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The defining moments: what we can learn

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“While we know that people who work in social housing work hard to get things right for our tenants and communities, there have been too many defining moments and too many heart-breaking stories where tenants and whole communities have been let down”

— Better Social Housing Review authors

We will look at

01 **Grenfell**

02 **Lakanal House**

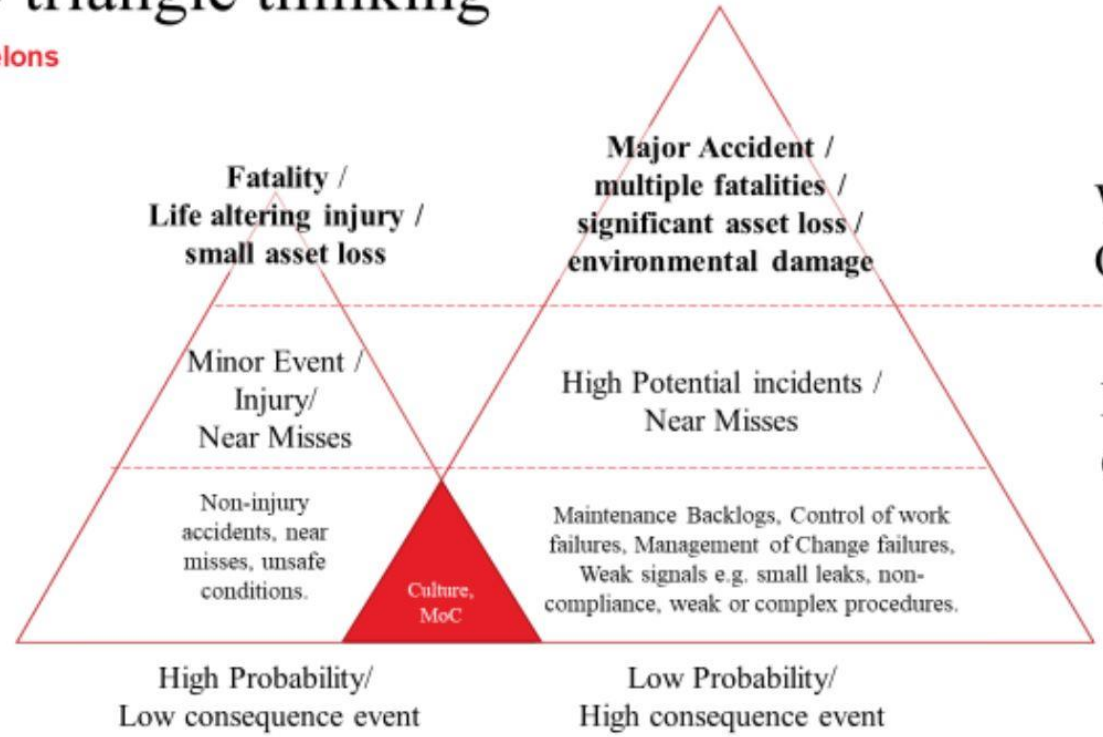
03 **Awaab Ishak**

04 **Sheila Seleoane**

ARUP

Two triangle thinking

Watermelons



Grenfell

- Neglect - years of disrepair across KCTMO stock. Huge repairs backlog. High priority fire safety incidents unaddressed. Key safety features (self-closers and smoke extraction) left broken despite warnings

- Stigmatisation - council officers referred to Grenfell as 'the Morrocan Tower' and 'little Africa'. Rebel residents. Practical implication: lifts.

- Not listening to complaints. “I felt like they thought I was a ‘troublemaker’ because I had been making complaint". Didn't allow residents to form a collective group. Board dismissed petition raising concerns about the refurbishment

- Vulnerability. Fire disproportionately killed children and disabled residents. "A landmark act of discimination against the disabled and vulnerable".

- Neglect - No fire risk assessment, despite legal duty being imposed four years before fire. Fire doors had non fire-resistant panels above them. Suspended ceilings circumvented fire breaks. Ducts connected flats, allowing smoke to spread.
- Not listening to complaints. "Every time we complained, they told use they had taken our concerns on board, but nothing changed."
- Vulnerability. Three of the six deaths were young children - one a three week old baby. Two more were mothers.
- At Lakanal and Grenfell - a belief that it couldn't happen here, an attachment to the status quo

Lakanal House

Awaab Ishak

- Neglect. There were serious issues with disrepair across the Freehold Estate where Awaab's family lived (almost 80% of homes had damp and mould) and in other homes in RBH's stock.

- Not listening to complaints. Awaab's father first complained about damp in 2017 - a year before his son was born. Health visitor sent letters in July and November 2020. Awaab died in December

- Stigmatisation. Family had been blamed for 'ritual bathing', which they didn't do. A culture of “othering” residents “lies at the heart” of the issues at RBH, says Ombudsman. One worker told damp and mould was “OK and acceptable” as “most of residents were refugees and… they are lucky they have [a] roof over their head”.

- Vulnerability. Young people with asthma are most at risk from damp and mould

- Neglect. Neighbourhood managers at Peabody covered 1,200 homes each on average. Long gone are the days of resident caretakers. Flat had been visited for gas inspection - but never done.

- Not listening to complaints. Residents had complained of smells from the flat, maggots and flies.

- Stigmatisation. the association made 89 attempts to contact Ms Seleoane between August 2019, the last time she made a direct rent payment, and when she was found by police in February 2022. Gas had been cut off in July 2020. Does this show enough concern about welfare?

Sheila Seleoane

1

All of these cases start with neglect. That is how we avoid them repeating

2

Complaints are among the most valuable data your organization has. Use it.

3

Are residents really being treated as humans with rights the same as yours? If not, what culture lies behind this?

4

Who is most vulnerable to becoming a victim of a tragedy? What can be done to make them as safe as possible?

“Every decision, every act, omission, interpretation, understanding, practice, policy, protocol, affects someone somewhere, someone who is unknown and unseen, but who is an adored child, a beloved sister, a respected uncle, a needed mother”

— Richard Millett KC

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Show Me The Bodies: How We Let Grenfell Happen

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