Thursday, 7 June 2018
(10.00 am)
SIR MARTIN MOORE-BICK: Good morning and welcome to today's hearing.
We are going to begin with an opening statement on behalf of the Fire Brigades Union from Mr Seaward.
Opening statement on behalf of the Fire Brigades Union
by MR SEAWARD
MR SEAWARD: Thank you, sir, may it please you and your assessors.
I may go slightly over my allotted time, sir. I have been given 20 minutes, and can I ask now for some leeway later. I've checked with both Louis Browne QC and Stephen Walsh QC and they are going to take no longer than their allotted times, and possibly a little less.
SIR MARTIN MOORE-BICK: You're going to hold them to that, are you?
MR SEAWARD: Sir, I think overall, we should be okay, yes.
SIR MARTIN MOORE-BICK: All right. We'll see how we get on, shall we?
MR SEAWARD: Thank you.
I act for the Fire Brigades Union, who represent most of the men and women who were on duty as firefighters and control staff that night, and who

confronted a situation which was unprecedented in living memory in the UK fire service. The fire spread up the east face with shocking rapidity and ferocity, soon becoming an inferno with terrible loss of life.
We are humbled by the suffering of the deceased and of the bereaved, survivors and residents, whom I refer as to the Grenfell Tower community. Ever since this inquiry has started, the FBU has consistently said that the Grenfell Tower community should be placed at its heart, and that is where they rightly are.
Many of those whom we represent were on that fire ground, some for long periods. They will never forget that night, and some of them remain traumatised.
The fire presented challenges beyond their knowledge, experience, training and procedures. The bravery of firefighters has been acknowledged by those representing the Grenfell Tower community, and the Fire Brigades Union invites you, sir, to consider whether the firefighters were put in an impossible possible.
Those representing the Grenfell Tower community, however, criticise the London Fire Brigade and say that public confidence in the fire and rescue service needs to be restored. We agree with the last part of that; we agree that public confidence in the fire and rescue service is of vital importance. The FBU recognises the

public interest in a successful and productive inquiry.
We have already assisted the police investigating the Grenfell Tower disaster and continue to do so. We want to assist both the Grenfell Tower community, the inquiry and the fire sector nationally, including the fire safety sector, to discover what went wrong and why and to contribute to the making of recommendations to avoid a recurrence.
Building upon the work done by the Grenfell Tower community in their moving commemorations and by those representing them, we are collaborating in piecing together a picture of who was where in Grenfell Tower in the early hours of 14 June.
I want to move on now, sir, if I may, to the state of Grenfell Tower on that night.
I refer to paragraphs 8 to 10 of our written submissions summarising Dr Lane's provisional opinion that the window surrounds, the rainscreen cladding system, the insulation and the incorrectly fitted and missing fire bricks created the means for a catastrophic condition, and that important fire protection measures were deficient, notably the flat entrance doors did not resist the fire for long enough, the single stairwell was too narrow, the lobby ventilation system could only clear smoke from one lobby at a time and, like the

lifts, could not be controlled by firefighters, and there was no wet riser.
The FBU agrees that, following the refurbishments from 2011 to 2016, Grenfell Tower was a highly combustible deathtrap.
As Stephen Hockman has set out in his written opening submissions and as Stephanie Barwise has explained this week, not only was there serial non-compliance with the Building Regulations, but there was no evidence of any sustained attempt at such compliance.
The FBU invites the inquiry to consider whether there was in the recent refurbishments a complete failure of the fire safety regime at each stage of the design, planning, building control, building works and supervision of works.
Furthermore, after the completion of the works, further opportunities to mitigate the fire hazards were missed under both the Housing Act 2004 and the Fire Safety Order 2005. In the result, Grenfell Tower became a highly combustible deathtrap.
Moving on now to weighing the emergency response.
The London Fire Brigade did not create the highly combustible deathtrap. Moreover, there's no evidence that the LFB or the firefighters who responded to what

initially seemed a routine call at 00.54 on the 14th were aware of the state of the building.

As Mr Stein submitted a couple of days ago, any criticisms of the emergency response should be assessed against this background and should not be exploited by those who created the danger. We ask the inquiry to maintain this sense of perspective.

The FBU invites the inquiry to consider to what extent, if at all, the firefighters, including commanders on the fire ground, were aware of the danger of rapid fire spread in the early stages of the fire and at significant stages thereafter, and to weigh the emergency response at each stage in light of such awareness or lack thereof.

In this context, Professor Torero indicates -- this is at his page 61 -- that it was not usual for an external fire to travel laterally once it had reached the top of an external face. In fact, having rapidly reached the top of the east face by about 1.30, the fire raced laterally along the crown to the north face.

Moving on, if I may, now, to firefighters as witnesses.

The FBU supports Danny Friedman's call for courageous accounting and Pete Weatherby's call for candour and frankness. To this end, the FBU standards

shoulder to shoulder with the LFB and the Fire Officers Association to encourage and support those firefighters and control staff who are called as witnesses to give frank, open and complete evidence without fear of recrimination. Their employer and their trade unions are united in supporting them in this way.

Although there has been inevitable delay due to the ongoing police investigations, we have now received about 250 witness statements from firefighters and control staff. Richard Millett indicated on Monday that about 52 of these witnesses will be called to give evidence to the inquiry and about 74 will be read into the record.

We ask the chairman to remember when assessing their evidence that these witnesses have not been allowed to retain a copy of their witness statement, nor to see what other witnesses have said. They have not had the chance to discuss their witness statements with the FBU or its legal team. In that sense, they will come cold to testify at this public inquiry. They are not professional witnesses; they are unfamiliar with the witness box and probably dread going into it.

Additionally, some firefighters may have been affected by metabolic heat stress on the night of the fire without even knowing it. This can impair cognitive

function, including executive decision-making, co-ordination and memory recall.

If needed, we will draw attention to the LFB's policy note on metabolic heat stress and the learning that led to it, together with the recommendation of Senior Coroner Nigel Meadows following the inquest into the death of Stephen Hunt in Manchester.

But despite these difficulties, the firefighters will do their best to assist the inquiry, as they have already assisted the police.

The inquiry is also invited to hold in mind that firefighters work as a team; they follow instructions and they operate within procedures that have been developed over decades of experience in which they are trained, including high-rise firefighting, policy note 633, and compartment firefighting, policy note 793.

The inquiry is asked to consider the extent to which firefighters showed initiative by adapting procedures in the extreme conditions of this disaster, often at personal risk, and sometimes decided to depart from those procedures, thereby knowingly putting themselves and their colleagues in danger to save lives where possible.

Equally importantly, we ask the inquiry to decide the extent to which firefighters, particularly the early

incident commanders, had procedures for and were trained in 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. We submit that, on the evidence so far disclosed, it appears there were no such procedures, nor had firefighters received any such training.

The fire Brigades Union invites 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.

It may also be relevant to ask what equipment, water supplies, fire protection and firefighting measures were available to them to fight the fire on the outside once the fire had broken out of the kitchen window, and likewise to fight the fire internally on multiple levels once it had broken back in again, and later to effect search and rescue operations and assist in voluntary evacuation and subsequently to evacuate the building.

The FBU invites the inquiry to consider specifically whether, unaware of the multiple failures of the fire safety measures that should have been in place to limit

and slow the spread of fire and smoke out of the kitchen of flat 16 to and then on the exterior and back into the building, and through the front entrance doors, into the lobbies and then to the single narrow stairway, the firefighters were always chasing a sinister fire they had no realistic chance of extinguishing.

Were they placed in an impossible position from top to bottom, with impossible decisions being asked of commanders and impossible tasks being undertaken by firefighters doing their best to apply the equipment, training and procedures which were available to them?

In this context, the inquiry might be assisted by Dr Lane's provisional view:

"I do not consider it to have been feasible, without prior warning, to implement effective external firefighting to level 4 in the very early stages of the fire."

That's paragraph 2.19.8.

Communications.

The evidence is likely to raise questions about the communication systems available to the firefighters to communicate with one another and with control, particularly at large-scale incidents. This is another area which the inquiry is asked to consider, both as to the problems encountered on the fire ground and

recommendations going forward, to ensure workable and reliable communications are available at future large-scale incidents, and any amendments to procedures and increased training that may be needed to include realistic training. The inquiry may need further expert advice to assist them on this issue, possibly drawing on military experience in this field.

Moving on to control staff.

The inquiry may conclude that they also confronted an impossible and unprecedented situation for which their experience, procedures or training were inadequate. Many of them will be haunted by their memories of that night. The inquiry will doubtless ask: when were control staff aware the fire had spread from the fourth floor fire flat, up the exterior and back in again? What did they know of the fire as it developed? Were they overwhelmed with fire survival guidance calls? Until they were asked to advise occupants to "Get out if you can" at about 2.47, what other advice could they have properly given, apart from "Stay put unless your flat is affected by heat, fire or smoke, in which case leave"? That's why we prefer to call it "stay put unless" It's not a rigid "stay put"; it's "stay put unless your flat is affected".

As with the work of the firefighters on the fire

ground, the inquiry is asked to weigh the advice which the control operators gave in light of their procedures and training, the long-standing successful use of "stay put unless", coupled with fire survival guidance, and to bear in mind the difference between what can be seen with the benefit of hindsight and what was possible on the night when they were flooded with calls of the most distressing nature.

Moving on now to not moving to an evacuation strategy.

The FBU notes the opinion of Dr Lane that the primary consequence of the rainscreen cladding fire starting at level 4 and spreading seven storeys within seven minutes and 19 storeys within 12 minutes was that it rendered the stay-put strategy unfit for purpose before 1.26.

Bearing in mind, however, both the difficulties and dangers of devising and implementing a phased or simultaneous evacuation plan on the fire ground on the one hand, and the continuous attempts to firefight, to undertake targeted search and rescues and to assist with evacuations in the meantime, the FBU reserves its position as to the precise time when the "stay put unless" strategy either could or should, even with the benefit of hindsight, have been discarded in preference

for an evacuation strategy on the night.

It's clear there is a huge concern over the continued application of "stay put unless" once compartmentation had been breached, but there remains no obvious and safe alternative strategy -- certainly no detailed plan or training for one.

The FBU invites the inquiry to consider what alternative strategy might have been implemented and whether, on the night and without any such procedure or training, the early incident commanders could or could not reasonably have moved to an immediate or phased evacuation at an early stage of the fire development.

The responsible person under the Fire Safety Order -- that's the Royal Borough of Kensington and Chelsea -- was required to have an evacuation plan, which was described by Mr Stokes in his fire risk assessment of June 2016 as a "stay put unless"; ie limited evacuation of persons affected by fire which is otherwise contained within one compartment.

Mr Stokes further recorded the possible need for a general evacuation which would be arranged by the LFB or TMO employees. The inquiry should investigate: was this assessment communicated to the LFB or TMO employees? What did Mr Stokes base it upon? What arrangements, if any, were made in case a general

evacuation became appropriate? The FBU has seen no evidence of any arrangements for any such general evacuation and, pending the outcome of the inquiry, it seems there were none.

The FBU asks the inquiry to consider whether there was a lack of planning for the scale of risk so that it should not have been left to firefighters to develop a strategy on the fire ground in the face of a breach of compartmentation.

Should there have been a procedure informed by pre-planning and embedded by training for operational firefighters and control room operators alike to safeguard the lives of those in the building when computation was breached? Why wasn't there?

Is the answer a lack of funding, national leadership and deregulation? The inquiry may need expert help to consider what sort of procedure, pre-planning, training and resources should be in place going forward, both in the short and medium term, to respond to a breach of compartmentation in a high-rise residential building.

Foreseeability.

The tragedy that unfolded was unforeseen by the fire service. The evidence is likely to reveal that experienced firefighters were shocked by the unprecedented and rapid spread of fire and smoke across

and inside the building, thus compromising the lobbies, the lifts and the single means of escape.

The FBU asks the inquiry to consider, however, whether such a disaster in a high-rise residential building was foreseeable, in that it was known from long-standing firefighting experience and from recent incidents (a) that fire is unpredictable; (b) that compartmentation could be breached; and (c) that fire can rapidly spread over the exterior of buildings and be very difficult to extinguish internally.

Recent events in the UK include Garnock Court, Harrow Court, Shirley Towers, Lakanal House, Shepherds Court. There have also been relevant incidents abroad, such as in Dubai and Melbourne. The FBU asks whether, if it was foreseeable, this was a failure at a national level in relation to the fire safety policy and within the national fire and rescue service to devise and embed an effective response in the event of a breach of compartmentation.

If I can now touch on race and class.

The FBU broadly supports the submission of Imran Khan and other representatives of the Grenfell Tower community that race and socio-economic factors may have played a role in the tragedy. The high proportion of black and ethnic minority residents in

Grenfell Tower justifies this factor being investigated, probably in Phase 2. But they are also factors which we would ask the chairman to keep in mind when he weighs the evidence in Phase 1.

However, the FBU strenuously reject the suggestion that firefighters may have been guilty of discrimination. That suggestion is offensive, it is wrong and it is unconstructive. Moreover, there is no evidential basis for it.

Moving on to recommendations.

The inquiry may later consider that, within the fire and rescue service nationally, there's been insufficient research into new building methods such as cladding and the risks associated with them, a loss of specialist skills in the fire safety departments, insufficient inspection, oversight and enforcement and a lack of national leadership, funding and regulation on issues that have arisen out of previous fatalities.

The FBU asks the inquiry to consider whether clear lines of responsibility are needed by legislative reform for taking steps to ensure proper measures are in place for fire safety to cover the structure and exterior of buildings, as well as adequate means of escape in the event of fire, with refuges as necessary, and to include provisions to help firefighters in the event of fire,

such as working lifts, wet risers and pre-planning.

We submit there needs to be increased awareness of fire safety within fire and rescue services and in housing departments. Firefighting is a technical and professional job. Understanding fire safety is an essential part of the job, and training and service in fire safety departments should be increased.

Such recommendations may involve significant investment in fire safety in high-rise residential buildings, in the fire service and in the establishment of national supervisory and advisory bodies. The FBU hopes the inquiry will agree and approve the layered approach described by Dr Lane, including the need for a properly resourced, equipped and trained emergency response service.

So specific recommendations may be needed, both to improve our national fire safety regime for high-rise residential buildings to include pre-planning by responsible persons under the Fire Safety Order, usually the owner, with the development of practised evacuation procedures such as we're all familiar with in offices; and to provide the operational procedures, pre-planning, training and resources which are needed for an effective emergency response that recognises both the risk that compartmentation might be breached and that fire might

spread unpredictably as a consequence.
Operational pre-planning should include obtaining information about the responsible person's evacuation procedure and developing an emergency evacuation procedure in light of that.
Urgently needed recommendations.
Most recommendations will require careful thought and will await the interim or final report. But some may be needed urgently and we fully support Michael Mansfield's call for these to be made urgently as soon as their need becomes clear. The FBU considers that these are matters for expert opinion. For example, a recommendation that the responsible person should provide an accessible fire blanket in all kitchens in a high-rise residential building may be better than having fire extinguishers above a certain level.
To this end, the FBU suggests that the inquiry instructs all its experts to report the need for any urgent recommendations which the chairman could consider making urgently.
In this context, the FBU supports an immediate ban on all but European A1 or UK equivalent class, ie all but non-combustible materials, on the exterior of high-rise residential buildings over 18 metres high. Such an approach has a good track-record. For example,

overrun too much.
Mr Browne, you are going to make a statement on behalf of the Fire Officers Association.

Opening statement on behalf of the Fire Officers Association
by MR BROWNE

MS BROWNE: Good morning, sir. My name is Louis Browne and I am instructed on behalf of the Fire Officers Association, FOA, and on behalf of two individual core participants: Richard Welch and Lee Drawbridge. I'm instructed by Jonathan Wall, Mike Mackey and Daniel Weed of Burton Copeland Solicitors.
Members of the FOA attended the fire at Grenfell Tower and Mr Welch undertook certain command roles during the night.
At the outset, the FOA wish to express their deepest sympathy to all of those who suffered loss in the Grenfell Tower tragedy. The magnitude of the fire at Grenfell Tower and its devastating consequences cannot be overstated.
In addition to the tragic consequences it had for the families, bereaved, survivors and residents, it has had life-changing consequences for many of the firefighters who attended the scene of the fire that night. Those firefighters were and are deeply moved by the tragic loss of life at Grenfell Tower. Those

domestic fires markedly decreased following the introduction of the Furniture and Furnishings (Fire Safety) Regulations 1988, requiring upholstery, components and composites used for furniture in the UK to meet specified ignition resistance levels. These regulations were recommended by a national advisory body for the fire sector known as the Central Fire Brigades Advisory Committee. The CFBAC was abolished by the Fire and Rescue Services Act 2004.
Over the last 15 years, there have been a succession of firefighter fatalities while fighting fire and several of these have been in tower blocks. Regrettably, not all of the lessons from those tragedies have been learned and embedded and we ask the chairman to consider a means of tracking and implementing the recommendations which he will make.
Specifically, the FBU calls for a national body to monitor research developments in and advise the fire sector, including the MHCLG, fire and rescue services, responsible persons under the FSO, fire risk assessors and others. That body should include representatives of the trade unions representing those who work in the fire sector.
Thank you, sir.
SIR MARTIN MOORE-BICK: Thank you very much. You didn't

firefighters were and are deeply affected by the fact that they were unable to do more to save the lives of those who died.
We submit, sir, that after all of the evidence in Phase 1 has been heard, and if you acceded to Mr Khan's submissions, you, sir, will be able to confidently state that issues of race, social class or religion played no part in the decision-making and actions of the firefighters who attended the fire at Grenfell Tower that night. What did motivate their decision-making and actions was the desire to do all they could to save the lives of those who were in the tower.
The scale of the rescue operation can be seen from the following.
The firefighter rescue operation at Grenfell Tower was the largest single operation of its kind in England since World War II. Before the fire, the FOA -- nor, so far as the FOA are aware, the LFB or the FBU -- were ever informed of the combustible nature of the rainscreen cladding installed at Grenfell Tower in the refurbishment works undertaken. Therefore, they were unaware that they would or might need to change their standard pump response for an intended internal high-rise residential fire.
Rather than having to deal with a fire within one

internal compartment, a major fire in the building envelope occurred. This was itself on multiple storeys and across multiple compartments. Further, there were many flashover fires internally in multiple compartments on multiple storeys.

The immense challenge to the firefighters that night can be gleaned by what was said by Dr Lane in her report, paragraph 2.16.2, and I quote:

"The building envelope created an intolerable risk on the night of the fire resulting in extreme harm. It did not adequately resist the spread of fire over the walls having regard to the height, and use of the building. The active and passive fire protection measures within the tower were then required to mitigate an extraordinary event, and as a result, the consequences were catastrophic."

This was a truly extraordinary event. The only way to undertake efforts to suppress the fire and rescue people trapped in the tower was to use a single protected escape stair and through the lobby on each level. The conditions on the stairs and in the lobbies were hugely challenging from a very early stage in the fire by reason of their compromise through smoke, reduced visibility, intense heat and toxicity. These conditions meant that the Fire Brigade bridgehead had to

remain at or below level 3 until about 7.30 am on 14 June.

In the context of a multi-storey fire, the single stair and lobbies did not create, nor were they designed to create, a safe escape route or safe working environment for the firefighters.

Simultaneous evacuation of residents in the event of fire is not factored into the design of buildings such as Grenfell Tower. That is evident from the fact that there is no common fire alarm and the only means of escape was a single stairwell. The stay-put policy is therefore a building design principle and is not a creation of the fire service.

Over the coming weeks, you will hear evidence from firefighters, including those who undertook command roles. When the evidence of those firefighters is heard, we respectfully ask that it be borne very clearly in mind that these men and women were required to take decisions in the unique and exceptional circumstances they faced, often instantaneous decisions, balancing risks. They did not have the time to weigh finely those risks. They were required to exercise professional judgment in the most appalling and rapidly changing circumstances. Accordingly, the inquiry should, we respectfully ask, avoid judging their actions with the

benefit of hindsight.

Can I briefly say something about simultaneous evacuation.

It is of course right that Dr Lane in her report -- paragraph 2.20.3 -- reaches the conclusion that there was a need for a total evacuation of the tower at an early stage. However, she also recognises that, in reaching that conclusion, she had the benefit of all the post-fire data, her analysis of the stairs, lobbies and evacuation flow rates.

In addition, we would respectfully ask the inquiry to note that she had a further real advantage in that she had a very great deal more time to analyse those issues than those taking command decisions on the night, who had only seconds or minutes. This is perhaps why she rightly recognises at paragraph 2.20.3:

"I do not wish to imply that this was an easy decision to make [referring to the total evacuation] during the unfolding and complex events that occurred during the Grenfell Tower fire."

We would also ask the inquiry to bear in mind that any change to stay put is not easily dealt with in the UK. There is no statutory requirement to provide an automatic detection and alarm system in high-rise residential buildings for the purpose for warning all

occupants that an all-building evacuation is required. Further, at Grenfell Tower there was no fire alarm panel provided with controls for the firefighters or others to make an all-out alarm call.

As was recognised by Dr Lane, there were very significant limitations on the ability to communicate. She refers to those in paragraph 2.20.11, subparagraph (d).

Drawing all of this together, sir, always assuming that it was within the authority of incident commanders to direct a simultaneous evacuation that night, the inquiry will hear evidence that such may not have been a truly viable option for the following five reasons:

1. The building was not designed or constructed to facilitate simultaneous evacuations through the provision of fire alarms.

2. The absence of any practicable mechanism by which to effectively communicate with the occupants of the entire building.

3. In the absence of a working firefighter lift, the availability of a single staircase as a fire escape route, and this staircase was the only means by which firefighters, wearing breathing apparatus and carrying equipment, could access the other floors.

4. The rapidly changing conditions in the building

as the fire spread, with the consequent adverse impact that had on rescue operations.

5. These rapidly deteriorating conditions caused an increase in smoke, the development of fire and toxic fumes, and those were the conditions through which the men, women and children in the fire would have to have escaped.

Finally, sir, we would say this: after hearing all relevant evidence from firefighters, the inquiry may well be left in little doubt that these men and women showed extraordinary courage that night, acted selflessly and at great risk to their own lives, and did all they could to save lives.

This is particularly so in circumstances where the very nature of the building, in the condition it was in, positively impeded efforts to save life.

SIR MARTIN MOORE-BICK: Thank you very much.

Now, Mr Walsh, you're going to make a statement on behalf of the London Fire Brigade.

Opening statement on behalf of the London Fire Brigade by MR WALSH

MR WALSH: Yes, sir.

Sir, Stephen Walsh is my name, as you know.

I appear together with Sarah Lefevre for the London Fire Brigade.

Sir, I'm going to say now, having just heard from Mr Browne QC and, of course, from Mr Seaward, that it is likely that I am going to echo -- I am going to try not to repeat unnecessarily -- things that both of those lawyers have said, but I will have to because of the context of the submissions I have to make.

Sir, the devastating fire at Grenfell Tower, which took so many lives and caused such unimaginable suffering to the bereaved, survivors and residents, was by far the most challenging incident which the London Fire Brigade has experienced in living memory; Mr Browne and others have said since the Second World War, in very different circumstances.

But for the firefighters, whose job it was to carry out the firefighting and rescue operation, and the control staff who took calls from residents in the tower, the memory of their experiences and the events which they witnessed will never leave them.

The LFB, the London Fire Brigade, and its staff at all levels express profound empathy with all of those who have been left scarred by this tragedy.

But, of course, that can only extend to empathy in relation to the appalling events of the fire itself. But anyone who attended the Millennium Gloucester Hotel and sat through all of those extraordinary commemorative

hearings will know that it is impossible to comprehend the depth and breadth of suffering of the bereaved. This was obviously -- obviously -- a human tragedy with far-reaching consequences.

But, sir, the London Fire Brigade is not a faceless corporate. It is comprised of human beings -- from novice firefighters, all the way through to the commissioner herself, who was once a novice firefighter -- many of whom experienced the horrors of that night and continue to be profoundly affected by it.

They are drawn from many different backgrounds, reflecting a diversity of which the brigade is extremely proud. I won't repeat but will echo the submissions made on behalf of the Fire Officers Association and the Fire Brigades Union in relation to any suggestion that any form of racism would have in any sense affected the carrying out of their duties on that night. Their collective and individual instinct is and was on the night to protect life and property, often at great risk to their own safety, resulting in physical and mental injury for many.

At the commemorative hearings, the bereaved, in some sense as well on behalf of the survivors and residents, reiterated their desire, their justifiable demand, for answers to many questions. The LFB will provide those

answers, clearly, wherever it can and with full candour.

Sir, this opening statement is intended to assist the inquiry to fulfil its Phase 1 terms of reference and, critically, understand the reasons why the fire spread so rapidly and how the LFB responded. The statement necessarily concerns primary the issues which the brigade understands to be relevant to Phase 1 -- that is to say the factual narrative of the fire itself, including the actions of firefighters, control staff and other LFB personnel -- which will, we hope, assist the inquiry to identify any lessons which will need to be learned, that much we know.

To that end, the brigade has undertaken an extensive disclosure exercise to identify material relevant to the inquiry's terms of reference, and in particular to the specific disclosure requests made of the LFB.

The material disclosed includes a comprehensive range of policies and procedures, training material also for high-rise firefighting, together with a document entitled "Organisational overview", which has been disclosed to the inquiry and I think has been passed on to CPs, which will provide the inquiry and CPs with a synopsis of the primary mechanisms by which the LFB provides fire and rescue services in London with a focus, of course, on high-rise residential buildings.

As to the investigative process to date, it's important to realise that the evidence which has been disclosed to the inquiry, including the many statements from firefighters, has been carried out in conjunction with the ongoing investigation by the Metropolitan Police, Operation Northleigh. It is they who have been responsible for taking the vast majority of statements so that there is one central body of evidence.

I won't repeat but acknowledge what Mr Seaward said about the extent to which firefighters have been able to look at those statements over the last few months. They will be given an opportunity in due course, but they of course are not professional witnesses, as Mr Seaward has made clear.

In the meantime, though, the LFB has deployed substantial resources to provide assistance in many forms, both to Operation Northleigh and to the inquiry. It continues to conduct its own complex analysis of the huge body of evidence which has emerged in an effort to piece together the clearest picture possible of the events of the fire.

That includes an operational response report for the first hour of the fire, which provides a minute-by-minute narrative of the actions of firefighters. It's a complicated document, because it

draws together their statements and cross-refers breathing apparatus telemetry -- much can be learned from that -- CCTV and other media.

This has been and continues to be an enormous and time-consuming undertaking. It has been disclosed to the inquiry, as I've said, and further reports dealing with subsequent hours -- that's the first hour that has been disclosed -- will of course be disclosed as they become available.

As Mr Millett said on Monday, the evidence given during Phase 1 is intended in part to provide a clear understanding of how conditions developed and changed within the building, including the rapidity and extent of those changes, the effects which they had upon the ability of firefighters to carry out their function and the impact which they had on the possibility of escape for residents on different floors at different times. I'll come back to that later.

All of this must be understood before any conclusions can be drawn, together with a clear understanding of the reasons why the fire behaved as it did. That much the inquiry's experts have acknowledged in their interim reports, emphasising, they say, that we are as yet at an early stage and much more evidence needs to be given before firm conclusions can be drawn.

But much of that evidence can only come from firefighters who were deployed into the building through the night and from residents of the building in due course.

Sir, it is our understanding that the purpose of Phase 1 has never been to determine the rights and wrongs of the actions of individual firefighters, including incident commanders and other fire service staff, or to apportion blame, let alone to prejudge them before any evidence has been given and before they have had a chance to explain the complexities of what they were required to do during the fire. And of course, Phase 2 will address all of those issues in detail when the full narrative of the night of the fire has been established in Phase 1.

Well, it is true to say that one has to wait to hear much of the evidence, but certain things are clear from the very beginning. For example, the London Fire Brigade is firm in its view that the Grenfell fire was a singular event. The rapidity with which the fire spread from the flat of origin across the external envelope and within the building itself is already well-documented and will be addressed in detail by the experts to the inquiry. But while the incidence of external fire spread on high-rise buildings is not

entirely unprecedented in the UK, it is extremely rare, and has never, of course, occurred on the scale of the Grenfell fire, as we know.

Similarly, internal fire spread beyond the flat of origin, such as that which occurred at Lakanal House in 2009, is not unknown, but it is also a rare occurrence in the UK. The extent to which and the rapidity with which the fire spread inside Grenfell Tower was also wholly extraordinary.

In case there is any doubt about it -- and there appears to be some doubt about it -- I had better clear it up: the LFB is of course aware that there can be breaches of compartmentation in these types of buildings and the possibility of external fire spread to some extent. The brigade has experience of addressing incidents of this kind. Policies and operational tactics to address them have been applied successfully on many occasions. Those policies and tactics are the result of learning from other fires and the difficulties which were identified in them, and from national guidance. This is a national issue; it's not just about London.

But the LFB believes the scale -- the sheer scale -- of failings at Grenfell Tower and the sheer scale of the fire which resulted from it was a combination of factors

which, taken together, created a unique and, in the UK at least, extraordinary and unprecedented set of challenges for the fire service nationally, as Dr Lane broadly acknowledges in her interim report.

There have been references to other buildings in the UK and around the world which have seen fires break out in external cladding and which have spread, usually -- nearly always -- vertically, straight up. They are, of course, important factors to consider when assessing the collective knowledge of fire services about fire spread on the exterior of buildings, and there are lessons that can be learned from them. We expect the inquiry to examine those issues in some detail, sir.

But it's important to realise, as Mr Weatherby recognised the other day, that those other fires were subject to their own specific facts and circumstances. They were often very different fires, in different buildings with different regulatory regimes. The extent, therefore, to which lessons may be learned from those fires may be affected for those reasons.

For example, in some of the fires there was little or no breach of internal fire safety measures, compartmentation. The fire went up a narrow part of the external envelope, burned away but didn't impinge internally because of the fire measures that were

present within the building.

Some involved external spread of fire only, as I have said, so that most of the building was unaffected. In Grenfell, there was both extensive vertical and lateral fire spread which enveloped the whole building so rapidly.

Sprinkler systems effectively extinguished or slowed internal fire in certain of the fires, and that is a key fire safety factor in high-rise buildings which the LFB has for many years campaigned for, the retrospective fitting of sprinklers in buildings such as Grenfell Tower that when they were built were not provided, of course.

In others of these buildings -- this is key to something I'm going to come back to in a moment -- they were expressly designed for simultaneous evacuation, with phased general fire alarms, tannoy systems, evacuation plans factored into the design of the building, and more than one protected stairway so that firefighting could be conducted while residents are evacuated by a separate, protected route which is sometimes pressurised. And that was the case in the Lacrosse fire in Melbourne, which Mr Weatherby touched upon, where, in addition, the sprinkler system played a significant part in extinguishing the fire.

All of these are factors from which the inquiry can and I know will, sir, learn when it comes to making recommendations in due course.

But those firefighters and other LFB personnel who were engaged in the Grenfell fire had never experienced anything like it. The nature and scale of the fire and the manner in which it developed and spread was exceptional in the long experience and collective knowledge of both the LFB and the fire service nationally.

The detail and precision of the evidence provided by firefighters, and by residents and survivors, will inevitably have to be considered in the context of the harrowing and challenging events which they will be required to recall.

We anticipate -- we know, sir -- that the inquiry will bear in mind that those who were involved in the emergency response will have been wholly unaware of defects in the fabric of the building from a fire safety perspective, and will not have known much of the information as to the state of the building and the conditions within it which have since emerged so as to provide the benefit of hindsight, as Mr Seaward said earlier on, and indeed Mr Browne as well.

That is an important point which Dr Lane also

recognises in her interim report. Decision-makers on the night, she says, will not have had the benefit of much of the information the experts now have.

The extensive fire and rescue policies and procedures which the brigade has established through generations of learning were tested to their limits during the fire, and there are likely to be examples in the evidence of departures from such policies because of the challenging circumstances in which the firefighters and control staff found themselves.

Just something here about the scale of the operation.

The emergency response carried out by the LFB required the deployment of an exceptional quantity of resources in terms of equipment and personnel within a relatively short space of time. For example, I am going to talk about fire survival guidance. That is where a person calls 999 and is spoken to by control staff and they may not be able to get out of the building in which they are in, they may feel otherwise challenged. What the control officers are required to do is give them fire survival guidance.

On the night, the LFB control centre was required to handle more calls requiring fire survival guidance from residents within Grenfell Tower than the total number of

such calls in the previous ten years from the whole of London. That must be understood in the context that individual control officers might take two or three such calls in a 30-year career.

More firefighters in breathing apparatus were deployed into the building than in any other single incident in the collective memory of the LFB, with more than 700 fire service personnel engaged in the emergency response during and after the fire.

Firefighters carried out many rescues of residents within the flats and assisted many others who they encountered elsewhere in the building to make their escape down the stairwell.

So the brigade hopes and knows, sir, that the inquiry will recognise the extraordinary courage and selflessness of the firefighters in facing those challenges, and the commanders.

The women and men who attended to fight the fire and conduct rescue operations were often placed in intolerable positions and were required to make decisions, in some cases, which involved stark choices with serious consequences, whatever they decided to do.

Just a few words now on the design and construction of buildings such as Grenfell Tower and its relevance to fire and rescue operations and the so-called stay-put

policy.

Mr Millett has taken us through the issues and deficiencies which have been identified in the experts' preliminary reports, including the active and passive fire measures which were and were not in place.

Principally, of course, the most important factor is the building design concept of compartmentation. I won't repeat all of that again here, obviously, but it bears repetition that fire safety is a crucial element of the design process, which frequently dictates the way in which fire services are expected to carry out fire and rescue operations.

Buildings such as Grenfell Tower were expressly designed so as to contain any fire in its compartment of origin, of course, for sufficient time to allow the fire service to extinguish it before it has the chance to spread. Accordingly, the building design is not intended -- this is the building design, that's when it was constructed -- to facilitate simultaneous evacuation of the whole building, especially at the same time as firefighting. That's why these buildings often don't have alarms or anything of that kind.

So this principle of compartmentation applies to each flat within the building, to the common corridors if there are any, to the lobbies and to the single

central stairway, which must itself be sufficiently protected from the effects of fire and smoke. And the requirement is that each must be protected from the other.

As we have heard, similar but differently expressed principles in the Building Regulations apply to the external envelope of the building, which is expected to be designed and constructed in such a way as to resist the spread of flame over its surface.

Crucially, though, from a fire safety perspective, the express intention of the current regulatory regime is that, in the event of fire, the occupants of flats within the building are safe -- should be safe -- to remain in place, to stay put, unless they are directly affected by fire or smoke. I say again: that is particularly important given the fact that simultaneous evacuation of the building is not factored into the design.

Now, this -- I am going to call it a so-called stay-put policy, because some call it a stay-put strategy, some call it a stay-put principle, but it is not a creation of fire services in the UK; rather, it is a principle of building design which is provided for in legislation, which fire services are expected to apply and which underpins the development of fire safety and

operational policies for buildings of this kind nationally.

It follows -- it hardly needs to be said, but I will anyway -- that strict adherence to the principle of compartmentation, together with a range of other active and passive fire measures, is obviously critical to the safety of such buildings in the event of fire. And if, during the life of a high-rise residential building, proper compartmentation is not maintained to the required standard, to the extent that the whole building is seriously compromised, the entire basis upon which fire services are expected to conduct fire and rescue operations in such buildings is fundamentally undermined. Very substantial challenges arise in those circumstances, which I'll come to shortly.

I'm going to be well within my time, sir, just in case you are concerned.

But it is important to state very clearly at this point that fire services, when attending fires in premises of this kind, do not interpret the stay-put principle to mean that residents should remain in their flats whatever the circumstances. It's not how it's applied. It's not how it's applied nationally and it wasn't how it was applied by the LFB during the Grenfell fire. Quite the contrary. Part of the advice to

residents who call the fire service control room is that if their flat is affected by fire or smoke, they should leave if it is safe to do so.

This is where we begin to see some of the real dilemmas and problems which fire services face, because the 999 calls and the fire survival guidance calls reveal that many of those who call the LFB control room on the night of the fire said that they could not leave because of the conditions in the lobbies: the smoke, lack of visibility, toxicity. This was so as early as 1.30 am.

Some say, as we know, and because they weren't, said that they were physically unable to do so, to leave their flats, whatever the conditions in the lobbies, and firefighters were deployed to try and effect rescues on multiple occasions in very challenging conditions indeed. But as I say, I'll come back to that towards the end of what I have to say.

At this point it's appropriate, I think it should be said, to note that while catastrophic failure of compartmentation occurred at Grenfell Tower on 14 June last year, in the experience of the LFB -- and I think this is true nationally -- the regulatory provisions concerning the design and construction of buildings such as Grenfell has historically been generally successful

from a fire safety perspective.

So from the information available, there are roughly 5,000 residential buildings in London with an occupied height of over 18 metres, and that means high-rise residential buildings. The LFB attend about 700 primary fires in such buildings a year, and in the five-year period to December 2017, of the 3,500 primary fires in buildings of this kind, 94 per cent were resolved by the initial attendance, the first attendance of the Fire Brigade, a further 2 per cent were resolved by five pumps or less, with only 4 per cent of high-rise residential fires requiring six pumps or more.

But what is now obviously far less clear and what requires urgent consideration by this inquiry is the extent to which maintenance programmes and refurbishments over the years have undermined the integrity of the original design and construction principles of these buildings from a fire safety perspective. This is a vital aspect of the consequences of the Grenfell fire in the LFB's assessment.

The inquiry, therefore -- we try to pose two questions, and it may be helpful to consider the issue in the context of those questions because these are issues that the LFB and fire services nationally must wrestle with.

Is it in the public interest either, or perhaps both: first, to make changes to the regulatory system which address potential non-adherence to fundamental fire safety principles and provides for a mechanism by which proper compliance can be achieved, so that fire services may have greater certainty and confidence in the development of operational policies for responding to and dealing effectively with high-rise residential fires?

Or -- and perhaps it's "and", perhaps it is -- is it in the public interest to require and expect fire services to develop new high-rise and rescue policy and capabilities, and receive funding for the purpose, on the express assumption that buildings have not been maintained in such a way as to comply with the regulatory regime under which they originally were designed and constructed, so as to render them -- a presumption -- inherently unsafe in the event of fire?

When we say inherently unsafe here, we're not talking about the sort of breaches of compartmentation and external spread of flame which fire services are used to dealing with; we're talking about building-wide total failure.

Now, it's accepted that these questions may oversimplify the complex issues which arise, but they do

highlight the stark choice faced by fire and rescue services which it is hoped the inquiry, sir, will address.

In that regard, the London Fire Brigade urges the inquiry to recommend appropriate changes to the regulatory system which provide a greater degree of certainty in respect of the provision of fire safety measures in residential high-rise buildings, including, but not limited to, external cladding, and addressing many of the issues, some of which were touched upon by Mr Mansfield yesterday, including the retrofitting of sprinkler systems, which the LFB has, as I have said, promoted for many years.

Perhaps I should say, insofar as that reflects at least one of the recommendations which Mr Mansfield urged, sir, upon you, the LFB is of the view that that recommendation is one which is capable of fairly early implementation.

For the present, though, the brigade anticipates that the inquiry will wish to consider the extent to which fire services should be expected to mitigate fire events, to adopt Dr Lane's phrase, in high-rise residential buildings under the current regulatory regime which result from substantial non-compliance.

In considering that question, sir, the inquiry is

encouraged to reflect on a number of factors, which I'm just going to set out as briefly as I can, which are likely to emerge from the evidence of firefighters and residents during Phase 1.

First, simultaneous evacuation.

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. That was a point effectively made by Mr Leonard for CS Stokes yesterday. And there are simple reasons for it.

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 simultaneous evacuation was ever a feasible option, or could've been a feasible option, as part of a contingency plan to fire commanders on the scene at Grenfell fire, given -- and there is an element of repetition here, but it really does bear repetition:

(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 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 also the only means by which firefighters, wearing breathing apparatus, carrying firefighting media and other equipment, could access 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.

Secondly, the inquiry is also invited to explore the multiple dilemmas faced by firefighters who were committed to the interior of the building and who faced dangerous and rapidly changing conditions in the flats, common corridors, lobbies and stairwell.

As I've said, the instinct of those firefighters who encountered residents in the common areas and within individual flats will have been to effect rescues wherever possible, often at significant risk to

themselves and to the residents. Many such rescues were carried out from an early stage, until the last person, who was visually impaired and whose safety in his flat was monitored by the LFB throughout the night, was brought out by firefighters at around 8 am.

But there are likely to have been many occasions when firefighters inside the building were required to make difficult and instantaneous decisions about the viability of immediate rescue depending upon the conditions which they faced at the time, the number and the vulnerability of the residents they encountered and the willingness of those residents to leave a place of relative perceived safety.

It is probable that firefighters were faced with difficult choices involving decisions whether to advise residents to remain in relatively clean pockets of air within the building, or to encourage them to venture into hazardous and toxic environments and seek escape down a stairwell in conditions that were constantly changing.

Officers in the London Fire Brigade's control room who handle calls from residents faced similar challenges. Remote from the fire ground, they have no means of carrying out an objective assessment of the conditions immediately outside the flat of a caller that

they have on the line.

The inquiry, sir, will hear that many of those who made calls during the fire felt extremely reluctant to leave their flats and to face the conditions beyond, and, as I've said, some were simply unable to do so.

The appalling dilemma -- I mean, really appalling dilemma -- which control officers face in circumstances such as this is that they cannot know -- cannot know -- when considering whether to advise residents to leave their flats, whether they may be directing them into a dangerous, untenable and potentially lethally toxic conditions.

There are numerous examples in the evidence which the inquiry will hear of rapidly changing conditions within the building by which smoke, toxicity and visibility radically changed within periods of time sometimes measured in seconds: no visibility one moment, clarity the next, no visibility seconds later.

It follows that advice to residents provided by firefighters within the building or by officers positioned remotely in the control centre involved assessments of risk which are not of a straightforward and binary "yes" or "no" nature. In a fire such as that which developed at Grenfell Tower, even from a relatively early point in the fire, advice to

residents whether to stay or leave involved substantial risk either way.

And these are the intolerable dilemmas which will always be faced by fire service personnel if fire services are expected to mitigate fire events in catastrophically failing buildings like Grenfell.

I'm instructed to say, given all of those issues, that the London Fire Commissioner, Dany Cotton, stands four-square behind every firefighter, commander and control officer who was involved on the night of the fire.

So there is a pressing need, sir, to address the question whether it is reasonably practicable in the public interest to expect fire services to develop operational policy on the presumption that buildings such as Grenfell Tower are inherently unsafe because they have not been maintained in accordance with the principles upon which they were originally designed and built.

Turning now fairly briefly to something which cannot be ignored: the safety of firefighters themselves.

Fire and rescue policy and training must cover a complex range of situations which any fire authority may be required to respond to. In London, there is a vast array and quantity of buildings and

installations, all of which have their own specific characteristics and risks. The safety of firefighters must be one of the primary considerations, because the LFB and other fire services around the country hold statutory duties to protect the health and safety of their employees.

Of course, firefighting is an inherently dangerous occupation, which makes it all the more important that the greatest care is taken to ensure that firefighters are not exposed to unacceptable risks of serious injury or even death, and in doing so create yet further casualties.

In the evidence received, sir, by the inquiry, there are likely to be many examples of firefighters acting instinctively to attack the fire and to try to protect and rescue residents with limited regard for their own safety.

It's also likely that incident commanders and other decision-makers in the rapidly developing dynamic circumstances of the incident were repeatedly required to make instantaneous choices which involved balancing the risk to firefighters' safety with that of the occupants of the building. The brigade has thus far found no evidence of any occasions when that balance was not struck in favour of the residents of Grenfell Tower,

despite the appalling challenges and conditions which the LFB personnel were required to face.

Sir, finally -- for the present, at least -- what measures have fire services put in place since the fire to address the safety of residents in buildings with the same or similar cladding to Grenfell Tower?

While the LFB awaits the inquiry's findings and recommendations, it has been in close liaison with the National Fire Chiefs Council, the NFCC, for the purpose of recommending to fire services in the UK interim control measures to mitigate failings in high-rise buildings which exhibit characteristics of a similar nature to those which we now know were present in Grenfell Tower.

The result of that liaison is the publication on 1 May 2018 of a document entitled "Guidance: to support a temporary change to simultaneous evacuation strategy in purpose-built blocks of flats". That's a national document.

And by the way, this is not a London thing. This is not something that's only of concern south of Watford. All of the fire services in the country -- it doesn't matter whether there's a block in Manchester or Glasgow or Cardiff or London or wherever it may be -- they all have the same issues in relation to the stay-put

strategy of building design and how that is to be dealt with.

Anyway, the guidance which the NFCC, with the assistance of the LFB, has produced recommends a process by which certain types of high-rise residential buildings be subject to fresh and immediate fire risk assessments, carried out by suitably qualified, competent persons acting on behalf of building owners or organisations responsible for the buildings. Where appropriate, a policy of immediate and simultaneous evacuation in the event of fire is to be implemented.

The guidance applies to purpose-built residential blocks of flats where a stay-put strategy was part of the original design, but has cladding similar to that found at Grenfell Tower. In addition, the cladding will have failed the large-scale tests commissioned by the government and carried out by the Building Research Establishment, BRE.

The guidance makes it clear that simultaneous evacuation strategies should only be a temporary measure until the risks within the building have been rectified. And given that the majority of high-rise residential buildings in the UK of this age were designed to have a stay-put strategy, under the current regulatory regime it is essential to acknowledge that such an evacuation

cannot be carried out without additional measures put in place by the owners or occupiers of the building. In essence, this is achieved by either establishing a 24-hour waking watch by numbers of suitably trained personnel on every floor whose responsibility it is to effect an immediate evacuation from the building as soon as a fire is reported, and even before the arrival of the Fire Brigade, or the provision of a central alarm system, combined with an evacuation plan, which is communicated to and understood by the residents and put in place by the building owner. Those are the interim measures.

In London, the LFB has also provided, for an interim period, an increase in the predetermined attendance required for such buildings, which increases the number of personnel and fire appliances which will attend a fire in the first instance, and the organisational overview document which I mentioned a few minutes ago provides further details of that.

These are obviously significant measures, which are dependent upon urgent and immediate risk assessments carried out by competent persons on behalf of the building owners. In the absence of a system by which simultaneous evacuation can be carried out quickly and safely, there is no doubt that all fire services face

significant challenges when conducting the type of fire and rescue operation which the LFB faced on the night of the Grenfell fire.

Sir, in conclusion, these are all factors which the brigade urges the inquiry to consider with care when making recommendations for the future safety of high-rise residential buildings in case of fire.

In particular, it is hoped that the inquiry will reflect upon the fact that the regulations which govern the design, construction and maintenance of such buildings are intended not only to ensure that residents are safe in their homes, but also to inform and often dictate how fire services are expected to carry out fire and rescue operations in a way which ensures the safety of firefighters.

The bereaved, survivors and residents of Grenfell Tower must be provided with the clearest understanding of what happened on the night of 14 June 2017, both as to the causes of the fire and the manner in which the firefighting and rescue operation was conducted, which would also, of course, inform fire service learning.

Sir, it is the LFB's continuing intention to use all of the resources at its disposal to support the inquiry through both phases of hearings in the coming months.

SIR MARTIN MOORE-BICK: Thank you very much.

Well, that's probably a convenient point at which to take a break, so we'll stop now and resume at 11.35, please.

Thank you.

(11.20 am)

(A short break)

(11.35 am)

SIR MARTIN MOORE-BICK: Right, welcome back. I am going to invite Mr Millett to make some concluding remarks on behalf of the inquiry.

Concluding remarks by MR MILLETT

MR MILLETT: Thank you, Mr Chairman. I propose to be extremely brief.

Throughout the course of its preparatory work, but particularly during the course of the preparation of the five experts' reports published on Monday, the inquiry has kept under close and regular review the question whether, and if so what, recommendations could and should be made as a matter of urgency.

Our present view is that it may very well be possible to make certain urgent interim recommendations before your Phase 1 report is published, although we doubt whether it would be sensible or possible to do so before the Phase 1 factual and expert evidence is

completed.

There is a broad measure of agreement among core participants, or at least among those core participants who have chosen to address you, for you to make urgent recommendations as soon as possible. No core participant, it appears, has suggested that it is too early to examine that possibility, and we think that it is not too early.

We will, accordingly, continue to give very careful consideration to the possibility of interim recommendations and at a time earlier than publication of the Phase 1 report, and we will keep core participants updated as to that.

That is all I wish to say by way of concluding remarks, Mr Chairman.

We will resume on Monday, 18 June with the expert presentation of Dr Lane, and we will circulate an up-to-date timetable in the next day or so.

So unless I can assist you, Mr Chairman, any further, that is all I propose to say by way of concluding remarks.

SIR MARTIN MOORE-BICK: Thank you very much.

Well, at this stage, then, we will break, as you've heard. There won't be any sitting next week. We shall resume on Monday, 18 June, when we shall hear the first

of the expert presentations, and I look forward to seeing you all, or as many as possible, on that occasion.

Thank you very much.

(11.40 am)

(The hearing adjourned until Monday, 18 June 2018 at 10.00 am)

I N D E X