31.16). The Council therefore must take a share of responsibility for the failures of the TMO and the Inquiry report shows that it did not act on the evidence that was brought to its attention about these failures (see paragraphs 4.34 to 4.54 of this report).
- Second, the Council has had direct responsibility for the delivery of housing management services (including the management and maintenance of its housing stock) since these services were handed back

by the TMO in 2018. Any criticisms levelled at the TMO in the report must therefore be carefully considered as criticisms that could be levelled at the Council now and as a benchmark against which to assess the current performance of housing management services.

4.5 This section therefore considers all three of the above failings in turn.

i) The failure to address the breakdown of the TMO's relationship with residents

4.6 The report finds that there had been a 'troubled' relationship between the TMO and residents for many years. It notes that 'serious flaws' had been identified in that relationship, including in two independent reports commissioned by the Council, which were produced in 2009: the Memoli and Butler reports (2.53; see also 33.2 to 33.6).

4.7 The Memoli and Butler reports identified multiple problems with the TMO in relation to its governance, customer service, staff attitudes and poor repairs service (2.53). The Memoli report, for example, 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, communication, performance and monitoring, and trust and confidence. Complaints had not been resolved, it was felt, for some years* (33.2).

4.8 The Butler report included a range of recommendations, which included a mediation or conciliation process to rebuild trust with residents, more proactive communication with residents about repairs and major works, the need to have greater regard to the diversity of residents, the need to build greater openness and transparency to overcome an entrenched 'us and them' culture and the need to ensure RBKC's had greater oversight of major works and repairs to make sure the TMO had the right technical expertise (33.5). The final point raises issues about the management of a large complex capital project which would turn out to be significant in relation to the refurbishment of Grenfell Tower (See Section 6 of this report below).

4.9 Although both the Council and the TMO responded formally to the reports (33.5), the Inquiry finds that the TMO (and, by extension, the Council) failed to act on these findings to the point that *eight years later the TMO had shown little sign of any change and appeared to have learnt nothing about how to treat, or relate to, residents*. The Inquiry finds that the recommendations made by the Memoli and Butler reports *could just as well have been contained in this [the Inquiry] report, given what we have found* (33.6). It therefore finds a complete failure effectively to learn from external reports and reviews.

4.10 In its overall assessment of the state of the relationship between the TMO and residents of Grenfell Tower specifically, the Inquiry report finds that:

4.11 *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* (33.67).

4.12 Despite the evident challenges of managing a large housing stock, the report is clear that this was not a normal state of affairs and that *relationships had deteriorated to the point at which they could be described as hostile* (30.4). It finds that *some, perhaps many, occupants of [Grenfell] tower regarded the TMO as a bullying overlord that belittled and marginalised them, regarded them as a nuisance, or worse, and failed to take their concerns seriously* (2.55). The report describes a complete breakdown of trust giving rise to a *toxic atmosphere fuelled by mistrust on both sides* (2.55).

4.13 Crucially, the Inquiry report finds that although the TMO and its staff frequently criticised the conduct of residents, particularly those they regarded as *a nuisance or worse* (2.55), ultimate responsibility for the state of the relationship with the 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* (2.56).

4.14 Specifically, the Inquiry finds that the TMO:

4.15 *lost sight of the fact that the residents were **people*** [emphasis added] *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 to ensure that, whatever the difficulties, the residents were treated with understanding and respect* (2.56).

4.16 Ultimately, the report finds that the TMO's failure to ensure this amounted to *serious failure on its part to observe its basic responsibilities* (2.57).

4.17 Although these findings are couched in general terms, there are several specific examples in the report of the TMO failing to respond to residents' questions and concerns. For example:

- *[Mr Ahmed] said he had never received a proper response from the TMO despite repeating his concerns for several years after the [2010] fire [at Grenfell Tower]* (33.18).

- *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. He never received an answer to that question* (33.45).

4.18 These examples are particularly egregious, given that they are concerned both with fundamental questions about the safety and wellbeing of residents and with issues that the Inquiry has found to be highly significant in relation to the refurbishment.

4.19 The Inquiry finds both that the TMO failed to respond to individual complaints and concerns and that it failed to engage collectively with residents. In particular, the report comments on the TMO's persistent refusal to recognise groups which came together to raise issues on behalf of other residents of the Tower, including the Grenfell Action Group and the Grenfell Compact, despite advice from expert bodies such as the Tenancy Participation Advisory Service (see, for example, 33.21).

4.20 This failure extended to the TMO's approach to formal consultation with residents. The Inquiry finds considerable evidence of a lack of meaningful consultation with residents of the tower, particularly in relation to the refurbishment, as evidenced in the following passages:

- *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 been given any collective say in relation to it, as required by the agreement between the TMO and RBKC* (33.33).
- *[D]espite residents' request for involvement [in developing the plans for the refurbishment], no proposals were developed* (33.46).
- *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, were ever invited to join a focus group* (33.47).
- *Six methods [of 'consultation'] 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* (33.50).

4.21 The Inquiry finds that, taken together, this amounts to a failure to treat residents with respect and decency. The report explains that the investigation of *what is alleged to have been a culture of racial and social discrimination in the institutions involved in one way or another in the refurbishment, particularly RBKC and the TMO* (1.2) was not within its terms of reference. In the same section of the report, however, it finds that *the TMO failed over the course of years to treat residents of the tower and the Lancaster West Estate*

more generally with the courtesy and respect due to them (1.22). In the context of the Inquiry's careful discussion about racial and social discrimination, this is a highly significant finding.

4.22 As discussed further below (in paragraphs 4.34 to 4.54 of this report), the Inquiry report is explicit that, despite the TMO's responsibility for delivering services on the Council's behalf under the modular management agreement, RBKC retained ultimate responsibility for its tenants and leaseholders (31.16). Under the terms of the agreement, the Council had an obligation to maintain effective oversight of the TMO's activities and ensure it was discharging its responsibilities effectively.

4.23 The report shows that that Council bears some responsibility for the breakdown of the relationship between residents and the TMO. In particular, as explored further below, the Inquiry finds evidence that the Council failed to act on the material presented to it, both by residents and their elected representatives, about the state of the relationship. At times, the report attributes direct responsibility to officers and members of the Council for these failings:

- *It is striking that senior officers of the TMO and RBKC appear to have been more interested in silencing Councillor Blakeman than in resolving residents' grievances* (33.53).
- *Although [Councillor Feilding-Mellen] told us that only a small concession was needed because the differences between them were not great, what he really meant, we think, was that he was looking for something trivial he could give away* (33.66).

ii) Individual and systemic failings in the management of the TMO

4.24 The report identifies a multitude of individual and systemic failings in the TMO's senior management, both in terms of the management arrangements themselves and the conduct of specific officers, particularly the Chief Executive, Robert Black, and the Health and Safety and Facilities Manager, Janice Wray. The failings identified in the report relate principally to the management of fire safety and can be broadly summarised as follows.

4.25 First, the report finds a lack of experience and training in relation to health and safety and fire safety management within the senior management team. In particular, there was a failure to ensure that senior staff were familiar with, and trained in, their responsibilities under the relevant legislation, especially the 2005 Fire Safety Order (31.22).

4.26 Second, the Inquiry finds that, within the TMO, there was an overreliance on one individual and their judgement on matters of fire safety without substantial assistance and effective oversight (31.23, 31.27 and 31.30). It concludes that the Chief Executive was *entirely reliant* on the judgement of one individual as to *whether a matter concerning fire safety or fire safety management should be drawn to the attention of the board* (31.30).

4.27 Third, the report finds evidence of confusion about roles and responsibilities (both within the TMO and between the Council and the TMO) in relation to health and safety and fire safety management. For example:

4.28 *Janice Wray's understanding was that 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. 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* (32.19).

4.29 Fourth, the report finds a consistent failure by senior TMO staff, especially the Chief Executive and the Health and Safety and Facilities Manager to disclose important information about fire safety to the attention of the TMO Board and to the Council's Housing and Property Scrutiny Committee. The report identifies a significant number of omissions in formal and informal reports that it finds were very likely to have been deliberate (31.34, 31.37, 31.38, 31.42, 31.42, 31.47, 31.54). It finds that:

4.30 *[t]he 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 its scrutiny committees. Reports to the scrutiny committees did not always contain the information that might reasonably have been expected.* (31.34)

4.31 Finally, the report finds that this pattern of omissions or deliberate withholding of information, from both the TMO Board and RBKC, was consistent with a wider *culture of concealment that had started at the top and filtered down to lower layers of management* (31.43). It finds evidence of this in the conduct of both the Chief Executive and the Health and Safety and Facilities Manager (see paragraph 4.30 of this report).

4.32 Although the Inquiry finds that the TMO's senior management deliberately withheld information from the Council, the report also shows that the arrangements in place by the Council to monitor and oversee the work of the TMO were either inadequate or were not followed in practice.

iii) Failures of oversight and monitoring of the TMO by RBKC

4.33 The report emphasises that, despite the modular management agreement in place with the TMO, the Council retained its basic responsibilities to its tenants and leaseholders:

4.34 *Neither [modular management] agreement transferred any ownership or rights in RBKC's housing stock to the TMO…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.* (31.16)

4.35 There was an important role for elected members in overseeing these responsibilities, as demonstrated by the then Leader Nicholas Paget-Brown's acceptance in his evidence to the Inquiry that:

4.36 *he had been responsible for ensuring that Councillor Feilding-Mellen was properly discharging his responsibilities as the cabinet member for housing, property and regeneration, which included the oversight of fire safety within the TMO's buildings, communicating with the LFB, social housing projects and the proper management of the TMO and the welfare of those who lived in RBKC's properties.* (32.10)

4.37 The Inquiry's findings about the specific deficiencies in the arrangements for monitoring and oversight of the TMO should be read against the backdrop of these findings about the fundamental and inalienable character of the Council's responsibilities to its tenants and leaseholders, which no arms-length management arrangement could alter.

4.38 The Inquiry concludes that *although there was a satisfactory system in place within the TMO for reporting 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* (31.54).

4.39 However, in several places the report attributes responsibility to the Council for failing to take steps to ensure the TMO was effectively discharging its responsibilities under the modular management agreement.

4.40 First, the report implies that the number of staff tasked with managing the relationship with the TMO within the Council (one or two dedicated officers in the Council's Housing Department) was not sufficient for overseeing the work of the TMO (see, for example, 32.14). The further implication is that the extensive powers that the Council gave the TMO to act on its behalf through the modular management agreement (and the bearing of those powers on the safety and wellbeing of residents) called for a far more intensive degree of oversight and monitoring than was in place within the Housing Department.

4.41 The report also suggests that outside formal committees, the day-to-day arrangements for managing the relationship with the TMO (which mainly took the form of monthly meetings with the Chief Executive or informal catch-ups with more junior officers) were not adequate for ensuring robust oversight (see, for example, 31.29).

4.42 Second, the report finds that Council policies that should have applied to premises managed by the TMO were not in practice applied to the Council's housing stock:

4.43 *The fire safety policy applied to any premises in respect of which other parties were the responsible persons by virtue of a contract of tenancy agreement, but in respect of which RBKC retained responsibilities as landlord. Accordingly, the policy applied to the premises managed by the TMO. 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 been established and that suitable protocols had been devised to ensure that compliance with fire safety requirements was assured.* (32.10)

4.44 The implication is that these matters were mainly left to the TMO or, at the very least, that there was a degree of confusion about the respective roles and responsibilities of the Council and the TMO in this area (32.19). Again, this finding is particularly serious given the importance of fire safety for the broader safety and wellbeing of residents.

4.45 Third, the report finds that the Council failed to effectively scrutinise all relevant information about the performance of the TMO in critical areas such as safety. For example, the report finds that the Council failed to agree key performance indicators with the TMO that related specifically to fire safety:

4.46 *Although the key performance indicators evolved over the years, 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* (32.17).

4.47 Given the importance of fire safety for the safety and wellbeing of residents, the concerns expressed by residents and some of the specific events that had taken place before June 2017 (notably the fire at Grenfell Tower in 2010), the report implies that this was a serious omission.

4.48 Moreover, the Inquiry finds that the information that was contained in reports written by the TMO for the Board and the Scrutiny Committee could not necessarily be relied on and that no steps were taken by Council officers or elected members to check the information that such reports contained.

4.49 It concludes that health and safety reports *contained no independently verified information about the TMO's performance* (32.21) and that some of the reports produced by the TMO *contained judgments and assessments that reflected well on how fire safety was being managed by the TMO* but that *[i]n practice, Janice Wray was effectively writing her own reference* (32.22).

4.50 Finally, while the report indicates that the Council's managerial arrangements did not provide effective scrutiny of the TMO at officer level, the Inquiry finds that the Council's Housing and Property Scrutiny Committee also failed to effectively scrutinise the work of the TMO.

4.51 As noted above, the Inquiry finds that the TMO withheld information, both from officers and from the Housing and Property Scrutiny Committee. Clearly the Scrutiny Committee could not be expected to scrutinise information which was concealed from it, but the report finds that the Scrutiny Committee failed to treat the evidence that was presented to it with sufficient seriousness, particularly the evidence of the total breakdown of the relationship between the TMO and its residents. For example:

- *Edward Daffarn told us that the residents had asked RBKC's Housing and Property Scrutiny Committee to consider the problems surrounding the power surges, but he felt that the matter had been covered over, with the result that the residents lost trust in the TMO's ability to take appropriate action in respect of fire safety* (33.26).
- *In December 2015, at Councillor Blakeman's suggestion, 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 ensure intolerable living conditions while the work on the tower was going on* (33.52).

4.52 As the Inquiry notes, some members of the Committee suggested that a working group should be set up and Councillors Blakeman and Press said that the reviewers should be independent of the TMO (33.55). However, this proposal was not taken forward, partly because the Chairman of the Committee was satisfied with the proposal for the internal review put forward by the TMO.

4.53 The Inquiry finds that not enough attention was paid by the Committee to the fundamental issue about the mistrust between the TMO and its residents, concluding that *the Scrutiny Committee failed in its task of ensuring that the relationship between the TMO and its residents was rigorously investigated* (33.63).

5. The management of fire safety at Grenfell Tower

5.1 Part 5 and Part 7 of the report address issues relating to the management of fire safety at Grenfell Tower and fire safety policies and practices of the TMO. As noted in the introduction to this report and at Section 4 above, the Inquiry's findings about the TMO, summarised below, have specific implications for the Council and how it undertakes the housing management function today.

5.2 As the Inquiry report sets out, *RBKC and the TMO were jointly responsible for the management of fire safety at Grenfell Tower* (2.58). The report criticises the Council in its lack of oversight of the TMO given this joint responsibility:

5.3 *RBKC was responsible for overseeing the TMO's activities, not monitoring its operations on a day-to-day basis, but its oversight of the TMO's performance was weak and fire safety was not subject to any key performance indicator. The absence of any independent or rigorous scrutiny by RBKC of the TMO's performance of its health and safety obligations, and in particular its management of fire safety, was a particular weakness* (2.59).

5.4 The report also criticises RBKC and the TMO for *a persistent indifference to fire safety, particularly the safety of vulnerable people* (2.58).

5.5 Part 5 of the report focuses on four key failings:

i) The failure of RBKC to maintain oversight of the TMO's fire safety work, and the TMO's lack of openness and transparency with RBKC and tenants as to the deficiencies in their fire safety work.
ii) Individual and systemic failings at senior management level and of staff with specific responsibility for fire safety at the TMO.
iii) Failure to identify, address, and monitor faults of specific fire safety features or considerations of Grenfell Tower.

iv) The TMO's reluctance to heed or act on fire safety warnings from residents and third-party auditors.

5.6 This section therefore considers all the above failings in turn.

i) RBKC's oversight of the TMO

5.7 The Inquiry report finds that Senior Leadership of the TMO gave misleading assurances to RBKC on important elements of fire safety work for vulnerable residents:

- *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. 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 intended to produce PEEPs [Personal Emergency Evacuation Plans] 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* (46.34).

- *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. 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* (46.35).

5.8 The Inquiry concluded that in addition to the *entrenched reluctance* of the TMO's Chief Executive referred to above:

5.9 *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 (31.54).

5.10 However, the report finds that the Council's lack of curiosity contributed to the TMO's ability to continue to mislead on these important issues, for example:

5.11 *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. Indeed, nobody from RBKC asked whether the TMO had completed any PEEPs* (46.36).

5.12 Moreover, the Inquiry finds that the Housing and Property Scrutiny Committee lacked curiosity in examining matters relating to fire doors:

5.13 *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* (41.78).

ii) Individual and systemic failings at senior management level and of staff with specific responsibility for fire safety at the TMO.

5.14 The report finds that there was no formal selection process of the Fire Risk Assessor, Carl Stokes:

- *Janice Wray could not recall whether [Carl Stokes'] appointment had been approved by the TMO executive team or RBKC or how the funding for it had been obtained. The TMO simply drifted unthinkingly into a broader retainer of Carl Stokes without any formalities* (38.35).
- *Carl Stokes was neither registered nor certificated by any professional or certification body as competent to carry out fire risk assessments* (38.24).
- *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* (38.37).
- *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* (38.38).

5.15 The report also found that staff who managed health and safety at the TMO lacked essential training:

5.16 *According to the policy, the TMO was required to make sure that staff with key roles in the management of health and safety were competent and adequately trained. However, Barbara Matthews told us that there was no document that described standards of competence or the training required for those members of staff* (36.3).

iii) Failure to identify, address, and monitor faults of specific fire safety features or considerations at Grenfell Tower.

5.17 The Inquiry finds that the TMO failed to undertake an appropriate programme of Fire Risk Assessments:

5.18 *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 P[ublicly] A[vailable] S[pecification] 7:2013. 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* (39.68).

5.19 Nor did the TMO address issues, recommendations or defects identified in Fire Risk Assessments in a timely manner:

5.20 *[T]here was no adequate system for ensuring that defects identified in fire risk assessments were remedied effectively and in good time*. *The TMO developed a huge backlog of remedial work that it never managed to clear, a situation that was aggravated by the failure of its senior management to treat defects with the seriousness they deserved* (2.64).

5.21 The Inquiry finds that that the Fire Safety Strategy had not been formally implemented by the TMO at the time of the fire:

- *In fact, there is no record of the document's (TMO Fire Safety Strategy) 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* (36.6).
- *... the delay speaks to an 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* (36.12).

5.22 Moreover, the TMO failed to identify relevant risks in the Health and Safety Policy:

5.23 *More fundamentally, Mr Hodgson [in his first report of his safety management review to Robert Black on 19 July 2013] 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* (37.37).

5.24 The Fire Risk Assessor failed to check whether the TMO had acted in response to risks he had identified in previous assessments:

- *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* (39.76).
- *Carl Stokes' form did not contain a section for the assessor to record any actions that had not been completed since the last inspection, nor did it contain an indication of the level of risk to the premises once the actions identified had been completed* (39.9).

5.25 The TMO failed to consider the known risks posed to residents caused by long-term delays of remedial works while awaiting larger refurbishment projects:

- *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* (39.73).
- *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 A[utomatic] O[pening] V[ent] system pending its modernisation* (43.25).

5.26 There was a lack of a maintenance, inspection and monitoring programme to ensure defects were rectified in respect of door self-closers, lift switches, the automatic opening vent system and other features of the building:

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 (41.23).

5.27 Certain important features of the fire prevention measures at Grenfell Tower were not of an appropriate standard. For example, the TMO had failed to specify the correct fire safety standard for the new front doors which had been installed:

5.28 *Carl Stokes was asked to advise the TMO on the requirements for fire doors in the relevant guidance and gave the TMO written advice on 7 March 2011, 23 May 2011 and 24 June 2011. 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 and believed that "S" indicated that a cold smoke seal was fitted. 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.* (40.14).

5.29 The Emergency Plan for Grenfell Tower was out of date and incomplete and did not reflect the changes brought about by the refurbishment. In addition, residents were not prepared for what to do in an emergency, and did not receive proactive or regular fire safety advice:

5.30 *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* (42.9).

5.31 The TMO failed to collect information about any vulnerable residents which would have enabled PEEPs to be prepared as well as appropriate measures to assist escape:

- *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 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* (46.90).
- *None of the draft policies relating to vulnerable residents dealt with fire safety* (46.64).

5.32 The TMO failed to consider how elements of a refurbishment might impact safety features of a site:

During the refurbishment landscaping works covered the [gas] pipeline isolation valves which may have been of critical importance to access (68.11).

5.33 The TMO also failed to ensure there were adequate controls and processes in place:

- *An audit of the TMO's Health and Safety department was carried out by RBKC in April 2013. 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. The audit provided only limited assurance that the TMO had adequate controls and processes in place in relation to health and safety* (37.32).
- *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. 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* (37.45)*. 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* (37.46).

5.34 Alongside the Inquiry's specific findings about the TMO, the Inquiry finds that the Council's Housing Director also failed to give sufficient weight to risk when making safety decisions:

5.35 *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* (41.69)*.*

5.36 The Inquiry also finds other areas where the Council did understand or effectively discharge its responsibilities, for example in relation to the supply of

gas to the building, where the Council was not clear about its responsibility and did not act on safety issues:

- *Cadent Gas Limited ("Cadent") is a gas transporter which owns and operates the pipes and apparatus that transport gas. Cadent does not own the gas itself but is paid by suppliers to deliver it through a network of pipes in a particular area. In the case of Grenfell Tower the area was that served by Cadent's North London gas distribution network. Cadent was responsible for the safety of the service pipework up to the point of the emergency control valve located at each customer meter; the installation pipework beyond the meter was the responsibility of RBKC as the owner of the building* (68.6*).*
- *The gas supply had been installed at the time the tower was built and by the time of the fire the pipework was almost 50 years old. It did not comply in a number of respects with current regulations* (68.4).

5.37 When asked *whether the work involved in the replacement of the gas riser required building control approval* the Council's Head of Building Control told the TMO that *the [gas] riser works were regarded as a repair and were a matter for a fire risk assessment* (68.50). The Inquiry stated that:

5.38 *Whether the work of replacing the gas riser required building control approval is a difficult question on which the evidence does not enable us to express a clear conclusion. However, we think that in cases where the structure of a building on which effective compartmentation depends is affected by the replacement of existing services, careful consideration should be given to the need to obtain building control approval as well as complying with any relevant industry guidance* (68.51).

5.39 The implication is that careful consideration was not given in this case.

iv) The TMO's reluctance to heed or act on fire safety warnings from residents and third-party auditors.

5.40 The TMO failed to act on resident concerns about fire safety and gave false assurances as to improvements, *By omitting that information [regarding issues with the effectiveness of the AOV system in the fire on 30 April 2010] 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* (43.41).

5.41 The report found multiple instances of the TMO receiving deficiency notices that it did not act on. For example:

5.42 *On 17 November 2016, the LFB issued a deficiency notice to the TMO in respect of Grenfell Tower. 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. The history of fire safety notices illustrates a reluctance on the part of the TMO to take active steps to promote fire safety* (42.48).

6. The Refurbishment of Grenfell Tower and Building Control

6.1 Part 6 of the report deals with the refurbishment of Grenfell Tower between 2012 and 2016, which the Inquiry states *lies at the heart of [its] investigations* (47.1). It considers *in detail the course of the project from its original inception to completion* (47.1), and it traces the origins of the refurbishment project and its relationship to the Kensington Aldridge Academy and Leisure Centre (KALC) projects. It covers the actions (and omissions) of a range of actors and organisation, including the TMO, as the client for the refurbishment and the Council's Building Control department, responsible for signing off the plans.

6.2 Overall, the Inquiry finds that: *None of those involved in the design of the external wall or the choice of materials acted in accordance with the standards of a reasonably competent person in their position. They were not familiar with or did not understand the relevant provisions of the Building Regulations, Approved Document B or industry guidance* (2.75).

i) Building Control

6.3 The Inquiry concludes that the Council's Building Control Department had a crucial role to play in the refurbishment, ensuring compliance with building regulations and thereby safeguarding the broader protection of the public:

6.4 *The requirement to obtain building control approval for the refurbishment should have ensured that any errors in design or the choice of materials were identified and put right before the work started. Regrettably, however, that did not happen. Given the importance of building control for the protection of the public, we have examined in some depth the reasons why the system failed to achieve the purpose for which it was designed* (47.6).

6.5 Specifically, the Inquiry concludes that:

6.6 *RBKC building control did not properly scrutinise the design or choice of materials and failed to satisfy itself that on completion of the work the building would comply with the requirements of the Building Regulations* (2.76).

6.7 Ultimately, the Inquiry makes a strong finding about the role of RBKC building control, concluding that:

6.8 *RBKC's building control department failed to perform its statutory function of ensuring that the design of the refurbishment complied with the Building Regulations. It therefore bears considerable responsibility for the dangerous condition of the building immediately on completion of the work* (2.86).

6.9 Many of the specific failures are attributed to the Building Control officer who dealt with the application under the building regulations. However, the Inquiry finds that the Council's management also bears responsibility for the failings:

6.10 *We have no doubt that the shortcomings in the management of the department to which we have referred played a significant part in Mr Hoban's failure to carry out his role properly* (62.63).

6.11 The specific failings of the individual officer include:

- A very limited understanding of the risks associated with the use of ACM panels (62.49).
- A failure to obtain full information about the construction of the external wall at the stage of the full plans application (62.35).
- Not asking whether Exova had provided a completed fire safety strategy (62.27).
- Approving the full plans application despite advice that *there was insufficient information in relation to functional requirement B1 to enable that to be done* (62.27).
- Consulting the fire authority without sufficient information and not waiting for a response before making his decision (62.27).
- A failure to carry out a methodical review of the documents submitted to him and failure to notice obvious errors and inconsistencies in the drawings (62.27).
- Paying little or no attention to the BBA certificate for Reynobond 55 PE (62.30).
- A failure to recognise that Celotex RS5000 insulation was not a material of limited combustibility and acceptance of the assertion that it was suitable for use on tall buildings (62.35).
- A failure to consider whether the external wall system proposed for Grenfell Tower was the same as that tested by Celotex and said to support the use of RS500 (62.35).

6.12 The Inquiry finds that failings of the building control officer, such as the failure to follow the statutory processes (62.14), were rooted in the practice of the department. For example, the reason given for not rejecting the full plans

application for a lack of information submitted was that the building control officer was trying to "work with" the applicant (67.17). The report comments that this *reflects a fundamental misunderstanding among many of those who work in the construction industry, contractors, building control bodies and others, that the function of building control is to provide a service to applicants rather than to enforce the regulations robustly for the benefit of the community at large* (62.14).

6.13 The report finds that *most, if not all, of those involved in the project regarded building control as, in effect, an additional consultant, whose function was to give advice on the design and choice of materials and act as a safeguard to ensure compliance with the Building Regulations* (67.17). This meant that the main contractors (especially Rydon, Studio E and Harley) failed to take proper responsibility for compliance with the building regulations. As the Inquiry puts it:

6.14 *This was bad enough, but it was compounded by the adoption of a similar attitude on the part of RBKC's building control department, which saw its function as being to 'work with' employers and contractors by enabling them to complete the work, rather than to act as the custodian and enforcer of the Building Regulations in the public interest* (67.17).

6.15 The report states that the legislation should not give way to commercial considerations and the practices of the construction industry, but it concludes that in this case, it did just that. (62.15). This amounted, as a significant failure given the importance of building control for what the Inquiry terms the *protection of the public* (47.6). The Inquiry concludes that:

6.16 *All in all, RBKC's approach to the full plans application shows a consistent lack of care and disregard for the procedural requirements of the Building Regulations. RBKC accepted that it bore some responsibility for the failure of the applicant to provide sufficient information in a structured and easily accessible format, but its failings at full plans stage were far more extensive than that. Mr Hoban failed to ask for basic information about the cladding, did not carry out a proper review of the information he was provided with and gave a conditional approval in circumstances where he ought to have rejected the application altogether. Mr Hoban's willingness to accommodate Studio E led him to disregard the primary function of building control, with the result that a critical opportunity to scrutinise the design of the cladding was missed* (62.28).

6.17 In addition to this fundamental misunderstanding of, and lack of regard to, the role of Building Control, the Inquiry also finds a range of other weaknesses in the practices of the department:

- that *the building control officer was hampered by an excessive workload and poor management of the department as a whole* (62.54).
- *a failure to take steps to ensure that the officer had the time and knowledge needed properly to oversee a project as substantial as the Grenfell refurbishment* (62.60).
- *a failure to ensure that officers within the department received the training they needed to do their work properly* (62.57).
- *a failure to check officers' skills to ensure that they had a basic knowledge and understanding of the problems that could arise* (62.60).
- *a failure to monitor the knowledge and skills of individual officers and to ensure that they received the training needed for them to carry out their function effectively* (62.60)
- *record-keeping within the department was poor and steps were not taken to address the building control officer's own poor practice* (62.61)
- that *the absence of a quality management system meant that the defects in the officer's work were not identified* (62.61)

6.18 The Inquiry's concluding observation on the role of Building Control is a stark summary of the extent of the Council's failings:

6.19 *In its opening and closing statements, RBKC candidly admitted that the work of its building control officers fell below the standard that could reasonably be expected of them, but in our view its admissions did not cover the full extent of its failures. Although we have found that other parties, in particular those responsible for the design of the cladding, bear considerable responsibility for the fact that following the refurbishment the external wall of Grenfell Tower did not comply with the Building Regulations and was dangerous, building control was the last line of defence and had a statutory obligation to check for compliance with the Building Regulations. It had a responsibility to protect the public and it wholly failed to perform that function. It therefore bears considerable responsibility for the dangerous condition of Grenfell Tower immediately on completion of the refurbishment* (62.64).

ii) The role of other organisations in the refurbishment

6.20 In addition to the specific findings about the responsibility of the Council's building control department for the dangerous condition of the building, the Inquiry makes findings about the broader refurbishment which are of relevance to the Council. This is particularly true of the findings about the role of the Tenant Management Organisation (TMO). The Inquiry finds that:

6.21 *Although our criticisms are directed principally towards Studio E, Exova, Rydon, Harley and RBKC building control, the TMO must also bear a share of the blame for the disaster because it failed to ensure that the position of Exova was*

clarified after Rydon had been appointed and that the fire safety strategy was completed (2.78).

6.22 As noted in both the Introduction and Section 4 of this report, it is vital that the Council studies closely the Inquiry's findings about the TMO. In relation to the refurbishment, this is particularly important given that the Council is a client for large construction projects, as the TMO was at the time of the refurbishment. Criticisms levelled at the conduct of the TMO and its officers in this section of the report are ones which are potentially applicable to the Council, both in relation to refurbishment projects involving its housing stock and wider construction projects funded through the capital programme.

6.23 Before turning to the TMO, in its examination about the inception of the refurbishment project, the Inquiry makes a general finding about the motivations for the initial decision to refurbish Grenfell Tower:

6.24 *[T]he initial motive for cladding Grenfell Tower was to improve its visual appearance and to prevent its looking like a poor relation to the KALC development next door. RBKC in particular wished to ensure that the significant investment involved in the refurbishment resulted in a visible legacy* (51.16).

6.25 The Inquiry finds a number of specific deficiencies in relation to the procurement process, which was led by the TMO as the 'client'. The report finds:

- That *[i]f a competitive procurement process for architectural services had been undertaken in relation to the Grenfell Tower project, it was unlikely that Studio E would have qualified for appointment* (52.22).
- evidence of inappropriate exercise of influence over the procurement process (and particularly the appointment of the principal contractor), concluding that 'Laura Johnson had exercised a decisive influence in favour of re-procurement (53.26). This showed the close links between the Council and the TMO, despite their notional separation: *when they gave evidence both Ms Johnson and Mr Maddison independently sought to downplay her influence over the direction of the Grenfell Tower project in order to preserve an appearance of independence from RBKC on the part of the TMO not wholly borne out by the contemporaneous evidence* (53.26).
- evidence of poor procurement practice, including *discussions between the TMO and Rydon which took place at a time when the procurement process had not been completed and were not contemplated by the legislation relating to procurement. Rydon was given an opportunity to amend its price in advance of the award of the contract* (53.41). In particular, the report finds that the approach was secretive and that 'secrecy was essential so far as both the TMO and Rydon were concerned because transparency might defeat its object' (55.55).

- evidence of confusion over critical roles and responsibility, specifically who was acting formally as the Project Manager for the refurbishment (50.10).
- that *despite the TMO saying that it had every intention of involving residents in the procurement process, their involvement was largely symbolic, having been hastily arranged and entirely undocumented* (53.38).
- evidence of misrepresentation in the procurement process, as when 'criticisms of the TMO were largely removed or watered down and replaced with criticisms of Leadbitter' (53.31).
- that the TMO's decision not to appoint Artelia as client design adviser was driven by a *combination of commercial considerations and an unrealistic view of the expertise available within the TMO* (53.51). Specifically, the report finds that *the TMO's decision not to appoint a client design adviser at modest expense was foolish and reflected an overconfidence in its ability to manage the design aspects of the project itself* (53.52).
- a failure to properly consider commercial interests and conflicts that might arise from them, noting that *[t]he TMO was kept entirely in the dark about Rydon's financial interest in recommending ACM* (55.60).

6.26 The report also finds weaknesses in the contractual arrangements between the parties involved in the refurbishment and, in particular a lack of attention to fire safety in those arrangements. It finds that:

- The lack of a formal written agreement between Studio E and the TMO demonstrated *a casual approach to the establishment of contractual relations which existed in relation to other aspects of the refurbishment and which appears to be widespread in the construction industry. A more rigorous and careful approach at all levels would significantly reduce the risks of disagreement about where responsibility for important matters lies* (52.16).
- Throughout the refurbishment, there is evidence of insufficient oversight of contractors and consultants involved, particularly in relation to important safety matters. For example, the Inquiry finds that *Exova [the fire safety consultant] was badly briefed on the project and that others, particularly Studio E, Rydon, and the TMO, failed to take a proper interest in its work* (54.163). It finds that the TMO showed a more general *failure to resolve fire safety concerns* (66.14), in particular *display[ing] a regrettable lack of interest in fire safety and a casual attitude to its responsibilities in that regard* (54.163).

6.27 In their conclusion to Part 6 of the report, the Inquiry makes broader findings about the way in which the main participants carried out the project, including:

- *In our view, such a casual approach to contractual relations is a recipe for disaster if events take an unexpected turn. All those involved in whatever capacity in a complex project need to understand clearly what they have agreed to do and what they are responsible for. A culture of getting on with*

the job without waiting for terms to be formally agreed is unprofessional and likely to result in a failure by those carrying out the work on site to understand the scope of their responsibilities (67.8).

- *Cost is always an important factor in any construction project. Realism, however, is essential and a sound understanding of the nature of the exercise being undertaken. In this case, the cost of employing an independent professional project manager would have been money well spent (67.22).*
- *What we have observed in the course of the evidence has led us to the conclusion that there is not only a need to improve the education and training of those involved in the construction industry but also a change in approach on the part of all concerned which prioritises safety over speed and cost and lays much greater emphasis on an understanding of the regulatory regime and its purpose* (67.24).

7. Response and Recovery (the Aftermath)

7.1 Part 10 of the report covers Response and Recovery in the first seven days after the fire, focusing primarily on the Council but also covering the role of central Government, London-wide arrangements, the TMO and voluntary, community and faith organisations.

7.2 The overriding question the Inquiry sought to address in this Part was whether the Council complied with its duties under the Civil Contingencies Act 2004 and if it did, whether it was sufficiently prepared for, and responded adequately to, the fire. The Inquiry stated that the most important question they had to consider was whether those affected by the fire received adequate emergency relief and assistance from the authorities.

7.3 The Inquiry finds that *many of those affected felt that in the hours and days that followed the fire they were abandoned by the authorities at the time of their greatest need* and *had been comprehensively failed by those to whom they looked for protection in the wake of a major disaster.* While the Inquiry focused on a relatively short period (in terms of aftermath) they recognised *that the appalling after-effects of the fire continue to this day* (98.1, 100.4 and 98.6).

7.4 The Inquiry report sets out four key elements which underpin a local authority's effectiveness in responding to an emergency:

(i) the existence of an emergency plan that has been well thought out, is well understood by those who have to implement it and has been practised with sufficient frequency and rigour to ensure that it can be put into operation without undue delay;

(ii) *sufficient human and financial resources to enable the plan to be implemented;*
(iii) *a chief executive with the necessary skills and strength of character to take control of the situation with the support of senior officers who are capable of taking responsibility for different aspects of the plan's implementation; and*
(iv) *an understanding within the organisation of the importance of resilience and a commitment to achieving it* (107.2)

7.5 However, the Inquiry concludes that all four requirements were lacking at the Council and goes on to make a significant number of critical findings regarding both the Council's preparedness and the actual response, which are summarised below.

7.6 *In the first week after the fire at Grenfell Tower the response of the government and RBKC was muddled, slow, indecisive and piecemeal. RBKC's systems and leadership were wholly inadequate to the task of handling an incident of such magnitude and gravity, involving, as it did, mass homelessness and mass fatalities* (2.103).

7.7 The Executive Summary goes on to state that:

7.8 *Certain aspects of the response demonstrated a marked lack of respect for human decency and dignity and left many of those immediately affected feeling abandoned by authority and utterly helpless. RBKC should have done more to cater for those from diverse backgrounds, in particular those many residents of the Muslim faith who were observing Ramadan at the time. They were left feeling that the council had no regard for their cultural and religious needs. For many, their only source of support was local voluntary organisations, which moved in to help and provide for basic needs where those in authority had failed. Many who had particular religious, cultural or social needs suffered a significant degree of discrimination in ways that could and would have been prevented if the guidance had been properly followed* (2.105).

7.9 In the context of its careful discussion about racial and social discrimination in the Introduction to the report (Part 1), the Inquiry finds that *we have seen some evidence of racial discrimination in the way in which some of those who survived the fire were treated in the days immediately following it at a time when they were at their most vulnerable* (1.22).

7.10 In terms of the reasons behind this failure, the Inquiry finds that:

7.11 *The response to the disaster was inadequate principally because RBKC did not have an effective plan to deal with the displacement of a large number of people from their homes and such plan as it did have did not make effective use of the TMO. It had made no contingency arrangements for obtaining a large amount of emergency accommodation at short notice and had no arrangements for identifying those who had been forced to leave their homes or for communicating with them. Arrangements for obtaining and disseminating reliable information were also lacking* (2.105).

7.12 *RBKC had failed to train its staff adequately. They did not have a sufficient understanding of the importance of resilience or sufficient commitment to it. Exercises had not been held regularly and staff had not been required to attend the training sessions run by the London Resilience Group. Deficiencies that were well known to senior management had not been corrected* (2.106).

7.13 *Over a number of years, RBKC had allowed the capacity of its staff to respond to major emergencies to decline. There had been clear warnings to senior management that it did not have enough trained staff to enable it to carry out its responsibilities as a Category 1 responder and that contingency plans had not been practised enough. As a consequence, RBKC lacked the people it needed to respond to the fire effectively, both for the purposes of staffing the borough emergency communication centre and to deal with those who needed help. It was therefore ill-equipped to deal with a serious emergency. None of that was due to any lack of financial resources* (2.107).

7.14 *RBKC's chief executive, Nicholas Holgate, was not capable of taking effective control of the situation and mobilising support of the right kind without delay. He had no clear plan and did not receive all the information he needed. He was not well suited to dealing with the crisis that was unfolding in front of him and lacked a strong group of officers to whom he could delegate responsibility for some aspects of the response. He was reluctant to take advice from those with greater experience and was unduly concerned for RBKC's reputation* (2.108).

7.15 *RBKC had failed to integrate the TMO into its emergency planning. It should have realised that the TMO's knowledge of its buildings and their occupants could play an important part in the response to any disaster affecting any part of its housing stock* (2.109).

7.16 *With the support of local voluntary organisations,* [members of the local community] *provided support in the hours immediately following the fire when the authorities were conspicuous by their absence. Indeed, one of RBKC's failings was to make too little use of the local voluntary organisations and to*

fail to have adequate standing arrangements to enable them to be called on in the event of a major emergency (2.114).

7.17 Beyond these overarching conclusions, the Inquiry report makes a large number of criticisms of the Council, in terms of its preparedness and response, which are summarised under thirteen key areas below:

i) *Capability and preparedness*

7.18 The Inquiry finds that:

- *The Council was systemically ill-equipped to deal with a serious emergency. Over a number of years, the capability of its staff to respond to a major emergency had been allowed to decline. There were clear warnings to senior management that it did not have enough trained staff and that contingency plans were not practised enough. As a result, RBKC was wholly unprepared to provide an adequate response to the Grenfell Tower fire* (101.65).
- *RBKC did not have an effective emergency plan that was directed to the displacement of a large number of people from their homes and such plan as it had did not make effective use of the TMO. This was a serious criticism of a local authority responsible for resilience in a densely populated urban area containing many large residential buildings, in some cases in close proximity to each other* (107.3).
- *RBKC's plans did not include a system for obtaining a large amount of emergency accommodation at short notice* [where fire is only one of a number of hazards that might necessitate this]. *Nor, significantly, did it make any provision for identifying those who had been evacuated or for communicating with them* (107.3).

7.19 The Inquiry finds that the risk of a tower block fire had not been identified in either the Borough Risk Register (for which the Council had responsibility) or the London Risk Registers, despite the fires at Lakanal House in 2009 and Adair Tower (in the borough) in 2015 (99.29-31).

ii) *Emergency planning*

7.20 The report contains a significant number of critical findings in relation to emergency planning, including:

- *A danger of over-reliance on one person's knowledge and experience* (101.12)*;*
- *an attitude to the identification of the vulnerable was defeatist and inappropriate [in light of Cabinet office guidance]* (101.28);

- *insufficient foresight, given that the whole point of contingency planning is to look to the future* (101.36);
- *no communications plan* (101.37);
- *training for those with designated roles in any response was not provided as often as the plan required* (101.53), *no formal training programme in place for Council Silver* (101.54) *and no training of senior managers in the TMO on the Council's emergency plan or for staff to manage rest centres* (105.6);
- *overarching feature of the absence of training records* (101.55);
- *exercises to practise the operation of the Contingency Management Plan were held infrequently and were of a limited nature* (101.56);
- *participation in London-wide exercises was on occasion hampered by a lack of available staff due to a combination of capacity, attitude and lack of commitment* (101.57);
- *lessons* [from exercises] *were not implemented* (101.58);
- *shortage of staff trained to deal with emergencies; senior management in general to be somewhat resistant to attending training* (101.59);
- *sense of inertia that prevailed in the Contingency Planning Unit and throughout RBKC towards planning for an emergency and its capacity to mount an effective response* (101.60);
- *humanitarian assistance plan out of date and found too difficult to update* (101.67);
- *one qualified rest centre manager and heavily reliant on the Red Cross and aid from neighbouring boroughs* (101.63);
- *continued lack of a trained HALO* [Humanitarian Assistance Lead Officer] (101.68);
- *accepted that the system in place at RBKC for identifying vulnerable people was materially inferior to those operated by its tri-borough partners* (101.70);
- *the Council did not have a strategy which actively considered and engaged the voluntary sector during the planning process or in training or exercises* (101.72);
- *a culture of neglect at RBKC over a number of years towards planning for humanitarian assistance* (101.73);
- *no system in place to inform senior management that it was not meeting the standards expected by Minimum Standards for London* (101.74);
- *no effective arrangement or shared understanding between the TMO and RBKC about the part that the TMO would play in the event of a major emergency affecting one or more of its properties and RBKC's Contingency Management Plan did not refer to the TMO* (105.5).

iii) *Initial response*

7.21 The report makes significant criticism of the Council's failure to mobilise in the hours immediately following the news of the fire:

- *The BECC* [Borough Emergency Control Centre] *was not operational at the Town Hall until about 06.00 on 14 June 2017; it should have been opened between about 03.00 and 04.00. That was a substantial delay that had significant consequences for RBKC's response, not least in identifying the number and location of the rest centres that had by then opened spontaneously. As hundreds of displaced people poured onto the streets of North Kensington in need of support, RBKC was already many hours behind in assessing and meeting those needs. We are reinforced in that view by the evidence of members of the Contingency Planning Unit whose own assessment of the initial response was that by the time the BECC opened RBKC had already lost control of the incident* (104.11).
- *The absence of its staff from the various community rest centres in the hours that followed the fire was a prominent feature of the council's early response* (104.28).
- *The Council did not send any senior managers or staff there [to Rugby Portobello Trust] and by 10.30 none of its staff had arrived at any of the other places of shelter which had opened during the morning to accommodate the growing number of evacuees. Its absence was noted by many survivors and added to the sense that they had been abandoned by the council* (104.29).
- *Council staff did not reach any of the rest centres for some eight hours after RBKC had been notified of the fire. That was far too long. In our view, the strategic decisions taken at the outset failed to reflect the seriousness and scale of the emergency. There was a consequent lack of urgency, direction and, ultimately, co-ordination* (104.36).
- *The lack of a trained HALO significantly affected its ability to deal with the consequences of the fire* (104.101).

iv) *Support for particular groups*

7.22 The Inquiry finds that the Council failed, both in its preparations and in the actual response, to make provision for the needs of particular groups:

- *The Council failed to give sufficient consideration to the needs of particular groups* (families with young children, pregnant women, people with mobility issues, families observing Ramadan) (100.18).
- *The Council failed to take any or any adequate steps to follow the guidance contained in those parts of Emergency Preparedness (2013) and Emergency Response and Recovery (2005). In particular, we conclude that RBKC failed to give any, or any adequate, consideration to the needs of the members of the various faith, religious, cultural and minority ethnic communities who were affected by the fire* (104.71).

- *What matters more is how people were treated in practice. It is enough to say that in our view many of those affected by the fire who had particular religious or cultural or social needs suffered a significant degree of discrimination in ways that could and would have been prevented if the guidance had been properly followed* (104.72).

7.23 As noted above, the Inquiry finds that this amounts to *evidence of racial discrimination in the way in which some people who survived the fire were treated* (1.22).

v) *Engagement with community organisations*

7.24 The report finds that, in addition to failing in discharging its specific responsibilities under the Civil Contingencies Act 2004, it failed to work effectively with community partners both in its emergency planning and its actual response to the incident at Grenfell Tower:

- *RBKC had an established arrangement with the Red Cross but it failed to involve important community organisations in its contingency planning arrangements. It had no plans for the participation of community organisations in North Kensington and had not identified a function for any of them if an emergency occurred. Although RBKC had some limited engagement with larger voluntary organisations, it had not asked community leaders to become involved in a community resilience strategy, despite the willingness of many of them to take part. This failure is particularly significant, given that local community organisations came to play a central part in the response to the fire* (106.6).
- *RBKC also failed to engage with and make full use of those organisations after the fire had occurred. There was little or no consideration given to the value that local community organisations could provide in responding to the fire. They had an understanding of the history, character and diversity of the North Kensington community that larger voluntary organisations, such as the Red Cross, lacked. It was the existing relationships and trusted networks that enabled local community organisations to cater for the particular needs of those affected, and to do so in sensitive, informed and specific ways. Not only was RBKC unable to do that itself; it lacked the willingness and the skill to recruit the local community networks to help it* (106.7).
- *The experience of the community, voluntary and faith groups was that the authorities kept their distance and were slow to respond to the immediate needs of those affected by the fire. There was a clear need for an overall plan but instead, people were left to fend for themselves and not*

surprisingly they turned to the voluntary and faith sector and other organisations they trusted to fill the gap (106.14).

- *There was widespread dissatisfaction about the absence of further information or a commitment to resolve any of the problems that those affected were facing. Those affected were left with the sense that the council and the government simply did not care.* (106.26).

vi) *Offers of assistance and the activation of the London Local Authority Gold arrangements*

7.25 Alongside its failure to work effectively with community partners, the report is clear that the Council did not make effective use of the support potentially available to it from other agencies and, in particular, the provision for mutual aid under the London Local Authority Gold arrangements:

- *[Offers of assistance from other public bodies] were, in the main, refused by RBKC, which did not wish to appear incapable of managing the situation but did not have sufficient regard to an objective analysis of its needs* (102.32).
- *As the day wore on it should have been increasingly obvious to RBKC that it did not have the capacity, skills or training required to lead the response on its own and should therefore have considered putting the London Gold arrangements into operation that day* (102.59).
- *We think that RBKC should have asked for assistance far sooner [than the evening of 15 June 2017]* (102.48).

vii) *Emergency Accommodation*

7.26 The Inquiry concludes that the Council failed to provide suitable emergency accommodation to those who lost their homes or were unable to return to them:

7.27 RBKC arranged emergency accommodation that *was in many cases wholly inadequate* (100.14)

- *Some people lived in inadequate and unsuitable conditions for months, and in some cases longer, while trying to rebuild their lives* (100.16).
- *There were no standing arrangements with local hotels of a kind that would facilitate the provision of accommodation for displaced residents* (104.50).
- *The initial allocation of accommodation was confused and inconsistent. The lack of any system meant that individual needs could not be catered for* (100.9).

7.28 The Inquiry finds that *many [people] were distressed to find they had been placed in rooms on high floors, in rooms that were too small and inadequate* (100.14), that there was a *lack of support in getting there* (100.13) and that they were *not told how long they would be able to stay there* (100.15). Accommodation was also often *in places far from their homes…[which] created a sense of loneliness and isolation* (100.17). After the Council had found them accommodation the housing department *did not communicate adequately with its residents* (104.64). Moreover, the report finds that *[a] number of Grenfell Tower residents were not told about the availability of emergency accommodation* (104.56).

viii) *The Walkways*

7.29 In addition to drawing conclusions about the treatment of survivors from Grenfell Tower, the report makes specific findings about the way other residents were treated, especially those from the 'Walkway' blocks adjacent to the Tower:

7.30 *Although RBKC was aware of the steps being taken by the TMO to help the residents, it did not offer any tangible support or resources to meet their needs or assist their return home, leaving the TMO to manage the needs of significant numbers of residents* (105.65).

7.31 *In our view, accounting for the significant number of displaced people and enabling them to return to their homes, where that was possible, was too great a task for the TMO. Although RBKC was the responder which should have assumed that responsibility, it concentrated its efforts on the needs of the survivors from the tower largely to the exclusion of those who had been evacuated from the surrounding buildings. It is understandable that it should have done so in the initial stages of the disaster, but it should not have taken it long to realise that those who had been hastily evacuated from neighbouring buildings had also been seriously affected and had many of the same needs. As a Category 1 responder, RBKC should in our view have provided more support to the TMO in its efforts to enable the residents of those buildings to return to their homes. The roles and responsibilities of RBKC and the TMO in relation to the residents of the surrounding buildings were never clearly defined. As a result, RBKC did not make additional resources available to the TMO to provide the help they needed, nor did the TMO ask for them* (105.66).

ix) *Rest Centres*

7.32 The report finds extensive evidence of failings in the establishment and management of rest centres to provide support to those affected in the immediate aftermath:

- *There were serious shortcomings in the way the official rest centre was set up and managed, which meant that those who needed it encountered significant difficulties in obtaining immediate humanitarian support* (100.31).
- *Many displaced people were asked to provide evidence of identity in order to enter the centre, despite the fact that they had lost everything in the fire* (100.32).
- *The process was described as astonishingly perfunctory and without compassion* (100.33).
- *Those in need of assistance had to go there [the Westway Centre] and say what they needed in order to receive support. However, that meant that some of those who were injured, traumatised or isolated felt that they could not obtain what they needed when they should have been the priority* (100.34).
- *The failure of communications led to a situation in which many who needed support did not know they should go to Westway Centre or what support was available there* (104.39).
- *The Council had a responsibility to register those who went to rest centres seeking support, but it failed to put in place an adequate registration process, which in turn made it difficult to identify, organise and deliver the support needed. The absence of RBKC staff at the rest centres in those crucial early stages directly affected the effectiveness of the registration process* (104.30).
- *In the absence of effective leadership there was no organised and integrated record of where people were and what they needed* (104.31).

x) *Financial assistance*

7.33 The report finds evidence that the provision of financial assistance was not effectively planned for by the Council in advance and that there was a marked lack of consistency and organisation in the way such assistance was provided in the aftermath of the fire:

- *How those affected should be supported financially had not been planned in advance, which caused delay in implementing a process for the distribution of funds* (104.74).
- *Following the activation of the Gold resolution, RBKC remained responsible for the provision of financial assistance. Despite efforts to*

establish a procedure for providing households with access to funds, the facility does not appear to have been fully used (104.75).

- *Financial assistance was initially provided only to those displaced from the tower and not to those displaced from the Walkways* (104.76).
- *The housing department did not take steps to inform those affected by the fire that they were entitled to financial assistance, which resulted in delays in their receiving the assistance to which they were entitled and in some cases to their not receiving it at all* (104.77).
- *Financial support provided to families staying in hotels was inconsistent; some families were left to support themselves. The problem was compounded by residents being placed in hotels at some distance from the Town Hall and the Westway Centre* (104.78).
- *Many people said they had encountered significant difficulty in obtaining financial support and as a result had been forced to rely on the generosity of charities and voluntary groups* (104.78).

xi) *Psychological support*

7.34 The Inquiry finds the same confusion and lack of consistency in the provision of psychological support to those affected, which is particularly important given the significant trauma they had experienced:

7.35 *Due to the delays in setting up the humanitarian assistance support group, it was unclear to those affected by the disaster what psychological support was available at the official rest centre. That in turn led to differences in the level of support received* (104.107).

7.36 *Survivors described how they struggled with their mental health after the fire, desperately needing help but not knowing where to get it at a time when they were at their most vulnerable. Most of those who had been affected indicated that psychological support had not been offered to them within the seven days following the fire* (104.109). *Some survivors reported a delay in receiving psychological support, in some cases for as much as six months* (104.110).

7.37 It also finds evidence of specific groups who did not receive psychological support, including children and (in particular) bereaved family members:

- *There were particular concerns about the lack of emotional support and counselling for children* (100.47).
- *Psychosocial provision for the bereaved was particularly lacking. Those who lost several members of their families in the fire received no offer of support at all from the council* (100.48).

xii) *Information*

7.38 The Inquiry finds that one reason for the failure to meet specific needs was the inadequacy of information about the residents who were directly affected by the fire:

- *As a Category 1 responder, RBKC should have had a plan in place to account for safe and missing residents in the event of an emergency affecting any of its properties* (105.37).
- *There was incomplete information relating to vulnerabilities, information about leaseholders rather than occupiers was recorded and contact details were out of date* (105.48).
- *The inability of RBKC throughout that period to obtain, maintain and record in full information about the situation was a significant failing and delayed support being directed to those who were in need* (104.22).
- *One of the recurring themes of the evidence given by those who had been displaced was that of the profound feeling of helplessness and despair they experienced as they desperately went from hospital to hospital, rest centre to rest centre, trying to obtain information about missing relatives, but to no avail* (104.79).
- *Many of those seeking information about family and friends did not know where the reception centre was or where they should go to obtain information* (104.83).
- *The co-ordination of the government's response was being severely hampered by inadequate information* (103.98).
- *Six days into the emergency response, the categorisation of residents was still changing, and the government remained unclear about the precise number of residents of Grenfell Tower and Grenfell Walk who were in emergency accommodation* (103.140).

xiii) *Communications*

7.39 In addition to failings in the planning and organisation of the response, the report finds that the Council failed throughout the initial response to ensure effective communications to those affected:

- *The stark truth is that RBKC's communications systems were quickly overwhelmed. As a result, it failed to provide the public with clear, consistent information in the days immediately following the fire* (104.90).
- *No dedicated helpline was set up at the outset to enable displaced residents to obtain information or advice* (104.91).
- *RBKC did not accept offers of assistance that could have strengthened and expanded its communications resources* (104.92).

- *The lack of information had a direct effect on the distribution of support. Those who obtained information about the support available were the first to receive assistance, while those who did not were left behind. That particularly affected vulnerable people, such as those with mobility problems and those who could not speak English* (100.59).

7.40 The Inquiry concludes that:

7.41 *No response to an emergency can be considered effective if it leaves those whom it is supposed to serve feeling abandoned and bereft. Yet that was the experience of very many of the people who had lost their homes in the Grenfell Tower fire or whose loved ones had lost their lives in it. Their experiences attest vividly to the failure of the system, but within the community in North Kensington the official response to the fire also served to confirm a deep distrust of those in authority, the existence of which long predated the fire. The community's perception was that in the days that followed the fire there was an absence of leadership, no central structure and nobody effectively in charge. Those who had been displaced suffered at first hand from the lack of co-ordination between the various organs of central and local government which should have been able to meet their needs but instead demonstrated an inability to deal adequately with a tragedy on the scale that confronted them* (107.1).

7.42 Against the backdrop of these significant failings by the Council, whose responsibility it was to prepare for a major incident and coordinate an effective response, the Inquiry concludes that:

Those who emerge from the events with the greatest credit, and whose contribution only emphasised the inadequacies of the official response, are the members of the local community (2.114).

8. Emerging Themes

8.1 As well as responding to specific failures, the Council also intends to examine what common themes or patterns can be found in the Inquiry's findings, in order to consider how it can continue to improve its management and culture to prevent such failures occurring again.

8.2 The list below represents our very early assessment of the themes that have emerged from our initial analysis of the report.

8.3 These are initial suggestions for further discussion, debate and challenge from elected members, bereaved and survivors and residents. The list is not intended to be in any way definitive or exhaustive at this stage.

8.4 **A breakdown of relationships with the community** – The Inquiry recounts a concerning disconnect between the Council, TMO, and the community they served. Relations between the TMO and many residents were *characterised by distrust, dislike, personal antagonism and anger* (33.67). Resident involvement was often *largely symbolic* (53.38), failing to genuinely engage with community concerns. During the aftermath of the fire there was a widespread feeling among residents that the Council had *no regard for their cultural and religious needs* (104.69), leaving residents feeling abandoned and unheard a time of crisis. Again, the Inquiry is clear that responsibility for rebuilding these relationships lies with the public authorities in question (33.68).

8.5 **Poor judgement and decision making** – There were many poor decisions and misjudgements made by Council and TMO staff, before and after the fire. In the critical hours and days after the fire, situational awareness was inadequate. Officers failed to *grasp the urgency of the situation* (104.09), leading to a loss of control over the emergency response. The chief executive's own decision-making *did not have sufficient regard to an objective analysis of (the Council's) needs* (102.32), delaying the request for external assistance.

8.6 **A lack of pace and urgency** – The Council's emergency response was marked by a *lack of urgency, direction and, ultimately, co-ordination* (104.36). This absence of prompt action, critical in an emergency, emerged as a significant shortcoming across the inquiry's findings. Even where the safety of life was at stake, implementing recommendations from external reviews was slow, reflecting a broader failure to act with necessary speed (101.49, 101.50, 101.58).

8.7 **An absence of curiosity and imagination** – Similarly the Inquiry highlighted a lack of curiosity, imagination, and foresight within the Council. Information from the TMO was often taken at face value without sufficient questioning or critical analysis. This was particularly evident in the monitoring of the TMO, where managers failed to probe deeper or challenge assumptions (32.21). The Council also exhibited *insufficient foresight* about potential emergencies, indicating a failure to imagine and prepare for complex scenarios (101.35).

8.8 **Low standards of competence, training and professionalism** – The weaknesses above seem to be compounded by deficiencies in basic

standards of competence in some areas, as well inadequate training. The building control department, for example, took a *casual approach* to examining the refurbishment of Grenfell Tower (62.43), with insufficient training and professional development. There was also a failure to monitor the knowledge and skills of individual officers and ensure they received necessary training.

8.9 **Ineffective management and leadership** – Allowing this poor performance to arise in the Council, even if only in certain areas, is a failure of management and leadership. The report is explicit that management in building control failed to recognise and address workload issues (62.54). In emergency planning there was an *over-reliance on one person's knowledge and experience* (101.12), suggesting a failure to cultivate broad-based expertise and resilience within teams. Even at the most senior level the Inquiry finds the Council lacked *a chief executive capable of taking control of the situation, understanding the magnitude of the task facing it and mobilising support of the right kind without delay* (107.6).

8.10 **Weak monitoring and oversight** – The Council's approach to monitoring the TMO has been found to be severely lacking. Its oversight of performance was described as *weak* (2.59). Performance reports from the TMO were described as their officials *writing* [their] *own reference* (32.22), and there was a persistent failure throughout the refurbishment to take a proper interest in the work of external contractors (Part 6 passim).

8.11 **Indifference towards and neglect of safety** – Worse still, perhaps, than these organisational weaknesses, the Inquiry makes evident that there was a culture of indifference and neglect in the Council and TMO's approach to many of their responsibilities, in particular matters relating to safety of life. The Inquiry found *a regrettable lack of interest in fire safety and a casual attitude to its responsibilities in that regard* (54.163). The TMO, in particular, *lost sight of the fact that the residents were people who depended on it for a safe and decent home* (33.69). This *basic neglect of its obligations in relation to fire safety* (2.68) was compounded by *a culture of concealment that had started at the top and filtered down to lower layers of management* (31.43).

9. Potential lines of enquiry

9.1 To prepare the Council's final response to the Inquiry report, we think we need to answer the following ten questions over the coming weeks:

1. Are there additional implications for the Council or emerging themes that should be considered?

2. Why did the Council fail?
3. What has changed or improved at the Council since 2017?
4. What hasn't changed or has got worse at the Council since 2017?
5. What does the Council need to do next?
6. How should the Council measure its progress?
7. What can we learn from others?
8. What wider changes should we be pushing for?
9. How should the Council be held to account?
10. How should we communicate our progress?

9.2 We intend to answer these questions with the commitments that the Council has made under the Hillsborough Charter firmly in mind. This means not responding defensively to criticism, embracing challenge, scrutiny and new ideas and being open and honest in our assessment of what has changed and what is still left to do.

10. Preparing the Council's full response – a collaborative response

The Council's immediate response

10.1 The Council's immediate response as set out in section 1, after the Inquiry report was published, the Leader of the Council wrote an open letter to the bereaved and survivors of Grenfell, apologising unreservedly on behalf of the Council, fully accepting the findings of the Inquiry and committing to a full and formal response by the end of November. A copy of the letter which was published on 4th September 2024 is set out below:

> *Today is a day for you, the residents and families of Grenfell. Those who survived and those who lost loved ones in the most horrific circumstances imaginable.*
>
> *On behalf of the Council, I apologise unreservedly and with all my heart to you, and to the local community, for our failure to listen to residents and to protect them. Put simply, we could, and should, have done more to keep people safe in their homes and to care for all of our residents in the aftermath of the fire.*
>
> *The Grenfell Tower Inquiry has laid bare the chain of events that led to that night. It shows how you were let down by the systems and people*

responsible for protecting you and your families. It shows – beyond doubt – that this Council failed the residents of Grenfell Tower and the 72 people, including 18 children, who died.

You have had to wait a long time for answers, and I hope the publication of this report is an important step forward in the ongoing search for justice. We fully accept the findings, which are a withering critique of a system broken from top to bottom. It is crystal clear – profits were put before people, clear warning signs were ignored, and Grenfell was wholly avoidable, with failure at every single level.

The Council's role will never be diluted by the large number of companies and organisations involved. We failed to keep people safe before and during the refurbishment and we failed to treat people with humanity and care in the aftermath. As a public authority, our primary concern should always be our residents and never our own reputation. The organisation I lead owes it to every single person who lost their lives to learn the lessons, change, and improve.

I know that seeing visible and tangible change is of utmost importance to you. I am grateful to all the bereaved, survivors and residents who are working with us to make change happen, showing us what we need to do differently, challenging us on progress and holding us to account for what we have not yet done. We will never forget that Grenfell happened here, on our watch, and we must work with our residents to build a local legacy here at the Council.

We will learn from every single criticism in the report. We will take time to study it further in detail, listen to the reflections from our communities, and publish a full and formal response in the autumn.

Finally, we know this is not an ending point, justice is still to be served. The Inquiry report creates urgent impetus for change – here at the Council, and no doubt nationally too. Grenfell can never be allowed to happen again.

Cllr Elizabeth Campbell
Leader of Kensington and Chelsea Council

10.2 Following this interim report on the Inquiry's implications for the Council, our attention will turn to following the lines of enquiry set out in Section 9 above to assess the key emerging themes and review the failures so that we can build a full response by November.

10.3 For this response to be effective, we must work collaboratively with our residents, staff and elected members to ensure this full response is

comprehensive, accurate, and embraced as a vehicle for lasting change across the Council.

10.4 The need for collective involvement in the Council's full response The Inquiry found that *some, perhaps many, 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*. (33.67). It holds the TMO and, by extension, RBKC responsible for a failure to listen to residents, to treat them with *courtesy and respect* (1.22) and to address the *serious flaws* in the relationship with residents (2.53).

10.5 Residents were not heard. An essential part of our response must therefore be to invite open dialogue about the report with our communities, embracing their challenge, scrutiny and ideas.

10.6 Our response will be inadequate unless we listen to the views and concerns of all those to whom the Council bears a responsibility, particularly the bereaved and survivors of Grenfell, the immediate local community, those who live in our social housing, and our broader population. We set out how we intend to do this below.

10.7 Councillors are elected to represent the views of their community and elected members of all parties and none must also be closely involved in the development of this response. This report will be considered by the Leadership Team, the Overview and Scrutiny Committee and the full Council. We will seek feedback from them through these and other mechanisms and we would welcome thoughts and reflections from all councillors.

10.8 Finally, the people who work for the Council, from frontline staff to senior managers, must also consider the implications of the report for them. As part of the development of the response, we will be encouraging staff to consider the working practices of their own services and teams in light of the Inquiry's findings and inviting them to reflect on what they hear from the communities they serve. We hope that this will support the development of a response that makes an honest and candid assessment of what the Council needs to do next.

Opportunities for the community to contribute to the response

10.9 We have a unique relationship with, and responsibility to, those affected, as an organisation partly responsible for what happened, as the local authority and as a landlord.

10.10 We want to invite an open dialogue with bereaved, survivors and residents to discuss the report, its implications for the Council and the plans for our response.

10.11 We have therefore developed plans for a range of community engagement and involvement activity focused on bereaved, survivors, those in the immediate community, our tenants and leaseholders and other interested residents.

10.12 These plans include regular communications, facilitated public meetings and drop-in sessions. These will be an opportunity for us to hear from residents what they think the report means for the Council and for residents to challenge us on our approach, ensuring it reflects what matters most to them.

10.13 We will then use that feedback to shape our final response and to design an ongoing mechanism for residents to hold us to account for the changes we are making and will need to make to respond to the Inquiry's recommendations.

10.14 The below table summarises details of the engagement planned for bereaved and survivors, residents in a 500m radius of the tower, all social housing tenants and anyone else in the community interested in participating.

10.15 Drop-in sessions, public meetings and contact details for the Project Inquiry team are being advertised through letters, flyers delivered directly to households, electronic noticeboards and on social media. We would welcome suggestions for other ways we might promote these events to our communities.

Date	Activity
August	The Council has written to registered providers in the borough to encourage them to consider their plans to communicate with their residents about the report and share messages about the Council's activity.
Late August	A letter has been sent to bereaved and survivors, those in the immediate local community, all tenants and leaseholders and voluntary and community sector partners. This outlines the plans for the response, including details of how to get involved.
w/c 2nd September	The Council has shared its initial statement with residents and partners, including specific messages for bereaved and survivors and the immediate community.
Thursday 19th September	Drop-in sessions for residents (Kensington Leisure Centre W10 6EX, 4-7pm). Separate drop-in sessions will be taking place for bereaved and survivors.

Date	Activity
Tuesday 24th September	Drop-in sessions for residents (Chelsea Theatre SW10 0DR, 4-7pm).
Monday 7 October and Thursday 7 November	Independently facilitated public meetings for residents (Morley College, North Kensington Centre W10 5QQ, 6-8pm). Separate meetings will be taking place with bereaved and survivors.
Post-13th November Leadership Team meeting	Communications to all bereaved and survivors, those in the immediate local community, all tenants and leaseholders and voluntary and community sector partners with details of the final response and next steps.
December 2024 / January 2025	Drop-in sessions and public meetings for residents on next steps, including ongoing mechanisms for monitoring progress against recommendations.

10.16 During an initial discussion about the Inquiry report at a meeting of the Housing and Communities Select Committee on 12 September 2024, members of the committee and residents raised questions about the precise purpose of the engagement, the 'leap of faith' that ward councillors and the community are being asked to take to trust the Council's commitment to community engagement and participation and what 'success' will look like in the context of this engagement.

10.17 These are important questions, which we will address in the further information about the format of the drop-ins and public meetings which will be shared with elected members and bereaved, survivors and residents over the coming days. We will set out clearly the purpose and scope of the engagement and what residents will be able to influence through the process.

10.18 We recognise that engagement with the Council will require a 'leap of faith' for many residents who have lost trust and we acknowledge that this breakdown of trust is the Council's responsibility to fix. We are taking advice from the Restorative Engagement Forum about how to ensure this engagement does not do further harm to our relationship with our communities.

10.19 In terms of measures of success, we are clear that the outcome of a successful programme of engagement with communities will be a response to the report which adequately reflects the concerns of those communities and ensures their effective participation in a longer-term plan to hold us to account for the changes we are making.

Council meetings and decision-making

10.20 This report will be presented to the Overview and Scrutiny Committee on 18 September 2024, to the Audit and Transparency Committee on the 23 September 2024 and to Leadership Team on the 25 September 2024.

10.21 Full Council on 9 October 2024 will be dedicated to the Grenfell Tower Inquiry, with Public Speaking opportunities being held for speakers on this topic, and Full Council debating the Grenfell Tower Inquiry's Report.

10.22 A final draft response to the Inquiry will be presented to Leadership Team on 13 November 2024, and to the Overview and Scrutiny Committee on the 20 November 2024.

10.23 The final response will be proposed by the Leader of the Council to full Council on 27 November 2024 for debate and agreement.

11 Further information

11.1 For further information about this report or to share feedback on the implications of the Inquiry report for the Council, please contact GTI.contact@rbkc.gov.uk.