

<p>1 Thursday, 7 June 2018</p> <p>2 (10.00 am)</p> <p>3 SIR MARTIN MOORE-BICK: Good morning and welcome to today's</p> <p>4 hearing.</p> <p>5 We are going to begin with an opening statement on</p> <p>6 behalf of the Fire Brigades Union from Mr Seaward.</p> <p>7 Opening statement on behalf of the Fire Brigades Union</p> <p>8 by MR SEAWARD</p> <p>9 MR SEAWARD: Thank you, sir, may it please you and your</p> <p>10 assessors.</p> <p>11 I may go slightly over my allotted time, sir.</p> <p>12 I have been given 20 minutes, and can I ask now for some</p> <p>13 leeway later. I've checked with both Louis Browne QC</p> <p>14 and Stephen Walsh QC and they are going to take no</p> <p>15 longer than their allotted times, and possibly a little</p> <p>16 less.</p> <p>17 SIR MARTIN MOORE-BICK: You're going to hold them to that,</p> <p>18 are you?</p> <p>19 MR SEAWARD: Sir, I think overall, we should be okay, yes.</p> <p>20 SIR MARTIN MOORE-BICK: All right. We'll see how we get on,</p> <p>21 shall we?</p> <p>22 MR SEAWARD: Thank you.</p> <p>23 I act for the Fire Brigades Union, who represent</p> <p>24 most of the men and women who were on duty as</p> <p>25 firefighters and control staff that night, and who</p> <p style="text-align: center;">Page 1</p>	<p>1 public interest in a successful and productive inquiry.</p> <p>2 We have already assisted the police investigating</p> <p>3 the Grenfell Tower disaster and continue to do so. We</p> <p>4 want to assist both the Grenfell Tower community, the</p> <p>5 inquiry and the fire sector nationally, including the</p> <p>6 fire safety sector, to discover what went wrong and why</p> <p>7 and to contribute to the making of recommendations to</p> <p>8 avoid a recurrence.</p> <p>9 Building upon the work done by the Grenfell Tower</p> <p>10 community in their moving commemorations and by those</p> <p>11 representing them, we are collaborating in piecing</p> <p>12 together a picture of who was where in Grenfell Tower in</p> <p>13 the early hours of 14 June.</p> <p>14 I want to move on now, sir, if I may, to the state</p> <p>15 of Grenfell Tower on that night.</p> <p>16 I refer to paragraphs 8 to 10 of our written</p> <p>17 submissions summarising Dr Lane's provisional opinion</p> <p>18 that the window surrounds, the rainscreen cladding</p> <p>19 system, the insulation and the incorrectly fitted and</p> <p>20 missing fire bricks created the means for a catastrophic</p> <p>21 condition, and that important fire protection measures</p> <p>22 were deficient, notably the flat entrance doors did not</p> <p>23 resist the fire for long enough, the single stairwell</p> <p>24 was too narrow, the lobby ventilation system could only</p> <p>25 clear smoke from one lobby at a time and, like the</p> <p style="text-align: center;">Page 3</p>
<p>1 confronted a situation which was unprecedented in living</p> <p>2 memory in the UK fire service. The fire spread up the</p> <p>3 east face with shocking rapidity and ferocity, soon</p> <p>4 becoming an inferno with terrible loss of life.</p> <p>5 We are humbled by the suffering of the deceased and</p> <p>6 of the bereaved, survivors and residents, whom I refer</p> <p>7 as to the Grenfell Tower community. Ever since this</p> <p>8 inquiry has started, the FBU has consistently said that</p> <p>9 the Grenfell Tower community should be placed at its</p> <p>10 heart, and that is where they rightly are.</p> <p>11 Many of those whom we represent were on that fire</p> <p>12 ground, some for long periods. They will never forget</p> <p>13 that night, and some of them remain traumatised.</p> <p>14 The fire presented challenges beyond their</p> <p>15 knowledge, experience, training and procedures. The</p> <p>16 bravery of firefighters has been acknowledged by those</p> <p>17 representing the Grenfell Tower community, and the Fire</p> <p>18 Brigades Union invites you, sir, to consider whether the</p> <p>19 firefighters were put in an impossible possible.</p> <p>20 Those representing the Grenfell Tower community,</p> <p>21 however, criticise the London Fire Brigade and say that</p> <p>22 public confidence in the fire and rescue service needs</p> <p>23 to be restored. We agree with the last part of that; we</p> <p>24 agree that public confidence in the fire and rescue</p> <p>25 service is of vital importance. The FBU recognises the</p> <p style="text-align: center;">Page 2</p>	<p>1 lifts, could not be controlled by firefighters, and</p> <p>2 there was no wet riser.</p> <p>3 The FBU agrees that, following the refurbishments</p> <p>4 from 2011 to 2016, Grenfell Tower was a highly</p> <p>5 combustible deathtrap.</p> <p>6 As Stephen Hockman has set out in his written</p> <p>7 opening submissions and as Stephanie Barwise has</p> <p>8 explained this week, not only was there serial</p> <p>9 non-compliance with the Building Regulations, but there</p> <p>10 was no evidence of any sustained attempt at such</p> <p>11 compliance.</p> <p>12 The FBU invites the inquiry to consider whether</p> <p>13 there was in the recent refurbishments a complete</p> <p>14 failure of the fire safety regime at each stage of the</p> <p>15 design, planning, building control, building works and</p> <p>16 supervision of works.</p> <p>17 Furthermore, after the completion of the works,</p> <p>18 further opportunities to mitigate the fire hazards were</p> <p>19 missed under both the Housing Act 2004 and the Fire</p> <p>20 Safety Order 2005. In the result, Grenfell Tower became</p> <p>21 a highly combustible deathtrap.</p> <p>22 Moving on now to weighing the emergency response.</p> <p>23 The London Fire Brigade did not create the highly</p> <p>24 combustible deathtrap. Moreover, there's no evidence</p> <p>25 that the LFB or the firefighters who responded to what</p> <p style="text-align: center;">Page 4</p>

<p>1 initially seemed a routine call at 00.54 on the 14th                  2 were aware of the state of the building.                  3 As Mr Stein submitted a couple of days ago, any                  4 criticisms of the emergency response should be assessed                  5 against this background and should not be exploited by                  6 those who created the danger. We ask the inquiry to                  7 maintain this sense of perspective.                  8 The FBU invites the inquiry to consider to what                  9 extent, if at all, the firefighters, including                  10 commanders on the fire ground, were aware of the danger                  11 of rapid fire spread in the early stages of the fire and                  12 at significant stages thereafter, and to weigh the                  13 emergency response at each stage in light of such                  14 awareness or lack thereof.                  15 In this context, Professor Torero indicates -- this                  16 is at his page 61 -- that it was not usual for an                  17 external fire to travel laterally once it had reached                  18 the top of an external face. In fact, having rapidly                  19 reached the top of the east face by about 1.30, the fire                  20 raced laterally along the crown to the north face.                  21 Moving on, if I may, now, to firefighters as                  22 witnesses.                  23 The FBU supports Danny Friedman's call for                  24 courageous accounting and Pete Weatherby's call for                  25 candour and frankness. To this end, the FBU standards</p> <p style="text-align: center;">Page 5</p>	<p>1 function, including executive decision-making,                  2 co-ordination and memory recall.                  3 If needed, we will draw attention to the LFB's                  4 policy note on metabolic heat stress and the learning                  5 that led to it, together with the recommendation of                  6 Senior Coroner Nigel Meadows following the inquest into                  7 the death of Stephen Hunt in Manchester.                  8 But despite these difficulties, the firefighters                  9 will do their best to assist the inquiry, as they have                  10 already assisted the police.                  11 The inquiry is also invited to hold in mind that                  12 firefighters work as a team; they follow instructions                  13 and they operate within procedures that have been                  14 developed over decades of experience in which they are                  15 trained, including high-rise firefighting, policy                  16 note 633, and compartment firefighting, policy note 793.                  17 The inquiry is asked to consider the extent to which                  18 firefighters showed initiative by adapting procedures in                  19 the extreme conditions of this disaster, often at                  20 personal risk, and sometimes decided to depart from                  21 those procedures, thereby knowingly putting themselves                  22 and their colleagues in danger to save lives where                  23 possible.                  24 Equally importantly, we ask the inquiry to decide                  25 the extent to which firefighters, particularly the early</p> <p style="text-align: center;">Page 7</p>
<p>1 shoulder to shoulder with the LFB and the Fire Officers                  2 Association to encourage and support those firefighters                  3 and control staff who are called as witnesses to give                  4 frank, open and complete evidence without fear of                  5 recrimination. Their employer and their trade unions                  6 are united in supporting them in this way.                  7 Although there has been inevitable delay due to the                  8 ongoing police investigations, we have now received                  9 about 250 witness statements from firefighters and                  10 control staff. Richard Millett indicated on Monday that                  11 about 52 of these witnesses will be called to give                  12 evidence to the inquiry and about 74 will be read into                  13 the record.                  14 We ask the chairman to remember when assessing their                  15 evidence that these witnesses have not been allowed to                  16 retain a copy of their witness statement, nor to see                  17 what other witnesses have said. They have not had the                  18 chance to discuss their witness statements with the FBU                  19 or its legal team. In that sense, they will come cold                  20 to testify at this public inquiry. They are not                  21 professional witnesses; they are unfamiliar with the                  22 witness box and probably dread going into it.                  23 Additionally, some firefighters may have been                  24 affected by metabolic heat stress on the night of the                  25 fire without even knowing it. This can impair cognitive</p> <p style="text-align: center;">Page 6</p>	<p>1 incident commanders, had procedures for and were trained                  2 in fighting cladding fires, or looking out for signs of                  3 a breach of compartmentation, or what to do if they                  4 noticed or suspected such a breach, and, in particular,                  5 when to abandon the stay-put strategy and how to effect                  6 an emergency evacuation of a high-rise residential                  7 building. We submit that, on the evidence so far                  8 disclosed, it appears there were no such procedures, nor                  9 had firefighters received any such training.                  10 The fire Brigades Union invites the inquiry to                  11 consider whether there was a lack of national                  12 leadership, regulation and funding on these key areas,                  13 in particular in light of the recommendations from the                  14 inquest into the Lakanal House fatalities.                  15 It may also be relevant to ask what equipment, water                  16 supplies, fire protection and firefighting measures were                  17 available to them to fight the fire on the outside once                  18 the fire had broken out of the kitchen window, and                  19 likewise to fight the fire internally on multiple levels                  20 once it had broken back in again, and later to effect                  21 search and rescue operations and assist in voluntary                  22 evacuation and subsequently to evacuate the building.                  23 The FBU invites the inquiry to consider specifically                  24 whether, unaware of the multiple failures of the fire                  25 safety measures that should have been in place to limit</p> <p style="text-align: center;">Page 8</p>

<p>1 and slow the spread of fire and smoke out of the kitchen                  2 of flat 16 to and then on the exterior and back into the                  3 building, and through the front entrance doors, into the                  4 lobbies and then to the single narrow stairway, the                  5 firefighters were always chasing a sinister fire they                  6 had no realistic chance of extinguishing.                  7 Were they placed in an impossible position from top                  8 to bottom, with impossible decisions being asked of                  9 commanders and impossible tasks being undertaken by                  10 firefighters doing their best to apply the equipment,                  11 training and procedures which were available to them?                  12 In this context, the inquiry might be assisted by                  13 Dr Lane's provisional view:                  14 "I do not consider it to have been feasible, without                  15 prior warning, to implement effective external                  16 firefighting to level 4 in the very early stages of the                  17 fire."                  18 That's paragraph 2.19.8.                  19 Communications.                  20 The evidence is likely to raise questions about the                  21 communication systems available to the firefighters to                  22 communicate with one another and with control,                  23 particularly at large-scale incidents. This is another                  24 area which the inquiry is asked to consider, both as to                  25 the problems encountered on the fire ground and</p> <p style="text-align: center;">Page 9</p>	<p>1 ground, the inquiry is asked to weigh the advice which                  2 the control operators gave in light of their procedures                  3 and training, the long-standing successful use of "stay                  4 put unless", coupled with fire survival guidance, and to                  5 bear in mind the difference between what can be seen                  6 with the benefit of hindsight and what was possible on                  7 the night when they were flooded with calls of the most                  8 distressing nature.                  9 Moving on now to not moving to an evacuation                  10 strategy.                  11 The FBU notes the opinion of Dr Lane that the                  12 primary consequence of the rainscreen cladding fire                  13 starting at level 4 and spreading seven storeys within                  14 seven minutes and 19 storeys within 12 minutes was that                  15 it rendered the stay-put strategy unfit for purpose                  16 before 1.26.                  17 Bearing in mind, however, both the difficulties and                  18 dangers of devising and implementing a phased or                  19 simultaneous evacuation plan on the fire ground on the                  20 one hand, and the continuous attempts to firefight, to                  21 undertake targeted search and rescues and to assist with                  22 evacuations in the meantime, the FBU reserves its                  23 position as to the precise time when the "stay put                  24 unless" strategy either could or should, even with the                  25 benefit of hindsight, have been discarded in preference</p> <p style="text-align: center;">Page 11</p>
<p>1 recommendations going forward, to ensure workable and                  2 reliable communications are available at future                  3 large-scale incidents, and any amendments to procedures                  4 and increased training that may be needed to include                  5 realistic training. The inquiry may need further expert                  6 advice to assist them on this issue, possibly drawing on                  7 military experience in this field.                  8 Moving on to control staff.                  9 The inquiry may conclude that they also confronted                  10 an impossible and unprecedented situation for which                  11 their experience, procedures or training were                  12 inadequate. Many of them will be haunted by their                  13 memories of that night. The inquiry will doubtless                  14 ask: when were control staff aware the fire had spread                  15 from the fourth floor fire flat, up the exterior and                  16 back in again? What did they know of the fire as it                  17 developed? Were they overwhelmed with fire survival                  18 guidance calls? Until they were asked to advise                  19 occupants to "Get out if you can" at about 2.47, what                  20 other advice could they have properly given, apart from                  21 "Stay put unless your flat is affected by heat, fire or                  22 smoke, in which case leave"? That's why we prefer to                  23 call it "stay put unless" It's not a rigid "stay put";                  24 it's "stay put unless your flat is affected".                  25 As with the work of the firefighters on the fire</p> <p style="text-align: center;">Page 10</p>	<p>1 for an evacuation strategy on the night.                  2 It's clear there is a huge concern over the                  3 continued application of "stay put unless" once                  4 compartmentation had been breached, but there remains no                  5 obvious and safe alternative strategy -- certainly no                  6 detailed plan or training for one.                  7 The FBU invites the inquiry to consider what                  8 alternative strategy might have been implemented and                  9 whether, on the night and without any such procedure or                  10 training, the early incident commanders could or could                  11 not reasonably have moved to an immediate or phased                  12 evacuation at an early stage of the fire development.                  13 The responsible person under the Fire Safety                  14 Order -- that's the Royal Borough of Kensington and                  15 Chelsea -- was required to have an evacuation plan,                  16 which was described by Mr Stokes in his fire risk                  17 assessment of June 2016 as a "stay put unless";                  18 ie limited evacuation of persons affected by fire which                  19 is otherwise contained within one compartment.                  20 Mr Stokes further recorded the possible need for                  21 a general evacuation which would be arranged by the LFB                  22 or TMO employees. The inquiry should investigate: was                  23 this assessment communicated to the LFB or TMO                  24 employees? What did Mr Stokes base it upon? What                  25 arrangements, if any, were made in case a general</p> <p style="text-align: center;">Page 12</p>

<p>1 evacuation became appropriate? The FBU has seen no                  2 evidence of any arrangements for any such general                  3 evacuation and, pending the outcome of the inquiry, it                  4 seems there were none.</p> <p>5 The FBU asks the inquiry to consider whether there                  6 was a lack of planning for the scale of risk so that it                  7 should not have been left to firefighters to develop                  8 a strategy on the fire ground in the face of a breach of                  9 compartmentation.</p> <p>10 Should there have been a procedure informed by                  11 pre-planning and embedded by training for operational                  12 firefighters and control room operators alike to                  13 safeguard the lives of those in the building when                  14 computation was breached? Why wasn't there?</p> <p>15 Is the answer a lack of funding, national leadership                  16 and deregulation? The inquiry may need expert help to                  17 consider what sort of procedure, pre-planning, training                  18 and resources should be in place going forward, both in                  19 the short and medium term, to respond to a breach of                  20 compartmentation in a high-rise residential building.</p> <p>21 Foreseeability.</p> <p>22 The tragedy that unfolded was unforeseen by the fire                  23 service. The evidence is likely to reveal that                  24 experienced firefighters were shocked by the                  25 unprecedented and rapid spread of fire and smoke across</p> <p style="text-align: center;">Page 13</p>	<p>1 Grenfell Tower justifies this factor being investigated,                  2 probably in Phase 2. But they are also factors which we                  3 would ask the chairman to keep in mind when he weighs                  4 the evidence in Phase 1.</p> <p>5 However, the FBU strenuously reject the suggestion                  6 that firefighters may have been guilty of                  7 discrimination. That suggestion is offensive, it is                  8 wrong and it is unconstructive. Moreover, there is no                  9 evidential basis for it.</p> <p>10 Moving on to recommendations.</p> <p>11 The inquiry may later consider that, within the fire                  12 and rescue service nationally, there's been insufficient                  13 research into new building methods such as cladding and                  14 the risks associated with them, a loss of specialist                  15 skills in the fire safety departments, insufficient                  16 inspection, oversight and enforcement and a lack of                  17 national leadership, funding and regulation on issues                  18 that have arisen out of previous fatalities.</p> <p>19 The FBU asks the inquiry to consider whether clear                  20 lines of responsibility are needed by legislative reform                  21 for taking steps to ensure proper measures are in place                  22 for fire safety to cover the structure and exterior of                  23 buildings, as well as adequate means of escape in the                  24 event of fire, with refuges as necessary, and to include                  25 provisions to help firefighters in the event of fire,</p> <p style="text-align: center;">Page 15</p>
<p>1 and inside the building, thus compromising the lobbies,                  2 the lifts and the single means of escape.</p> <p>3 The FBU asks the inquiry to consider, however,                  4 whether such a disaster in a high-rise residential                  5 building was foreseeable, in that it was known from                  6 long-standing firefighting experience and from recent                  7 incidents (a) that fire is unpredictable; (b) that                  8 compartmentation could be breached; and (c) that fire                  9 can rapidly spread over the exterior of buildings and be                  10 very difficult to extinguish internally.</p> <p>11 Recent events in the UK include Garnock Court,                  12 Harrow Court, Shirley Towers, Lakanal House,                  13 Shepherds Court. There have also been relevant                  14 incidents abroad, such as in Dubai and Melbourne. The                  15 FBU asks whether, if it was foreseeable, this was                  16 a failure at a national level in relation to the fire                  17 safety policy and within the national fire and rescue                  18 service to devise and embed an effective response in the                  19 event of a breach of compartmentation.</p> <p>20 If I can now touch on race and class.</p> <p>21 The FBU broadly supports the submission of                  22 Imran Khan and other representatives of the                  23 Grenfell Tower community that race and socio-economic                  24 factors may have played a role in the tragedy. The high                  25 proportion of black and ethnic minority residents in</p> <p style="text-align: center;">Page 14</p>	<p>1 such as working lifts, wet risers and pre-planning.</p> <p>2 We submit there needs to be increased awareness of                  3 fire safety within fire and rescue services and in                  4 housing departments. Firefighting is a technical and                  5 professional job. Understanding fire safety is                  6 an essential part of the job, and training and service                  7 in fire safety departments should be increased.</p> <p>8 Such recommendations may involve significant                  9 investment in fire safety in high-rise residential                  10 buildings, in the fire service and in the establishment                  11 of national supervisory and advisory bodies. The FBU                  12 hopes the inquiry will agree and approve the layered                  13 approach described by Dr Lane, including the need for                  14 a properly resourced, equipped and trained emergency                  15 response service.</p> <p>16 So specific recommendations may be needed, both to                  17 improve our national fire safety regime for high-rise                  18 residential buildings to include pre-planning by                  19 responsible persons under the Fire Safety Order, usually                  20 the owner, with the development of practised evacuation                  21 procedures such as we're all familiar with in offices;                  22 and to provide the operational procedures, pre-planning,                  23 training and resources which are needed for an effective                  24 emergency response that recognises both the risk that                  25 compartmentation might be breached and that fire might</p> <p style="text-align: center;">Page 16</p>

<p>1 spread unpredictably as a consequence.</p> <p>2 Operational pre-planning should include obtaining</p> <p>3 information about the responsible person's evacuation</p> <p>4 procedure and developing an emergency evacuation</p> <p>5 procedure in light of that.</p> <p>6 Urgently needed recommendations.</p> <p>7 Most recommendations will require careful thought</p> <p>8 and will await the interim or final report. But some</p> <p>9 may be needed urgently and we fully support</p> <p>10 Michael Mansfield's call for these to be made urgently</p> <p>11 as soon as their need becomes clear. The FBU considers</p> <p>12 that these are matters for expert opinion. For example,</p> <p>13 a recommendation that the responsible person should</p> <p>14 provide an accessible fire blanket in all kitchens in</p> <p>15 a high-rise residential building may be better than</p> <p>16 having fire extinguishers above a certain level.</p> <p>17 To this end, the FBU suggests that the inquiry</p> <p>18 instructs all its experts to report the need for any</p> <p>19 urgent recommendations which the chairman could consider</p> <p>20 making urgently.</p> <p>21 In this context, the FBU supports an immediate ban</p> <p>22 on all but European A1 or UK equivalent class, ie all</p> <p>23 but non-combustible materials, on the exterior of</p> <p>24 high-rise residential buildings over 18 metres high.</p> <p>25 Such an approach has a good track-record. For example,</p> <p style="text-align: center;">Page 17</p>	<p>1 overrun too much.</p> <p>2 Mr Browne, you are going to make a statement on</p> <p>3 behalf of the Fire Officers Association.</p> <p>4 Opening statement on behalf of the Fire Officers Association</p> <p>5 by MR BROWNE</p> <p>6 MS BROWNE: Good morning, sir. My name is Louis Browne and</p> <p>7 I am instructed on behalf of the Fire Officers</p> <p>8 Association, FOA, and on behalf of two individual core</p> <p>9 participants: Richard Welch and Lee Drawbridge. I'm</p> <p>10 instructed by Jonathan Wall, Mike Mackey and Daniel Weed</p> <p>11 of Burton Copeland Solicitors.</p> <p>12 Members of the FOA attended the fire at</p> <p>13 Grenfell Tower and Mr Welch undertook certain command</p> <p>14 roles during the night.</p> <p>15 At the outset, the FOA wish to express their deepest</p> <p>16 sympathy to all of those who suffered loss in the</p> <p>17 Grenfell Tower tragedy. The magnitude of the fire at</p> <p>18 Grenfell Tower and its devastating consequences cannot</p> <p>19 be overstated.</p> <p>20 In addition to the tragic consequences it had for</p> <p>21 the families, bereaved, survivors and residents, it has</p> <p>22 had life-changing consequences for many of the</p> <p>23 firefighters who attended the scene of the fire that</p> <p>24 night. Those firefighters were and are deeply moved by</p> <p>25 the tragic loss of life at Grenfell Tower. Those</p> <p style="text-align: center;">Page 19</p>
<p>1 domestic fires markedly decreased following the</p> <p>2 introduction of the Furniture and Furnishings (Fire</p> <p>3 Safety) Regulations 1988, requiring upholstery,</p> <p>4 components and composites used for furniture in the UK</p> <p>5 to meet specified ignition resistance levels. These</p> <p>6 regulations were recommended by a national advisory body</p> <p>7 for the fire sector known as the Central Fire Brigades</p> <p>8 Advisory Committee. The CFBAC was abolished by the Fire</p> <p>9 and Rescue Services Act 2004.</p> <p>10 Over the last 15 years, there have been a succession</p> <p>11 of firefighter fatalities while fighting fire and</p> <p>12 several of these have been in tower blocks.</p> <p>13 Regrettably, not all of the lessons from those tragedies</p> <p>14 have been learned and embedded and we ask the chairman</p> <p>15 to consider a means of tracking and implementing the</p> <p>16 recommendations which he will make.</p> <p>17 Specifically, the FBU calls for a national body to</p> <p>18 monitor research developments in and advise the fire</p> <p>19 sector, including the MHCLG, fire and rescue services,</p> <p>20 responsible persons under the FSO, fire risk assessors</p> <p>21 and others. That body should include representatives of</p> <p>22 the trade unions representing those who work in the fire</p> <p>23 sector.</p> <p>24 Thank you, sir.</p> <p>25 SIR MARTIN MOORE-BICK: Thank you very much. You didn't</p> <p style="text-align: center;">Page 18</p>	<p>1 firefighters were and are deeply affected by the fact</p> <p>2 that they were unable to do more to save the lives of</p> <p>3 those who died.</p> <p>4 We submit, sir, that after all of the evidence in</p> <p>5 Phase 1 has been heard, and if you acceded to Mr Khan's</p> <p>6 submissions, you, sir, will be able to confidently state</p> <p>7 that issues of race, social class or religion played no</p> <p>8 part in the decision-making and actions of the</p> <p>9 firefighters who attended the fire at Grenfell Tower</p> <p>10 that night. What did motivate their decision-making and</p> <p>11 actions was the desire to do all they could to save the</p> <p>12 lives of those who were in the tower.</p> <p>13 The scale of the rescue operation can be seen from</p> <p>14 the following.</p> <p>15 The firefighter rescue operation at Grenfell Tower</p> <p>16 was the largest single operation of its kind in England</p> <p>17 since World War II. Before the fire, the FOA -- nor, so</p> <p>18 far as the FOA are aware, the LFB or the FBU -- were</p> <p>19 ever informed of the combustible nature of the</p> <p>20 rainscreen cladding installed at Grenfell Tower in the</p> <p>21 refurbishment works undertaken. Therefore, they were</p> <p>22 unaware that they would or might need to change their</p> <p>23 standard pump response for an intended internal</p> <p>24 high-rise residential fire.</p> <p>25 Rather than having to deal with a fire within one</p> <p style="text-align: center;">Page 20</p>

<p>1 internal compartment, a major fire in the building                  2 envelope occurred. This was itself on multiple storeys                  3 and across multiple compartments. Further, there were                  4 many flashover fires internally in multiple compartments                  5 on multiple storeys.                  6 The immense challenge to the firefighters that night                  7 can be gleaned by what was said by Dr Lane in her                  8 report, paragraph 2.16.2, and I quote:                  9 "The building envelope created an intolerable risk                  10 on the night of the fire resulting in extreme harm. It                  11 did not adequately resist the spread of fire over the                  12 walls having regard to the height, and use of the                  13 building. The active and passive fire protection                  14 measures within the tower were then required to mitigate                  15 an extraordinary event, and as a result, the                  16 consequences were catastrophic."                  17 This was a truly extraordinary event. The only way                  18 to undertake efforts to suppress the fire and rescue                  19 people trapped in the tower was to use a single                  20 protected escape stair and through the lobby on each                  21 level. The conditions on the stairs and in the lobbies                  22 were hugely challenging from a very early stage in the                  23 fire by reason of their compromise through smoke,                  24 reduced visibility, intense heat and toxicity. These                  25 conditions meant that the Fire Brigade bridgehead had to</p> <p style="text-align: center;">Page 21</p>	<p>1 benefit of hindsight.                  2 Can I briefly say something about simultaneous                  3 evacuation.                  4 It is of course right that Dr Lane in her report --                  5 paragraph 2.20.3 -- reaches the conclusion that there                  6 was a need for a total evacuation of the tower at                  7 an early stage. However, she also recognises that, in                  8 reaching that conclusion, she had the benefit of all the                  9 post-fire data, her analysis of the stairs, lobbies and                  10 evacuation flow rates.                  11 In addition, we would respectfully ask the inquiry                  12 to note that she had a further real advantage in that                  13 she had a very great deal more time to analyse those                  14 issues than those taking command decisions on the night,                  15 who had only seconds or minutes. This is perhaps why                  16 she rightly recognises at paragraph 2.20.3:                  17 "I do not wish to imply that this was an easy                  18 decision to make [referring to the total evacuation]                  19 during the unfolding and complex events that occurred                  20 during the Grenfell Tower fire."                  21 We would also ask the inquiry to bear in mind that                  22 any change to stay put is not easily dealt with in the                  23 UK. There is no statutory requirement to provide                  24 an automatic detection and alarm system in high-rise                  25 residential buildings for the purpose for warning all</p> <p style="text-align: center;">Page 23</p>
<p>1 remain at or below level 3 until about 7.30 am on                  2 14 June.                  3 In the context of a multi-storey fire, the single                  4 stair and lobbies did not create, nor were they designed                  5 to create, a safe escape route or safe working                  6 environment for the firefighters.                  7 Simultaneous evacuation of residents in the event of                  8 fire is not factored into the design of buildings such                  9 as Grenfell Tower. That is evident from the fact that                  10 there is no common fire alarm and the only means of                  11 escape was a single stairwell. The stay-put policy is                  12 therefore a building design principle and is not                  13 a creation of the fire service.                  14 Over the coming weeks, you will hear evidence from                  15 firefighters, including those who undertook command                  16 roles. When the evidence of those firefighters is                  17 heard, we respectfully ask that it be borne very clearly                  18 in mind that these men and women were required to take                  19 decisions in the unique and exceptional circumstances                  20 they faced, often instantaneous decisions, balancing                  21 risks. They did not have the time to weigh finely those                  22 risks. They were required to exercise professional                  23 judgment in the most appalling and rapidly changing                  24 circumstances. Accordingly, the inquiry should, we                  25 respectfully ask, avoid judging their actions with the</p> <p style="text-align: center;">Page 22</p>	<p>1 occupants that an all-building evacuation is required.                  2 Further, at Grenfell Tower there was no fire alarm panel                  3 provided with controls for the firefighters or others to                  4 make an all-out alarm call.                  5 As was recognised by Dr Lane, there were very                  6 significant limitations on the ability to communicate.                  7 She refers to those in paragraph 2.20.11,                  8 subparagraph (d).                  9 Drawing all of this together, sir, always assuming                  10 that it was within the authority of incident commanders                  11 to direct a simultaneous evacuation that night, the                  12 inquiry will hear evidence that such may not have been                  13 a truly viable option for the following five reasons:                  14 1. The building was not designed or constructed to                  15 facilitate simultaneous evacuations through the                  16 provision of fire alarms.                  17 2. The absence of any practicable mechanism by                  18 which to effectively communicate with the occupants of                  19 the entire building.                  20 3. In the absence of a working firefighter lift,                  21 the availability of a single staircase as a fire escape                  22 route, and this staircase was the only means by which                  23 firefighters, wearing breathing apparatus and carrying                  24 equipment, could access the other floors.                  25 4. The rapidly changing conditions in the building</p> <p style="text-align: center;">Page 24</p>

<p>1 as the fire spread, with the consequent adverse impact 2 that had on rescue operations. 3 5. These rapidly deteriorating conditions caused 4 an increase in smoke, the development of fire and toxic 5 fumes, and those were the conditions through which the 6 men, women and children in the fire would have to have 7 escaped. 8 Finally, sir, we would say this: after hearing all 9 relevant evidence from firefighters, the inquiry may 10 well be left in little doubt that these men and women 11 showed extraordinary courage that night, acted 12 selflessly and at great risk to their own lives, and did 13 all they could to save lives. 14 This is particularly so in circumstances where the 15 very nature of the building, in the condition it was in, 16 positively impeded efforts to save life. 17 SIR MARTIN MOORE-BICK: Thank you very much. 18 Now, Mr Walsh, you're going to make a statement on 19 behalf of the London Fire Brigade. 20 Opening statement on behalf of the London Fire Brigade 21 by MR WALSH 22 MR WALSH: Yes, sir. 23 Sir, Stephen Walsh is my name, as you know. 24 I appear together with Sarah Lefevre for the London Fire 25 Brigade.</p> <p style="text-align: center;">Page 25</p>	<p>1 hearings will know that it is impossible to comprehend 2 the depth and breadth of suffering of the bereaved. 3 This was obviously -- obviously -- a human tragedy with 4 far-reaching consequences. 5 But, sir, the London Fire Brigade is not a faceless 6 corporate. It is comprised of human beings -- from 7 novice firefighters, all the way through to the 8 commissioner herself, who was once a novice 9 firefighter -- many of whom experienced the horrors of 10 that night and continue to be profoundly affected by it. 11 They are drawn from many different backgrounds, 12 reflecting a diversity of which the brigade is extremely 13 proud. I won't repeat but will echo the submissions 14 made on behalf of the Fire Officers Association and the 15 Fire Brigades Union in relation to any suggestion that 16 any form of racism would have in any sense affected the 17 carrying out of their duties on that night. Their 18 collective and individual instinct is and was on the 19 night to protect life and property, often at great risk 20 to their own safety, resulting in physical and mental 21 injury for many. 22 At the commemorative hearings, the bereaved, in some 23 sense as well on behalf of the survivors and residents, 24 reiterated their desire, their justifiable demand, for 25 answers to many questions. The LFB will provide those</p> <p style="text-align: center;">Page 27</p>
<p>1 Sir, I'm going to say now, having just heard from 2 Mr Browne QC and, of course, from Mr Seaward, that it is 3 likely that I am going to echo -- I am going to try not 4 to repeat unnecessarily -- things that both of those 5 lawyers have said, but I will have to because of the 6 context of the submissions I have to make. 7 Sir, the devastating fire at Grenfell Tower, which 8 took so many lives and caused such unimaginable 9 suffering to the bereaved, survivors and residents, was 10 by far the most challenging incident which the London 11 Fire Brigade has experienced in living memory; Mr Browne 12 and others have said since the Second World War, in very 13 different circumstances. 14 But for the firefighters, whose job it was to carry 15 out the firefighting and rescue operation, and the 16 control staff who took calls from residents in the 17 tower, the memory of their experiences and the events 18 which they witnessed will never leave them. 19 The LFB, the London Fire Brigade, and its staff at 20 all levels express profound empathy with all of those 21 who have been left scarred by this tragedy. 22 But, of course, that can only extend to empathy in 23 relation to the appalling events of the fire itself. 24 But anyone who attended the Millennium Gloucester Hotel 25 and sat through all of those extraordinary commemorative</p> <p style="text-align: center;">Page 26</p>	<p>1 answers, clearly, wherever it can and with full candour. 2 Sir, this opening statement is intended to assist 3 the inquiry to fulfil its Phase 1 terms of reference 4 and, critically, understand the reasons why the fire 5 spread so rapidly and how the LFB responded. The 6 statement necessarily concerns primary the issues which 7 the brigade understands to be relevant to Phase 1 -- 8 that is to say the factual narrative of the fire itself, 9 including the actions of firefighters, control staff and 10 other LFB personnel -- which will, we hope, assist the 11 inquiry to identify any lessons which will need to be 12 learned, that much we know. 13 To that end, the brigade has undertaken an extensive 14 disclosure exercise to identify material relevant to the 15 inquiry's terms of reference, and in particular to the 16 specific disclosure requests made of the LFB. 17 The material disclosed includes a comprehensive 18 range of policies and procedures, training material also 19 for high-rise firefighting, together with a document 20 entitled "Organisational overview", which has been 21 disclosed to the inquiry and I think has been passed on 22 to CPs, which will provide the inquiry and CPs with 23 a synopsis of the primary mechanisms by which the LFB 24 provides fire and rescue services in London with 25 a focus, of course, on high-rise residential buildings.</p> <p style="text-align: center;">Page 28</p>

<p>1 As to the investigative process to date, it's  2 important to realise that the evidence which has been  3 disclosed to the inquiry, including the many statements  4 from firefighters, has been carried out in conjunction  5 with the ongoing investigation by the Metropolitan  6 Police, Operation Northleigh. It is they who have been  7 responsible for taking the vast majority of statements  8 so that there is one central body of evidence.  9 I won't repeat but acknowledge what Mr Seaward said  10 about the extent to which firefighters have been able to  11 look at those statements over the last few months. They  12 will be given an opportunity in due course, but they of  13 course are not professional witnesses, as Mr Seaward has  14 made clear.  15 In the meantime, though, the LFB has deployed  16 substantial resources to provide assistance in many  17 forms, both to Operation Northleigh and to the inquiry.  18 It continues to conduct its own complex analysis of the  19 huge body of evidence which has emerged in an effort to  20 piece together the clearest picture possible of the  21 events of the fire.  22 That includes an operational response report for the  23 first hour of the fire, which provides  24 a minute-by-minute narrative of the actions of  25 firefighters. It's a complicated document, because it</p> <p style="text-align: center;">Page 29</p>	<p>1 But much of that evidence can only come from  2 firefighters who were deployed into the building through  3 the night and from residents of the building in due  4 course.  5 Sir, it is our understanding that the purpose of  6 Phase 1 has never been to determine the rights and  7 wrongs of the actions of individual firefighters,  8 including incident commanders and other fire service  9 staff, or to apportion blame, let alone to prejudge them  10 before any evidence has been given and before they have  11 had a chance to explain the complexities of what they  12 were required to do during the fire. And of course,  13 Phase 2 will address all of those issues in detail when  14 the full narrative of the night of the fire has been  15 established in Phase 1.  16 Well, it is true to say that one has to wait to hear  17 much of the evidence, but certain things are clear from  18 the very beginning. For example, the London Fire  19 Brigade is firm in its view that the Grenfell fire was  20 a singular event. The rapidity with which the fire  21 spread from the flat of origin across the external  22 envelope and within the building itself is already  23 well-documented and will be addressed in detail by the  24 experts to the inquiry. But while the incidence of  25 external fire spread on high-rise buildings is not</p> <p style="text-align: center;">Page 31</p>
<p>1 draws together their statements and cross-refers  2 breathing apparatus telemetry -- much can be learned  3 from that -- CCTV and other media.  4 This has been and continues to be an enormous and  5 time-consuming undertaking. It has been disclosed to  6 the inquiry, as I've said, and further reports dealing  7 with subsequent hours -- that's the first hour that has  8 been disclosed -- will of course be disclosed as they  9 become available.  10 As Mr Millett said on Monday, the evidence given  11 during Phase 1 is intended in part to provide a clear  12 understanding of how conditions developed and changed  13 within the building, including the rapidity and extent  14 of those changes, the effects which they had upon the  15 ability of firefighters to carry out their function and  16 the impact which they had on the possibility of escape  17 for residents on different floors at different times.  18 I'll come back to that later.  19 All of this must be understood before any  20 conclusions can be drawn, together with a clear  21 understanding of the reasons why the fire behaved as it  22 did. That much the inquiry's experts have acknowledged  23 in their interim reports, emphasising, they say, that we  24 are as yet at an early stage and much more evidence  25 needs to be given before firm conclusions can be drawn.</p> <p style="text-align: center;">Page 30</p>	<p>1 entirely unprecedented in the UK, it is extremely rare,  2 and has never, of course, occurred on the scale of the  3 Grenfell fire, as we know.  4 Similarly, internal fire spread beyond the flat of  5 origin, such as that which occurred at Lakanal House in  6 2009, is not unknown, but it is also a rare occurrence  7 in the UK. The extent to which and the rapidity with  8 which the fire spread inside Grenfell Tower was also  9 wholly extraordinary.  10 In case there is any doubt about it -- and there  11 appears to be some doubt about it -- I had better clear  12 it up: the LFB is of course aware that there can be  13 breaches of compartmentation in these types of buildings  14 and the possibility of external fire spread to some  15 extent. The brigade has experience of addressing  16 incidents of this kind. Policies and operational  17 tactics to address them have been applied successfully  18 on many occasions. Those policies and tactics are the  19 result of learning from other fires and the difficulties  20 which were identified in them, and from national  21 guidance. This is a national issue; it's not just about  22 London.  23 But the LFB believes the scale -- the sheer scale --  24 of failings at Grenfell Tower and the sheer scale of the  25 fire which resulted from it was a combination of factors</p> <p style="text-align: center;">Page 32</p>



<p>1 which, taken together, created a unique and, in the UK                  2 at least, extraordinary and unprecedented set of                  3 challenges for the fire service nationally, as Dr Lane                  4 broadly acknowledges in her interim report.                  5 There have been references to other buildings in the                  6 UK and around the world which have seen fires break out                  7 in external cladding and which have spread, usually --                  8 nearly always -- vertically, straight up. They are, of                  9 course, important factors to consider when assessing the                  10 collective knowledge of fire services about fire spread                  11 on the exterior of buildings, and there are lessons that                  12 can be learned from them. We expect the inquiry to                  13 examine those issues in some detail, sir.                  14 But it's important to realise, as Mr Weatherby                  15 recognised the other day, that those other fires were                  16 subject to their own specific facts and circumstances.                  17 They were often very different fires, in different                  18 buildings with different regulatory regimes. The                  19 extent, therefore, to which lessons may be learned from                  20 those fires may be affected for those reasons.                  21 For example, in some of the fires there was little                  22 or no breach of internal fire safety measures,                  23 compartmentation. The fire went up a narrow part of the                  24 external envelope, burned away but didn't impinge                  25 internally because of the fire measures that were</p> <p style="text-align: center;">Page 33</p>	<p>1 All of these are factors from which the inquiry can                  2 and I know will, sir, learn when it comes to making                  3 recommendations in due course.                  4 But those firefighters and other LFB personnel who                  5 were engaged in the Grenfell fire had never experienced                  6 anything like it. The nature and scale of the fire and                  7 the manner in which it developed and spread was                  8 exceptional in the long experience and collective                  9 knowledge of both the LFB and the fire service                  10 nationally.                  11 The detail and precision of the evidence provided by                  12 firefighters, and by residents and survivors, will                  13 inevitably have to be considered in the context of the                  14 harrowing and challenging events which they will be                  15 required to recall.                  16 We anticipate -- we know, sir -- that the inquiry                  17 will bear in mind that those who were involved in the                  18 emergency response will have been wholly unaware of                  19 defects in the fabric of the building from a fire safety                  20 perspective, and will not have known much of the                  21 information as to the state of the building and the                  22 conditions within it which have since emerged so as to                  23 provide the benefit of hindsight, as Mr Seaward said                  24 earlier on, and indeed Mr Browne as well.                  25 That is an important point which Dr Lane also</p> <p style="text-align: center;">Page 35</p>
<p>1 present within the building.                  2 Some involved external spread of fire only, as                  3 I have said, so that most of the building was                  4 unaffected. In Grenfell, there was both extensive                  5 vertical and lateral fire spread which enveloped the                  6 whole building so rapidly.                  7 Sprinkler systems effectively extinguished or slowed                  8 internal fire in certain of the fires, and that is a key                  9 fire safety factor in high-rise buildings which the LFB                  10 has for many years campaigned for, the retrospective                  11 fitting of sprinklers in buildings such as                  12 Grenfell Tower that when they were built were not                  13 provided, of course.                  14 In others of these buildings -- this is key to                  15 something I'm going to come back to in a moment -- they                  16 were expressly designed for simultaneous evacuation,                  17 with phased general fire alarms, tannoy systems,                  18 evacuation plans factored into the design of the                  19 building, and more than one protected stairway so that                  20 firefighting could be conducted while residents are                  21 evacuated by a separate, protected route which is                  22 sometimes pressurised. And that was the case in the                  23 Lacrosse fire in Melbourne, which Mr Weatherby touched                  24 upon, where, in addition, the sprinkler system played                  25 a significant part in extinguishing the fire.</p> <p style="text-align: center;">Page 34</p>	<p>1 recognises in her interim report. Decision-makers on                  2 the night, she says, will not have had the benefit of                  3 much of the information the experts now have.                  4 The extensive fire and rescue policies and                  5 procedures which the brigade has established through                  6 generations of learning were tested to their limits                  7 during the fire, and there are likely to be examples in                  8 the evidence of departures from such policies because of                  9 the challenging circumstances in which the firefighters                  10 and control staff found themselves.                  11 Just something here about the scale of the                  12 operation.                  13 The emergency response carried out by the LFB                  14 required the deployment of an exceptional quantity of                  15 resources in terms of equipment and personnel within                  16 a relatively short space of time. For example, I am                  17 going to talk about fire survival guidance. That is                  18 where a person calls 999 and is spoken to by control                  19 staff and they may not be able to get out of the                  20 building in which they are in, they may feel otherwise                  21 challenged. What the control officers are required to                  22 do is give them fire survival guidance.                  23 On the night, the LFB control centre was required to                  24 handle more calls requiring fire survival guidance from                  25 residents within Grenfell Tower than the total number of</p> <p style="text-align: center;">Page 36</p>

<p>1 such calls in the previous ten years from the whole of 2 London. That must be understood in the context that 3 individual control officers might take two or three such 4 calls in a 30-year career. 5 More firefighters in breathing apparatus were 6 deployed into the building than in any other single 7 incident in the collective memory of the LFB, with more 8 than 700 fire service personnel engaged in the emergency 9 response during and after the fire. 10 Firefighters carried out many rescues of residents 11 within the flats and assisted many others who they 12 encountered elsewhere in the building to make their 13 escape down the stairwell. 14 So the brigade hopes and knows, sir, that the 15 inquiry will recognise the extraordinary courage and 16 selflessness of the firefighters in facing those 17 challenges, and the commanders. 18 The women and men who attended to fight the fire and 19 conduct rescue operations were often placed in 20 intolerable positions and were required to make 21 decisions, in some cases, which involved stark choices 22 with serious consequences, whatever they decided to do. 23 Just a few words now on the design and construction 24 of buildings such as Grenfell Tower and its relevance to 25 fire and rescue operations and the so-called stay-put</p> <p style="text-align: center;">Page 37</p>	<p>1 central stairway, which must itself be sufficiently 2 protected from the effects of fire and smoke. And the 3 requirement is that each must be protected from the 4 other. 5 As we have heard, similar but differently expressed 6 principles in the Building Regulations apply to the 7 external envelope of the building, which is expected to 8 be designed and constructed in such a way as to resist 9 the spread of flame over its surface. 10 Crucially, though, from a fire safety perspective, 11 the express intention of the current regulatory regime 12 is that, in the event of fire, the occupants of flats 13 within the building are safe -- should be safe -- to 14 remain in place, to stay put, unless they are directly 15 affected by fire or smoke. I say again: that is 16 particularly important given the fact that simultaneous 17 evacuation of the building is not factored into the 18 design. 19 Now, this -- I am going to call it a so-called 20 stay-put policy, because some call it a stay-put 21 strategy, some call it a stay-put principle, but it is 22 not a creation of fire services in the UK; rather, it is 23 a principle of building design which is provided for in 24 legislation, which fire services are expected to apply 25 and which underpins the development of fire safety and</p> <p style="text-align: center;">Page 39</p>
<p>1 policy. 2 Mr Millett has taken us through the issues and 3 deficiencies which have been identified in the experts' 4 preliminary reports, including the active and passive 5 fire measures which were and were not in place. 6 Principally, of course, the most important factor is 7 the building design concept of compartmentation. 8 I won't repeat all of that again here, obviously, but it 9 bears repetition that fire safety is a crucial element 10 of the design process, which frequently dictates the way 11 in which fire services are expected to carry out fire 12 and rescue operations. 13 Buildings such as Grenfell Tower were expressly 14 designed so as to contain any fire in its compartment of 15 origin, of course, for sufficient time to allow the fire 16 service to extinguish it before it has the chance to 17 spread. Accordingly, the building design is not 18 intended -- this is the building design, that's when it 19 was constructed -- to facilitate simultaneous evacuation 20 of the whole building, especially at the same time as 21 firefighting. That's why these buildings often don't 22 have alarms or anything of that kind. 23 So this principle of compartmentation applies to 24 each flat within the building, to the common corridors 25 if there are any, to the lobbies and to the single</p> <p style="text-align: center;">Page 38</p>	<p>1 operational policies for buildings of this kind 2 nationally. 3 It follows -- it hardly needs to be said, but I will 4 anyway -- that strict adherence to the principle of 5 compartmentation, together with a range of other active 6 and passive fire measures, is obviously critical to the 7 safety of such buildings in the event of fire. And if, 8 during the life of a high-rise residential building, 9 proper compartmentation is not maintained to the 10 required standard, to the extent that the whole building 11 is seriously compromised, the entire basis upon which 12 fire services are expected to conduct fire and rescue 13 operations in such buildings is fundamentally 14 undermined. Very substantial challenges arise in those 15 circumstances, which I'll come to shortly. 16 I'm going to be well within my time, sir, just in 17 case you are concerned. 18 But it is important to state very clearly at this 19 point that fire services, when attending fires in 20 premises of this kind, do not interpret the stay-put 21 principle to mean that residents should remain in their 22 flats whatever the circumstances. It's not how it's 23 applied. It's not how it's applied nationally and it 24 wasn't how it was applied by the LFB during the Grenfell 25 fire. Quite the contrary. Part of the advice to</p> <p style="text-align: center;">Page 40</p>

<p>1 residents who call the fire service control room is that                  2 if their flat is affected by fire or smoke, they should                  3 leave if it is safe to do so.                  4 This is where we begin to see some of the real                  5 dilemmas and problems which fire services face, because                  6 the 999 calls and the fire survival guidance calls                  7 reveal that many of those who call the LFB control room                  8 on the night of the fire said that they could not leave                  9 because of the conditions in the lobbies: the smoke,                  10 lack of visibility, toxicity. This was so as early as                  11 1.30 am.                  12 Some say, as we know, and because they weren't, said                  13 that they were physically unable to do so, to leave                  14 their flats, whatever the conditions in the lobbies, and                  15 firefighters were deployed to try and effect rescues on                  16 multiple occasions in very challenging conditions                  17 indeed. But as I say, I'll come back to that towards                  18 the end of what I have to say.                  19 At this point it's appropriate, I think it should be                  20 said, to note that while catastrophic failure of                  21 compartmentation occurred at Grenfell Tower on 14 June                  22 last year, in the experience of the LFB -- and I think                  23 this is true nationally -- the regulatory provisions                  24 concerning the design and construction of buildings such                  25 as Grenfell has historically been generally successful</p> <p style="text-align: center;">Page 41</p>	<p>1 Is it in the public interest either, or perhaps                  2 both: first, to make changes to the regulatory system                  3 which address potential non-adherence to fundamental                  4 fire safety principles and provides for a mechanism by                  5 which proper compliance can be achieved, so that fire                  6 services may have greater certainty and confidence in                  7 the development of operational policies for responding                  8 to and dealing effectively with high-rise residential                  9 fires?                  10 Or -- and perhaps it's "and", perhaps it is -- is it                  11 in the public interest to require and expect fire                  12 services to develop new high-rise and rescue policy and                  13 capabilities, and receive funding for the purpose, on                  14 the express assumption that buildings have not been                  15 maintained in such a way as to comply with the                  16 regulatory regime under which they originally were                  17 designed and constructed, so as to render them --                  18 a presumption -- inherently unsafe in the event of fire?                  19 When we say inherently unsafe here, we're not                  20 talking about the sort of breaches of compartmentation                  21 and external spread of flame which fire services are                  22 used to dealing with; we're talking about building-wide                  23 total failure.                  24 Now, it's accepted that these questions may                  25 oversimplify the complex issues which arise, but they do</p> <p style="text-align: center;">Page 43</p>
<p>1 from a fire safety perspective.                  2 So from the information available, there are roughly                  3 5,000 residential buildings in London with an occupied                  4 height of over 18 metres, and that means high-rise                  5 residential buildings. The LFB attend about 700 primary                  6 fires in such buildings a year, and in the five-year                  7 period to December 2017, of the 3,500 primary fires in                  8 buildings of this kind, 94 per cent were resolved by the                  9 initial attendance, the first attendance of the Fire                  10 Brigade, a further 2 per cent were resolved by five                  11 pumps or less, with only 4 per cent of high-rise                  12 residential fires requiring six pumps or more.                  13 But what is now obviously far less clear and what                  14 requires urgent consideration by this inquiry is the                  15 extent to which maintenance programmes and                  16 refurbishments over the years have undermined the                  17 integrity of the original design and construction                  18 principles of these buildings from a fire safety                  19 perspective. This is a vital aspect of the consequences                  20 of the Grenfell fire in the LFB's assessment.                  21 The inquiry, therefore -- we try to pose two                  22 questions, and it may be helpful to consider the issue                  23 in the context of those questions because these are                  24 issues that the LFB and fire services nationally must                  25 wrestle with.</p> <p style="text-align: center;">Page 42</p>	<p>1 highlight the stark choice faced by fire and rescue                  2 services which it is hoped the inquiry, sir, will                  3 address.                  4 In that regard, the London Fire Brigade urges the                  5 inquiry to recommend appropriate changes to the                  6 regulatory system which provide a greater degree of                  7 certainty in respect of the provision of fire safety                  8 measures in residential high-rise buildings, including,                  9 but not limited to, external cladding, and addressing                  10 many of the issues, some of which were touched upon by                  11 Mr Mansfield yesterday, including the retrofitting of                  12 sprinkler systems, which the LFB has, as I have said,                  13 promoted for many years.                  14 Perhaps I should say, insofar as that reflects at                  15 least one of the recommendations which Mr Mansfield                  16 urged, sir, upon you, the LFB is of the view that that                  17 recommendation is one which is capable of fairly early                  18 implementation.                  19 For the present, though, the brigade anticipates                  20 that the inquiry will wish to consider the extent to                  21 which fire services should be expected to mitigate fire                  22 events, to adopt Dr Lane's phrase, in high-rise                  23 residential buildings under the current regulatory                  24 regime which result from substantial non-compliance.                  25 In considering that question, sir, the inquiry is</p> <p style="text-align: center;">Page 44</p>

<p>1 encouraged to reflect on a number of factors, which I'm 2 just going to set out as briefly as I can, which are 3 likely to emerge from the evidence of firefighters and 4 residents during Phase 1.</p> <p>5 First, simultaneous evacuation.</p> <p>6 It is a fundamental misunderstanding of the events 7 of the fire and of fire service capabilities to assume 8 that the building's stay-put policy can be changed to 9 simultaneous evacuation at the stroke of a fire 10 incident commander at whatever time. That was a point 11 effectively made by Mr Leonard for CS Stokes yesterday. 12 And there are simple reasons for it.</p> <p>13 If there is no policy applied by the building owner 14 which provides for a policy of simultaneous evacuation, 15 and there are no evacuation plans and there are no 16 general fire alarms, what is an incident commander on 17 the fire ground to do?</p> <p>18 The inquiry is invited to consider the extent to 19 which simultaneous evacuation was ever a feasible 20 option, or could've been a feasible option, as part of 21 a contingency plan to fire commanders on the scene at 22 Grenfell fire, given -- and there is an element of 23 repetition here, but it really does bear repetition:</p> <p>24 (a) that the building was not designed or 25 constructed to facilitate such evacuations through the</p> <p style="text-align: center;">Page 45</p>	<p>1 themselves and to the residents. Many such rescues were 2 carried out from an early stage, until the last person, 3 who was visually impaired and whose safety in his flat 4 was monitored by the LFB throughout the night, was 5 brought out by firefighters at around 8 am.</p> <p>6 But there are likely to have been many occasions 7 when firefighters inside the building were required to 8 make difficult and instantaneous decisions about the 9 viability of immediate rescue depending upon the 10 conditions which they faced at the time, the number and 11 the vulnerability of the residents they encountered and 12 the willingness of those residents to leave a place of 13 relative perceived safety.</p> <p>14 It is probable that firefighters were faced with 15 difficult choices involving decisions whether to advise 16 residents to remain in relatively clean pockets of air 17 within the building, or to encourage them to venture 18 into hazardous and toxic environments and seek escape 19 down a stairwell in conditions that were constantly 20 changing.</p> <p>21 Officers in the London Fire Brigade's control room 22 who handle calls from residents faced similar 23 challenges. Remote from the fire ground, they have no 24 means of carrying out an objective assessment of the 25 conditions immediately outside the flat of a caller that</p> <p style="text-align: center;">Page 47</p>
<p>1 provision of fire alarms or other mechanisms which might 2 form part of a fire strategy put in place by the 3 building owner;</p> <p>4 (b) the absence of any practical mechanism by which 5 effectively to communicate with the occupants of the 6 entire building;</p> <p>7 (c) the availability of a single staircase as a fire 8 escape route, which was also the only means by which 9 firefighters, wearing breathing apparatus, carrying 10 firefighting media and other equipment, could access 11 upper floors in the absence of a working firefighter 12 lift; and</p> <p>13 (d) the likelihood that the rapidly changing 14 conditions in the building as the fire developed created 15 toxic and potentially lethal conditions through which 16 residents would be required to pass.</p> <p>17 Secondly, the inquiry is also invited to explore the 18 multiple dilemmas faced by firefighters who were 19 committed to the interior of the building and who faced 20 dangerous and rapidly changing conditions in the flats, 21 common corridors, lobbies and stairwell.</p> <p>22 As I've said, the instinct of those firefighters who 23 encountered residents in the common areas and within 24 individual flats will have been to effect rescues 25 wherever possible, often at significant risk to</p> <p style="text-align: center;">Page 46</p>	<p>1 they have on the line.</p> <p>2 The inquiry, sir, will hear that many of those who 3 made calls during the fire felt extremely reluctant to 4 leave their flats and to face the conditions beyond, 5 and, as I've said, some were simply unable to do so.</p> <p>6 The appalling dilemma -- I mean, really appalling 7 dilemma -- which control officers face in circumstances 8 such as this is that they cannot know -- cannot know -- 9 when considering whether to advise residents to leave 10 their flats, whether they may be directing them into 11 a dangerous, untenable and potentially lethally toxic 12 conditions.</p> <p>13 There are numerous examples in the evidence which 14 the inquiry will hear of rapidly changing conditions 15 within the building by which smoke, toxicity and 16 visibility radically changed within periods of time 17 sometimes measured in seconds: no visibility one moment, 18 clarity the next, no visibility seconds later.</p> <p>19 It follows that advice to residents provided by 20 firefighters within the building or by officers 21 positioned remotely in the control centre involved 22 assessments of risk which are not of a straightforward 23 and binary "yes" or "no" nature. In a fire such as that 24 which developed at Grenfell Tower, even from 25 a relatively early point in the fire, advice to</p> <p style="text-align: center;">Page 48</p>

<p>1 residents whether to stay or leave involved substantial 2 risk either way.</p> <p>3 And these are the intolerable dilemmas which will 4 always be faced by fire service personnel if fire 5 services are expected to mitigate fire events in 6 catastrophically failing buildings like Grenfell.</p> <p>7 I'm instructed to say, given all of those issues, 8 that the London Fire Commissioner, Dany Cotton, stands 9 four-square behind every firefighter, commander and 10 control officer who was involved on the night of the 11 fire.</p> <p>12 So there is a pressing need, sir, to address the 13 question whether it is reasonably practicable in the 14 public interest to expect fire services to develop 15 operational policy on the presumption that buildings 16 such as Grenfell Tower are inherently unsafe because 17 they have not been maintained in accordance with the 18 principles upon which they were originally designed and 19 built.</p> <p>20 Turning now fairly briefly to something which cannot 21 be ignored: the safety of firefighters themselves.</p> <p>22 Fire and rescue policy and training must cover 23 a complex range of situations which any fire authority 24 may be required to respond to. In London, there is 25 a vast array and quantity of buildings and</p> <p style="text-align: center;">Page 49</p>	<p>1 despite the appalling challenges and conditions which 2 the LFB personnel were required to face.</p> <p>3 Sir, finally -- for the present, at least -- what 4 measures have fire services put in place since the fire 5 to address the safety of residents in buildings with the 6 same or similar cladding to Grenfell Tower?</p> <p>7 While the LFB awaits the inquiry's findings and 8 recommendations, it has been in close liaison with the 9 National Fire Chiefs Council, the NFCC, for the purpose 10 of recommending to fire services in the UK interim 11 control measures to mitigate failings in high-rise 12 buildings which exhibit characteristics of a similar 13 nature to those which we now know were present in 14 Grenfell Tower.</p> <p>15 The result of that liaison is the publication on 16 1 May 2018 of a document entitled "Guidance: to support 17 a temporary change to simultaneous evacuation strategy 18 in purpose-built blocks of flats". That's a national 19 document.</p> <p>20 And by the way, this is not a London thing. This is 21 not something that's only of concern south of Watford. 22 All of the fire services in the country -- it doesn't 23 matter whether there's a block in Manchester or Glasgow 24 or Cardiff or London or wherever it may be -- they all 25 have the same issues in relation to the stay-put</p> <p style="text-align: center;">Page 51</p>
<p>1 installations, all of which have their own specific 2 characteristics and risks. The safety of firefighters 3 must be one of the primary considerations, because the 4 LFB and other fire services around the country hold 5 statutory duties to protect the health and safety of 6 their employees.</p> <p>7 Of course, firefighting is an inherently dangerous 8 occupation, which makes it all the more important that 9 the greatest care is taken to ensure that firefighters 10 are not exposed to unacceptable risks of serious injury 11 or even death, and in doing so create yet further 12 casualties.</p> <p>13 In the evidence received, sir, by the inquiry, there 14 are likely to be many examples of firefighters acting 15 instinctively to attack the fire and to try to protect 16 and rescue residents with limited regard for their own 17 safety.</p> <p>18 It's also likely that incident commanders and other 19 decision-makers in the rapidly developing dynamic 20 circumstances of the incident were repeatedly required 21 to make instantaneous choices which involved balancing 22 the risk to firefighters' safety with that of the 23 occupants of the building. The brigade has thus far 24 found no evidence of any occasions when that balance was 25 not struck in favour of the residents of Grenfell Tower,</p> <p style="text-align: center;">Page 50</p>	<p>1 strategy of building design and how that is to be dealt 2 with.</p> <p>3 Anyway, the guidance which the NFCC, with the 4 assistance of the LFB, has produced recommends a process 5 by which certain types of high-rise residential 6 buildings be subject to fresh and immediate fire risk 7 assessments, carried out by suitably qualified, 8 competent persons acting on behalf of building owners or 9 organisations responsible for the buildings. Where 10 appropriate, a policy of immediate and simultaneous 11 evacuation in the event of fire is to be implemented.</p> <p>12 The guidance applies to purpose-built residential 13 blocks of flats where a stay-put strategy was part of 14 the original design, but has cladding similar to that 15 found at Grenfell Tower. In addition, the cladding will 16 have failed the large-scale tests commissioned by the 17 government and carried out by the Building Research 18 Establishment, BRE.</p> <p>19 The guidance makes it clear that simultaneous 20 evacuation strategies should only be a temporary measure 21 until the risks within the building have been rectified. 22 And given that the majority of high-rise residential 23 buildings in the UK of this age were designed to have 24 a stay-put strategy, under the current regulatory regime 25 it is essential to acknowledge that such an evacuation</p> <p style="text-align: center;">Page 52</p>

<p>1 cannot be carried out without additional measures put in 2 place by the owners or occupiers of the building. In 3 essence, this is achieved by either establishing 4 a 24-hour waking watch by numbers of suitably trained 5 personnel on every floor whose responsibility it is to 6 effect an immediate evacuation from the building as soon 7 as a fire is reported, and even before the arrival of 8 the Fire Brigade, or the provision of a central alarm 9 system, combined with an evacuation plan, which is 10 communicated to and understood by the residents and put 11 in place by the building owner. Those are the interim 12 measures.</p> <p>13 In London, the LFB has also provided, for an interim 14 period, an increase in the predetermined attendance 15 required for such buildings, which increases the number 16 of personnel and fire appliances which will attend 17 a fire in the first instance, and the organisational 18 overview document which I mentioned a few minutes ago 19 provides further details of that.</p> <p>20 These are obviously significant measures, which are 21 dependent upon urgent and immediate risk assessments 22 carried out by competent persons on behalf of the 23 building owners. In the absence of a system by which 24 simultaneous evacuation can be carried out quickly and 25 safely, there is no doubt that all fire services face</p> <p style="text-align: center;">Page 53</p>	<p>1 SIR MARTIN MOORE-BICK: Thank you very much. 2 Well, that's probably a convenient point at which to 3 take a break, so we'll stop now and resume at 11.35, 4 please. 5 Thank you. 6 (11.20 am) 7 (A short break) 8 (11.35 am) 9 SIR MARTIN MOORE-BICK: Right, welcome back. I am going to 10 invite Mr Millett to make some concluding remarks on 11 behalf of the inquiry. 12 Concluding remarks by MR MILLETT 13 MR MILLETT: Thank you, Mr Chairman. I propose to be 14 extremely brief. 15 Throughout the course of its preparatory work, but 16 particularly during the course of the preparation of the 17 five experts' reports published on Monday, the inquiry 18 has kept under close and regular review the question 19 whether, and if so what, recommendations could and 20 should be made as a matter of urgency. 21 Our present view is that it may very well be 22 possible to make certain urgent interim recommendations 23 before your Phase 1 report is published, although we 24 doubt whether it would be sensible or possible to do so 25 before the Phase 1 factual and expert evidence is</p> <p style="text-align: center;">Page 55</p>
<p>1 significant challenges when conducting the type of fire 2 and rescue operation which the LFB faced on the night of 3 the Grenfell fire. 4 Sir, in conclusion, these are all factors which the 5 brigade urges the inquiry to consider with care when 6 making recommendations for the future safety of 7 high-rise residential buildings in case of fire. 8 In particular, it is hoped that the inquiry will 9 reflect upon the fact that the regulations which govern 10 the design, construction and maintenance of such 11 buildings are intended not only to ensure that residents 12 are safe in their homes, but also to inform and often 13 dictate how fire services are expected to carry out fire 14 and rescue operations in a way which ensures the safety 15 of firefighters. 16 The bereaved, survivors and residents of 17 Grenfell Tower must be provided with the clearest 18 understanding of what happened on the night of 19 14 June 2017, both as to the causes of the fire and the 20 manner in which the firefighting and rescue operation 21 was conducted, which would also, of course, inform fire 22 service learning. 23 Sir, it is the LFB's continuing intention to use all 24 of the resources at its disposal to support the inquiry 25 through both phases of hearings in the coming months.</p> <p style="text-align: center;">Page 54</p>	<p>1 completed. 2 There is a broad measure of agreement among core 3 participants, or at least among those core participants 4 who have chosen to address you, for you to make urgent 5 recommendations as soon as possible. No core 6 participant, it appears, has suggested that it is too 7 early to examine that possibility, and we think that it 8 is not too early. 9 We will, accordingly, continue to give very careful 10 consideration to the possibility of interim 11 recommendations and at a time earlier than publication 12 of the Phase 1 report, and we will keep core 13 participants updated as to that. 14 That is all I wish to say by way of concluding 15 remarks, Mr Chairman. 16 We will resume on Monday, 18 June with the expert 17 presentation of Dr Lane, and we will circulate 18 an up-to-date timetable in the next day or so. 19 So unless I can assist you, Mr Chairman, any 20 further, that is all I propose to say by way of 21 concluding remarks. 22 SIR MARTIN MOORE-BICK: Thank you very much. 23 Well, at this stage, then, we will break, as you've 24 heard. There won't be any sitting next week. We shall 25 resume on Monday, 18 June, when we shall hear the first</p> <p style="text-align: center;">Page 56</p>

<p>1 of the expert presentations, and I look forward to  2 seeing you all, or as many as possible, on that  3 occasion.  4 Thank you very much.  5 (11.40 am)  6 (The hearing adjourned until Monday, 18 June 2018  7 at 10.00 am)  8  9  10  11  12  13  14  15  16  17  18  19  20  21  22  23  24  25</p> <p style="text-align: center;">Page 57</p>	
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