

IN THE PUBLIC INQUIRY INTO THE FIRE AT GRENFELL TOWER

**EQUALITY AND HUMAN RIGHTS COMMISSION
SUBMISSIONS FOLLOWING PHASE 1 OF THE INQUIRY**

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A. SUMMARY

1. O 10 December 2017, the Commission launched "*Following Grenfell: The Human Rights and Equality Dimension*". When the project was launched, the Commission explained that the purpose of the project is to examine the human rights and equality dimensions of the Grenfell Tower disaster, and to consider, in particular, whether the State is fulfilling its duties under human rights and equality law.¹ On 18 December 2017, the Commission made its first public submission to the Inquiry.² This is the Commission's second public submission.
2. The Commission's submissions are provided in the hope that they will assist the Inquiry in properly identifying and understanding the relevant human rights obligations. UN Special Rapporteur Leilani Farha highlighted the importance of the Inquiry considering the nature of the human rights obligations that apply to different levels of Government.³ Considering the tragedy through a human rights framework allows examination of whether national laws satisfied, and continue to satisfy, the UK's international and domestic human rights obligations.
3. The Commission's submissions also have a secondary purpose, which is to educate the wider public as to the human rights and equality dimensions of the Grenfell Tower disaster. Although the Commission does not seek to downplay, at all, the significance of the forensic exercise being undertaken to ascertain the precise cause of the fire at Grenfell Tower, there are also broader human rights and equality issues at play that are relevant to the wider community. The

¹ [See 'Following Grenfell'.](#)

² *ibid.*

³ Letter from Special Rapporteur on adequate housing as a component of the right to an adequate standard of living to His Excellency Mr Julian Braithwaite, 14 July 2017.

Commission has, consistent with this objective, launched a series of briefings on human rights issues relating to the Grenfell Tower fire. These briefings are intended to build awareness and knowledge of human rights and how they apply in the context of the Grenfell Tower fire, and its aftermath. To date, the briefings have covered: the right to life; the right to adequate and safe housing; the right to be free from torture and cruel, inhuman or degrading treatment; children's rights and the right to equality and non-discrimination. These matters are considered in the Commission's submissions below. The Commission also commissioned research to gather evidence of the lived experiences of those affected by the fire in accessing services and support. This qualitative research has resulted in a report published alongside these submissions: *"Following Grenfell – Grenfell Residents' Access to Public Services and Support"*. This Report mainly considers the support provided in the aftermath of the fire but it also records the earlier experience of residents, in particular in raising concerns about fire risk.

4. After setting out the applicable legal framework, the submissions address the following issues:
 - (1) the risk to life posed by the cladding on Grenfell Tower, and the extent to which the State took all reasonable action to avoid that risk (§§48-76 below);
 - (2) the extent to which the State is taking all reasonable action to address concerns about cladding on other buildings in the UK and on-going risk (§§77-87 below);
 - (3) additional fire safety issues relevant to the Grenfell Tower tragedy (§§88-100 below).
 - (4) the extent to which special protection was afforded to vulnerable groups living in Grenfell Tower (§§101-118); and
 - (5) the extent to which the State complied with its equality and non-discrimination duties (§§119-120 below).

5. In addition, the submission addresses a number of concerns that have arisen in relation to the Inquiry process itself (§§121-126). As the Inquiry is aware, the Inquiry has critical role to play in discharging the UK's human rights obligations, in particular under Article 2 ECHR. As a result, there are a number of safeguards which must be satisfied to ensure the effective participation of the survivors, bereaved and former residents of Grenfell Tower and surrounding blocks. These obligations were addressed in some detail in the Commission's 18 December 2017 submissions.
6. The Commission is mindful of the separation of issues between Phases 1 and 2 of the Inquiry. This stage of the Inquiry – Phase 1 – is focussed on the factual narrative of events of 14 June 2017, on identifying *what* happened, rather than *why* it happened (and who was responsible).⁴ As such, the Commission expects that many matters relevant to the right to life will not be fully canvassed until Phase 2. However, the Chairman has made clear that *"it would be unwise to draw a hard and fast line between Phase 1 and Phase 2"*;⁵ that *"[i]f the analysis of the origin and physical progress of the fire reveals any obvious defects in the building, it is important that appropriate recommendations be made as soon as possible for the benefit of others who live elsewhere in buildings of a similar kind"*;⁶ and, particularly in relation to the question of whether Grenfell Tower complied with the relevant legislation, that *"the boundary between Phase 1 and Phase 2 must remain flexible"*.⁷
7. The Commission also notes and welcomes the Chairman's statement on 12 December 2018 that, in light of the conclusions reached in the Phase 1 report, it

⁴ In his oral opening submissions to the Inquiry, counsel to the Inquiry identified the aspects of the list of issues that will be addressed at Phase 1 (see [1/9/19ff]) and summarised the scope of Phase 1 as follows: *"the focus of Phase 1 will be the events of the night of 14 June 2017 and, in particular, the state of the building at the time of the fire, including the existing fire safety and prevention measures at Grenfell Tower; where and how the fire started; the development of the fire and smoke; how the fire and smoke spread from its original seat to other parts of the building; the chain of events before the fire was finally extinguished; and the circumstances of the residents and others present in the tower, including those who evacuated the tower. As the chairman has said in the past, it would be sensible to retain a significant degree of flexibility in relation to the scope of the different phases."*

⁵ Chairman's response to submissions on 11-12 December 2017, §19.

⁶ Chairman's response to submissions on 11-12 December 2017, §19.

⁷ Chairman's response to submissions on 11-12 December 2017, §19; and Chairman's response to submissions made on 21 March 2018, §11.

may be possible to make certain recommendations without waiting for the final report at the end of Phase 2, and that in considering whether recommendations are appropriate, he intends to “*canvass the views of those who have relevant experience*”. As the Inquiry is aware, the Commission is one of the National Human Rights Institutions for the United Kingdom, with statutory responsibility to promote the awareness, understanding and protection of human rights. Notwithstanding the fact that it does not have CP status in the Inquiry, it clearly has “*relevant experience*” as to the scope of the State’s human rights obligations, which, the Commission submits, must be a key consideration for the Inquiry in deciding whether to make interim recommendations; in deciding upon final recommendations; and in deciding what those recommendations should be and how the Inquiry should now proceed.

8. Finally, it is important to stress that this submission does not seek to duplicate the work already done by those involved in or following the Inquiry, nor does it seek to comprehensively address every aspect of the evidence or matters relating to the fire. It would not be possible for the Commission to do so. The Commission is not a CP and therefore does not have access to all of the evidence before the Inquiry, nor has it heard this evidence first hand. In preparing this submission, the Commission has reviewed (i) the transcripts of the Phase 1 hearings; (ii) the summaries of the expert reports; and (iii) a number of key external documents and reports. The Commission has also spoken to a number of key stakeholders, including survivors, bereaved and former residents of Grenfell Tower and surrounding blocks. This more limited review exercise has been undertaken to allow the Commission to raise key areas of concern to the Inquiry, rather than reach any final conclusions.
9. The Commission’s conclusions, and recommendations, can be summarised as follows:
 - (1) There is a substantial body of evidence that suggests that, prior to the Grenfell Tower fire, the State either knew, or ought to have known of the

real and immediate risk to life posed by the cladding on Grenfell Tower, and that it failed to take reasonable steps to avoid that risk by reason of:

- (a) its failure to put in place an appropriate regulatory framework to prohibit the use of cladding in residential blocks, and/or its failure to ensure that the regulatory framework was effectively monitored and enforced; and
- (b) its failure to grant residents the right to access information about the dangers posed by the cladding.

The Commission considers that these failures have given rise to a systemic breach of the State's positive human rights obligation to ensure that the right to life is protected.

- (2) In light of the evidence that is already available, including as a result of the Inquiry, it is likely that the State is in on-going breach of its positive obligation to ensure that the right to life is protected. The Commission understands, for instance, that a substantial number of residential buildings across England remain fitted with cladding material that is likely to present a fire hazard (and the same is true of an unknown number of private blocks, hotels, hospitals and schools; see §§84-85 below). Although some important remedial steps have been put in place, and the Commission welcomes the Government's recent announcement of a ban of the use of combustible materials on new high-rise homes, and support to local authorities to carry out emergency works to remove and replace unsafe cladding, it is concerned that this is insufficient. In light of the on-going risks to residents of high-rise buildings with unsafe cladding, the Commission considers that this is an issue that must be addressed as part of the Inquiry's Phase 1 report.
- (3) A number of concerns have arisen from the evidence in relation to fire safety measures in place prior to the Grenfell Tower fire. The Commission considers that, in order to comply with its on-going positive obligations

under Article 2 ECHR, the State must: (i) implement training for firefighters on combatting cladding fires; (ii) reconsider the application of/alternatives to the stay put policy for buildings with similar cladding combinations to Grenfell Tower, and implement firefighter training on this issue; and (iii) ensure that residents are provided with sufficient fire safety advice. The evidence that the Commission has reviewed from the Inquiry and elsewhere suggests that the State has failed, and is continuing to fail, to satisfy these obligations. Given the immediate relevance of these matters to the rights of residents of high-rise buildings with a similar construction and cladding combination to Grenfell Tower, the Commission urges the Inquiry to address these issues in its Phase 1 report.

- (4) The evidence suggests that the State failed, and continues to fail, to take appropriate protective measures that adequately corresponded to the needs of particularly vulnerable groups. The Commission considers that this should be addressed by the Inquiry in its Phase 1 report, so that appropriate measures may be taken in other similar buildings in the UK.
- (5) The evidence indicates that the State has failed, and continues to fail, to meet its equality and non-discrimination obligations, in particular in relation to disabled people, older people, women and children, and in relation to people from ethnic minority groups. The Commission considers that this should be addressed by the Inquiry in its Phase 1 report, so that adequate steps are now taken to discharge those duties including in relation to housing allocation policy and in deciding upon protective measures to address on-going risk.
- (6) Finally, the Commission has had a number of individuals and groups raise concerns about the difficulties that they are encountering in effectively participating in the Inquiry. The Commission wishes to draw these matters to the Inquiry's attention in the hope that these matters can be addressed prior to the commencement of Phase 2.

10. This submission addresses: (i) first, the applicable human rights and equality legal framework (§§11-47 below); (ii) secondly, the use of cladding on Grenfell Tower, and other high-rise tower buildings in the UK (§§48-87 below); (iii) thirdly, additional fire safety issues (§§88-100); (iv) fourthly, the special protection of vulnerable and minority groups living in Grenfell Tower (§§101-118 below); (v) fifthly, the equality and non-discrimination issues (§§119-120); (vi) sixthly the Inquiry process (§§121-126 below).

B. THE LEGAL FRAMEWORK

11. It is important to acknowledge that although, given the scope of Phase 1, these submissions are focused on the right to life, a number of other human rights are engaged by the Grenfell Tower fire. These include the right to adequate and safe housing, the right to access to justice, children's rights, the right to equality and non-discrimination and the right not to suffer inhuman and degrading treatment. Many of these human rights overlap with the right to life in the context of the fire at Grenfell Tower and, for this reason, some of these are addressed below (§§30-47).

(1) The right to life

12. The right to life is one of the fundamental guarantees in international law.⁸ In many respects it is a prerequisite to, and closely interlinked with, the enjoyment of other rights. The right is protected under international and regional human rights treaties. For the UK, the most significant of these guarantees is Article 2 ECHR. Article 2(1) ECHR provides: *"Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which the penalty is provided by law"*.
13. Article 2 can only be derogated from when absolutely necessary and in accordance with the law: see Article 2(2) and *McCann v UK* (1996) 21 EHRR 97 at §149. In the UK, Article 2 is incorporated into domestic law by virtue of s.6 of the Human Rights Act 1998. The UK is also bound by Article 6 of the ICCPR

⁸ See, for example, comments of the ECtHR in *Šilih v Slovenia* (2009) 49 EHRR 37 at §147.

– which similarly guarantees the right to life – and the ECtHR draws on the provisions of the ICCPR in applying and determining the scope of Article 2: see, for example, *Demir v Turkey* (2009) 48 EHRR 54 at §69.

14. In addition to imposing a negative obligation not to interfere with the right to life, the right to life also imposes positive duties on the State. The positive duty requires the State to take proactive steps to enable people to enjoy their right to life and create conditions conducive to this. If individuals or groups of individuals are at risk of having their right to life violated – for example, as a result of an eviction, the refusal of vital medical treatment, the lack of escape routes at a large event, or deportation to a place where there is a known risk of danger to life – the State must take steps to ensure those risks do not occur. This means that the UK Government must protect life by enforcing criminal laws, regulating the delivery of public services (even if delivered by private providers, for example, social housing providers) in line with international human rights standards, protecting life under immediate threat, and taking steps to avoid accidental deaths. Even if a public service (for example, housing or water) is privatised, the UK Government ultimately remains responsible for the protection of human rights.
15. The ECtHR has emphasised that Article 2 may be engaged even where a person fortuitously survives, including, for example, in cases of environmental disaster (*Kolyadenko v Russia* (2013) 56 EHRR 2 at § 155).
16. The submissions below address the key aspects of the positive obligation.
 - (a) The adoption of preventative measures to protect against known risks to life
17. The State is required to do everything “that could reasonably be expected of them to avoid a real and immediate risk to life of which they have or ought to have had knowledge”: see *Osman v UK* (2000) 29 EHRR 245 at §116. In order for this obligation to arise, the State must know or have constructive knowledge of the

risk.⁹ Hence, in *Öneryildiz v Turkey* (2005) 41 EHRR 20, the ECtHR held that Turkey had violated the right to life after 39 people died as a result of an explosion and subsequent fire in a municipal rubbish tip, which was located close to slum dwellings where the victims lived. Prior to the explosion, the State had been told that the tip contravened relevant regulations and posed a major health risk. The Court confirmed that the State must do everything within its power to protect individuals from immediate and known risks to which they were exposed. If the State has done everything within its power and the harm nonetheless transpires, there may not be a violation of Article 2: *Öneryildiz* at §109.

18. Preventative measures include:

- (1) Putting in place an appropriate legislative and administrative framework. This is the primary duty on the State under this obligation: see *Öneryildiz* at §89 and below at §§21-23 which specifically addresses the scope of this duty.
- (2) Ensuring that the provisions of the legislative and administrative framework are observed and enforced: see *Öneryildiz* at §109.
- (3) Where a risk to life is posed to disabled or vulnerable persons, taking particular care to ensure that measures taken correspond to those persons' particular needs. For example, the ECtHR held in *Jasinskis v Latvia* (2014) 58 EHRR 21 at §59 (which concerned the detention of a disabled person) that the State "*should demonstrate special care in guaranteeing such conditions as correspond to [a person's] special needs resulting from his disability*"; the court also noted the State's general obligations to "*take particular measures to provide effective protection of*

⁹ If, for example, the State has access to expert reports that demonstrated the risk and nonetheless failed to put in place adequate safeguards, that may amount to a violation of Article 2: see *Brincat v Malta* (60908/11) 24 July 2014 at §106.

vulnerable persons from ill-treatment of which the authorities had or ought to have had knowledge" (see also below: §§47, 101).

- (4) Granting the public a right to information such that they can properly assess the risks they might run as a result of the choices they have made: see *Öneryildiz* at §§90 and 108.
 - (5) Putting in place practical measures, such as installing an early warning system for flooding or a gas-extraction system to prevent explosions: see *Öneryildiz* at §§58 and 107, and *Kolyadenko* at §182.
 - (6) Adopting emergency measures, both essential emergency services (such as fire brigades) and more specific emergency services (such as mountain rescue): see *Furdik v Slovakia* (2009) 48 EHRR SE9 at §157.
19. The positive obligation should not impose an *"impossible or disproportionate burden"* on the State and its scope will depend on *"the origin of the threat and the extent to which one or the other risk is susceptible to mitigation"*: see *Öneryildiz* at §107; *Budayeva v Russia* (2014) 59 EHRR 2 at §§136-137; and *Kolyadenko* at §161.
20. The UN Human Rights Committee – which monitors the protection of rights enshrined in the ICCPR – has noted that this positive obligation requires the State to take appropriate measures and exercise due diligence in protecting against violation of the right to life by private parties as well as State agents: see *UNHRC General Comment No 31* at §8. This includes taking appropriate legal measures in order to protect life from all foreseeable threats: see *Draft General Comment No 36* at §§7 and 22.
- (b) The implementation of a legal framework to ensure the protection of everyone's right to life
21. The obligation to implement a legal framework to ensure the protection of everyone's right to life is the principal obligation imposed on the State by the obligation to take appropriate measures to prevent known risks to life: *Öneryildiz* at §89. The positive obligation on States to take steps to safeguard

the lives of those within their jurisdiction “*must be construed as applying in the context of any activity, whether public or not, in which the right to life may be at stake, and a fortiori in the case of*” activities that are inherently dangerous: see Öneriyildiz at §71. In the context of such dangerous activities “*special emphasis must be placed on regulations geared to the special features of the activity in question, particularly with regard to the level of the potential risk to human lives. They must govern the licensing, setting up, operation, security and supervision of the activity and must make it compulsory for all those concerned to take practical measures to ensure the effective protection of citizens whose lives might be endangered by the inherent risks*”: see Öneriyildiz at §90.

22. The relevant regulations must “*provide for appropriate procedures, taking into account the technical aspects of the activity in question, for identifying shortcomings in the processes concerned and any errors committed by those responsible at different levels*”: see Öneriyildiz at §90. The legal framework must also be accessible and foreseeable. That is, the legal framework must be formulated with “*sufficient precision to enable any individual – if need be with appropriate advice – to regulate his conduct*”: see *Al Nashif v Bulgaria* (2003) 36 EHRR 37 at §119.
 23. The UN Human Rights Committee has interpreted this obligation as requiring States to enact effective criminal prohibitions on all forms of arbitrary deprivations of life and establish adequate institutions and procedures to prevent deprivation of life: see *UNHRC Draft General Comment No 36* at §§23 and 24.
- (c) The duty to conduct a prompt and effective investigation
24. In addition to the substantive duties described above, Article 2 imposes a corresponding duty on States to “*hold an effective investigation into any death where it appears that one or other of the state’s substantive obligations has been, or may have been, violated and that agents of the state are, or may be, in some way*

implicated".¹⁰ This procedural obligation operates to ensure that the rights guaranteed under the ECHR are practical and effective.¹¹

25. The obligation to hold such an investigation is separate and autonomous from the substantive obligations set out above and is independent of the issue of a substantive breach of Article 2: see *Šilih v Slovenia* (2009) 49 EHRR 37 at §159. As a result, even if the State is not directly responsible for the death, it will still have an obligation to inquire into the circumstances, cause and responsibility for the deprivation of life.
26. The purposes an Article 2 investigation can be summarised as follows:
 - (1) To “secure the effective implementation of the domestic laws safeguarding the right to life and, in those cases involving State agents or bodies, to ensure their accountability for death occurring under their responsibility”; it must therefore be “broad enough” to address “all the surrounding circumstances, including such matters as the planning and control of the operations in question ... to determine whether the state complied with its obligation to protect life”: see *Al-Skeini v UK* (2011) 53 EHRR 589 at §163.
 - (2) To address broader issues of State responsibility, including systemic issues and such matters as training, policies and practices, failures of supervision or inspection and “lessons learned”: see *Al-Skeini* at §174.
 - (3) To secure the right to truth, for direct victims of Article 2 violations as well as their relatives and society at large. International human rights law “underlines the great importance ... not only for [an] applicant and his family but also for other victims of similar crimes and the general public, who

¹⁰ *Al-Saadoon v SSHD* [2015] 3 WLR 503, §17. Similar investigative duties may arise under Art 3 (“No one shall be subjected to torture or to inhuman or degrading treatment or punishment”) and this will be relevant, in particular, in the case of those who experienced great suffering in consequence of the fire but who were not at immediate risk of death, including residents of the ‘finger blocks’ (*Assenov v Bulgaria* (1998) 28 EHRR 652; *D v Commissioner of Police of the Metropolis (Liberty and others intervening)* [2018] 2 WLR 895).

¹¹ *Ilhan v Turkey* (2002) 34 EHRR 36, §91.

had the right to know what had happened”: see *El-Masri v Macedonia* (2013) 57 EHRR 25 at §§175-179 and 191.

- (4) To prevent any appearance of impunity. This is important in maintaining public confidence in the rule of law. It also explains where there must be *“a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as in theory”*: see *Öneryildiz* at §94, *El-Masri* at §192 and *Al-Skeini* at §167.
- (5) To ensure that the full facts are brought to light, that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing is (if unjustified) allayed; that dangerous practices and procedures are rectified; and, that those who have lost a relative have at least the satisfaction of knowing that lessons have been learned from the death which could save the lives of others in future: see *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653 at §1.

27. An Article 2 investigation must have the following essential features.

- (1) The investigation must be effective. The investigation must be capable of determining whether or not there has been a violation of Article 2. The State must, therefore, *“take the reasonable steps available to them to secure the evidence concerning the incident, including inter alia eye-witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings including the cause of death”*: see *Al-Skeini* at §166.¹² The investigation must also – particularly in situations involving preventable threats – be capable of *“ascertaining the circumstances in which the incident took place and any shortcomings in the operation of the regulatory system”* as well as *“identifying the state officials or authorities involved in whatever capacity in the chain of events in issue”*: see *Öneryildiz* at §96.

¹² See also *Jaloud v Netherlands* (2015) 60 EHRR 29 at §186; *Öneryildiz* at §94.

- (2) The investigation must be independent. The investigation must be undertaken by a person sufficiently independent from the State agents who may bear responsibility for the death: see *Mustafa Tunç and Fecire Tunç v Turkey* (24014/05) 14 April 2015 at §217. This independence means both an absence of a hierarchical or institutional connection, but also “*independence in practical terms*”: see *El-Masri* at §184.¹³
 - (3) The investigation must be reasonably prompt. This requires the State to act on its own volition once the matter has come to its attention as the passage of time will otherwise erode the amount and quality of available evidence, cast doubt on the good faith of investigative efforts and “*drag out the ordeal*” for victims and their families: see *Edwards v UK* (2002) 35 EHRR 19 at §86.
 - (4) The Article 2 investigation must be public and accessible to the victim’s family. The victim’s next of kin must be involved to the extent “*necessary to safeguard his or her legitimate interests*”: see *Al-Skeini* at §167.
 - (5) The investigation must have a sufficient element of public scrutiny, in order to secure accountability in practice as well as theory: see above at §§26(4).
28. The UN Human Rights Committee has interpreted the equivalent obligation arising under the ICCPR in a similar way. It has emphasised that the obligation requires States to investigate and prosecute allegations of deprivation of life by State authorities or private entities: see *Draft General Comment No 36* at §31; that the essential features of an investigation are that it be prompt, thorough, effective, undertaken by independent and impartial bodies, initiated *ex officio*, and be accessible to victims or their next of kin¹⁴; that victims must be informed

¹³ See also *Al-Skeini* at §167; *Öneryildiz* at §94.

¹⁴ See *Boboev v Tajikistan*, Communication No 2173/12, UN Doc CCPR C/120/D/2173/2012 (2017) at §9.6. See also *Ernazarov v Kyrgyzstan* Communication No 2054/11, UN Doc CCPR/C/113/D/2054/2011 (2015) at §9.6; and *Zakharenko v Belarus* Communication No 2586/15, UN Doc CCPR/C/119/D/2586/2015 (2017) at §10.

about the progress of the investigation¹⁵; and that if the investigation reveals a violation of the right to life, States have an obligation to ensure that those responsible are brought to justice and to provide compensation: see *Boboev* at §11.¹⁶

(d) The right to enjoy a life with dignity

29. The right to life also includes the right to enjoy a life with dignity. The UN Human Rights Committee has emphasised that the right to life must not be interpreted narrowly, and that States are under a broader obligation to “take appropriate measures to address the general conditions in society that may eventually give rise to direct threats to life or prevent individuals from enjoying their right to life with dignity”. These “general conditions” include high-levels of violence, traffic accidents, poverty and homelessness: see *UNHRC Draft General Comment No 36* at §30. Measures required to address these general conditions include both short-term measures designed to ensure access to essential goods and services (including shelter) and long-term measures: see *UNHRC Draft General Comment No 36* at §30. A clear example of such a measures is the provision of adequate and safe shelter and housing. As the UN Special Rapporteur on housing has recently explained, “[l]ived experience illustrates that the right to life cannot be separated from the right to secure a place to live, and the right to secure a place to live only has meaning in the context of a right to live in dignity and security, free of violence”.¹⁷

(2) The right to equality and non-discrimination

(a) International law and the ECHR

¹⁵ See *Boboev* at §11. If, for example, families are not given a timely opportunity to contribute their knowledge to an investigation then this may amount to a violation of the duty to investigate: see *Ičić v Bosnia and Herzegovina*, Communication No 2028/11, UN Doc CCPR/C/113/D/2028/2011 (2015).

¹⁶ See *Boboev* at §11. See also *UNHRC General Comment No 31* at §18.

¹⁷ Report of the Special Rapporteur on Housing “Adequate Housing as a Component of the Right to an Adequate Standard of Living, and on the Right to Non-Discrimination in this Context” (2016) UN A/71/310, p.2.

30. The right to equality is fundamental in international law. It is found in all of the main international human rights treaties, including in Article 26 of the ICCPR and in Article 2 of the ICECSR.
31. For the UK, the most significant of these guarantees is found in Article 14 ECHR. Article 14 provides: *"The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."* Other "status" includes disability¹⁸ and age.¹⁹ In the UK, Article 14 is incorporated into domestic law by virtue of s.6 of the Human Rights Act 1998. As with the provisions addressing the right to life, the UK is bound by Article 26 of the ICCPR and Article 2 of the ICECSR as a matter of international law.
32. Article 14 is engaged where the circumstances *"fall within the ambit"* of one or more of the rights under the ECHR. Those rights include the right to life under Article 2 in all its aspects²⁰ (§§12-29 above) and *"the right to respect for ...private and family life [and] ..home"* under Article 8, ECHR. Discrimination under Article 14 is only permissible if it is justified. The test for justification is fourfold: (i) does the measure or treatment have a legitimate aim sufficient to justify the limitation of a fundamental right; (ii) is the measure or treatment rationally connected to that aim; (iii) could a less intrusive measure have been used; and (iv) bearing in mind the severity of the consequences, the importance of the aim and the extent to which the measure or treatment will contribute to that aim, has a fair balance been struck between the rights of the individual and the interests of the community?²¹

¹⁸ *Glor v Switzerland* (2009) (Application no. 13444/04) at §80.

¹⁹ *Schwizgebel v Switzerland*, (2010) (Application no. 25762/07) at §85.

²⁰ *Menson v UK* (2003) 37 EHRR CD 220; *R (Amin) (on the application of) v Secretary of State for the Home Department* [2004] 1 AC 653.

²¹ *R (Tigere) v Secretary of State for Business, Innovation and Skills (Just For Kids Law intervening)* [2015] 1 WLR 3820 at §33.

33. Discrimination may occur in a number of ways under Article 14. It may take place where a person is treated less favourably than another in an analogous situation.²² A general policy or measure that has disproportionately prejudicial effects on a particular group may also be considered discriminatory notwithstanding that it is not specifically aimed at that group.²³ Discrimination may also result from a *de facto* situation.²⁴ Finally, discrimination may occur where there has been a failure to make reasonable accommodations for disabled people.²⁵ This means that where, for example, the State fails “to recognise the factual specificity of the applicant's situation with regard to the question of basic infrastructure and technical accommodation requirements to meet the special housing needs of his family”²⁶ it may violate Article 14. A State must, then, take into consideration the concrete circumstances of a person and take into account particular needs attributable to disability.²⁷
34. There are a number of specialist human rights treaties that address equality for particular groups that may experience disadvantage attributable to their status or characteristics. The courts will draw on those specialist treaties in understanding and applying Article 14.²⁸ This is because: “the [ECHR] cannot be interpreted in a vacuum but must be interpreted in harmony with the general principles of international law. Account should be taken ... of ‘any relevant rules of international law applicable in the relations between the parties’, and in particular the rules

²² *Willis v United Kingdom* (2002) 35 EHRR 21 at §48; and *Okpiz v Germany* (2006) 42 EHRR 32, at § 33.

²³ *Jordan v United Kingdom* (2003) 37 EHRR 2 at §154; and *Hoogendijk v Netherlands* (2005) 40 EHRR SE22.

²⁴ *Zarb Adami v Malta* (2007) 44 EHRR 3 at §76. See too *D.H. Opuz v Turkey* (2010) 50 EHRR 28 at §183 and *D.H. and Others v. Czech Republic* (2008) 47 EHRR 3 at §§175-180.

²⁵ *Çam v Turkey* (2016) (Application No 51500/08).

²⁶ *Guberina v Croatia* (2018) 66 EHRR 1 at §86.

²⁷ *ibid* at §92.

²⁸ See, for example, *Guberina v Croatia* (disability and UNCRPD); *In re McLaughlin* [2018] 1 WLR 4250 at §40; *ZH (Tanzania) v Secretary of State for the Home Department* [2011] 2 WLR 148 at §21 *et seq*; *R (HC) v Secretary of State for Work and Pensions (AIRE Centre intervening)* [2017] 3 WLR 1486 (children and CRC); *A and others v Secretary of State for the Home Department. X and another v Secretary of State for the Home Department* [2005] 2 AC 68.

concerning the international protection of human rights’” (*Neulinger v Switzerland* (2012) 54 EHRR 31 at §131).

35. The specialist treaties to which a court will have regard include CERD, CEDAW, CRC and the CRPD.
36. Article 1(1) of CERD defines racial discrimination as *“any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life”*. CERD requires States to undertake to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law. The State’s undertaking extends to eliminating discrimination in the enjoyment of the *“right to security of person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual group or institution”* (Article 5(b)) and of the *“right to housing”* (Article 5(e)(iii)).
37. Article 1 of CEDAW provides that the term *“‘discrimination against women’ shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.”* Article 2 provides that States Parties *“agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake.... [to] embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realization of this principle”*. Any policy or practice that exposes the carers of children to risks linked to their responsibility to keep their children safe will engage the provisions of CEDAW. This is because women remain the primary carers of children. Since only women can become pregnant, any disadvantage to which they are subject because of their pregnancy will also fall within the scope of CEDAW.

38. The CRC is the most important of the international instruments addressing the rights of the child. Article 3 provides that: *"1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. 2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures. 3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision" (emphases added). The "best interests" obligation under the CRC and its primacy is regularly acknowledged by the ECtHR and the UK's domestic courts.²⁹ Further, a child who is "capable of forming his or her own views" has "the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child" (Article 12(1)). This includes the right to be heard in any judicial proceedings affecting them, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law (Article 12(2)).*
39. The CRC obliges States to "recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development" (Article 27(1)) and "in accordance with national conditions and within their means" to "take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to...housing"(Article 27(3)). States are also required to "ensure to the maximum extent possible the survival and development of the child" (Article 6(2)). Finally, for present purposes, States are required to ensure that the rights set out in the CRC are afforded "to each child within their

²⁹ *ibid.*

jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status" (Article 2).

40. The CRPD defines discrimination on the basis of disability as *"any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation". "Reasonable accommodation" is the "necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms"* (Article 2).
41. States Parties to the CRPD *"undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability"* (Article 4).

(b) The Equality Act 2010

42. The EA 2010 imposes positive equality duties on public authorities.
43. The PSED requires public authorities to *"have due regard"* when exercising their functions to *"the need"* (emphasis added) to *"(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under [the 2010 Act] (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it"* (section 149). The *"protected characteristics"* include age, disability status, race (including colour, nationality and ethnic or national origins³⁰) and

³⁰ Section 9.

sex.³¹ Having “*due regard*” to the need to “*advance equality of opportunity*” involves having due regard, in particular, to the need to “(a) *remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic; (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it.*”³² The steps involved in meeting the needs of disabled people that are different from the needs of people who are not disabled include, in particular, “*steps to take account of disabled persons’ disabilities*”.³³

44. The PSED is “*not a duty to achieve a result*” but a duty “*to have due regard to the need*” to achieve the goals identified in paragraphs (a) to (c) (*Baker v Secretary of State for Communities and Local Government* (Equality and Human Rights Commission intervening) [2009] PTSR 809 at §31 and *Hotak v Southwark London Borough Council* (Equality and Human Rights Commission and others intervening) and *O’rs* [2016] AC 811 at §74). It is directed at ensuring that there is “*a culture of greater awareness of the existence and legal consequences of [in that case] disability*” (*Pieretti v Enfield London Borough Council* [2011] PTSR 565, at §28). The weight and extent of the duty are highly fact-sensitive and dependent on individual judgement (*Hotak* at §74). However, the duty must be exercised in “*substance, with rigour, and with an open mind*” (*R (Brown) v Secretary of State for Work and Pensions* (Equality and Human Rights Commission intervening) [2009] PTSR 1506 at §92) and there must be “*a proper and conscientious focus on the statutory criteria*” (*R (Hurley) v Secretary of State for Business, Innovation and Skills* [2012] HRLR 13 at §78)
45. Typically public authorities discharge their “*due regard*” obligation under the PSED by the preparation of an equality impact assessment (“EIA”) in relation to existing and proposed policies and practices. An EIA will include details of the characteristics of the groups that may be affected by any policy or practice and an assessment of the impact, both disadvantageous and advantageous, on those groups. It will also *weigh* the impact on those groups, taking into account

³¹ Section 4.

³² Section 149(3).

³³ Section 149(4).

any mitigating measures, as against the aims of any policy or practice.³⁴ This will then inform a public authority's decision on whether to adopt, or to retain, the policy or practice in question.

(c) Discrimination and unlawful acts

46. The concept of discrimination under the EA 2010 includes direct discrimination (less favourable treatment because of a protected characteristic) and indirect discrimination (the adoption or continuance of unjustified provisions, criteria or practices which though facially neutral put, or would put, groups sharing a particular protected characteristic at a disadvantage when compared with groups not sharing that characteristic). In this way, the EA 2010 outlaws individual instances of less favourable treatment and also systemic forms of discrimination.
47. In particular, the EA 2010 makes discrimination by public authorities unlawful.³⁵ The EA 2010 also imposes a positive duty on public authorities to make "*reasonable adjustments*" for disabled people. The duty comprises three requirements. First, where a provision, criterion or practice (this would include, for example, a housing allocation policy) puts a disabled person at a substantial disadvantage in comparison with persons who are not disabled, a public authority is under a duty to take such steps as it is reasonable to have to take to avoid the disadvantage. Secondly, where a physical feature puts a disabled person at a substantial disadvantage in comparison with persons who are not disabled, a public authority is under a duty to take such steps as it is reasonable to have to take to avoid the disadvantage. Thirdly, where a disabled person would, but for the provision of an auxiliary aid, be put at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, a public authority is under a duty to take such steps as it is

³⁴ There are also allied monitoring and publication duties: Equality Act 2010 (Specific

³⁵ Section 29. This does not apply to children (under the age of 18) who are excluded from this unlawful act (section 28(1)(a)). They are not excluded from the PSED and accordingly the duties in respect of advancing equality and fostering good relations apply to both children and adults (see Sch 10, EA 2010 for general exemptions).

reasonable to have to take to provide the auxiliary aid.³⁶ Where the first or third requirements relate to the provision of information, the steps which it is reasonable to have to take include steps for ensuring that the information is provided in an accessible format.³⁷ In relation to the second requirement, a reference to avoiding a substantial disadvantage includes a reference to removing the physical feature in question, altering it, or providing a reasonable means of avoiding it.³⁸ This second requirement is imposed on private and public authorities that let premises except that the obligation to *alter* the physical features of premises in certain circumstances does not apply.³⁹ It is intended instead that the requirement to adjust physical features of premises to accommodate disabled people will be met by the Building Regulations and related requirements.⁴⁰ In relation to third requirement, “*auxiliary aid*” includes “*an auxiliary service*”.⁴¹

C. THE USE OF COMBUSTIBLE CLADDING IN THE UNITED KINGDOM

(1) A breach of the State’s positive obligations in respect of the Grenfell tower fire

48. The State is required to do everything that could reasonably be expected of it to avoid “*a real and immediate risk to life of which they have or ought to have had knowledge*”: *Osman* §116. In *Öneryildiz* the ECtHR confirmed that those measures include putting in place an appropriate legislative and administrative framework, ensuring that the provisions of that framework are observed and enforced, granting the public a right to information about the risk to life, and putting in place practical measures to mitigate the risk.

³⁶ Section 20 and 21 read with 29(7), EA 2010.

³⁷ Section 20(6), EA 2010.

³⁸ Section 20(9), EA 2010.

³⁹ Section 38, read with sections 20 and 21 and Sch 4.

⁴⁰ Building Regulations 2010 and Approved Document M: access to and use of buildings, volume 1: dwellings.

⁴¹ Section 20(11), EA 2010.

49. There is a substantial body of evidence that suggests that, prior to the Grenfell Tower fire, the State either knew, or ought to have known of the real and immediate risk of life posed by the cladding on Grenfell Tower, and that it failed to take reasonable steps to avoid that risk by reason of:

- (1) failing to put in place an appropriate regulatory framework to prohibit the use of cladding in residential blocks, and/or failing to ensure that the regulatory framework was effectively monitored and enforced; and
- (2) failing to grant residents the right to access information about the dangers posed by the cladding.

The Commission considers that these failures have given rise to a systemic breach of the State's positive human rights obligation to ensure that the right to life is protected.

(a) What the State knew or ought to have known prior to the fire?

50. The Commission considers that the evidence demonstrates that the State knew, or ought to have known, of the risk to life posed by the cladding at Grenfell Tower. There have been a significant number of warnings raised in the past that have not been acted upon. The following examples are provided by way of illustration only.

51. In 1999, a fire which occurred in a multi-storey block of flats in Irvine, Ayrshire, drew attention to the potential risk which could be posed by fire spread involving external cladding systems. In a report published in 2000, the Environment, Transport and Regional Affairs Committee, the Committee said this: *"[W]e do not believe that it should take a serious fire in which many people are killed before all reasonable steps are taken towards minimising the risks. The evidence we have received strongly suggests that the small-scale tests which are currently used to determine the fire safety of external cladding systems are not fully effective in evaluating their performance in a 'live' fire situation. As a more appropriate test for*

external cladding systems now exists, we see no reason why it should not be used” (§19).⁴²

52. There were further fires, resulting in deaths, in high-rise buildings in England in 2005 at Harrow Court, and in 2010 at Shirley Towers Southampton. There were “Rule 43” coroner reports in both cases which made many fire safety recommendations that have never been fully addressed.
53. The most significant warning sign came in 2013, where the inadequacies of the applicable regulatory framework in relation to external envelope fires were *expressly* brought to the attention of the UK Government in 2013. On 28 March 2013, following inquests into deaths during the fire at Lakanal House in July 2009, the Assistant Deputy Coroner wrote to the then Secretary of State for Communities and Local Government, informing him that evidence adduced at the inquests gave rise to a concern that *“action should be taken to prevent the occurrence or continuation of such circumstances [that caused the deaths], or to eliminate or reduce the risk of death created by such circumstances”* (the “Rule 43 Letter”). The Rule 43 Letter highlighted action that, in the Assistant Deputy Coroner’s view, the Secretary of State should take.
54. In relation to ADB specifically, the Rule 43 Letter recommended that the Government review the document to ensure that it (emphases added):

“ - provides clear guidance in relation to Regulation B4 of the Building Regulations, with particular regard to the spread of fire over the external envelope of the building and the circumstances in which attention should be paid to whether proposed work might reduce existing fire protection
- is expressed in words and adopts a format which are intelligible to the wide range of people and bodies engaged in construction, maintenance and refurbishment of buildings, and not just to professionals who may already have a depth of knowledge of building regulations and building control matters

⁴² [Available online.](#)

- provides guidance which is of assistance to those involved in maintenance or refurbishment of older housing stock, and not only those engaged in design and construction of new buildings."

55. On 20 May 2013, the Secretary of State responded that *"the design of fire protection in buildings is a complex subject and should remain, to some extent, in the realm of professionals"* but that the department was nonetheless reviewing ADB with a view to publishing a new edition of the document in 2016/2017. The Secretary of State stated that this edition would be drafted with the aim of being *"more easily understood"*.⁴³ Despite this response, a revised version of ADB was not produced until after the fire at Grenfell Tower.
56. In May 2017, the Assistant Commissioner of the LFB wrote to landlords and local authorities seeking to *"highlight the external spread of the fire"* at Shepherd's Court in August 2016. The letter stated that the LFB was of the view that filler panels on the external faces of blocks *"were a contributory factor to the external fire spread"* and noted that (unless otherwise stated, emphases added):

"The [LFB] have seen a number of cases where it appears, on the basis of the information available to us, that the level of fire protection to the external face of the building did not comply with the requirements of Part B of the Building Regulations insofar as they seek to limit the speed with which a fire can travel and spread over the external face of a building or may contribute to a fire. Testing of panels has found that the combustibility of the composition of the panels at Shepherd's Court did not meet the levels expected for conformity with the building regulations. On testing it was found that panels may deform or delaminate exposing any combustible core to constituent material resulting in the panel becoming involved in the fire and allowing the fire to spread and enter flats other than the flat of origin of the fire.

...

In the light of fires that have occurred, I would urge you to consider carefully your arrangements for specifying, monitoring and approving all aspects of future replacement and improvement to building facades and construction of new buildings for which you are responsible. Contracts for the provision and installation of replacement elements of building facades, including insulation, replacement double glazing and associated spandrel and in-fill panels must

⁴³ Letter from DCLG to the Assistant Deputy Coroner, 20 May 2013.

ensure compliance with all⁴⁴ parts of Part B if they are to secure public safety and minimise fire losses.

I would therefore strongly urge that you consider this issue as part of the risk assessment process for premises under your control."

57. In her evidence to the Inquiry, Commissioner Cotton accepted that senior figures in the LFB were aware of the fire risks posed by cladding in high-rise buildings. She also accepted that this was a risk "*with others*" that had been on the LFB's radar at least 9 months before the fire at Grenfell Tower [50/53/11ff].
58. Professor Torero, an expert to the Inquiry, observed that the fire safety of complex façade systems such as that used on Grenfell Tower was a global concern and that the spread of fire at Grenfell Tower was not unique or wholly unforeseeable. In particular, the Torero Report contains the following observations (at p.28, line 929):

"façade systems of [the nature of Grenfell Tower] were an accepted concern worldwide. Thus, whilst I consider the functional requirements and guidance to have been unacceptably unclear, this should not have prevented professionals with a minimum level of competence from establishing that such a system would completely undermine the integrity of the fire safety strategy and therefore provide a medium for fire spread that would definitely pose a risk to health and safety. Given the importance of 'no' vertical and horizontal spread, it would have been clear that the occupants of a high-rise building cladded by such a façade system would have been at risk and thus a detailed analysis of the impact of vertical horizontal flame spread should have been a critical consideration in the design and implementation of the fire safety strategy."

According to Professor Torero, once the fire was established on the outside of the façade system, "*fire spread was inevitable*" and "*[b]ased on similar international events, the rate of spread was not unusual*" (Torero Report, p.128, line 3072).⁴⁵

⁴⁴ Emphasis in the original.

⁴⁵ The Commission acknowledges that this view is not uniformly held by the experts. For example: Mr Todd stated that "[n]early all fire deaths in blocks of flats occur in the flat in which fire starts. The extent to which the Grenfell Tower fire was an exception to this experience is unique and, as it has commonly been described, unprecedented" (§2.89) and Professor Bisby stated in his oral presentation that "[t]he Grenfell Tower fire is somewhat unusual in the context of similar cladding fires that have occurred internationally in that the fire not only spread vertically upward, but it also spread downward and horizontally" (see [7/99/25ff]). He also reiterates the "unusual" nature of the fire at [7/105/15].

59. The actual or constructive knowledge of the State is understandably a key concern of many of the victims and survivors of Grenfell Tower. In their submissions, a number of the CPs referred the Inquiry to open-source material that demonstrated that the risks posed by cladding were known to Government, including by reference to previous fires in the UK, and abroad. G4 (BSR) made the following submission:

“the very specific danger of using polymeric materials such as polyethylene near materials such as uPVC window surrounds was known certainly to government, which was warned of that precise risk by BRE’s report in November 1992 following the Knowsley Heights fire in 1991, in which fire spread vertically up the cavity behind the cladding, melting the aluminium supports and attacking the uPVC window frames.

Both Knowsley Heights and Garnock Court resulted in significant changes to the Building Regulations. More recently, the cladding fire at Lakanal House of 2009, on which the coroner reported in 2013, would have been in everyone’s minds ... since the turn of the century, both internationally and in the UK, fires involving external cladding systems have become the archetypal form of mass fire disaster.” [2/32/17ff]

60. G3 (BSR) observed that “Cladding fires are not new; they have happened around the world and they have been a cause of concern for many years” [2/64/12]. The following submissions were made to illustrate the point:

“In December 1999, the select committee on environment, transport and regional affairs reported on the potential risk of fire spread in buildings via external cladding systems following the cladding fire in Irvine, Ayrshire in June 1999, and referred then to the responsible attitude taken by the major cladding manufacturers towards minimising the risks of excessive fire spread had been impressed upon us throughout this inquiry. The select committee said, in words that now appear sadly prophetic: ‘Notwithstanding this, we do not believe that it should take a serious fire in which many people are killed before all reasonable steps are taken towards minimising the risk’” [2/85/15].

“National and local policies plainly required contingency plans for when stay put became untenable because of fire spread and breach of compartmentation. Well-known out-of-control façade and cladding fires in high rise buildings across the world and in London itself showed the clear need for such contingency planning. Post-Lakanal, the coroner had made express reference to stay put in the context of where compartmentation was compromised and people died ... Article 2 of the European Convention on Human Rights required that the LFB had a practical and effective policy framework for known risks. The failure to have any contingency plan was a breach of this fundamental duty” [2/113/23].

"[The Ministry of Housing, Communities and Local Government ("MHCLG")] failed over many years to rewrite the guidance under the Building Regulations long after everyone knew that it was defective. There has been widespread reference to headline comments of the interim report of Dame Judith Hackitt that the regulations were 'not fit for purpose'. But the Building Regulations were criticised long ago, including following the Lakanal disaster. Why were they not drafted by 2017? We remind the current minister from open source material of the number of former officials and junior ministers who prevaricated and thought that such an exercise was not a priority. Between 2010 and the time of the fire, the All-Party Parliamentary Fire Safety and Rescue Group sent a series of letters to the department. Ministers, senior officials, including then minister Eric Pickles ... all batted away attempts to persuade them of the urgency of the situation. By September 2016, then Housing Minister Gavin Barwell confirmed in Parliament that the department had not made formal plans to review the regulations but intended to do so 'following the Lakanal fire'. By that point, Lakanal had occurred several years previously. The coroner's report was three years old. How long did the department need?" [2/122/13ff]

(b) The adequacy of the preventative measures adopted by the State

61. In order to comply with Article 2, the relevant legal framework must both put in place a legislative framework, but also ensure that the provisions of that framework are observed and enforced. The framework must (i) be attentive to the special features of the regulated activity and the level of risk to human lives, (ii) *"govern the licensing, setting up, operation, security and supervision of the activity and must make it compulsory for all those concerned to take practical measures to ensure the effective protection of citizens whose lives might be endangered by the inherent risks";* and (iii) *"provide for appropriate procedures, taking into account the technical aspects of the activity in question, for identifying shortcomings in the processes concerned and any errors committed by those responsible at different levels"* (Öneryildiz §90).
62. Having considered the expert evidence before the Inquiry and relevant reports published to date, the Commission is of the view that the State failed to put in place an appropriate regulatory framework to prohibit the use of cladding in residential blocks, and/or failed to ensure that the regulatory framework was effectively monitored and enforced. Either of these scenarios would give rise to a violation of the positive obligations enshrined in Article 2.

63. The Commission does not seek to replicate the detailed submissions made by the CPs, including in their closing submissions, on the adequacy of the regulatory framework and/or the compliance with the regulatory framework at Grenfell Tower. The Commission draws attention to the following points.
64. As regards the adequacy of the regulatory framework, the Commission notes that there is disagreement between the experts that appeared before the Inquiry as to whether the regulatory framework prohibited the use of the cladding used on Grenfell Tower. The fact that the regulatory framework can be so uncertain as to cause this level of disagreement indicates, in itself, a violation of Article 2. As Professor Torero explains, “[i]t is not reasonable to expect professionals, no matter how competent they are, to correct the inconsistencies of functional requirements and guidance” (Torero Report, p.28, line 922).
65. The deficiencies in the regulatory framework in place at the time of Grenfell Tower fire were identified, in clear terms, by Dame Judith Hackitt in her interim report in December 2017 (the “Interim Hackitt Report”), and her final report in May 2018 (the “Final Hackitt Report”). The Interim Hackitt Report expressed conviction as to *“the need for a new intelligent system of regulation and enforcement for high-rise and complex buildings which will encourage everyone to do the right thing and will hold to account those who try to cut corners”* (p.6). Its key finding was that *“the current regulatory system for ensuring fire safety in high-rise and complex buildings is not fit for purpose. This applies throughout the life cycle of a building, both during construction and occupation, and is a problem connected both to the culture of the construction industry and the effectiveness of the regulators”* (emphasis added) (p.9). The bases for that finding were that (i) the current regulations are *“too complex”*; (ii) that there is insufficient clarity of roles and responsibilities; (iii) the means of assessing and assuring the competency of key people throughout the system is *“inadequate”*; (iv) *“compliance, enforcement and sanctions processes are too weak”*; (v) *“the route for residents to escalate concerns is unclear and inadequate”*⁴⁶;

⁴⁶ See further §§71-76 below.

(f) *"the system of product testing, marketing and quality assurance is not clear"* (p. 9, 16ff).

66. More specifically, the Interim Hackitt Report noted that (i) the Approved Documents *"are not produced in a user-friendly format"* with *"separate specifications for overlapping or common elements of a building, with no easy means for these to be integrated into a single, compliant specification"* (§1.10); (ii) key definitions in the regulatory framework are unclear, *"leaving too much open to interpretation"* (§1.11); (iii) people are not aware of their responsibilities under the regulatory framework (§1.16); (iv) there are no statutory registration or accreditation requirements for fire risk assessors undertaking risk assessments on complex and high-risk buildings (§1.20); (v) there is no statutory competence framework for Local Authority Building Control inspectors (§1.21); (vi) there is no requirement in the Building Regulations for existing buildings to be brought up to the latest fire safety standards, as long as during any refurbishment the existing provisions are not made worse (§1.25).
67. The Final Hackitt Report stated that, since the publication of the Interim Hackitt Report, Dame Judith had seen *"further evidence confirming the deep flaws in the current system"* – including the lack of an audit trail regarding safety work on large panel system tower blocks and fire doors not performing to their stated specification – and that this *"strengthened [her] conviction that there is a need for a radical rethink of the whole system and how it works"* (p.5). She concluded that there is a need for a new regulatory framework addressing the *"system failure identified in the interim report"* and that only the establishment of this framework *"will ensure that people living in high rise buildings are safe and have confidence in the safety of their building, both now and in the future"* (p.11). She considered that any such framework must (i) be more streamlined; (ii) have stronger enforcement powers; (iii) be simpler to navigate; and (iv) incorporate a more effective testing regime (p.13).
68. The Interim Hackitt Report and Final Hackitt Report are a damning indictment on the regulatory framework and systems in place prior to the Grenfell Tower fire. This is particularly so when viewed against the evidence as to what the

State knew, or ought to have known, prior to the Grenfell Tower fire (see §§50-60 above).

69. Similar points have been raised in a report published by the University of Bristol and the University of Kent, commissioned by Shelter: *"Closing the Gaps: Health and Safety and Home"*. In respect of building and fire safety regulations, the report notes that *"there are serious problems in the current iterations of [these regulations]"* (p.8); that a particular concern is the fact that *"no consensus, even amongst experts, has been reached about what the Building Regulations actually require when it comes to fire safety, and the addition of cladding in particular"* (p.8); that there is a *"need for legislative clarity about the responsibilities of landlords and managers in connection with the breach of regulations"* (p.18); that there is a concern over whether those responsible for carrying out assessments have the adequate experience or resources to do so (p.19); and that there are concerns over the adequacy of enforcement (p.19).
70. As regards the implementation of the regulatory framework, there is overwhelming evidence that Grenfell Tower, and in particular the cladding system, did not satisfy the applicable regulatory framework. This was accepted in terms by RBKC in its opening submissions: *"it is clear that the cladding system, as installed in the refurbishment, did not satisfy the functional requirement of schedule 1, part B4 of the Building Regulations"* [3/94/18]. The FBU similarly stated that that *"following the refurbishments from 2011-2016, Grenfell Tower was a highly combustible death trap"* and that *"not only was there serial non-compliance with the Building Regulations, but there was no evidence of any sustained attempt at such compliance"* [4/4/3]. Although the matter has yet to be explored in detail by the Inquiry, it is reasonable to infer from the extent of the regulatory failings that there was a corresponding failure in monitoring and enforcement. At the very least, there are serious questions regarding the State's responsibility in this context that must be addressed, particularly in light of the information that was known, or ought to have been known, by the State prior to the Grenfell Tower fire.

71. There is a further dimension which must be considered, which relates to the requirement, under Article 2, to ensure that the public had adequate information so as to properly assess any relevant risk to life. The Commission is of the view that the State failed to provide residents with the right to access information about the dangers posed by the cladding used on Grenfell Tower. The evidence also indicates that the State failed to afford residents the ability to effectively raise concerns in relation to fire safety at Grenfell Tower. The Commission draws the Inquiry's attention to the following.⁴⁷

72. In November 2016 the Grenfell Action Group published a blog which read:

"It is our conviction that a serious fire in a tower block or similar high-density residential property is the most likely reason that those who wield power at the KCTMO will be found out and brought to justice! [We] believe that the KCTMO narrowly averted a major fire disaster at Grenfell Tower in 2013 when residents experienced a period of terrifying power surges that were subsequently found to have been caused by faulty wiring. We believe that our attempts to highlight the seriousness of this event were covered up by the KCTMO with the help of the RBKC Scrutiny Committee who refused to investigate the legitimate concerns of tenants and leaseholders."

73. A petition signed by 51 residents in December 2015 complained that refurbishment works to Grenfell Tower had made living conditions *"at times intolerable"* and called for compensation.⁴⁸ The matter was referred to the Housing and Property Scrutiny Committee in January 2016, where residents made specific complaints about the Tenant Management Organisation's (the "TMO") management of the refurbishment. Residents called for *"urgent scrutiny of the management of the works that had been carried out, which needs to be conducted as an independent investigation"*. These complaints did not result in an independent review of the works. Instead, an investigation was carried out by TMO Board members. The report of that investigation was not made public. Ms Blakeman, ward councillor for the estate, noted that this investigation

⁴⁷ And see *"Following Grenfell – Grenfell Residents' Access to Public Services and Support"* (§3 above).

⁴⁸ This account is set out in Peter Apps, ['Grenfell: the paper trail'](#) (*Inside Housing*, 11 August 2017).

underreported the number of complaints made by residents and observed that throughout the refurbishment, there had been no mechanisms in place for complaints to be raised. In May 2016, the chief executive of the TMO appeared before the Housing and Property Scrutiny Committee but Ms Blakeman was prevented from voicing the residents' concerns.

74. In its initial report published in October 2017, the Independent Grenfell Recovery Taskforce (the "Taskforce") found that the relationship between the community and RBKC prior to the tragedy was *"at best 'distant', and at worst one of 'neglect'"*. The report noted that, in the aftermath of the tragedy, *"[i]t will take a long time to build up any sense of trust between survivors, victims and the community affected and RBKC"* and that *"there has been a significant deficit in the understanding of the council's community leadership role"*. The second report of the Taskforce, published in March 2018, again noted the mistrust between the community and RBKC, observing that *"[t]hat mistrust remains, and it will take many years to change that"*⁴⁹ and that historically RBKC had not listened to the community and this needed to change in order to aid recovery.⁵⁰
75. The Interim Hackitt Report (published in December 2017) found that *"the route for residents to escalate concerns is unclear and inadequate"* and that *"[t]here must be a clear, quick and effective route for residents' concerns to be addressed"* (pp.9-10). In particular, the report noted that *"information provided to residents of complex and high-risk buildings on the key fire safety measures, their importance and residents' responsibilities is highly variable and too often non-existent"* (§1.32).⁵¹ The Final Hackitt Report (published in May 2018) recommended that the new regulatory framework give residents a voice (at p.3):

"providing reassurance and recourse for residents of all tenures by providing: greater transparency of information on building safety; better involvement in decision making through the support of residents associations and tenant panels; and a no risk route for residents to escalate concerns on fire safety where necessary,

⁴⁹ Independent Grenfell Recovery Taskforce, Second Report, 16 March 2018, §1.9.

⁵⁰ Independent Grenfell Recovery Taskforce, Second Report, 16 March 2018, §3.34.

⁵¹ And see *"Following Grenfell – Grenfell Residents' Access to Public Services and Support"* (§3 above).

through an independent statutory body that can provide support where service providers have failed to take action, building on ongoing work across government."

76. On 19 January 2018, several resident associations sent an open letter to the RBKC and Sajid Javid MP that registered concern over the lack of involvement of residents in decision making and policy that concerned them. The letter noted that *"there are currently no formal mechanisms for resident associations and other groups to raise issues of concern for our residents or to be encouraged to fully participate at strategic and operational levels"*. A resident-led review of governance in RBKC, dated 19 March 2018, noted that at that time RBKC was yet to publish a *"community engagement strategy"*.⁵² The review stated that prior to the tragedy, *"[w]hen residents' concerns were voiced, Residents associations [sic] were trapped in a system of local management that gave them no power to hold KCTMO accountable either directly or through RBKC"*.⁵³ The lack of trust between residents and RBKC is also referred to by those interviewed for a Theos report on the response of faith groups to the tragedy (published in May 2018).⁵⁴ This is contrasted to the relationship between residents and local faith groups, which is reported to have been characterised by longstanding trust and intimacy.⁵⁵

(2) **An on-going breach of the State's positive obligations in respect of the use of cladding on buildings in the United Kingdom**

77. In light of the evidence that is already available, including as a result of the Inquiry, it is the Commission's view that there is likely to be an on-going breach of the State's positive obligation to ensure that the right to life is protected. The Commission welcomes the Government's recent publication of the Building (Amendment) Regulations 2018, which ban the use of combustible materials in relation to certain parts of certain buildings (see below §78(6)), but remains of

⁵² *Independent resident-led review of governance: a report by the people for the people – North Kensington*, presented to the RBKC Executive and Corporate Services Scrutiny Committee on 19 March 2018, at §1.4.

⁵³ *Id.*, at §2.3.

⁵⁴ Theos, *After Grenfell: the Faith Groups' Response* (May 2018), 32.

⁵⁵ *Id.*, 49.

the view that until this ban is extended to all existing buildings, it is likely that there is an on-going violation of the positive obligations under Article 2.

78. It is now clear that the Government recognises that the regulatory framework in force at the time of the fire did not adequately provide for safe housing. This is clear from the steps taken by the Government following the Grenfell Tower fire. A brief chronology is set out below.

- (1) On 16 February 2018, following the publication of the Interim Hackitt Review, the MHCLG published a guidance circular which stated, inter alia, that (i) proper consultation by building control bodies with fire and rescue authorities was essential *“for delivering safe buildings within the current regulatory framework”* and (ii) the Government was consulting on two proposed changes to ADB, namely revision of desktop studies and clarifying the document in order to make it easier to use. This is an exercise that should, in the Commission’s view, have taken place well before the Grenfell Tower fire, in light of the information set out at §§50-60 above.
- (2) Following publication of the Final Hackitt Review, the Government stated that it would, among other things, launch a consultation on banning the use of combustible materials in cladding systems on high rise buildings.⁵⁶ Consultation documents published in June and July 2018 recognised that the test set out in ADB *“does not offer as straightforward a way of meeting the requirements of the Regulations as would a ban on the use of combustible materials”* and that *“using products which are non-combustible or limited combustibility is undoubtedly the lower risk option”*. The relevant Government departments therefore *“consider it right to consult on a ban which would, as a consequence, remove the flexibility offered to cladding design by the BS 8414 test on high-rise residential buildings”* and proposed that the

⁵⁶ Ministry of Housing, Communities and Local Government, [‘Government commits to major building safety reforms’](#) (17 May 2018).

ban be incorporated into Building Regulations which, unlike guidance in an Approved Document, can be enforced by Magistrates' Courts.⁵⁷

- (3) The Commission responded to the consultation in August 2018, expressing support for the ban and noting, in particular, that: *"much more needs to be done to prevent another Grenfell Tower fire and make all existing high-rise buildings containing combustible cladding safe for residents and other people who access and use them"*. The Commission emphasised that the Government has duties under Article 2 ECHR to protect against risks to life; that private leaseholders are too often being held responsible for the cost of removing and replacing combustible cladding; that *"the timescales for the remedial work to be carried out is uncertain"*; and that the costs of remedial work *"stem from the state's failure to provide a building construction and fire safety system that is fit for purpose, consistent with its responsibilities to have appropriate legal and administrative measures in place that effectively protect against real known risks to life under article 2 ECHR/HRA"*.
- (4) On 19 July 2018, the MHCLG launched a consultation on *"clarification of statutory guidance (Approved Document B)"*.⁵⁸ As part of that consultation, a new draft edition of ADB was published. This draft ADB provided that all external walls must be of an A2 standard, removing the distinction previously made between external walls (which, under §12.6 of ADB, had to *"meet the provisions in Diagram 40"*) and insulation (which, under §12.7 of ADB, had to be of *"limited combustibility"*, a higher standard).⁵⁹ It is reasonable to infer from the amendment, that the Government has acknowledged that the regulatory framework that was in place at the time of the Grenfell Tower fire was insufficiently clear, in particular in respect of whether combustible cladding was permitted for use on high

⁵⁷ Ministry of Housing, Communities and Local Government, *Banning the use of combustible materials in the external walls of high-rise residential buildings* (June 2018); and Welsh Government Consultation Document, *Banning the use of combustible materials in the external walls of high-rise residential buildings* (19 July 2018). The consultation process ended in September 2018.

⁵⁸ [See online.](#)

See §13.1 of that draft ADB.

⁵⁹

rises. An article published by Inside Housing reports that the “*industry believed Class 0 cladding [as stipulated in Diagram 40] was permitted for use on high rises*”.⁶⁰ This position was supported by two of the Inquiry’s experts. It is regrettable that notwithstanding this uncertainty this was the first material amendment relevant to cladding on high-rise buildings to be published since 2006.⁶¹

- (5) On 5 October 2018, the Government announced that it would ban the use of anything other than materials classed A1 or A2 in external wall systems, and that the ban would be implemented through changes to building regulations in late autumn. The Government stated that the ban will not apply to existing buildings, nor to hotels and office buildings, and not to buildings below 18m in height.⁶²
- (6) On 29 November 2018, the Building (Amendment) Regulations 2018 (the “Amended Regulations”) were laid before Parliament. The Amended Regulations ban the use of combustible materials on the external walls (and specified attachments) of new buildings higher than 18m and

⁶⁰ Peter Apps, [‘How politics prevented the chance of stopping Grenfell’](#) (*Inside Housing*, 23 July 2018).

At §2.51, the Todd Report stated that “[t]he current version of ADB is that published in 2006, and amended in 2007, 2010 and 2013. The amendments did not result in changes that are material for the purposes of the Inquiry; the relevant recommendations have not been changed since 2006.”

⁶¹ BBC, [‘Combustible cladding ban set to be announced’](#) (30 September 2018); Josh Halliday, [‘Firefighters say post-Grenfell partial cladding ban does not go far enough’](#) (the *Guardian*, 1 October 2018); Robert Booth, [‘Grenfell survivors welcome outright ban on combustible cladding’](#) (the *Guardian*, 30 September 2018); Harriet Agerholm, [‘Grenfell Tower: New cladding ban ‘still allows flammable panels’, firefighters warn’](#) (the *Independent*, 2 October 2018); Aaron Morby, [‘Government bans combustible cladding above 18m’](#) (the *Construction Enquirer*, 2 October 2018).

containing flats, as well as some other stipulated types of building (see amended reg.7(4)) and material changes to those buildings (see amended reg. 6(3)). The Amended Regulations came into force on 21 December 2018 (see reg. 1(4) of the Amended Regulations). The Explanatory Memorandum to the Amended Regulations⁶³ acknowledges the previous ambiguity in ADB in describing the effect of the new ban as follows: “[t]he ban will ... leave no room for doubt as to what is suitable for use on external walls of buildings 18m or more in height.” ADB and Approved Document 7 were also amended so as to give statutory guidance on the Amended Regulations (these amendments included redrafting of section 12 of ADB; they came into force on 21 December 2018).

(7) On the same day, the Government announced that:⁶⁴

- (a) the Communities Secretary is “taking action to speed up the replacement of unsafe ACM cladding” on existing buildings;
- (b) “[l]ocal authorities will get the government’s full backing, including financial support if necessary, to enable them to carry out emergency work on affected private residential buildings with unsafe ACM claddings”; and,
- (c) “[t]he government is already fully funding the replacement of unsafe ACM cladding on social sector buildings above 18 metres”.

79. In their oral Opening Submissions to the Inquiry in June 2018, the MHCLG acknowledged that “the Grenfell Tower fire uncovered widespread failures in the fire safety regime for high-rise buildings. That is why [the department] immediately worked with fire safety experts to issue advice to owners of affected buildings, taking steps to

⁶³ [Available online.](#)

at

See [press release of 29 November 2018.](#)

⁶⁴

ensure that every high-rise building with unsafe cladding was identified and made safe as soon as possible, and committed to a full review of the building regulatory system to make sure that all of the lessons from the tragedy were fully realised and acted on” [3/136/1ff]. In its written closing submissions, MHCLG acknowledged the conclusion of the Hackitt review that the regulatory system was “not fit for purpose” (p.1), recognised that “[n]othing is more important than ensuring that people are safe in their homes” (p.1) and provided an assurance that “MHCLG is determined to learn the lessons from the Grenfell Tower fire and bring about a fundamental change in the building safety system”.

80. The Commission welcomes that acknowledgement and the assurances provided by MHCLG to the Inquiry. However, although the ban on combustible materials, and the announcement regarding works on existing buildings, are a positive development, the Commission is concerned that the ban (i) only applies to buildings over 18m in height; and (ii) only applies to a limited class of buildings. The Commission is also concerned about the number of buildings that await remedial work eighteen months after the fire. Further, the Commission notes that the MHCLG told the Inquiry in November 2018 that it would “publish its full plans for implementing a new system of fire safety in late 2018.” This does not appear to have happened.⁶⁵
81. The Commission’s concerns are shared by others.⁶⁶ By way of example, the Housing, Communities and Local Government Committee, which is the

⁶⁵ [‘MHCLG Position Statement on Actions Taken to Address Public Safety Following the Grenfell Tower Fire’](#) (Nov 2018) §11.

⁶⁶ See, e.g., Luke Barratt, Government ban on combustible materials comes into force ([Inside Housing](#), 29 November 2018). See also Hugh Robertson, [‘Government cladding ban ignores most workplaces’](#) (TUC blog, 30 November 2018). See also statements made by (i) Jonathan O’Neill, managing director of the Fire Protection Association: “The Fire Protection Association welcomes the announcement, but we would urge the ministry to urgently consider banning the use of combustible materials for all high risk occupancies regardless of the height of the building. We also believe they need to build on the work we published [last week] and to consider the toxicity of all building materials in case of fire”; (ii) Roy Wilsher, chair of the National Fire Chiefs Council: “I am disappointed this ban does not go further and apply to buildings of any height. Buildings below 18 metres should be afforded the same protection as other buildings. This

Parliamentary body responsible for monitoring the policy, administration and spending of the MHCLG, has been particularly critical of the regulatory framework. It has supported the ban on the use combustible material and has called for extension of the ban to all non-residential buildings that pose a risk to life. In its response to the Final Hackitt Report,⁶⁷ the Committee agreed with Dame Judith that the building regulations require simplification, that fire safety should be addressed throughout the life cycle of a building, and that residents require a more meaningful voice to challenge fire-safety processes in their homes (§12). The Committee also stressed that these recommendations should be applied to a wider range of buildings (than high-rise residential) and to the construction industry as a whole (§13).

82. The Committee called for a *“strong, prescriptive approach to ensure minimum standards and guarantee the safety of residents”* (§22). In the Committee’s view, *“the government was right to signal its intention to ban the use of materials which are not of limited combustibility in the cladding of high rise buildings”*, but the Committee would extend the ban to cover existing buildings and non-residential buildings where there is a significant risk to life, and require the Government to fully fund the replacement of any cladding required by the ban (p.4, §§36-40).
83. The Committee also noted its concern over reports that works removing cladding from buildings since the Grenfell Tower fire had failed to make those buildings compliant with fire safety regulations (§§78-80).⁶⁸ It recommended

threshold is a historical height which does not reflect modern firefighting equipment and practices. As such, we hope the full review of [ADB] the Government has committed to will properly reconsider the appropriateness of the 18 metre threshold. We believe the ban should extend not just to hospitals, care homes, and student accommodation, but to all buildings that house vulnerable people, such as specialised housing”; (iii) Terry McDermott, National Fire Chiefs Council lead for water suppression systems, who called for sprinklers being made a requirement for buildings over 18m in height; and (iv) the FBU’s call for “a blanket ban on all combustible materials which do not meet A1 classification, or are deemed to be of ‘limited combustibility’ but are ultimately still flammable” ([all available online](#)).

House of Commons, *Independent review of building regulations and fire safety: next steps* (16 July 2018).

⁶⁷

House of Commons, *Independent review of building regulations and fire safety: next steps* (16 July 2018), §§78-80.

⁶⁸

that the Government conduct an urgent review into responsibility and liability for private buildings in relation to the replacement of dangerous cladding. The Committee observed that *“more needs to be done now to ensure that unsafe cladding is removed urgently”* and recommended that the Government introduce a low interest loan scheme for private sector building owners to ensure remedial work is carried out as soon as possible (§§84-87).

84. As the Inquiry will be aware, there remain a significant number of high-rise buildings in England with unsafe cladding combinations. Figures published by the BSP/MHCLG show that as at 31 December 2018⁶⁹ there were 437 high-rise residential buildings with ACM cladding systems: 160 of these are social sector residential buildings; and 268 of these are private sector buildings, of which 176 are residential, 30 are hotels and 62 are student accommodation. There remain 13 private sector buildings where the cladding status is still to be confirmed. Of the 437 buildings, only 67 have finished remediation. This leaves a total of 370 high-rise residential and publicly owned buildings in England currently with ACM cladding systems that need remediation:

- (1) As regards the 160 social sector buildings: 37 have completed remediation work; 81 have begun remediation work; 40 have remediation plans in place; and building owners *“intend”* to remediate the remaining three buildings.
- (2) The figures are even starker for private sector buildings: 30 have finished remediation; 18 have begun remediation work; 126 have remediation plans in place; and remediation plans are unclear for 56 buildings.

85. The Commission notes the statement made in the House of Commons by Kit Malthouse (The Minister for Housing) on 22 January 2019 which was given in response to an Urgent Question from his Shadow counter-part John Healy.⁷⁰

⁶⁹ [See figures online.](#)

⁷⁰ HC Debs 22 January 2019 Vol 653, Col 133-134.

The Minister indicated that *“interim measures have been put in place on all 176 high-rise private residential buildings with unsafe cladding”* and stated that *“permanent remediation must rightly now be our key focus.”*⁷¹ The Commission also notes that the Prime Minister was also robustly challenged about the Government’s response to the Grenfell Tower Fire at Prime Minister’s Questions, the following day.⁷² The Commission has been and remains concerned about; the rate and speed at which work is being undertaken;⁷³ the confusion as to which State (or other) body is responsible for ensuring that the cladding is removed; the funding that has been made available and whether it is adequate,⁷⁴ and the number of buildings in which unsafe cladding remains in place. Apart from the grave risk posed, the stress caused to residents of private sector buildings by these uncertainties is considerable.⁷⁵

86. The Commission also notes in particular the concerns raised by the FBU that the Government is *“grossly underestimating the number of buildings clad in combustible material”*, and the FBU’s view that *“to prevent another tragedy from occurring, all combustible cladding must urgently be replaced on all buildings, irrespective of height. This would require a major national programme to assess and prioritise the scale of the risk and adopt interim safety measures which residents, other building users and firefighters could have confidence in. Combustible cladding must be avoided at all costs”*.⁷⁶

⁷¹ *ibid.*

⁷² HC Debs 23 January 2019 Vol 653, Col 242.

⁷³ [*Inside Housing* 10 January 2019.](#)

[*Inside Housing* 8 January 2019.](#)

⁷⁴ ‘Dispute over plan to make landlords fund recladding’ Times 20 October 2018.

⁷⁵ [*The Guardian* 13 January 2019](#)

⁷⁶ [Available online.](#)

87. Although it is important to acknowledge the steps that have been taken by the Government since the Grenfell Tower fire, serious questions remain as to why these steps were not taken earlier, and whether the steps that have been taken are sufficient to comply with the State's obligations under Article 2 ECHR. As MHCLG has acknowledged, "*[n]othing is more important than ensuring that people are safe in their homes*". The Commission agrees. In light of the information available to the State, both prior to the Grenfell Tower fire, and as a result of the Inquiry and other work undertaken since the Grenfell Tower fire, there is an urgent and immediate obligation on the UK Government to take all reasonable preventative measures to protect against future risks to life. In light of the Inquiry's role in discharging the UK's investigative obligations under Article 2 ECHR, it is critical that the Inquiry make recommendations as to appropriate preventive measures as soon as possible. This cannot and should not wait until the end of Phase 2, which may be several years away.

D. ADDITIONAL FIRE SAFETY ISSUES

88. A number of concerns have arisen from the evidence in relation to fire safety measures in place prior to the Grenfell Tower fire. Although these submissions do not address the operational response to the fire, certain aspects of the firefighter evidence adduced in Phase 1 raised matters relevant to Article 2 ECHR. The Commission considers that, in order to comply with its positive obligations under Article 2 ECHR, the State must: (i) implement training for firefighters on combatting cladding fires; (ii) reconsider the application of/alternatives to the stay put policy for buildings with similar cladding combinations to Grenfell Tower, and implement firefighter training on this issue; and (iii) ensure that residents are provided with sufficient fire safety advice. The evidence that the Commission has reviewed from the Inquiry suggests that the State has failed, and may continue to fail, to satisfy these obligations. Given the immediate relevance of these matters to the rights of residents of high-rise buildings with a similar construction and cladding combination to Grenfell Tower, the Commission urges the Inquiry to address these issues in its Phase 1 report.

(1) Firefighter training

89. As set out at §§50-60 above, the Commission is of the view that the State knew or should have known of the risk to life posed by the cladding combination on Grenfell Tower. In particular, the 2013 Rule 43 Letter concerning the fire at Lakanal House recommended that the Government consider amending the Fire and Rescue Authorities Operational Guidance to give consolidated national guidance on, among other things, (i) the matters that should be noted by fire brigade crews making section 7(2)(d) familiarisation visits, (ii) awareness that fire can spread downwards, upwards and laterally, and (iii) awareness that insecure compartmentation can permit transfer of smoke and fire. The Commission's view is that as part of the preventative measures required by Article 2 ECHR, the State should have implemented training for firefighters that focussed on combatting cladding fires.
90. The evidence adduced before the Inquiry suggests that this did not occur. The oral evidence of a number of firefighters makes clear that although they were trained on high-rise fires, this did not involve training on what to do if the exterior of a building caught fire: see, for example, Charlie Batterbee's evidence at [12/12]; Daniel Brown's evidence at [12/174]; David Badillo's evidence at [13/52]; Thomas Abell's evidence at [14/7]; John O'Hanlon's evidence at [16/61]; and Brian O'Keefe's evidence at [17/130]. Amongst at least some teams of firefighters it appears that there was not even a general awareness of the risks to high-rise buildings that exterior cladding systems posed. For instance, Christopher Dorgu stated that he and his colleagues had never considered the risks external cladding posed to Grenfell Tower, nor had they had any training or guidance been given on the need to understand what products are being used in a façade system on a high-rise block [19/78-80]: see also Daniel Egan's evidence at [15/83/9]; Christopher Secrett's evidence at [16/159]; Adrian Fenton's evidence at [24/31/6ff]; and Norman Harrison's evidence at [46/39/3ff] (noting that he did not even think that cladding could burn).
91. In the years before the fire, the LFB conducted a number of familiarisation visits to Grenfell Tower. However, Commissioner Cotton confirmed that officers

were not specifically trained in how to conduct these visits (see the oral evidence of Commissioner Cotton [50/40/15ff] and the oral evidence of Dean Ricketts and Nicholas Davis on Day 51 e.g. [51/76/21ff]). This appears to have contributed to an inconsistent approach to these visits, despite specific provision being made for the features of a building that should be checked. The Commission also notes that consideration was given to a complete s.7(2)(d) re-assessment following the major refurbishment works but this was not pursued. The last familiarisation visit, just months before the fire, on 27 March 2017 focused on Grenfell Tower's basement [51/94/4ff]. The fact that cladding had been installed was discussed but not in any great detail [51/197/10ff]. This raises serious questions about the effectiveness of these visits and is indicative of further missed opportunities to address some of the risks inherent in the structure of Grenfell Tower.

92. The points identified above were made by a number of the CPs in their submissions to the Inquiry. Counsel for G4 (BSR) submitted that the fire at Grenfell Tower was *"a fire beyond the training"* of the firefighters that attended it and that it represented a *"systemic failure of foresight [and thus] a violation of the state's responsibility to have training and policy in place that is fit for responding to foreseeable risk to life in cladding fires of this nature"* [2/50/3ff]. To similar effect, Counsel for the FBU submitted that on the evidence so far disclosed it appears to them that there were no *"procedures for ... fighting cladding fires, or looking out for signs of a breach of compartmentation, or what to do if they noticed or suspected such a breach, and, in particular, when to abandon the stay-put strategy and how to effect an emergency evacuation of a high-rise residential building"* nor was there any training for firefighters on these issues [4/8/1ff]. The FBU *"invite[d] the Inquiry to consider whether there was a lack of national leadership, regulation and funding on these key areas, in particular in light of the recommendations from the inquest into the Lakanal House fatalities"* [4/8/10ff].

(2) The "Stay-put policy"

93. The 2013 Rule 43 Letter concerning the fire at Lakanal House also contained recommendations concerning (i) the need for guidance on failure of

compartmentation and (ii) the need for the DCLG to “publish consolidated national guidance in relation to the ‘stay put’ principle and its interaction with the ‘get out and stay out’ policy, including how such guidance is disseminated to residents”. In the Commission’s view, as part of the preventative measures required by Article 2 ECHR, the State should have reconsidered the application of/alternatives to the “stay put policy” for buildings with such cladding combinations and implemented appropriate firefighter training on this issue.

94. The evidence adduced before the Inquiry suggests that this did not occur. In particular, the evidence indicates that (i) there was no specific training on what to do if compartmentation failed, and (ii) the construction of Grenfell Tower would have made evacuation difficult if not impossible as the fire spread and intensified.
 - (1) Several firefighters confirmed that they were not trained on what to do if compartmentation failed: see, for example, Daniel Brown’s evidence at [12/173/4-7]; David Badillo’s evidence at [13/53]; Thomas Abell’s evidence at [14/7]; Brian O’Keefe’s evidence at [17/130].
 - (2) Several firefighters confirmed that they were not trained on how to conduct a phased or total evacuation of a high-rise building: see, for example, David Badillo’s evidence at [13/53]; Thomas Abell’s evidence at [14/7].
 - (3) As regards the feasibility of an evacuation, Michael Dowden, of the LFB explained that “[G]enerally, if we need to evacuate residents, the ideal thing in a high-rise block would be to have two staircases so we can facilitate one as a rescue staircase and one as a firefighting staircase. In the case of somewhere like Grenfell Tower, that only had one communal staircase. As you can imagine, it would be very difficult to facilitate evacuation of residents when we have firefighters and equipment going up the same staircase as well. And that references back into the stay-put policy, why that would be implemented” [9/24-25].

- (4) Mr Dowden gave further evidence that he had no practice or training in evacuating people with mobility issues, the elderly or children from high floors in high rise blocks: see [9/36/19] and [9/69/9]. He explained that by 1.24am it would have been *“impossible”* to *“facilitate and change a stay-put policy to a full evacuation”* because he *“didn’t have the resource at that time”* [10/161/22ff]. According to Mr Dowden, *“[t]he way that Grenfell Tower was constructed with that one central staircase, a number of residents in that block, the number of firefighters entering the equipment, how distressed people are, confused in that environment”* would have made it *“very, very difficult”* to undertake a full-scale evacuation at 1.28am [11/31/24ff].
- (5) Daniel Brown, of the LFB, stated that *“the whole evacuation – we can’t – when a fire happens, if it has an alarm system, that is the evacuation point. By the time we get there, the evacuation point is lost. There is no chance to evacuate. The whole point of having an evacuation procedure is you have an integrated fire alarm. We don’t do evacuations; we do assist and rescues. There is no evacuation procedure we can do. It’s impossible. You’re asking people to come down through stairs that could be smoke-logged, they might not make it”* [12/179].
- (6) Brian O’Keefe, of the LFB, stated that *“if people started to evacuate, there would become multiple casualties in the stairs and we would have great difficulty in finding out where people were, because when you have an FSG, you know where someone is, and if they are protected, you know you have a destination, X or Y flat, number of people. But if people start evacuating when the entire building’s on fire ... and the only way down is impossible, that would have been – well, a huge catastrophe for – well, it would’ve really impacted our rescue operation”* [18/88/24ff]. He also stated that by 2am it *“would’ve been unsafe, dangerous”* for residents to evacuate the building [18/108/12].
- (7) Adrian Fenton, of the LFB, observed that if there was a possibility that compartmentation was going to fail *“then the building should be built to suit full evacuation with a PA system and systems in place to allow the residents or the occupiers of the building to know that a full evacuation is needed. It would have to have a fire alarm, it would have to have many other fire safety points in place to support that within the building”* He also stated that he wouldn’t

expect there to be a contingency plan for evacuation in a building that is supposed to operate on a stay put policy, “because if the building has compartmentation, the fire should not be spreading out of the compartmentation, so there wouldn’t be an expectation for a full or phased evacuation within that building, because it wouldn’t be required” [24/25].

95. In their oral opening submissions to the Inquiry, Counsel for the LFB noted that the inability to evacuate Grenfell Tower stemmed from the failure to implement a policy of evacuation prior to the fire and the failure to construct Grenfell Tower in a manner that would facilitate such a policy:

“It is a fundamental misunderstanding of the events of the fire and of fire service capabilities to assume that the building’s stay-put policy can be changed to simultaneous evacuation at the stroke of a fire incident commander at whatever time ... If there is no policy applied by the building owner which provides for a policy of simultaneous evacuation, and there are no evacuation plans and there are no general fire alarms, what is an incident commander on the fire ground to do?”

The inquiry is invited to consider the extent to which a simultaneous evacuation was ever a feasible option, or could’ve been a feasible option ... given ... (a) that the building was not designed or constructed to facilitate such evacuations through the provision of fire alarms or other mechanisms which might form part of a fire safety strategy put in place by the building owner; (b) the absence of any practical mechanism by which effectively to communicate with the occupants of the entire building; (c) the availability of a single staircase as a fire escape route, which was the only means by which firefighters ... could access the upper floors in the absence of a working firefighter lift; and (d) the likelihood that the rapidly changing conditions in the building as the fire developed created toxic and potentially lethal conditions through which residents would be required to pass.” [4/45/6ff]

96. In her oral evidence, Commissioner Cotton accepted that “although the risk was on the LFB’s radar and it was brought to the attention of local authorities, the London Fire Brigade itself didn’t itself adapt any of its own training or information in order to be able to alert firefighters to the particular risk” [50/65/22ff]. She stated that “we wouldn’t expect to give people training to understand looking at a cladding system to see whether or not that was a risk, because it would be almost impossible to look at a building and ascertain whether or not the external parts of the building [in and of themselves would pose a fire risk]’s... [L]ooking at a building and seeing its clad wouldn’t equate to risk in the eyes of a normal firefighter” [50/37/11ff], and that

“...my firefighters would never be able to recognise what cladding was flammable. That was the point for me. Anyone of us could not recognise what cladding is flammable, because it shouldn’t be flammable” [50/64/10ff].

97. However, the London Safety Plan (March 2017) recognised a need for firefighters at all levels to understand the impact of construction materials on fire spread. The LFB had no plans in place between March and June 2017 to ensure this was the case [50/66/3ff]. In responding to this the Commissioner referred to resourcing constraints, and the need to prioritise training, resources and community safety work to tackle the greatest risk to life which, for the LFB, are domestic fires. The Commission is deeply concerned about the suggestion that the failure to train operational firefighters in identifying and responding to cladding fires could be justified by resource pressures on organisations like the LFB.

(3) Fire safety advice

98. The 2013 Rule 43 Letter concerning the fire at Lakanal House specifically warned that evidence during the inquest had demonstrated that there was *“insufficient clarity about advice to be given to residents of high-rise residential buildings in case of fire within the building.”* In the Commission’s view, compliance with Article 2 required the State to ensure that residents were provided with sufficient fire safety advice.
99. The evidence of firefighters suggests that this did not occur. Specifically, information (i) was not routinely delivered to residents; (ii) was not prominently posted throughout Grenfell Tower; and (iii) was not made available in languages other than English. An image of a sign that was posted between the lifts in Grenfell Tower was put to Michael Dowden during his oral evidence [9/114/5]. The sign read: *“If you are safely within your flat and there is a fire elsewhere in the block you should initially be safe to stay in your flat keeping the doors and windows closed. On arrival the Fire Brigade will make an assessment and will assist with evacuation if required”*. In response, Michael Dowden stated that he didn’t recall if he had discussed with the building owner other measures taken to ensure that residents understood what to do in case of a fire [9/114/15].

Justin O’Beirne stated that he didn’t recall whether he had been to Grenfell Tower to give fire safety advice: [14/121/6ff]. Thomas Abell stated that he didn’t keep a record of the residents to whom fire advice had been given but that one may have been stored centrally: [14/20/24]. Joanna Nicole Smith stated that control room operators did not have training on how to manage calls from callers for whom English was not their first language: [21/71/12].

100. The evidence from the LFB is, regrettably, consistent with the experience of the BSRs. By way of example, the daughter of Sakineh Afrasiabi stated that whilst her mother was living in Grenfell Tower she *“did not receive any information whatsoever about fire safety. She was given no information about how to get out of the building in the event of an emergency”* [2/145/12ff]. Sakineh Afrasibi’s son stated that he knew *“for sure that my mother was given no information about fire safety at Grenfell Tower. No one came to her place to talk about it, nor to tell her what should be done in the event of a fire. It was simply that she collected her keys and was told to get on with it. There was no culture of talking about public safety”* [2/145/23ff]. A number of residents also observed that the fire safety sign by the lift was only in English: [2/146/23ff].

E. SPECIAL PROTECTION AFFORDED TO VULNERABLE AND MINORITY GROUPS

101. In circumstances where a risk to life is posed to a vulnerable groups, the case-law makes it clear that the State should take particular care to ensure that measures taken *“correspond to [those persons’] special needs”*: *Jasinskis* §59. The Commission considers that Grenfell Tower posed a particular threat to life for vulnerable groups, such as children, pregnant women, elderly people, disabled people and those who were not fluent in English (that is, from certain minority/racial/national groups). The Commission is of the view that the Government failed to take protective measures that adequately corresponded to the needs of these vulnerable groups. As well as raising issues under equality and non-discrimination law (which is addressed below §§119-120), this also raises issues in respect of Article 2 ECHR.

102. There were a number of residents with mobility issues living above the 15th floor of Grenfell Tower. A number of their personal stories were shared by surviving relatives or residents. To take just one example, Nazanin Aghlani gave this account in respect of her mother, Sakineh Afrasiabi, and her experience of moving into Grenfell Tower with acute health and mobility challenges [30 May/41,11ff]:

"Unfortunately, a few years back, in Iran my mum had an accident that badly impaired her knees but didn't know about her rights and what she could do about it.....The pain was made much worse as she had to climb many steps in order to reach her [previous] property where she ended up having to manage for some 20 years before she was finally rehoused. She had to stop working as her arthritis worsened. She developed diabetes and her overall health deteriorated. As early as 2003, the RBKC housing department formally recognised and stated that, due to my mum's disability and deteriorating health, she should not be housed in a lifted property above the fourth floor. I emphasise that was in 2003. The fourth floor, because that was her human right to escape, the right every single person should have. After being refused many suitable properties, after 16 years of waiting, she was rehoused in 2016 into flat 151 on the 18th floor of Grenfell Tower. By this point, my mum was partially-sighted and could only get around with the aid of a tri-walker. The move to Grenfell was out of desperation and pressure from the council. She was to take Grenfell Tower or to be suspended from allocations for one year. She was very upset by the new place."

103. After describing her mother's difficulties in accessing her flat during the major refurbishment works, Ms Aghlani continued:

"Grenfell Tower and flat was not welcoming to her, but she took it out of pressure and desperation. I remember vividly the only thing she kept saying about flat 151 was that she just wanted to put all her furniture in it and go back to Iran for a while. It was a home she already wanted to get away from and I don't blame her. She was a vulnerable disabled person and she was put in a place that was worse than her own. The fear of living so high in her condition was always in the back of our minds."

104. For further examples from the commemoration hearings, see the commemorations of Anthony Disson [23 May/14/8]; the Choucair family [22 May/90/22]; Kamru and Rabeya Begum [24 May/28/15].

105. A number of the BSRs also gave evidence to the Inquiry in relation to this. Elpido Bonifacio was a resident of the 11th floor with his wife. He is partially sighted and registered as blind. His witness statement vividly described how

the major refurbishment works had rendered his home unfamiliar to him [71/167/22ff]:

"Before the refurbishment I didn't have difficulty navigating the building as a blind man. Following the refurbishment it was not easy for me to find my way around because the tower now had 3 additional floors. It became a different way of living for me. There were too many doors which made it confusing for me to know which floor I was on. Especially when the lift was not working, I would find it very hard to find my way around."

106. The Commission also notes this account from Mr Bonifacio [68/166/18ff]:

"The TMO knew I had disabilities. Every time my wife would go down to the TMO office to report a repair they would often tell her to do it herself. She would then remind them that I was elderly and blind and then would escalate our repair turn over time. Despite this there were never any conversations about the Council relocating me to a flat on a lower floor."

107. Joseph Daniels had lived on the 16th floor since 1983. Joseph developed dementia and required permanent care from his son, Samuel. Samuel described how his father was prone to confusion and disorientation; loud or sudden noises were particularly difficult for him. Joseph and Samuel were known to social services. However, Samuel explained that no one had ever given him any advice on what he and his father should do in the event of fire nor how they might evacuate. Samuel described trying to convince his father to leave Grenfell Tower once the fire had taken hold and it had become apparent they would not be rescued. By this time, Joseph had become disorientated and refused to move. Unable to move him, Samuel was forced to leave his father behind in search of help. Joseph was later found to have died outside the door of his flat [57/4/9ff] (see also the evidence of Rita Tankarian, living in flat 151 on the 17th floor [60/78/11ff, 60/81/22ff]).

108. The Inquiry heard similar evidence about vulnerable residents living elsewhere in Grenfell Tower. Ms Toyoshima-Lewis, lived in flat 9 on the 3rd floor. She was unable to walk and mobilised using a wheelchair. She had a motorised scooter for use outdoors and used a manual wheelchair in her flat. She had to charge her motorised scooter by the front door of her flat. She describes waiting 45

minutes for a firefighter to arrive after her initial call to 999 and their reaction when they did (WS of Mariko Toyoshima-Lewis of Flat 9, 3rd Floor §29):

"When the firefighters saw me and my family they just started swearing. I have never heard swearing like it before, they said words to the effect of "Fucking Jesus Christ! What are you doing?" I think they were freaking out because of the wheelchair and mobility scooter blocking the front door. I remember them telling me that I had nearly killed my children because I hadn't followed health and safety guidelines. One fireman was kicking one of the wheelchairs. I told them that I had keys for the mobility scooter and that to move the large power wheelchair you just needed to push a button ... but I think the firefighters moved them with brute force."

109. In her oral evidence, she went on to describe screaming in pain as she was dragged out of Grenfell Tower by firefighters [57/56/14ff].

110. Nicholas Burton, whose wife Pily had dementia and who died in the wake of the fire, gave evidence of them being rescued by firefighters but becoming separated. Mr Burton described his anguished wait for news and then shock at the Pily's appearance when she was brought into a gym that was being used as an emergency shelter [68/77/17ff]:

"It just seemed forever and ever and ever, and I was panicking, because I didn't know whether my wife was out first or she was behind me, because, you know, I didn't know what was happening. But I knew that I was standing my ground and I wasn't going to leave that tower until I knew where my wife was. And then -- boom -- the door burst open, and, you know, four fire officers had my wife, one on each limb, so they were holding her backwards. Apart from her little top, she had no clothes on, no socks, no shoes, no underwear, no trousers, no cardigan, and I just thought she was dead. I thought maybe she got burnt or something's happened in that stairwell, and, you know, she had no clothes on. So I was just standing there in total disarray and shock. What's happened to her? She dead, they're just bringing her out. They come past me and they didn't even stop to look at me, really, but I had the towel, so I just threw it over her, and they just continued."

111. In their oral opening submissions, Counsel for G3 (BSR) observed "how problematic" simultaneous evacuation would be "in a social housing single staircase block and ever more so for people of age, with ill-health or people with children and those of limited mobility" [2/89/6ff]. Counsel went on to provide the example of one family in particular, where "[t]here appears to have been no plan, no contingency, no thought for the vulnerable" [2/113/4ff].

112. Evidence of the call room operators indicated an assumption that residents with disabilities or other vulnerabilities would volunteer that information. See for example: [21/108/25ff] and [22/60/15ff].
113. Call room operators appeared to give no particular priority to calls from these particularly vulnerable residents [*id*]. Where there was evidence indicating the contrary, it demonstrated that there was to little or no practical effect. This can be heard in the only “999” call that was played during the hearing in full, from Maricio Gomes – who led his heavily pregnant wife Andreia Perestrelo and their two daughters down the stairs. In the call, the call room operator can be heard repeating an assurance that the family had been identified as a priority for rescue and that firefighters would intercept them part way down (see, for example, [71/93/7ff]). They did not encounter firefighters until they were almost at the bottom of the Tower [71/140/11ff]. As the Inquiry will recall, at the outset of the Inquiry, Mr Gomes led a commemoration for his son Logan, who was still-born hours after the fire.
114. Similarly, Paulos Tekle described telling operators that he was trapped with children and being told to stay put. That was reiterated by a firefighter who attended during the fire. However, when the “*stay put*” advice was changed, Mr Tekle had to find a way to evacuate with his two sons. The eldest, Isaac, who was five years old, was with a neighbour and a firefighter as they made their way down the Tower. Isaac was lost at some point during the escape attempt and was later found to have died.
115. The overwhelming weight of the fire service evidence demonstrated that no priority was given to, or maintained, in respect of calls from those who were exceptionally vulnerable. This tended to be explained on the basis that the extent of the fire meant that all residents were a priority for rescue [48/68/22ff]. Although some firefighters did assert that specific priority was given to calls from residents affected by difficulties due to age or disability etc, it is by no means clear what that system of prioritisation was or how it was applied to meaningful effect on the night [15/120/16ff]; [15/158/1ff]; and [30/47/20ff].

116. Michael Dowden, of the LFB, gave evidence that he didn't recall investigating whether there were persons in the block whose command of English may affect their understanding of fire safety advice and that he didn't investigate whether there were children, elderly or people with mobility challenges living in the block who may need assistance with evacuation [9/114-115].
117. As noted in the Todd Report, the Fire Safety Order 2005 does not include any provision for arrangements of evacuation of a vulnerable resident when a fire occurs in their own flat. The Todd Report went on to state that this *"does not imply that nothing can, or should, be done to address the risk to vulnerable residents from a fire within their own flat. On the contrary, this is important, but it is a matter for multi-agency co-operation to identify vulnerable persons, assess their risk and provide appropriate support"* (see §§2.103 - 2.104).
118. The Lane Report at §2.20.11(e) expressed concern about how the absence of a statutory requirement to fit blocks of flats with a means of raising an alarm or providing announcements would *"affect those who require assistance to evacuate from high-rise residential buildings"* (at §2.20.11(e)). According to Dr Lane, *"the lack of provision [in the LGA guidance] for persons requiring assistance in a high rise residential building is unacceptable, and results in a substantial breach of the functional requirement for means of escape under the Building Regulations. In my view, the LGA guidance should be updated to adequately deal with persons requiring assistance from 'general needs' blocks"* (§2.25.10). In her oral presentation, Dr Lane noted that *"[t]here is no provision required in the statutory guidance for residential buildings, unlike other building types, to provide equipment for [persons requiring assistance], so there is no provision made for them to either contact building management, should they even be present in a building, nor to communicate directly with the fire service present in the building. The person can only make a personal 999 call. In other building types, refuges with communication devices are required"* [5/35/3ff].

F. EQUALITY AND NON-DISCRIMINATION

119. As will be apparent, the failures by the State identified above give rise to a number of equality and discrimination issues. The Commission believes that these require consideration by the Inquiry. On the evidence available the

Commission considers that a number of the failures identified above and below indicate a breach of the State's equality and non-discrimination duties. They include:

- (1) The absence of any legal requirement to ensure that high-rise residential buildings are fitted with means that would allow disabled people, elderly people, pregnant women or those with children or otherwise needing assistance, to raise the alarm, to evacuate from high-rise residential buildings or to find refuge in a safe place (§118 above).
- (2) The failure to take account of the special needs of disabled people, elderly people or pregnant women and (particularly very young) children when allocating housing in the upper floors of a tower block. No regard appears to have been had as to how their safety would be secured in the event of an urgent need to evacuate.⁷⁷
- (3) The failures identified above put black children and children from other minority groups at particular risk, and continue to do so. This is because, as research demonstrates, black children are disproportionately housed in tower blocks, and the higher up one goes the greater the proportion of black children: *"A child looking down on London, or Birmingham, or Oxford from an upper window of a tower block will, odds on, be black. This has been true since at least 2001. Britain is segregated in all kind of ways, most of all through its housing..... 'Cut Britain up horizontally rather than by neighbourhood, and you do find minority – majority areas. For example, above the fifth floor of all housing in England and Wales a minority of children are white. Most children growing up in the tower blocks of London and Birmingham – the majority of*

⁷⁷ Seven of the deceased were aged 70+; 18 were children (including one child who was not carried to term shortly after the fire); 29 were women: Mark Rice Oxley, [*"Grenfell: the 72 victims, their lives, loves and losses"*](#), The Guardian, 14 May 2018.

children 'living in the sky' in Britain – are black''' (D Dorling, 'Peak Inequality: Britain's Ticking Time Bomb' (2018) Policy Press, 90⁷⁸).⁷⁹

- (4) The presence of an apparently disproportionate number of adult and child residents in Grenfell Tower from ethnic and/or national minority groups raises concerns about the housing allocation policies and practices more generally. The indications are that the majority of those who died in the fire at Grenfell Tower were from ethnic and/or national minorities⁸⁰ (including the vulnerable). If disproportionate numbers of adults and children from ethnic and/or national minority groups are housed in tower blocks and/or housing which is unsafe, this raises the question whether housing allocation policies or practices operate (and continue to operate) in a racially discriminatory way (§§46-47).
- (5) The failure to provide fire safety advice to disabled and elderly people and pregnant women or those with children residing in Grenfell Tower on the steps they should take in the event of a need to urgently evacuate despite the greater risk to them posed by a fire (§§99-100 above).
- (6) The failure to provide fire safety advice in languages other than in written English (§§99 above).
- (7) The absence of any plan for the evacuation of disabled people, elderly people or pregnant women and women with (particularly very young) children in the event of an urgent need to evacuate Grenfell Tower in

⁷⁸ Quoting D Dorling *'Why Trevor is wrong about race ghettos'*, The Observer, 25 September 2005.

⁷⁹ The Commission has not seen a break down by race of the occupants of Grenfell and in particular the colour/ ethnicity of the children living there and the height at which they lived. This is evidence which the Commission will seek and it invites the Inquiry to do the same.

⁸⁰ 7 of the deceased were White British victims; 19 different nationalities were represented among the deceased and 31 UK-national victims [The Guardian, 14 May 2018](#).

advance of the night of the fire, or on the night of the fire despite the greater risk to them posed by a fire (§§94(4), 95).

- (8) The absence of any prioritising of disabled people, elderly people or pregnant women and people with (particularly very young) children for evacuation on the night of the fire despite the greater risk to them posed by the fire (§§113-115).

- 120. The Commission has seen no evidence which would indicate that the PSED was discharged (i) in the formulating of housing allocation policy; (ii) in the preparation of fire safety plans; (iii) in the development of guidance; (iv) in the provision of information, or (v) in the development of Building Regulations.

G. THE INVESTIGATIVE DUTY

- 121. The Inquiry will invariably act as the primary means by which the State will discharge its duty to investigate under Article 2.⁸¹ As set out above, the purpose of an Article 2 investigation is to secure the effective implementation of the right to life and to ensure accountability for deaths for which the State is responsible. Accordingly, the scope of the investigation must be broad enough to address all relevant surrounding circumstances, in order to ascertain whether the State has complied with its obligation to protect life. Such an investigation must include consideration of any equality and non-discrimination issues that arise.⁸² The investigation must also involve the next of kin and be effective, independent, prompt and subject to public scrutiny.
- 122. From the outset, the Commission has been concerned about the scope of the Inquiry, and the narrow terms of the terms of reference and list of issues. The Commission welcomes the Inquiry's indication that the terms of reference are not intended to limit its ability to to "*pursue any avenue of investigation which it*

⁸¹ See the Commission's first public submission to the Inquiry, dated 18 December 2017, at §20; and INQUEST's response to the Inquiry's Terms of Reference Consultation.

⁸² See, among others, *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653; *D.H. Opuz v Turkey* (2010) 50 EHRR 28; *Menson v UK* (2003) 37 EHRR CD 220.

considers appropriate", and that the list of issues is not intended to be prescriptive, and that it "*may be subject to revision during the course of the inquiry*".

123. As this submissions had sought to demonstrate, in order to determine whether the State complied with its obligation to protect life, a key feature of an Article 2 investigation, the Inquiry must address the following issues which relate to State responsibility: (i) whether the State violated the right to life in relation to the cladding combination on Grenfell Tower by either failing to put in place an adequate legislative framework or failing to implement that framework; (ii) whether that violation is on-going in relation to other buildings in the UK; (iii) whether the State violated the right to life in relation to vulnerable residents in particular; (iv) whether the State violated the right to life through failing to implement appropriate fire fighter training, through implementing a stay put policy on buildings with the same cladding combination as Grenfell Tower, or through inadequate provision of fire safety advice to residents of such buildings and (v) whether the State failed to meet its equality and non-discrimination duties. In the Commission's view, an Inquiry that fails to address these broader issues relating to State responsibility will not satisfy the procedural investigative obligation inherent in Article 2 ECHR.
124. The Commission is also concerned about delay. The Inquiry has now made it clear that Phase 2 will not commence until late 2019 at the earliest. In light of the volume of material to be considered, it is possible that it will not conclude until 2021 or possibly even 2022. As the Inquiry is aware, one of the key purposes of an Article 2 investigation is to ensure that lessons are learned, and that dangerous practices and procedures are identified and rectified. On the basis of the evidence already before the Inquiry, it is clear that a number of interim recommendations could reasonably be made, in order to mitigate ongoing violations of the right to life and the risk of further life-threatening fires in other buildings. In this regard, the Commission welcomes the Chairman's indication that he will consider making in interim recommendations in early 2019.

125. Finally, critical to discharging the State's obligation under Article 2 is the proper and effective participation of the survivors, bereaved and former residents of Grenfell Tower and surrounding blocks. This is necessary to ensure that all relevant evidence is heard, but it is also necessary to ensure the legitimacy of the process. As the Commission observed in its earlier submissions to the Inquiry, it is imperative that the Inquiry is organised and conducted in a way which allows for survivors, bereaved and former residents to effectively participate in the Inquiry. This is complemented by the EA 2010, which imposes specific obligations on public authorities, and in relation to certain of its functions on the Inquiry itself, to ensure equality in access. The Inquiry should be mindful too of the right of children to have their voices heard, conformably with their age and stage of development (§38 above). In this regard, the Commission invites the Inquiry to review its "*Protocol for vulnerable witnesses*" as it affects children (§16) and in particular its application in practice.
126. Throughout the course of the "*Following Grenfell*" project, CPs and their lawyers have raised a number of concerns about their inability to effectively participate in the Grenfell Inquiry. These include the following:
- (1) *Venue*. Concerns have been raised about the venue from the outset. The Holborn Bars is remote from the community where the Grenfell Tower fire occurred. The main Inquiry room is too small, and there are insufficient breakout rooms. As a result, very few (and frequently none) of the survivors, the bereaved and members of the wider community attend the Inquiry. In this regard, the Commission welcomes the indication from the Chairman on 12 December 2018 that premises have been secured in West London, with a larger hearing room.
 - (2) *Restrictions on ability to put questions directly to witnesses*. The legal representatives representing survivors, the bereaved and other affected members of the community have been prevented from putting questions to witnesses themselves. There is concern that the limited facility to request that Counsel to the Inquiry ask particular questions of witnesses has proved inadequate in meeting the expectations of the survivors, the

bereaved and affected members of the community and that it has resulted in some issues not being fully explored.

- (3) *Disclosure*. Disclosure has been voluminous as would be expected. However, the burden on the legal representatives representing the survivors, the bereaved and other affected members of the community appears to have been enormous given the limits of the resources available to them.

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Equality and Human Rights Commission

25 January 2019

GLOSSARY

ADB	Approved Document B
Bisby Report	Professor Luke Bisby, <i>Grenfell Tower Inquiry Phase 1 – Expert Report</i> (2 April 2018)
BSP	Building Safety Programme
BSRs	Bereaved, Survivors and Residents
CEDAW	United Nations Convention on the Elimination of All Forms of Discrimination Against Women (1979)
CERD	United Nations Convention on the Elimination of All Forms of Racial Discrimination (1965)

Commission	The Equality and Human Rights Commission
CPs	Core Participants CRC United Nations Convention on the Rights of the Child (1989)
CRPD	United Nations Convention on the Rights of Persons with Disabilities (2006).
DCLG	Department for Communities and Local Government
EA 2010	Equality Act 2010
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
FBU	Fire Brigades Union
Final Hackitt Report	Dame Judith Hackitt, <i>Building a Safer Future. Independent review of building regulations and fire safety: Final report</i> , May 2018
FSG	Fire Survival Guidance
G3 (BSRs)	Group 3 of Bereaved, Survivors and Residents
G4 (BSRs)	Group 4 of Bereaved, Survivors and Residents
ICCPR	International Covenant on Civil and Political Rights
Interim Hackitt Report	Dame Judith Hackitt, <i>Building a Safer Future. Independent review of building regulations and fire safety: Interim report</i> , December 2017
Lane Report	Dr Barbara Lane, <i>Grenfell Tower – fire safety investigation: the fire protection measures in place on the night of the fire, and conclusions as to: the extent to which they failed to control the spread of fire and smoke; the extent to which they contributed to the speed at which the fire spread</i> (12 April 2018)
LFB	London Fire Brigade MHCLG Ministry of Housing, Communities and Local Government
NKLC	North Kensington Law Centre
PSED	Public Sector Equality Duty
RBKC	Royal Borough of Kensington and Chelsea
Rule 43 Letter	Letter sent from Assistant Deputy Coroner to the Secretary of State for Communities and Local Government on 28 March 2013

Taskforce	The Independent Grenfell Recovery Taskforce
TMO	Tenant Management Organisation
Todd Report	Mr Colin Todd, <i>Report for the Grenfell Tower Inquiry on Legislation, guidance and enforcing authorities relevant to fire safety measures at Grenfell Tower</i> (March 2018)
Torero Report	Professor José Torero, <i>Grenfell Tower: Phase 1 Report</i> (23 May 2018)