

# Family reflections on Grenfell: No voice left unheard

INQUEST report of the  
Grenfell Family Consultation Day

May 2019



## About INQUEST

INQUEST is an independent charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes death in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. This includes work around the Hillsborough football disaster and the Grenfell Tower fire.

## Acknowledgements

The Family Consultation Day model is designed to place families at the heart of the discussion about the State's response to mass fatalities. INQUEST would like to place on record their thanks and gratitude to all those families who participated. Their brave and honest contributions have informed the report's findings.

A particular thanks to Grenfell United who INQUEST have worked closely with from the outset and whose support for this day has been invaluable.

This report was written for INQUEST by independent consultant Chris Tully. He assisted in designing the Family Consultation Day model. He has 28 years experience of working with voluntary sector organisations and has also conducted monitoring and evaluation projects for Clinks, Women in Prison and INQUEST.

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# Foreword



What follows is a powerful evidence based report with the family voice at its heart. What comes across is the defiance and dignity of a grieving community.

On 14 June 2017, one of the worst preventable disasters in modern UK history resulted in the deaths of 72 people. The Grenfell Tower Fire.

Since the disaster, INQUEST have been working with and supporting families of those who died. We empower families through the provision of information about the investigative processes that follow a contentious state related death and uphold the rights of bereaved families as victims, to be treated with dignity and respect.

Our focus is on ensuring family voices are heard. Following the conclusion of phase one of the Grenfell Public Inquiry and conversations with families, their legal teams and community organisations, INQUEST convened a Family Consultation Day (FCD) to directly hear from those who have been bereaved.

What follows is a powerful evidence based report with the family voice at its heart. Bereaved people are a group of individuals with unique personal stories, needs and insights. This is an account of the consultation day rooted in their humanity. All families who took part welcomed the fact that their voices were being heard and the opportunity afforded them to be able to have their say. What comes across is the defiance and dignity of a grieving community.

Families want to have trust in the process but there is a need for the authorities and Inquiry team to earn that trust and to recognise their central role. Playing a meaningful role in the Inquiry is important for bereaved people who cannot properly begin to grieve until they have found out the truth behind their loss. This is central to recovery and healing.

Certainty around Inquiry dates and timeframes is key to ensuring that families are kept properly informed and not left in the dark. There is a desire to ensure that this is a thorough public inquiry but also a demand for interim recommendations as soon as possible to protect others and prevent a repeat of this disaster

It is high time the Inquiry team and the Government listened to these voices to provide the foundations for an inquiry that delivers structural change and accountability. This must be the lasting legacy of Grenfell.

INQUEST has worked with families bereaved after other mass fatalities and supported their struggles for justice, accountability and prevention and better treatment of traumatically bereaved people. INQUEST acknowledges their determination and perseverance. We stand in solidarity with the families of Grenfell and those who have campaigned for justice before them.

**Deborah Coles**

**Executive Director, INQUEST**

# Executive summary

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*'I wanted people to know that I had lost a lot. My family mattered and so did all the other families. I wanted the general public, government and RBKC [Royal Borough of Kensington Chelsea] to know that. I wanted them to know how much they have taken away from me. Our families should not be forgotten about.'*

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In early 2019, INQUEST consulted with bereaved families about the events of the immediate aftermath of the fire and placed their thoughts on record. This provided invaluable insight into what could and should have been offered to them as a community of bereaved people after the disaster. They then considered the impact of the first phase of the Public Inquiry and discussed their suggestions for how things might be done differently in the future.

INQUEST's Family Consultation Day is designed to place families at the heart of the discussion about state responses to mass fatalities. From a wholesale re-think of how the UK responds to a disaster, to ensuring the Inquiry room is comfortable, the range of suggestions and observations made by families are rooted in a painful reality. For that very reason it is vital they are considered valuable and utilised as a catalyst for informing best practice.

## What bereaved families told us - key findings

### Immediate aftermath of the fire

- Support, information and communication was chaotic and inconsistent.
- The haphazard nature of the emergency response increased families' anxiety and trauma.
- Families felt abandoned by the state at all levels; central and local government and by the Tenant Management Organisation (TMO).
- The inadequacy of the state's response meant the local community, Non-Governmental Organisations (NGOs) and families were forced to assume the role of advocates, carers and sources of information.
- With an inadequate centrally co-ordinated response families felt access to vital support and information was inconsistent, resulting in inequality of provision for many, particularly exacerbated for bereaved families' non-resident in the UK.

- Families were disappointed by the quality of support they received from Family Liaison Officers (FLOs), who work for the police, and key workers, provided by the RBKC, although individual examples of excellent care and support did emerge.
- There was positive feedback from those that had met the coroner.
- The importance of specialist legal representation following a mass fatality was not explained to families and many were anxious about the cost, and/or unaware of the benefits of specialist representation (i.e. assisting with active participation in the Inquiry).

### Phase one of the Public Inquiry

- Families considered the pen portraits and commemoration as a fitting and appropriate way to begin the Inquiry.
- They felt there was no systematic plan for communicating to families when the Public Inquiry would start, its terms of reference and how families could engage with it.
- Subsequent communication from the Inquiry team was not comprehensive. Examples included little family awareness of the Inquiry team's drop-in sessions and a reliance on messaging through social media and the Inquiry website, which some families simply didn't see.
- There were concerns as to why the first phase of the Inquiry did not appoint a diverse independent decision-making panel at its inception.
- Families were disappointed that they had not been consulted on the proposed venue.
- They felt the venue and facilities at Holborn Bars were not sufficiently family friendly; whether that was comfortable seating, suitable 'break-out' space or the provision of 'little things' like tea, coffee and flowers to make the venue more comfortable.
- Families also said they wanted to be seated centrally so they could "look into the eyes" of those being questioned.
- Those for whom English is a second language require additional support and interpreters with specialist legal understanding as well as the appropriate dialects.
- Not all families are networked with community organisations such as *Grenfell United*, *Justice 4 Grenfell*, *Relative Justice* *Humanity for*

*Grenfell, Grenfell Trust etc.* and remain isolated adding to their trauma.

- There is a shared frustration at the procedures for the Inquiry. There was particular dismay that their questions could not be put directly to witnesses but must go through the Inquiry team. This resulted in a shared suspicion that the process allowed those giving evidence to evade the questions families want answered.
- Families were critical of a perceived lack of candour on the part of authorities and corporate entities when being questioned.
- There was anger that no interim recommendations had been made as at February 2019.
- Whilst some were impatient at the amount of time the process has taken already, most were in favour of a thorough inquiry that held those responsible to account.
- Families benefit from the live streaming, allowing those who are unable to attend to keep up with proceedings.

## **What do families want? Suggestions on good practice**

Having made their observations on what had been, families brought their lived experience to identify a series of suggestions for what good practice could look like in the future. In many cases these involved practical and achievable solutions to some of the problems they had encountered;

- a centralised information hub offering support, advice and pastoral care following a mass fatality;
- trained and experienced key workers;
- a unique case number thus avoiding the emotional toll of having to constantly re-tell their story each time there was contact with the authorities;
- free independent mental health provision;
- specialist independent advice on rights and expert legal representation;

The families' key suggestions regarding the second phase of the Inquiry concentrated on putting families at the heart of the Inquiry process;

- the need for an independent diverse decision-making Inquiry panel;
- meaningful consultation on selecting the venue;
- practical improvements ensuring facilities are family friendly;

- support for families whose first language is not English e.g. skilled interpreters proficient in the specific dialects spoken by individual families;
- re-examination of procedures for questioning witnesses to enable family lawyers to directly ask questions;
- adoption of a duty of candour by public authorities and public entities;

Further suggestions which would have a positive impact on encouraging participation in the Inquiry process include;

- seminars to un-pick technical jargon;
- advance notice of hearings and prompt disclosure of legal papers;
- support for employers enabling families to take time off work without losing annual leave entitlement;

There was recognition of the need for a duty on the Government to implement recommendations made by the Inquiry and systematic monitoring and follow up on implementation.

# Introduction

For almost 40 years, INQUEST has provided free, confidential advice about contentious deaths and their investigation to bereaved people, community groups, lawyers and the voluntary sector. It is independent of government and uniquely placed to advise on the Public Inquiry and inquests following the fire at Grenfell Tower. Since the terrible events in June 2017, which resulted in the loss of 72 lives, INQUEST has been;

- working with bereaved and survivors, assisting them with navigating the complex issues around the Inquiry;
- coordinating meetings with the Grenfell INQUEST Lawyers Group<sup>1</sup> who are representing those bereaved by the disaster;
- meeting with families and monitoring the Inquiry process with a fully funded member of staff dedicated to working on the Grenfell Tower fire;
- undertaking policy, parliamentary, campaigning and media work to try and ensure the legal processes can deliver the truth, effect meaningful cultural change and prevent future deaths.

Following conversations with families, their legal teams and the community support organisations that have evolved since the fire it was agreed that INQUEST could usefully run a Family Consultation Day (FCD), based on its Family Listening Day model,<sup>2</sup> to hear directly from families on a number of key issues. These included; what support and information was made available in the aftermath of the fire, their impressions and thoughts on the first phase of the Public Inquiry, their thoughts on how families become central to the process and recommendations for what good practice could look like in the future.

The event took place at the Kensington Hilton Hotel, London on the 2 February 2019. A full methodology for how families were contacted, the consultation process and the structure of the day is provided in Appendix 1 of this report.

In total 38 bereaved family members were present on the day, from 21 different families, representing 46 individuals who lost their lives.

Families worked in three groups, each facilitated by experienced INQUEST staff, and feedback on the groups' evidence was shared at the end of the day.

This report acts as a record of the consultation day, drawing out the thematic issues that arose in conversation and uses anonymised family quotes to illustrate the evidence and ideas.

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<sup>1</sup> The Grenfell INQUEST Lawyers group are lawyers who represent Grenfell bereaved families in the Public Inquiry. INQUEST coordinates meetings with the Grenfell INQUEST Lawyers group.

<sup>2</sup> <https://www.inquest.org.uk/family-listening-days>



We have a perception that the Government will always look after us, thought there would have been an organised response, but there wasn't.

Families who were unable to attend on the day were encouraged to contribute via interviews and a survey conducted by INQUEST and subsequently the organisation has now heard from families of 55 of the 72 people who died.

## 1. Aftermath of the fire

### 1.1 Provision of information and support

Families identified problems with accessing information and support and suggested these shortcomings were apparent almost as soon as the fire started. Many felt this set the tone for the subsequent interaction with the emergency services, local and national government working with families navigating their way through the unfolding tragedy.

Families said there was a lack of a coordinated emergency response and what one person described as “*figures in authority who could answer questions*”. Families sought news of missing relatives, waiting days, weeks and in some cases months for confirmation of a death.

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*“There was no support in the immediate aftermath. It was absolutely crazy. Three days of wandering around hospitals trying to find some answers. Different hospitals wouldn't let us in”.*

*“We were told to go the Salvation Army and sat there for hours waiting for answers. We were told to go the Westway and were interviewed by a detective. We then heard nothing for two days. It was all such a shambles”.*

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Understandably families expressed anger at central government, the Royal Borough of Kensington Chelsea (RBKC) and the Tenant Management Organisation (TMO), as lacking strategic oversight and control.

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*“When it happened, the Royal Borough of Kensington and Chelsea and the Government were around but not in force. They didn't understand the scale of it. We have a perception that the Government will always look after us, thought there would have been an organised response, but there wasn't. It was chaotic and people didn't know where to go”.*

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Families were left to fend for themselves and many recounted the terrible events as they tried to locate and identify relatives, sort out temporary accommodation and support extended family;

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*“I spoke to other residents and did a lot of research about what help was available. I was told to go to the Westway Centre. I went there and was turned away. I wasn't given any help in terms of accommodation or a keyworker. This is while I was looking for my family in various hospitals and asking the police for help in finding them. After a week and a half, I got the news confirmed to me that none of my family had survived”.*

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There seems to have been serious inequality in the aftermath. The loudest were heard and the quietest were ignored.

Families were perplexed that no up-to-date register was available from RBKC or the TMO to help determine who was resident in Grenfell Tower which duly impacted on the efforts of the emergency services to establish how many people they were looking for;

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*“There was no central register of who was safe, who was in which hospital. The next of kin should have been told”.*

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In the absence of a coordinated state response, the need for self-reliance and mutual support became a recurring theme in conversations with families;

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*“We were running around hospitals for days. It was only through running into people [other families] in hospitals that we were giving each other information. It was catastrophic to say the least. It was not the way family should have been treated in those circumstances”.*

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It was also noted that the failure to provide consistent, coordinated support resulted in inequalities of provision with one family suggesting,

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*“There seems to have been serious inequality in the aftermath. The loudest were heard and the quietest were ignored”.*

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## 1.2 Emergency helpline

The helpline set up by emergency services was seen as ineffective and in some cases families felt it exacerbated their anxiety and distress. Families complained of limited contact, confused messaging and a lack of professionalism and humanity from those responding to calls.

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*“We got to the tower and were given an emergency response number to find out where our family members were. When we rang we heard a bored voice telling us to leave a message. We gave the DOB and the flat details of the family but got no response to our request for information. Then we tried again, it was the same voice, left another message and eventually 24 hours later we got a response”.*

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Another family member went further, suggesting;

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*“There was a 0800 number, we rang and left a message and someone got back to us 3 days later. The initial response was disastrous. The Government response was a disaster”.*

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The lack of a coordinated advice strategy meant families were often asked to repeat information that had already been provided to other switchboard staff. The need to continually revisit and retell traumatic experiences proved extremely distressing. One family member observed

that the helpline appeared more interested in gathering information than providing it;

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*“The helpline numbers, they are one of the biggest bones of contention for my family. They only took information. They didn’t give any advice and asked for the same details time after time”.*

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### **1.3 Family Liaison Officers, key workers and counselling**

There were some examples of good practice; skilled, empathetic Family Liaison Officers (FLO) employed by the Police and key workers from RBKC providing advice, care and support to families. Families also commended Hestia, Cruse Bereavement Care and the NHS for their counselling support. However, many more families were frustrated and angry with the quality of ‘specialist’ support provided by the police and local government.

**1.3.1** FLOs were deemed a “mixed bag” regarding skills and knowledge; there was evidence of inconsistent approaches from those tasked with this crucial role. A number of families highlighted the importance of specialist skills required to work sensitively and empathetically with bereaved people;

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*“Some just didn’t have the skills. The communication with FLOs was poor as well because we were so frustrated. I thought if you’re not going to give me an answer I’m just going to go straight to the source”.*

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Other families described how the relationship with their FLO proved distressing because they simply failed to respond in a timely fashion or with the correct information;

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*“It was four days before we had the FLOs come out. We were told our relatives were on a safe list, we thought they were ok and then we were told they were not accounted for”.*

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In one instance the family found out their FLO had been taken off traffic duty to take up the role.

Where families did have positive experiences they identified training, experience and commitment as key;

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*“My FLO specialised in kidnapping, so she was on the ball. She was clearly qualified for the role”.*

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Another commended the time made available to her and her family;

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*“The FLOs were also with us 16 hours a day, checking to see if the families were ok”.*

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**1.3.2** The response of keyworkers was also viewed as troubling. The failures of RBKC's initial response fostered suspicion about the quality and commitment of the keyworkers provided by the Local Authority. These concerns focussed on inconsistent knowledge of what services were available to families;

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*"All keyworkers should be aware of what services they have to offer. They should have a meeting with all key workers so they know what is available. Some key workers said one thing. Others said another. There is no consistency".*

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Another person identified inconsistent standards of key worker performance;

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*"My sister got a lot of support through her keyworker, I didn't get anything".*

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Accusations of insensitivity were also voiced:

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*"I called my key worker and said I couldn't work, that I work with patients and I am crying all the time. She said, 'I can't do anything at all. You can go to the job centre.' She didn't even try to get me help".*

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Shockingly, one woman described her key worker responding to a query about financial aid by suggesting;

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*"The money we're giving you is coming from our salaries".*

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Families welcomed the opportunity to work with counsellors and acknowledged the importance of early interventions in dealing with trauma. However, the offers of support were patchy, often offered during working hours and this proved a barrier to take up. One family who lived in the North of England were referred to specialist support in their area but felt *"they didn't recognise the impact"* of what had occurred.

There was also concern that continuing support, for the long term, was not guaranteed;

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*"It was very useful during the first phase but it was something the families had to fight for, it wasn't included in the Inquiry team's provision".*

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Families identified the dearth of services on offer for children and young people. One person suggested they had been forgotten in the process;

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*"Children have been totally forgotten, they need support at school psychologically for the long term impact. They should be able to access a child psychiatrist privately to avoid the stigma associated with it".*

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Our response to terrorism has got better so we have to be better for tragedies like this. The Government's response to Grenfell was terrible, it was so slow.

In the end these failings were devastating for families. Trauma and grief left people unwell in their physical and mental health. They struggled to combine family and work life with their efforts to locate relatives, to support friends and family and in some cases the toll resulted in relationship breakdown. Families torn apart by the impact of the fire.

#### 1.4 Community self-reliance and the role of non-government organisations

Many of those who responded to INQUEST suggested the families became their own advocates informing extended family and friends as to what was happening;

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*"We received no guidance, no support at all. It was a few days before someone got in touch with the direct next of kin in our family. We were very much left to our own devices. In those early hours we [families and the community] began to network, building our own support network initially".*

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Families also commended other community and faith centres for their humanity, sensitivity and the speed of their responses in the aftermath of the fire;

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*"We got help from Islamic relief and Red Cross. They offered us shelter and support; they asked if anybody needed help. It was really tough for us as it was Ramadan and it was really hot".*

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Another added;

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*"The community centres and faith centres stand out as being helpful. If they weren't around, I don't know what would have happened".*

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In the days that followed it was community groups, for example *Grenfell United* amongst others that began to mobilise support; communicating essential advice and information (especially via social media with family WhatsApp groups proving invaluable in creating a bank of knowledge and help for families in need). Aid organisations and NGOs such as the Red Cross, Muslim Aid and INQUEST were also commended for their action following the fire, both in terms of offering immediate care and then specialist advice.

Ultimately families were angry and felt abandoned by the nature and pace of the emergency response organised by national and local government. They questioned why the state failed to respond in the same manner as it has to other national emergencies;

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*"Our response to terrorism has got better so we have to be better for tragedies like this. The Government's response to Grenfell was terrible, it was so slow".*

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## 1.5 Understanding rights, accessing legal representation and the legal process

Families highlighted the utter confusion surrounding their legal rights in the aftermath of the fire. At a time when families were experiencing multiple needs, there was no timely, independent source of advice from the state to help them negotiate complex matters such as reporting a missing person, determining who had responsibility for their relatives' bodies or funeral arrangements. Families were simply unaware of their rights in these matters and how expert legal advice could benefit them.

To address the absence of information INQUEST were requested to produce a leaflet by a number of community organisations (this was made available in 21 languages) describing what families could expect and the importance of expert legal advice. Families who saw the leaflet commented on its effectiveness, but others had not seen it. In the absence of state provision families relied on other sources for support; North Kensington Law Centre, the Kensington Citizen's Advice Bureau and the Victim Support Unit were all mentioned.

**1.5.1** Understandably families focused on fulfilling primary concerns before considering their legal rights;

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*“Our first concern was for our family members because we wanted to bury them. We weren't looking for information about our rights, about solicitors or the Inquiry that only comes after we buried them. Then we started to think that we need a solicitor and started looking for help”.*

*“There was an initial meeting in the community centre nearby where some lawyers came along to explain how they could help. I don't think a lot of us were in that frame of mind to take that information in. It was almost too soon”.*

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However, there was no structured approach to inform families of what their legal rights were. This resulted in an information void, causing confusion and anxiety. A coordinated approach to the provision of specialist advice should have been in place, sharing information and supporting families' needs.

In the months following the fire, inquests into all deaths were opened and adjourned by Dr Fiona Wilcox, the senior coroner for Inner West London, pending the outcome of the inquiry. One person explained that they had not been aware that an inquest into their loved one's death had been opened and had no interaction with the coroner. However, those that were aware of the inquests were fulsome in their praise for the coroner. She was complimented for her efficiency and empathy in the immediate aftermath of the fire. Significantly, families described her personal approach which was in contrast to other “officials” they had encountered.

One person explained;

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*“The coroner was also great, she kept the bodies together and that meant a lot to us. We could tell she was personally affected by what had happened”.*

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Others agreed;

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*“Dr Fiona Wilcox made it easier, she really personalised it. She became part of the family in the way she delivered what she had to deliver, she made it seem as if she felt your pain. She didn’t have to do that”.*

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**1.5.2** There were concerns raised about the involvement of lawyers at the outset who may not have had the required experience and skills to properly represent bereaved people following a mass fatality. How were families supposed to know who could best represent them and their interests? Selecting an appropriate lawyer should have been based on specialist knowledge but too often it was left to speculative decision making;

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*“Within this time, lawyers were just there. They were there from the beginning. I remember once in a meeting near the tower, there were six or seven law firms asking if we had solicitors. After some time we were just looking around and asking for recommendations for solicitors”.*

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Another person identified a solution to the problem of lawyers approaching families without the required skills or experience to take on such complex cases;

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*“Can they have an organisation to look after families in terms of helping them choose lawyers”?*

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Key support staff seemed either unaware or unsure about how to access, or the value of, specialist legal representation;

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*“The key workers were telling me I had no rights because I don’t live here. It led to my ill health. I went through two months of pain until I got a solicitor. When I had a solicitor, I felt like I had a backbone, someone guiding me and giving me information”.*

*“I didn’t know about lawyers till around eight months after. I heard about getting legal representation from other families”.*

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Other organisations filled the void and families spoke enthusiastically of the support they got;

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*“We were questioning the information they were giving so they cut off contact with us. We went to the North Kensington Law Centre. We knew about the law centre previously so that’s why we went there”.*

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People have fears about accessing legal advice; a lot of people cannot afford a lawyer. So it was a relief to know that our lawyer would be paid for and that we had people to fight our corner.

Another added;

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*“The Victim Support Unit was very good. They suggested a lawyer who we took on and who proved to be good in supporting us. But if the Unit hadn’t been there, we’d be totally lost”.*

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Families also complimented INQUEST on “*providing good advice and information*”, noting the quality and clarity of its family centred approach “*You are doing what families are asking of you*”.

**1.5.3** Specialist legal advice and representation proved fundamental to active participation in the first phase of the Inquiry. For those families who were fortunate enough to secure representation early in the process the benefits were tangible;

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*“I had to apply for core participation status twice; I never got a response to my first application. My solicitors did the second application”.*

*“Once we got with a good firm we did get the information. They would tell us about meetings and would go on our behalf if we couldn’t go. It felt like we could actually trust someone to know what was happening. We didn’t have any idea before”.*

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For others, ensuring core participation was more down to fortune;

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*“We weren’t informed [about core participant status/application]. That’s when I went to the families’ WhatsApp group and asked who would people recommend? We nearly missed the deadline for making the core participant application”.*

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Information sharing should have been coordinated more effectively. Families said they had initial concerns regarding the costs of legal representation at the Inquiry;

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*“We didn’t know who was paying for the solicitor. We didn’t have the money to pay. We thought we weren’t going to have solicitor. This should have been explained to us from the start. It would have made a difference if we had known”.*

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On a positive note, families were granted automatic, non-means tested funding to meet the costs of legal representation at the Inquiry;

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*“People have fears about accessing legal advice; a lot of people cannot afford a lawyer. So it was a relief to know that our lawyer would be paid for and that we had people to fight our corner”.*

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**1.5.4** Understandably families expressed some trepidation about the inquest function which is to be heard as part of the Inquiry, to look at the last movements of those who died, the location and cause of death. Their concerns centered around timely advance disclosure of the evidence that



Families were clear that during the inquest function of the Inquiry they wanted their lawyers to have responsibility for representing them and as such be tasked with questioning witnesses and experts.

would be heard, suggesting this was vital before the inquest happened citing examples from the first phase of the Inquiry as problematic;

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*“Disclosure requests from families’ lawyers were all being turned down. Inquiry team were doing what they wanted. If we’re going to have an inquest like that where they deny us information, then you’re not going to have a proper inquest. It’s very important for bereaved to have more of a role. We don’t want to have to fight to get the evidence to find out exactly what happened. They shouldn’t be able to hold back on crucial information that would be important to the family”.*

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Another contributor agreed on the importance of advance disclosure;

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*“We should not have to fight to get access to the evidence”.*

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Families also felt they should be consulted about the release of sensitive material which will form part of the inquest function;

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*“Any recordings or sensitive material should be discussed with the bereaved and there should be a choice. There should be a consultation with each family and it should come down to family choice”.*

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Another person agreed, suggesting the process needed to be conducted with dignity and respect the families’ wishes;

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*“There has to be some dignity where they respect the family. There were some things families want to keep personal. It’s a culture thing as well. It can be painful to live this again and for other people to know and talk about it. 999 recordings are an example, it’s in the public domain but to play it is very personal. Bereaved should have a say”.*

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Families were also clear that during the inquest function of the Inquiry they wanted their lawyers to have responsibility for representing them and as such be tasked with questioning witnesses and experts.

Additionally, suitable support and consideration for families’ needs has to be acknowledged if the inquest function is to have a meaningful outcome for those bereaved by the fire. Examples included provision of mental health support, in the appropriate languages for participants and recognition of care responsibilities experienced by some;

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*“The inquest hearings shouldn’t be held during school holidays when we can’t attend”.*

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## 2. The Public Inquiry

### 2.1 Initial information and trust in the process

There appeared to be no systematic approach to contacting families about the initial phase of the Public Inquiry. Families who were part of community support groups, or who had met with the Inquiry team or were legally represented were informed quickly and felt more engaged. However, many of the families were not networked to the same extent and relied on word of mouth, the media and in one case, from posters in the local area. This chimes with the lack of coordinated communication that characterised the immediate aftermath of the fire.

**2.1.1** The lack of coordinated messaging meant the initial news about the Inquiry was randomly received. One family heard about the announcement at;

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*“A meeting at the church, it was word of mouth mostly”.*

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Another said;

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*“Posters were put up randomly around the area. That is how we found out”.*

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Others were reliant on information provided by groups such as *Grenfell United* and *Justice 4 Grenfell*. Some were made aware by monitoring social media, but there was evidence that some families were simply not aware the Inquiry had been convened. This has proven to be an-ongoing issue, suggesting a lack of reflection on the team’s communication strategy. An example being a lack of awareness for the families’;

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*“That the Inquiry team are holding drop in sessions in the community”.*

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**2.1.2** If informing families of the first phase of the Inquiry was considered inadequate there were also concerns that the terms of reference were agreed without broad based consultation and support:

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*“In relation to the terms of reference, there was not enough research done, they didn’t consult enough with the community or engage enough”.*

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Another family had attended a meeting with the Inquiry team but felt families’ opinions were closed down;

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*“I felt that we were talked at. They did take some questions but I felt they only took questions they wanted. Other people raising valid points were moved on quickly”.*

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There needs to be full participation of victims that is the key to recovery, if there ever will be a recovery. Pushing back victims is delaying and stopping that recovery.

Families were clear that if open consultation had taken place, their preference for an independent diverse decision-making panel, rather than an individual chair, was the best way to encourage participation, trust and ensure the process reflected the diversity of the affected community

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*“I think a panel can bring more diversity and empathy”.*

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Others highlighted the conflict of interest that lies at the heart of the process;

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*“We can’t have confidence in a one-person chair [from the establishment] making a single judgement on Grenfell and our experiences. When the state has a hand in the death, then the state has a duty to address the lack of trust and confidence in the process. The state has a duty to answer that”.*

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Inevitably this has led families to express a concern that their experiences and views are not properly reflected, leaving them suspicious of the Inquiry process itself, regarding it as self-serving and designed to obfuscate rather than identify and hold those responsible to account;

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*“I was very wary about it and I had heard someone say about how inquiries were set up by the Government of the day to save themselves. It takes the pressure off them straight away”.*

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Another person agreed;

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*“It’s not a public inquiry; it’s a lawyer’s inquiry”*

*“The Inquiry is not for the people. A lot of people are angry”.*

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It was argued that without trust, families would be less likely to take part and that would inevitably impact on their perception of whether justice had been served:

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*“Participation in a meaningful way is what would give the Inquiry credibility. Justice must be seen to be done”.*

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Another person felt engagement was crucial to how the community could begin to heal following the fire;

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*“There needs to be full participation of victims that is the key to recovery, if there ever will be a recovery. Pushing back victims is delaying and stopping that recovery”.*

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The pen portraits were so important – our loved ones were not just numbers, they represented a life, a family. The commemoration was really important to honour the loved ones.

## 2.2 Pen portraits and commemoration hearings

Families appreciated the pen portrait and commemorations and highlighted the importance of recognising relatives and humanising a legal process that some described as feeling “cold” and “impersonal”. Families were in broad agreement that the pen portraits also had a positive impact for the Inquiry team and the legal community.

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*“It was effective because a lot of the people that needed to listen were there. Not just lawyers for the family and families themselves but lawyers for RBKC and others. They need to know who these people are”.*

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*“The pen portraits were so important – our loved ones were not just numbers, they represented a life, a family. The commemoration was really important to honour the loved ones”.*

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Another person agreed;

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*“The pen portrait for my family was the only way her mother was able to say her last goodbye to her daughter and show the world how beautiful she was. It was cathartic to an extent; a way of healing. [The commemoration hearings] were a way of the world knowing how beautiful these individuals were.”*

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Others mentioned the importance of acknowledging the value of community cohesion and hearing the individual commemorations cemented a sense of shared loss and grief;

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*“For me, we’re all in this together. I’ve met beautiful people through this. For me, it was an honour to understand who everyone was. The fact that my niece was a child and I know there were a lot of children who passed. She was amongst people who looked after her. That’s a bond that will never go away. That’s why it’s important that we stick with this all the way through”.*

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*“As difficult as it was to watch, I grew up in Grenfell Tower and it was nice to see other families who I’d known there. I knew their relatives who had died. Overall, I thought it was good that it happened even though I had my reservations about it before”.*

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There were isolated complaints about the way the Inquiry team had handled the pen portraits however, with some complaining that they had been restricted in what they could say;

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*“They refused us to say what we wanted to say. They edited us. They cut a lot out. How we wanted to say it as well. If this is about your family, you need to be able to say what you want to say. People need to know. Our right was taken away”.*

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I only had horrible memories of that building and months later we're going in for the Inquiry.

Ultimately though the vast majority of families agreed that the pen portraits were a fitting way to begin the Inquiry process;

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*"It was cathartic to an extent; a way of healing. The commemoration hearings were a way of the world knowing how beautiful these individuals were".*

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## 2.3 Venue and facilities

The vast majority of families INQUEST heard from expressed some disquiet and anger at the choice of venue for the first phase of the Inquiry, and were disappointed that no consultation was undertaken to determine what families wanted from a venue. However, for some families it was a relief that the venue was not in West London;

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*"I wouldn't like it near the tower, I haven't been back since it happened, and I don't think I could".*

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Another person suggested:

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*"The central London location is good as it's good for relatives who come from a far. Good links to central London".*

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However, for some wanting a central London venue, the choice of Holborn Bars was a misjudgement. It triggered traumatic memories of its previous function as the Family and Friends Assistance Centre in which families met with the coroner to be told their loved ones had died in the fire.

A family member explained;

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*"It makes me really angry because the first official meeting we had was at Holborn Bars. It was where we heard some very tough messaging. To then have the Inquiry held in the same place where there were people who were responsible for my niece's death was very tough".*

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They went on say;

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*"I only had horrible memories of that building and months later we're going in for the Inquiry. I feel it's heavily loaded towards the authorities, the corporates. It just felt really wrong".*

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For one person the lack of consultation on the venue highlighted the need for the family voice to be central to the Inquiry decision making;

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*"It's very disempowering whereas the feel of the other hotel [where the commemoration hearings were heard] was different. We felt we were more in control of the process at the hotel".*

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There were also practical failings with the venue with families describing the need for more parking spaces for those people who travelled by car, a lack of refreshments, insufficient rooms where families could consult privately with their lawyers and cultural insensitivity for people of faith who required a space for prayer and contemplation;

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*“In the prayer room, the sheets were dirty, and signal to prayer was in the wrong direction”.*

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These improvements are relatively simple to bring about but would go a long way to achieving a family friendly environment when the second phase of the Inquiry convenes.

**2.3.1** The families that spoke to INQUEST were mostly critical of the space and layout of the room for the Inquiry. They were disappointed by the “feel” of the room, suggesting it was primarily designed for the benefit of lawyers and the Inquiry team rather than for them. Whilst recognising there needed to be a practical element to the geography of the room, families were clear that their needs should be paramount and this included seating arrangements that allowed them to see and be seen by those giving evidence and acknowledging the role of interpreters in communicating what was happening for speakers of other languages.

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*“You walk into the room and it’s very corporate and all the lawyers are there tapping away on their laptops”.*

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Another explained that it was not conducive to participation;

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*“That room makes you feel ill when you’re sat in there all day. You’re cramped and sitting on top of each other when it is full”.*

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Families felt this was unacceptable and described how the hugely distressing evidence they were listening to deserved a family friendly space with room to recover from the emotional impact of the evidence;

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*“For us, we had to listen to 999 calls, the last moments. They told the whole story. Having to go through that again will be traumatising, very difficult. What the Inquiry could do would be to make the venue and layout as comfortable as possible. You want to be at the front to make sure you hear everything but if things get difficult, you want easy exit and somewhere to go to deal with your emotions”.*

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A common complaint centred on the logistics of the room which meant families felt distanced from those giving evidence. Families reiterated their desire to be situated in front of those speaking so they could see their faces as they spoke and believed anyone being questioned should do so while face to face with those bereaved by the fire.

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*“We should be directly in front of the witnesses; they should be looking us in the eye”.*

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**2.3.2** The need for specialist interpreters was paramount for those whose first language is not English. Families described how important the relationship with their interpreter was; specifically around trust in the quality of interpretation to ensure information was correctly relayed.

As such continuity of relationship with skilled professionals was vital;

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*“Continuity of interpreter for me has helped me to access information. At the beginning I had difficulties understanding the interpreter [provided by the Inquiry team] because of difference in dialect. It’s important for me to trust that the interpreter is getting all the information and passing it on to me”.*

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Others identified the difficulties caused by interpreters speaking simultaneously and creating background noise in the Inquiry room.

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*“There is no space for us whenever we go to the Inquiry. They always object when we have an interpreter who might speak loudly. We prefer to go to other room, so we don’t disturb people”.*

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It was suggested that families could use headphones in order to listen to their interpreters.

However, the job of translating complex legal information is a difficult one and some felt the Inquiry lawyers had a responsibility to acknowledge this when speaking;

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*“They [lawyers] have to be more inclusive as there are barriers. For those where English is not a first language, they talk too fast for the interpreter to be able to interpret properly”.*

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Finally, there was a very positive response to the live video stream from the Inquiry which enabled those unable to attend, for both practical and emotional reasons, to keep up with the proceedings;

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*“It’s important the Inquiry is lived screened. Some people can’t cope to be at the Inquiry. You also have to use up half a day. Go on the bus, come back. You can’t just go for an hour. We have families, people to look after, children to look after”.*

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## **2.4 Legal procedures, candour and interim recommendations**

Families drew attention to their frustrations at the limitations of the procedural framework of the Inquiry’s first phase.

**2.4.1** Chief amongst these were concerns as to why their lawyers did not have the power to directly question those giving evidence, instead having to submit questions in advance to counsel to the Inquiry. Many felt this placed them one stage removed from proceedings and felt the five-day time frame for lodging questions limited their ability to digest evidence before framing their follow up.



If our lawyers had the chance to speak, it would have been far better. What are we doing there if we are not allowed to scrutinise?

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*“I think legal representatives should be able to put questions forward rather than passing them on post-it notes. It is about the way in which you deliver the question. I know you have to be factual, but I think there is a way in which it is delivered now that makes it less impactful. I think that impact is missing”.*

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Others agreed, believing the requirement to submit questions five days in advance was restricting their effective participation and in determining the truth;

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*“Our lawyers should be able to ask questions. When you’re sitting there, questions will come up as you go along. It’s also part of the healing process to get answers to your questions, whether Martin Moore Bick [Inquiry chair] wants to ask that question, wants that answer, or not. We want the answer to that question”.*

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Families simply wanted an opportunity to participate as fully as possible and to have the ‘family voice’ heard during the Inquiry;

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*“clearly then it’s the family voice that is being expressed”.*

*“I can speak freely with my legal representative but when my question gets passed to them [the Inquiry team] I don’t feel like I’m being heard”.*

*“If our lawyers had the chance to speak, it would have been far better. What are we doing there if we are not allowed to scrutinise?”*

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**2.4.2** If scrutiny was deemed vital, families were even more vocal in their dissatisfaction with what they saw as a lack of candour on the part of the authorities and corporate entities. It was a consistent complaint arising in each of the facilitated groups with families criticising perceived evasiveness;

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*“We all have lapses in memory. The bereaved and families from our side who went up to give evidence had an extraordinary level of recollection. In comparison the corporate entities had an amnesia fix. The chair should have been stronger to say, you have to try and recall. That’s such a disrespectful approach to those who have been affected”.*

*“It feels like certain people are being let off the hook, not being asked important questions. Now the first phase is finished. We don’t feel satisfied”.*

*“I’m frustrated with the people being questioned constantly saying ‘I don’t recall’ it’s the same as saying no comment”.*

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One person made clear why this was as important to bereaved individuals as well others:

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*“Many still don’t know what happened to their relatives. That isn’t acceptable”.*

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The complexity of legal language was also identified as difficult for families with the technicalities regarded as a hindrance to full engagement and participation;

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*“Some technical issues and legal terms are hard to follow”.*

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Families suggested it was left to them to interpret complex information for circulation amongst the broader community and felt this was the responsibility of both family and Inquiry lawyers;

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*“It is the lawyer’s job to make it understandable for us. We have done that through Grenfell United, but we shouldn’t have to”.*

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One family suggested this may be changing and reiterated the importance of making the Inquiry as accessible as possible;

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*“The lawyers should be providing a summary for layman terms. My law firm have started to do this. We’re not experts. It should be in layman terms as a matter of course. It is in the public interest for us as families to understand”.*

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Others supported the idea of seminars to distil technical information;

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*“I like the idea of having seminars with experts there to explain the technicalities of the process. A lot of the information was hard to understand.”*

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**2.4.3** There was outrage and exasperation that the Inquiry chair, Sir Martin Moore Bick, had yet to publish his interim recommendations as of February 2019, describing it as a “farce”. Families pointed out that central government had made safety commitments in the aftermath of the fire but, 20 months later, little had changed. Families felt interim recommendations would signal a move towards making buildings safer, improve emergency services responses and provide reassurance to families that their relatives’ deaths marked a sea change in housing policy. Instead they are left questioning the effectiveness of an inquiry that is failing to recommend life savings changes as early as possible.

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*“If the chair has put a deadline for experts, why isn’t he using the same mechanism for interim recommendations? I think we should demand a time limit. These are only interim recommendations and they should put it into effect”.*

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The same person explained she had relatives living in the tower opposite Grenfell and;

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*“They are in exactly the same position. I think it’s disgusting. The other thing is around cladding, the Government made a commitment, but nothing has taken place. I don’t know why”.*

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Others agreed, suggesting;

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*“There have to be changes. 100 per cent. Nobody else should have to go through this. I don’t think that the chair should carry on sitting on his laurels; he has the power to make changes. We are coming up to two years in June and nothing has changed”.*

---

Families presented what they believed to be key interim recommendations and felt these needed to be nationally enforceable in order to guarantee the safety of residents in similar tower blocks. They want;

- The ‘stay put’ policy to be abandoned for buildings over 10 storeys high;
- Combustible cladding to be completely banned;
- Every tower block to be inspected by the Fire Brigade to ascertain the need for, and effectiveness of, dry/wet risers;
- First responders to receive improved and effective training, including control room staff;
- At least one aerial ladder to be available in each London borough;
- A duty on the Government to implement interim recommendations (and future final recommendations) made by the Inquiry and a system for monitoring and following up on implementation;

However, for all the frustrations the consensus from the groups was that a thorough and meticulous inquiry would best serve the families and future generations living in tower blocks.

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*“I am pleased with the process. I understand it’s a process and I know I can’t make it go any faster. I would rather have a proper inquiry than a rushed inquiry”.*

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One person suggested families needed to prepare for the long haul. Families had mentioned they did not want this Inquiry to become “another Hillsborough” but had to be prepared and resilient in order to successfully achieve justice and accountability.

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*“I think we need to manage people’s expectations as to how long it is going to take, how long we will have to wait”.*

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Another said;

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*“It’s not about getting the recommendations out quickly. It shouldn’t be rushed. This means too much to us”.*

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The visa issue is hanging over those of us who came here to follow up on the Inquiry. I don’t know when I’ll be told to leave.

### 3. Difficulties faced by families who are non-resident in the UK

Whilst acknowledging the commonality of concerns shared by all those affected by the fire, it became clear that these were significantly amplified for non-UK residents. They identified unacceptable delays in discovering what had happened to their relatives, uncertainty around travel arrangements, visas and securing accommodation when in the UK, the prohibitive costs of participating in the Inquiry and fears that their right to be in the UK would be rescinded before the conclusion of the process. Another recurring issue was the need for skilled interpreters.

For those waiting on information whilst living in another country the delays were harrowing and increased their anxiety and trauma;

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*“I had to come from Egypt. I was totally lost. I didn’t have any support. Due to the language [barrier] I felt totally isolated and in pain. I knew nothing. I started to search online and through Facebook I reached a journalist who was kind enough to link me with someone who could help. This person linked me to a solicitor. This was two months after being totally lost without knowing what to do”.*

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It was also evident that responsibility for updates and news fell to relatives in the UK rather than on the authorities;

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*“Before coming here [the UK] we were in another country it was difficult for us to find information. Our cousin called us, roughly up to four days after it was realised that [our relative] was missing. Then they found out they were in the building and had passed away. It was 20 days after that until the police called us for the first time and told us”.*

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Families also described the additional bureaucratic difficulties they had to navigate to obtain a visa to enter the UK, with immigration processes described as costly, restrictive and uncertain. They felt the normal requirements and costs should have been waived in the circumstances. Others were refused a visa, despite the loss of close relatives, which added to their trauma;

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*“We were told we couldn’t come here [the UK] even to identify the bodies through DNA”.*

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*“I wanted my partner’s mum to come for a short visit to help my son as she was my mum’s best friend. I had to pay for the visa application and the visa was refused”.*

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Those granted entry reported this is limited to a six month stay which has fallen short of the time required to take part in the first phase of the Inquiry. There is growing anxiety about whether or not they will be granted leave for the next stages;

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*“The visa issue is hanging over those of us who came here to follow up on the Inquiry. I don’t know when I’ll be told to leave. I haven’t reached a resolution. I should not need to deal with that. It has been a traumatising thing. I’m thinking all the time will I know when I need to leave beforehand”?*

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Concerns over accommodation exacerbated this anxiety, with some families experiencing financial hardship. One family described the problems faced by a relative after her housing allowance was removed:

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*“She was given accommodation at a hotel, then a flat in Earl’s Court, and they were paying her a weekly allowance. Then they said, ‘we can’t afford to accommodate you, you need to accommodate yourself’. We’ve taken her in [relatives]. They’ve stopped all her money. This has stopped her from getting involved. She doesn’t have other resources”.*

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It is apparent that overseas families are less likely to be linked to supportive community organisations and social media groups. As such they were more likely to be excluded from collective information sharing and experience greater levels of isolation.

Another factor for non-UK residents is the importance of the relationship developed with interpreters. As was noted earlier, this relates in part to having the same interpreter in order to develop trust but also having access to specialists who can speak the required dialect for their client;

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*“Initially she had an interpreter at the Inquiry that was quite good. Later, the Inquiry said she had to use their interpreter. We speak Moroccan Arabic which has a different dialect. She used to call me during the day because she couldn’t understand her interpreter. Then it might be that the next day there might be no interpreter. When this happened, she was just sat there looking at the screen. They can’t give her a translated version of documents because she can’t read. She needs someone to explain things to her. She would have to wait until end of the day for me to summarise the information”.*

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The families INQUEST heard from were clear that they required certainty regarding their visa status and to be truly able to participate in the Inquiry they must receive the necessary specialist support and resources to facilitate engagement on an equal footing.

## 4. Families' suggestions for establishing good practice

Having made their observations on what had been, families brought their lived experience to identify a series of suggestions for what good practice could look like in the future. In many cases these involved practical and achievable solutions to some of the problems they had encountered. This included emergency responses and the second phase of this Inquiry to ensure family participation and recognition of the family voice at the heart of the process.

### Emergency response

- There should be an organised coordinated response from authorities e.g. central and local government and emergency services providing a central point of support for families to contact e.g. for information about missing relatives, legal rights, pastoral support etc. Families described this as a Central Support Hub;
- Families should be given a unique reference number relating to their relatives so each time they contact the authorities, they can just quote the reference number, without going through re-traumatisation by having to repeat the same distressing information;
- There should be free, independent mental health support available for families at the critical early stages;
- Professionals (e.g. keyworkers, FLO's) dealing with families should receive proper training in the skills required to carry out the role effectively;
- Every family should have a trained, lead key worker, independent of the council, with responsibility to communicate information/developments and ensure families have the resources required following a disaster on this scale.

### Phase two of the Inquiry

- Phase two of the Inquiry should not start until a diverse decision-making panel is in place;
- Families should be engaged in an inclusive consultation exercise to determine a mutually acceptable venue;

- Wherever the second phase convenes, it would be useful to have a family centre near the Inquiry so that information and support can be accessed centrally and throughout the proceedings;
- The Inquiry room needs to be made more comfortable for families attending;
- Better facilities need to be arranged and maintained for families;
- The layout of the room must situate families at the heart of the proceedings rather than as bystanders;
- There needs to be a better way to facilitate those who attend the Inquiry with interpreters;
- Families' lawyers should be able to question witnesses themselves without giving prior notice of questions they want to raise;
- Duty of candour - public officials and corporate entities should be held to a duty of candour and should sign up to the Charter for Families Bereaved through Public Tragedy<sup>3</sup>. (RBKC have signed up to the Charter);
- There needs to be more certainty around dates of hearings with advance notice for families who work/live abroad/have other commitments without unnecessary delay;
- The Government should implement a mechanism through which working family members can participate in the Inquiry process without losing their annual leave or having to take unpaid leave, similar to the jury service mechanism;
- The Inquiry team must review its communication strategy, recognising that some families are not following the Inquiry team on the Inquiry website or social media, and that it is dealing with a diverse group of people;
- Implementation of seminars to help unpick and understand the technical evidence.

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<sup>3</sup> Bishop James Jones proposed a 'Charter for Families Bereaved through Public Tragedy' in his report into the experiences of the Hillsborough Families (2017). This charter would require public bodies to place public interest over their own reputations and avoid seeking to defend the indefensible.

## Appendix 1 – Methodology

All lawyers representing bereaved families were consulted by INQUEST and subsequently received invitations for their clients to attend the Family Consultation (December 2018 and again in January 2019).

INQUEST spoke to *Grenfell United* about the FCD and they informed their members. The invitation to attend was placed on the bereaved families WhatsApp group and other community WhatsApp groups.

INQUEST spoke to bereaved families that are in direct contact with the organisation.

The Victim Support Service and Family and Friends Assistance Centre were made aware of the FCD and asked to pass details onto bereaved families.

In January 2019, INQUEST met with the Grenfell INQUEST Lawyers Group to discuss the content of the FCD.

In total 38 bereaved family members attended the consultation on 2 February 2019, from 21 different families and representing 46 individuals who lost their lives<sup>4</sup>.

Careful thought and consideration was given to the areas that should be covered with bereaved families. It was decided that the focus should be on the events surrounding the immediate aftermath of the fire, the first phase of the Inquiry process, what lessons could be learned and what could be improved.

To make the conversations manageable the families worked in smaller, facilitated groups with sessions in the morning and afternoon and a plenary at the end of the day.

These groups had the following numbers of bereaved family members (only counting those bereaved and not friends, interpreters etc.).

Group 1 - 12 family members; Group 2 - 12 family members; Group 3 - 14 family members.

Families were provided with refreshments throughout the day and enjoyed lunch as a group.

The well-being of those attending was of primary concern and so the NHS and Hestia were invited to attend to provide support if needed. The NHS Grenfell Outreach Team [Central and North West London NHS Foundation Trust] attended the day.

Prior to the FCD, INQUEST met with two families to record their responses. Following the FCD, INQUEST met with three further families and spoke with one family over the phone.

An online questionnaire, conducted using Survey Monkey, received three responses. Details of this were sent to all who attended the FCD and lawyers and directly to some of those who didn't attend.

Based on the FCD and other means of obtaining feedback, INQUEST has received responses from families of 55 out of the 72 that died.

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<sup>4</sup> A total of 72 people died as a result of the fire

## In memory of the 72 people who lost their lives in Grenfell Tower

Anthony Disson  
Bassem Choukair  
Nadia Choucair  
Mierna Choucair  
Fatima Choucair  
Zainab Choucair  
Hashim Kedir  
Nura Jemal  
Yahya Hashim  
Firdaws Hashim  
Yaqub Hashim  
Sirria Choucair  
Logan Gomes  
Abdulaziz El-Wahabi  
Faouzia El-Wahabi  
Yasin El-Wahabi  
Nur Huda El-Wahabi  
Mehdi El-Wahabi

Gary Maunders  
Berkti Haftom  
Biruk Haftom  
Hamid Kani  
Isaac Paulos  
Fatemeh Afrasiabi  
Sakineh Afrasiabi  
Vincent Chiejina  
Khadija Khalloufi  
Kamru Miah  
Rabeya Begum  
Mohammed Hamid  
Mohammed Hanif  
Husna Begum  
Joseph Daniels  
Sheila  
Steve Power  
Zainab Deen

Ligaya Moore  
Jessica Urbano Ramirez  
Omar Belkadi  
Farah Hamdan  
Malak Belkadi  
Leena Belkadi  
Mary Mendy  
Khadija Saye  
Victoria King  
Alexandra Atala  
Mohamednur Tuccu  
Amalahmedin Tuccu  
Amaya Tuccu  
Amna Mahmud Idris  
Maria 'Pily' del Pilar Burton  
Marjorie Vital  
Ernie Vital  
Debbie Lamprell

Jeremiah Deen  
Mohammad al-Haj Ali  
Denis Murphy  
Ali Yawar Jafari  
Abdeslam Sebbar  
Fathia Ahmed Elsanosi  
Abufars Mohamed Ibrahim  
Isra Ibrahim  
Mohamed Amied "Saber" Neda  
Hesham Rahman  
Rania Ibrahim  
Hania Hassan  
Fethia Hassan  
Marco Gottardi  
Gloria Trevisan  
Raymond "Moses" Bernard  
Eslah Elgwahry  
Mariem Elgwahry



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