GRENFELL TOWER INQUIRY

OPENING STATEMENT ON BEHALF OF THE FIRE OFFICERS ASSOCIATION AND ITS INDIVIDUAL MEMBERS WHO ARE CORE PARTICIPANTS (COLLECTIVELY "FOA")

1. As no doubt with all other CP's, the FOA is wholly committed to giving all assistance it can to the Inquiry to enable it to reach conclusions on those issues raised in the Inquiry Terms of Reference for Phase 1.

2. At the outset, FOA wish to express their deepest sympathy to all of those who suffered loss in the Grenfell Tower tragedy.

The fire at Grenfell Tower ("GT")

3. The magnitude of the fire at GT and its devastating consequences cannot be overstated.

4. In addition to the tragic consequences it had for the families, bereaved survivors and residents, it has had life changing consequences for many of the firefighters who attended the scene of the fire that night.

5. The scale of the rescue operation can be seen from the following. The firefighter rescue operation at GT was the largest single operation of its kind in England since World War II.

6. Before the fire, the FOA (nor LFB/FBU, as far as FOA is aware) were never informed of the combustible nature of the rainscreen cladding installed at GT in the refurbishment works undertaken.

7. Therefore, they were unaware that they would/might need to change their standard pump response for an intended internal high risk residential fire.

8. Rather than having to deal with a fire within one internal compartment at GT, a major fire in the building envelope occurred. This was itself on multiple storeys and across multiple compartments. Further, there were many post-flashover fires internally, in multiple compartments on multiple storeys.

9. The immense challenge to the firefighters attending that night can in part be gleaned from the following. In her Report, Dr Barbara Lane, BLAR00000001_0044 at paragraph 2.16.2 says this:

> *"The building envelope created an intolerable risk on the night of the fire, resulting in extreme harm. It did not adequately resist the spread of fire over*

the walls having regard to the height, and use of the building. The active and passive fire protection measures within the Tower were then required to mitigate an extraordinary event, and as a result, the consequences were catastrophic."

10. The scale and spread of the fire was unprecedented in the experience of those FOA members (and likely FBU members also). This was a truly extraordinary event.

11. It seems clear that the first call to the LFB on the night is recorded at 00.54.29 (LFB00000003_001). By 01.14, the internal kitchen fire in Flat 16, on Level 4, broke out of the top portion of the kitchen window, around the kitchen extract fan, with flames protruding behind a column overclad with a new rainscreen cladding system.

12. These flames started an external fire in the rainscreen cladding system. Very shortly after that (and so, by 01.29) the external fire had spread to the top of Level 23, on the East Elevation of GT; as to the rate of spread of fire thereafter see also BLAR00000001_0018_0019 paragraphs 2.8.4 – 2.8.5; see also BLAR00000001_0027_0028 at paragraphs 2.11.9 – 2.11.11, 2.11.13 and 2.11.16.

13. The only way to undertake efforts to suppress the fire and rescue people trapped in GT was through the single protected escape stair and through the lobby on each level.

14. The conditions on the stairs and in the lobbies were hugely challenging from a very early stage in the fire by reason of their compromise through smoke, reduced visibility, intense heat and toxicity.

15. These conditions meant that the Fire Brigade Bridgehead had to remain at or below Level 3 until about 7.30am on 14 June.

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

Some issues presently arising from Dr Barbara Lane's expert report

17. In the following paragraphs, Dr Lane states that firefighters were not being committed above Level 4 after the times therein set out:

Paragraph 2.13.16	BLAR00000001_0037	(03.39)
Paragraph 2.14.12	BLAR00000001_0039	(03.39)
Paragraph 2.16.48	BLAR00000001_0049	(03.39)

Paragraph 20.4.17 BLAR00000001 0015_0013

18. While the FOA has yet to see all relevant firefighters' witness statements, it is thought that Dr Lane's understanding in this regard is not correct.

19. Crews did attempt rescue operations above Level 4 after 03.39 on 14 June 2017.

The approach to the assessment of the evidence of firefighters to be given at the Inquiry

20. In evaluating the evidence of firefighters, and in particular those taking command decisions on the night, the Inquiry must bear in mind the enormous pressures and challenges they faced in attempting to deal with what was a wholly unprecedented and wholly unanticipated set of circumstances.

21. Equally, the Inquiry must guard against assessing the actions of such firefighters with the benefit of hindsight.

22. After hearing all relevant evidence from firefighters, the Inquiry may well be left in little doubt that these men and women did all they could to save lives that night, in an extraordinary set of circumstances in which protocols,

guidance, static risk assessments and the like would have nothing to offer to assist the rescue operation.

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