FBU's Opening Statement for Phase 1 of the GTI (v.3)

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1) We are all humbled by the suffering of the deceased and the bereaved, survivors and relatives of the deceased (BSRs) as a result of the catastrophe that befell those in the Grenfell Tower. Firefighters, control staff and other emergency services workers have also suffered.

2) This inquiry should be a turning point in fire safety and in the provision of fire and rescue services (FRSs). Occupants of high rise residential buildings ("HRRB") should not have to fear the risk of fire but should be reassured that a "layered approach" to fire safety providing "defence in depth" has been and is being applied and enforced to their homes. Likewise, firefighters and control staff should never again be put in an impossible position such as faced them on 14/06/17.

3) The FBU is committed to full participation in the GTI in order (i) to assist the BSRs understand what happened and why (ii) to defend firefighters and control staff from unwarranted criticism and (iii) to ensure that appropriate, workable and lasting recommendations are made. Recommendations may be needed both

   a) to improve our national fire safety regime for HRRB to include pre-planning by responsible persons (under the Fire Safety Order 2005) with the development of practiced evacuation procedures, and
   b) 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.

4) Core participants have now (as of 17/05/18) had access to the witness statements and/or contemporaneous notes of (at the last count) 97 firefighters and control staff, 3 residents and one employee of Cadent Gas Ltd together with the expert reports of Mr Todd, Professor Nic Daeid, Professor Bisby, and Dr Lane and their appendices. All the experts' reports are provisional pending further evidence. Much material has yet to be disclosed for Phase 1, let alone Phase 2. At this late stage the GTI team have still not disclosed the operational procedure for firefighting in high rise buildings which was current as of 14/06/17 (PN 633).

5) The balance of the available witness evidence, especially of the BSRs, the remaining firefighters and control staff is also awaited. On 17/05/18 we received a list of the firefighters and control staff whom it is intended to call or read. The FBU will do its best to suggest further or different witnesses whose evidence may assist the experts, assessors and the Chairman to decide the questions arising in Phase 1, to meet members in accordance with the protocol agreed with the GTI team by correspondence concluded at the end of March 2018, and to address any special measures they may require to give oral evidence. We have tried to achieve a working protocol since December 2017 and warned of the problems of delaying disclosure of these statements until 6 weeks before the Inquiry opens. We will continue to do our best to participate in the inquiry, and to that end will furnish a list of additional questions for CTI to consider putting to witnesses of fact and/or to apply for permission to ask questions under Rule 10.

6) A reliable time-line is the starting point of proper analysis of what happened and why - an essential tool for the Inquiry. In order to establish a reliable time line it is necessary to factor in all the 'hard evidence' including the crucial Breathing Apparatus (BA) telemetry which has not yet been considered by the GTI's experts. The FBU hopes the Inquiry team is obtaining such a time line which will be available on Relativity in time to raise any additional questions for CTI to consider before the firefighters are called to testify. There may be some disputes about some of the inferences drawn or conclusions reached in preparing the time-line, but these will be few and they can't even be identified until the time-line is available.

7) Several Phase 1 expert reports are still awaited and there is obviously much work still to be done as the evidence, lay and expert, surrounding this disaster unfolds. The FBU has not yet seen, and fully reserves its position in respect of, the anticipated report from the Inquiry's firefighting expert Mr McGuirk who is not due to report until Phase 2 when many of these issues will be revisited.

8) Grenfell Tower on 14th June 2017, in its refurbished state, had a readily combustible exterior and lacked important fire safety measures. The FBU invites the Inquiry to investigate what happened during the disaster against the

background of Dr Lane's conclusions in her provisional report for Phase 1 about the state of the building. In particular, taking them in the order of the fire development from the kitchen in Flat 16:

a) Window surrounds: The type of materials and the way in which they were arranged around the window provided no means to limit the spread of fire and smoke (Lane 9.7.4). The combustible materials used in the window surrounds was the primary cause of the early fire spread from Flat 16 to the cladding (Lane 9.7.3), and contributed to the horizontal and vertical fire spread on the exterior of the building (Lane 10.5.8 and 10.6.11), and from there back into the building (Lane 10.10.3):
   i) the materials forming the enclosure around the windows, from the inside of the flat to the window frame, were, in general, combustible materials (Lane 9.1.9).
   ii) There were cavities around the window and between the windows and the rainscreen cladding on the outside of the building (Lane 9.2.1) fitted with combustible insulation (Lane 9.2.2).
   iii) The windows were not enclosed with fire resisting cavity barriers around their perimeter (Lane 9.7.2(b)).

b) The insulation attached to the original concrete wall in the cavity behind the rainscreen cladding and installed around kitchen extract fans was combustible (Lane 11.21.8). As a result, "there is evidence of fuel lining each face of the cavity over its whole height" (Lane 10.3.11)

c) The cladding panels had a combustible polyethylene core which was exposed around the perimeter of the panel (Lane 8.10.29). These panels contributed to horizontal fire spread across the building (Lane 10.4.11) and vertical fire spread in both directions (Lane 10.3.24).

d) Firebreaks "both the horizontal and vertical fire stopping were installed incorrectly..." (Lane 2.18.6) and "some of the cavity barriers ... were not installed on the night of the fire, specifically the cavity barriers required around window openings" (Lane 11.21.9).

9) Dr Lane reports that as a result, once a fire penetrated in the rainscreen cladding system there was no provision to impede the spread fire and smoke around the building. This created the means for a catastrophic condition (Lane 9.7.6). "...the ... rainscreen cladding layer coupled with the ventilation cavity backed by the ... insulation ..., incorporating defective vertical and horizontal cavity barriers, failed to control the spread of fire and smoke" (Lane 2.18.13). "The arrangement and

type of construction materials in the rainscreen cladding system caused dire consequences including:

a) Multiple internal fires many with flashovers;
b) Multiple fires impacting on flat entrance doors;
c) Large quantities of polymeric based smoke;
d) Smoke egress through flats to multiple lobbies;
e) the need for smoke control on multiple lobbies simultaneously (which was never the intention of the relevant guidance or regulations);
f) the need for suppression by LFB on multiple floors simultaneously (which was again never the intention of the relevant guidance or regulations);
g) the very early and simultaneous requirement for external firefighting, which again, was not provided for…"
h) The need to change the evacuation strategy, for which no communication systems were provided …
i) the need for all mobility impaired persons to self-evacuate, for which no facilities were provided ... (Lane 2.18.18).

10) Additionally, important fire protection measures were deficient in Grenfell Tower, notably:

a) The flat entrance doors were supposed to be fire resistant for either 30 or 60 minutes and the FBU invites the Inquiry to determine which. In either event, the FEDs could not control the spread of fire, smoke and heat to the lobbies with dire consequences (Lane 2.21.21-24).

b) The stairs were too narrow (Lane16.5.5) and lacked clear signage.

c) The lobby ventilation system cleared smoke from only one lobby (on only one floor) at a time, so it could not clear smoke from multiple levels (Lane 2.22.10). Moreover, it did not operate as intended in that it could not be controlled by firefighters so as to make it operate on a different floor (Lane 2.22.9).

d) The fire lift did not work in that firefighters were unable to operate the switch to give exclusive use to the fire service (Lane 2.22.16).

e) There was no wet riser inside Grenfell Tower. The dry riser, when charged could not supply enough water for firefighting on the upper levels (Lane 2.22.31).

11) Fire safety regime: The FBU invites the Inquiry to consider whether there was, in the refurbishment of Grenfell Tower from 2011 to 2017 (to include the doors, the main refurbishment and the gas supply works) a complete failure of fire safety regime, both at the design, planning, building works and building control stages and, after completion of the works, under both the Housing Act 2004 and the Fire Safety Order 2005. The Inquiry may consider that within the Fire and Rescue Service nationally there has been insufficient research into new building methods and the risks associated with them, a loss of specialist skills in Fire Safety Departments, and insufficient inspection oversight and enforcement. 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 in high rise buildings and pre-planning. There needs to be increased awareness of fire safety at every layer. Firefighting is a technical and professional job. Promoting fire safety is a core function of the Fire Rescue Service and training and investment in FSDs should be increased.

12) In so considering, 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.

13) Firefighters: The FBU invites the Inquiry to consider to what extent if at all the firefighters, including commanders, on the fire-ground on 14/06/17 were aware of the failure of fire safety measures in Grenfell Tower, both in the early stages of the fire and at significant stages thereafter. The Inquiry is asked to weigh the emergency response at each stage in light of such awareness or lack thereof.

14) In weighing the emergency response, the Inquiry is invited to consider that firefighters are obliged to operate within procedures that have been developed over decades of experience and on which they are trained, in particular High Rise Firefighting (PN633) and Compartment Firefighting (PN793). 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 try to save lives where possible.

15) 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 thence to the single narrow stairway, the firefighters were always chasing a sinister and rapidly developing fire they had no realistic chance of extinguishing. It may be relevant to ask what equipment, water supplies and firefighting measures were available to them:

a) to fight the fire on the outside once the fire had broken out of the kitchen window, and likewise
b) to fight the fire internally on multiple levels once it had broken back in again and later
c) To effect search and rescue operations and assist in voluntary evacuation, and subsequently
d) To evacuate the building.

16) 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 fireground and recommendations going forward to ensure workable and reliable communications are available at future large scale incidents, any amendments to procedures and/or increased training to include realistic training. The Inquiry may need further expert advice to assist them on this issue possibly drawing upon the military experience in this field.

17) Finally, the FBU asks the Inquiry to consider, in light of the state of the building and the fire prevention and fire safety measures in place, what could the firefighters have done to fight this fire once it had reached the exterior of the building. In this context the Inquiry might be assisted by Dr Lane's provisional view that: "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" (Lane 2.19.8).

18) In summary the FBU asks the Inquiry to consider whether the firefighters were placed in an impossible position from top to bottom with impossible decisions being asked of commanders, and impossible tasks being undertaken by firefighters.

19) Control staff: The Inquiry may conclude they also confronted an impossible and unprecedented situation for which their experience, procedures or training had not prepared them. Many of them will be haunted by their memories of that night. The Inquiry will doubtless ask when were control operators aware the fire had spread from the 4th 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 (FSG) calls? How many calls from Grenfell Tower had to be transferred to other control rooms? What information was provided to those other control rooms about the fireground? Until they were asked to advise occupants to "Get out if you can" at about 02:47, what other advice could they have properly given apart from "Stay put unless your flat is affected by fire and smoke in which case leave" ("Stay put unless"). As with the work of the firefighters on the fireground, the Inquiry is asked to weigh the advice which control operators gave in light of their procedures and training, the long-standing successful use of "Stay put unless" coupled with FSG, and to bear in mind the difference between what can be seen with the benefit of hindsight and what was possible on the night.

20) Moving from the "Stay Put unless" strategy: Dr Lane states that "…*the primary consequence of the rainscreen cladding fire starting at Level 4, and spreading seven stories within 7 minutes, and 19 storeys within 12 minutes, was that it rendered the Stay Put strategy unfit for purpose before 01:26*…" (Dr Lane at 2.11.135). The FBU invites the Inquiry to consider the difficulties and dangers of devising and implementing a phased or simultaneous evacuation plan on the fireground, 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 strategy" either could or should, even with the benefit of hindsight, have been discarded in preference for another strategy on the night.

21) No procedure to evacuate HRRBs: The FBU asks to the Inquiry to consider whether, there was a lack of planning for this scale of risk so that it should not have been left to firefighters to develop a strategy on the fire ground in face of a breach of compartmentation i.e. the fire breaking out of the kitchen window of Flat 16 igniting the façade and breaking back into another flat. Should there have been a procedure, embedded by training for operational firefighters and control staff alike, to safeguard the lives of those in the building when compartmentation was breached? Should such a procedure involve watching out for a failure of compartmentation, immediate escalation of the incident upon that risk materializing to mobilise sufficient resources for BA wearers to reach the upper levels and assist with evacuation, carry out search and rescue and firefighting operations as needed, immediate adjustment of the 'Stay put unless' strategy to implement a phased and/or simultaneous evacuation in tandem with firefighting to contain the spread of fire and targeted search and rescue operations. Should such a procedure be embedded by training and informed by pre-planning, adapted to the particular circumstances of particular high rise residential buildings. Should it include extra resources for the initial attendance by the FRS, ensure an adequate watch is maintained for breach of compartmentation, the carefully controlled use of Extended Duration BA ('EDBA'), the provision of fire escape hoods to assist in evacuation, access to all sides of the building and a discrete water supply for an aerial appliance and external firefighting, wet risers

for internal firefighting and revised systems and improved training in the use of communications equipment at large scale incidents? 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 an HRRB.

22) Unforeseen but foreseeable?: The Inquiry is asked to consider whether or not the tragedy that unfolded at Grenfell Tower 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, lifts and the single means of escape. The FBU also asks the Inquiry to consider whether such a disaster in a high rise residential building was foreseeable in that it was known from longstanding firefighting experience and from recent incidents (a) that fire is unpredictable, (b) that compartmentation could be breached and (c) that fire can spread over the exterior of buildings. Recent incidents in the UK include Garnock Court (11/06/99), Lakanal House (3/07/2009) and Shepherd's Bush Green (19/08/2016). 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 national level in relation to both fire safety policy and, within the national FRS, to devise and embed an effective response in the event of a breach of compartmentation.

23) Disclosure: As soon as possible after disclosure of both the final tranche of Phase 1 documents and the proposed contents list of the Phase 1 Bundle, the FBU will advise the GTI team of any further documents which it may submit should be included in the Phase 1 Bundle.

24) These submissions do not fully address the outstanding issues of expert evidence, appointment of further experts if necessary, the appointment of assessors, or the community forum but, in the absence of progress before the Inquiry opens on 21st May, the FBU may make further and supplementary submissions in writing or orally as appropriate.

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IN THE GRENFELL TOWER INQUIRY

Chaired by
SIR MARTIN MOORE-BICK

DRAFT of FBU's Opening Statement for Phase 1 of the GTI

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