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1	Monday, 10 December 2018	1	sheer scale of the incident in multiple respects.
2	(10.00 am)	2	It is a stark fact that one of the largest fire
3	SIR MARTIN MOORE-BICK: Good morning, everyone. Welcome to	3	services in the world was severely challenged, in some
4	today's hearing.	4	elements overwhelmed, in the performance of its
5	We've reached the stage at which we are going to	5	functions. This was not by reason of an insufficiency
6	hear closing statements from those of the core	6	or inadequacy of the greatest number of resources ever
7	participants who wish to make them that is oral	7	deployed to a fire in residential premises, but by
8	statements. I have received many written statements,	8	a savage fire that rapidly progressed through a building
9	some from those who are going to speak and some from	9	which, on the evidence of the inquiry's experts, was
10	those who don't wish to speak.	10	fundamentally non-compliant with fire safety
11	So I think we begin by inviting Mr Walsh for the	11	requirements in multiple respects.
12	London Fire Brigade to make their closing statement.	12	This was a unique fire, not just because of its
13	Yes, Mr Walsh.	13	unprecedented scale and rapidity, but also because of
14	Closing submissions on behalf of London Fire Brigade	14	the way it behaved. The initial fire, of a kind which
15	by MR WALSH	15	long-term residents described as being similar to
16	MR WALSH: Good morning, sir.	16	a number of fires which had been attended by the fire
17	Sir, it seems a very long time since we attended the	17	service in the past without difficulty, resulted in
18	commemorative hearings in May to honour those who died	18	a major incident involving residential premises on
19	as a result of the Grenfell Tower fire. But the	19	a scale never before experienced in the United Kingdom.
20	accounts which were given by those who spoke with such	20	Now, there are lessons which obviously must be
21	dignity at those hearings remain fresh in the memory and	21	learned with hindsight. Some have already emerged
22	are a constant reminder of the reasons why we are still	22	during the Phase 1 hearings, to which I will come in due
23	here in December.	23	course as far as they concern the Brigade itself and the
24	Since then, the catastrophic events of the night of	24	measures which the Brigade has adopted and the
25	14 June 2017 have rightly been the subject of intense	25	concessions which it makes. Some of those are detailed
	Page 1		Page 3
	1 age 1		1 age 5
1	scrutiny during Phase 1 of the inquiry.	1	much later on in the written statement, which I'm not
2	The London Fire Brigade has always recognised the	2	going to read out, but I will touch upon them in due
3	pressing need for the clearest understanding of what	3	course.
4	happened on the night to be provided to the bereaved,	4	But, sir, there is a significant difference between
5	survivors and residents of Grenfell Tower and others	5	an assessment of lessons which can and must be learned
6	affected from within the local community, both as to the	6	in hindsight, and a consideration of what incident
7	causes of the fire and the manner in which firefighting	7	commanders, firefighters and control staff did "in the
8	and rescue operations were conducted.	8	moment", to use Dr Lane's phrase. They went beyond what
9	Beyond that, in the wider public interest, the	9	might have been expected of them in the ordinary course
10	Brigade repeats the assertions which it made in its	10	of their duties, and many, we know, risked their lives
11	opening statement. Meaningful lessons must be learnt by	11	time and again in doing so. Firefighters were pushed
12	many, including the Brigade, and fundamental changes	12	well beyond their physiological limits in trying to
13	made wherever possible to ensure that a disaster of this	13	effect rescues and in firefighting. At the same time,
14	kind never happens again. No one again should be	14	they were required to make very difficult decisions "in
15	subject to the unimaginable suffering of the bereaved	15	the moment", which had significant implications.
16	families and friends of those who tragically died in the	16	Sir, in addition to assisting you and the inquiry to
17	fire, those who survived and many of those nearby	17	fulfil your terms of reference, and again with the
18	residents who witnessed the events of the night as they	18	benefit of hindsight, the Brigade has invested
19	unfolded.	19	considerable time and effort in understanding and
20	It is beyond question, sir, that on the night of the	20	assessing the events of the night for the purpose of
21	fire, the Brigade was faced with the biggest challenge	21	identifying lessons which must be learned. The London
22	of any fire service in the UK in living memory. Its	22	Fire Commissioner also ensured that a number of urgent
23	policies, procedures and training were strained to their	23	actions were undertaken following the fire. Certain
24	limits and, in some respects, well beyond. That is	24	changes of policy have been made already and many are
25	accepted. But that was because, in large degree, of the	25	under detailed consideration.
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	Page 2		Page 4

Mr Chairman, the evidence given so clearly by the bereaved, survivors and the residents, both in writing and from the witness box, has been of enormous importance to the inquiry, but also to the Brigade. It establishes and helps to establish the clearest possible picture of what happened on the night, but it went far beyond that; it described the human suffering -- this is a human tragedy on a colossal scale -- of those who were affected by the fire in the most poignant terms. It is a testament to their courage in facing and recounting the horrors of the night, for the purpose of assisting the inquiry and in honouring those who tragically perished.

The firefighters and control staff who gave evidence to the inquiry also found the experience extremely challenging and, in many cases, particularly harrowing. Those who gave evidence did so from a sense of duty, which is perhaps an old-fashioned phrase, but it has a modern, current meaning when considered in the context of what they did on the night. It was applicable in equal measure to their conduct during the fire and in coming to give evidence before the inquiry, and to recount and relive their experiences under public scrutiny. It was challenging for all of them.

Sir, immediately following the fire, the Brigade,

facilitating the complex process of taking written statements by the Metropolitan Police from many hundreds of firefighters who attended on the night, and ensuring the attendance at this inquiry of over 90 Fire Brigade staff who gave oral evidence.

It is, sir, no exaggeration to say that this inquiry in Phase 1 alone has conducted one of the most extensive and forensic examinations of the events of a major fire which has ever been undertaken. But those events did not occur in a vacuum, and the inquiry has inevitably considered matters which touch upon Phase 2 and which will rigorously be scrutinised in that next phase.

As Dr Lane pointed out in her initial reports, in which she was at pains to emphasise that incident commanders would not have known many of the facts which have since emerged, and that there is an important distinction which must be drawn between an analysis of the actions of firefighters in the moment, in the dynamic and rapidly changing events they faced, by contrast with that which may be conducted over several months afterwards in the cold light of day, with the benefit of considerable quantities of material and evidence. That is, of course, what we, sir, have been engaged in for the last several months, quite properly, of course.

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under the instruction, again, of the London Fire Commissioner, deployed substantial resources to provide assistance in many forms to both Operation Northleigh, the Metropolitan Police, and the inquiry. The Brigade continues to carry out the complex task of analysing the huge body of evidence which has been gathered in an effort to piece together the clearest possible picture of the events of the night. That work has included the compilation, sir, as you know, of operational response reports for each of the first seven hours of the fire, which provide a minutely detailed narrative -- second by second, where possible -- of the actions of firefighters, drawing together key information from witnesses which are cross-referenced with breathing apparatus telemetry, CCTV and other media. A similar exercise has been conducted in the preparation of a single control report which details the actions of officers situated in the Brigade control room on the night. That has been -- and it continues to be because it

That has been -- and it continues to be because it is an ongoing process, to which many resources are devoted -- an enormous undertaking.

Sir, therefore, the Brigade hopes that it has provided real and meaningful assistance to the inquiry, both through the preparation of these reports and by

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Evidence has been received, for example, concerning the design and construction of Grenfell Tower. But there remains much to be understood, as the inquiry's experts have pointed out. This concerns, among other things, the manner in which the refurbishment of the building was undertaken, and the impact which it had on the active and passive fire safety measures.

Therefore, if one is looking at the impact on the active and passive fire safety measures and the way in which the building behaved, that is directly relevant to the actions of firefighters on the night in relation to them. So there is much yet to be learnt.

Many firefighters have been asked in detail about their individual understanding and adherence to certain of the Brigade's policies and procedures; but the basis for the development of those policies must also wait until Phase 2.

Sir, with that in mind, I want now to touch briefly upon the written closing submissions of some of the core participants, just to touch upon one or two issues, which include a number of criticisms of the Brigade as an organisation, which is part of the legitimate function of this inquiry and part of their right to do so -- I'll come to those in due course to some extent -- but also of individuals. Now, I will come to the

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2 (Pages 5 to 8)

1	Brigade itself as an organisation later, but right now	1	evidence that has emerged since the fire that, even
2	I'm speaking of the individual firefighters and control	2	then, they do not all agree on everything.
3	staff who came to give evidence.	3	In those circumstances, sir, it would, in our
4	First, they did so in relation to their training and	4	submission, be unfair to pass judgement on individual
5	Brigade procedure with absolute candour. That is	5	actions of any of the firefighters or control staff
6	obvious from the accounts that they gave, from the fact	6	until more of these issues are fully examined at
7	that they did not always agree with each other on	7	Phase 2, which has always, as we understand it, been the
8	certain issues. It would be odd if they did, given the	8	intention of the inquiry. And it is impossible to make
9	number who gave evidence and the traumatic and dynamic	9	judgements about what they did without fully
10	events they had to recount. They had difficult choices	10	acknowledging the sheer scale of what was happening and
11	to make, which involved substantial risks to life,	11	the rapidity with which it happened.
12	either way. More than once, sir, you may recall	12	The fact is that none of the firefighters who
13	firefighters using the phrase "damned if you do and	13	attended the fire or the control officers in Stratford
14	damned if you don't" effectively to some up the	14	should ever, as individuals, have been placed in the
15	situations they found themselves in. But they acted in	15	often impossible situations they were by reason of the
16	many instances with heroism, paying scant regard for	16	catastrophic failings in that building, according to the
17	their own safety, and returning into the building,	17	inquiry's experts' findings thus far.
18	sometimes, time and time again, on the instructions of	18	Sir, that is another reason it's perhaps
19	commanders, who themselves struggled profoundly, as you	19	a secondary reason, but it is one of no less
20	heard them say when they gave evidence, with the	20	importance why meaningful lessons must be learned so
21	knowledge that they were deploying colleagues into	21	that fire service staff up and down the country, both
22	perilous surroundings. They did not give up because	22	firefighters and those in control rooms, are never
23	they are hardwired to save life while there is still	23	placed in those situations again.
24	a chance.	24	So much for the individuals.
25	Of course, similar considerations apply to the	25	But, of course, in answer to many of these issues
	Page 9		Page 11
1	control room stoff as individuals, who worked constantly	1	which I have reject in relation to the individuals
1	control room staff as individuals, who worked constantly	1	which I have raised in relation to the individuals,
2	and tirelessly throughout the night. They faced	2	understandably it has been suggested that the Brigade
2 3	and tirelessly throughout the night. They faced numerous personal challenges, which were highly	2 3	understandably it has been suggested that the Brigade itself, as an organisation, should have had contingency
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2 3 4 5	and tirelessly throughout the night. They faced numerous personal challenges, which were highly distressing and, in many cases, impossible. They were open and honest in their views about Brigade procedure	2 3 4 5	understandably it has been suggested that the Brigade itself, as an organisation, should have had contingency plans in place to address an incident on this unprecedented scale, and training implemented to deal
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1 which is useful to know, or wise to be aware of; it 1 At Phase 2, according to its purpose, those issues 2 2 can be properly and very fully explained, and it would, provides the fundamental basis upon which fire services 3 3 in our submission, be wrong to pass summary judgment on are required to carry out their functions in buildings 4 these matters now before those explanations are before 4 of this kind. 5 5 Buildings such as Grenfell Tower were expressly the inquiry. designed so as to contain any fire in its compartment of 6 Sir, it is for that reason, actually, as we 6 7 7 understand it, that the inquiry's fire and rescue origin for sufficient time to allow the fire service to 8 8 expert, Mr McGuirk, has not been required to prepare extinguish it before it has a chance to spread. 9 Accordingly, the building design is not intended, as the 9 a report for Phase 1. We await that report for the 10 purposes of Phase 2. 10 experts have told us, to facilitate simultaneous 11 Therefore, sir, insofar as you have been asked to 11 evacuation of residents, especially at the same time as 12 12 make critical findings at this stage, by which I mean firefighting. There is, for example, no common fire 13 findings other than those of pure fact, which determine 13 alarm provided for that purpose, and the sole means of 14 individual or systemic failings, it is the Brigade's 14 escape is down a single stairwell, and unless provided 15 firm position that such findings, unless arguably they 15 in some way by the building owner, no simultaneous 16 16 bear upon urgent recommendations you consider should be evacuation plan which residents are aware of. 17 17 made, can only properly be made when the full context is In simple terms, the design of such buildings is 18 examined in Phase 2. 18 subject to the crucial building design principle known 19 Sir, I turn now, as we did in the opening statement 19 as "compartmentation", which we have heard so many times 20 20 of the Brigade, to the crucial importance of the during the last few months. It is intended to inhibit 21 principles which govern the design, construction and 21 rapid fire spread within the building from one area to 22 22 maintenance of high-rise residential buildings. another. That is achieved, as we have heard, through a variety of passive and active fire safety measures, 23 23 The reason why we want just to touch upon some of 24 the key principles again, is that before it is possible 24 such as fire-stopping, fire resistant self-closing doors 25 25 and the use of fire resistant materials in the to have any appreciation of the actions of Brigade staff Page 13 Page 15 1 on the night of the fire, it is essential to restate 1 construction and maintenance of the building. 2 that fire and rescue services, policies and procedures 2 The principle applies to each flat in the building, 3 3 for different types of fires in different types of to the common corridors and to the single central 4 buildings, are underpinned by the regulatory 4 staircase and lobbies, which must themselves be 5 requirements for their design and construction. 5 sufficiently protected from the effects of fire and 6 The inquiry's experts have devoted considerable time 6 smoke. 7 and space to these principles in their reports, and for 7 Crucially, in this case, similar but differently 8 8 good reason. expressed principles apply to the external envelope of 9 9 But for now, as I say, we want to emphasise and the building, which is expected to be designed and 10 10 restate some of the most significant principles. constructed in such a way as to resist the spread of 11 First, a reminder that the stay-put strategy is not 11 flame over its surface. 12 a Brigade or fire and rescue service procedure; it is 12 The express intention of the regulatory regime is 13 a key principle of building design and construction, but 13 that, in the event of fire, the occupants of flats 14 it is one, of course, that fire services must understand 14 within the building are safe to remain in place, 15 15 and apply. according to the regulatory principles, to stay put, 16 It is, on the evidence of Dr Lane -- I am quoting 16 unless they are directly affected by fire, smoke or 17 here -- the single safety condition provided for the 17 heat. That is obviously an issue which is under close 18 design of high-rise residential buildings. The 18 scrutiny in this inquiry. That is particularly 19 statutory guidance, she says, makes no provision within 19 important, though, given the fact that simultaneous 20 20 the building for anything other than the stay-put evacuation of the building is not factored into the 21 21 statutory requirements which govern the design of 22 It follows, sir, that fire safety is a crucial 22 buildings of this kind. 23 element of the building design process which dictates 23 We make no apology for repeating that the stay-put 24 the way in which fire services are expected to carry out 24 strategy is not a creation of fire services in the UK, 25 fire and rescue operations. It is not just something 25 but rather a principle of building design which Page 14 Page 16

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underpins the development of fire safety and operational policy for buildings of this kind.

It is obvious, in those circumstances, that strict adherence to the principle of compartmentation through a range of active and passive fire protection measures is critical to the safety of such buildings and their residents in case of fire.

Now, I have no doubt that people have spoken to friends and relatives -- I know I have at home -- and we speak of the stay-put strategy, and the Brigade is well aware -- as am I -- of the fact that the stay-put strategy, which I have described as part of the regulatory building design, is something of a counter-intuitive operation. Many have said, "Why would you stay in a building that's on fire? You have to get out." But it is important to emphasise, particularly for those who live in such buildings, that this system of building design which is required by the Building Regulations has -- it's important to say this -- achieved its purpose in the vast majority of cases for decades, in accordance with the principles upon which these buildings were built, by contrast with substantial refurbishments which may have occurred in later years.

Just to put some context on that -- we said this in

in the need to effect a full evacuation of an entire 2 high-rise residential building, even if it were possible 3 to do so.

That is because, in practice, fire services address localised breaches of compartmentation through a system of sectorisation. We haven't heard a great deal of evidence about this, though we have heard some, in Phase 1, and I'm very conscious of the fact that I shouldn't be giving evidence, but I anticipate that in Phase 2 an analysis of the principle of fire service practice, which is sectorisation, will be made. It involves -- it's important to understand this now -establishing an operational fire sector in a building where the main firefighting and rescue operations are taking place, which typically incorporates the floor involving the compartment of origin and one floor above and one floor below. Within that fire sector, the flats above and adjacent to the compartment of origin can be evacuated if necessary, and further evacuation within the fire sector may be considered or implemented depending upon the development of the fire beyond the compartment of origin.

Now, Brigade policy, and Brigade policies all over the country, provide for sectorised firefighting and rescue and the practicality of partial evacuation in

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our opening statement, but it's worth saying again -there are, for example, in London about 5,000 residential high-rise buildings. That's in London alone. The Brigade attends about 700 fires in such buildings each year, and in the last five years to the end of 2017, which obviously does not include the Grenfell Tower fire, 94 per cent were resolved by the initial attendance of fire crews. I suppose the key point is that only 2 per cent needed the attendance of six fire engines or more, and it had never been necessary to suspend the stay-put strategy for an entire building in all of that time, not for decades. The suspension of the stay-put strategy on the night of 14 June 2017 was the first time that it had occurred, insofar as we are aware, ever.

The national picture, as we understand it, is much the same. That is not because every building, however, has always performed perfectly in respect of compartmentation, because fires such as these, those which have been attended over the years and been addressed very often by the first crews who attended, in those kind of fires, breaches of compartmentation to some degree have not been uncommon. It's a misunderstanding of fire and rescue policy to assume that any breach of compartmentation will always result

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certain circumstances, such as those that occurred at Shepherds Court, about which we have heard much, on 19 August 2016, where that policy was engaged. The fire sector was extended to account for the fire spread within the building, and limited evacuation of flats in the localised sector was affected.

The fire was extinguished within the sector, without spreading to the rest of the building and without a full-scale evacuation. That is chiefly because the design principles in the Building Regulations to some extent contemplate an element of compartmentation failure by providing for layers of redundancy in various active and passive fire measures. So if one fails, another one is there, and then if that fails, another one is there. That's why fire services, the Brigade in London, have been able to and have under policy managed buildings of this kind for decades.

However, in the Grenfell Tower fire, it was impossible to adopt a sectorisation process on the basis of localised fire spread. The uniqueness of the fire, which was evidenced by the rapid vertical, lateral and downward spread, possibly encouraged, as we understand it from the inquiry's experts, by the existence of the architectural crown, wholly compromised the stay-put strategy. In other words, the condition of

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5 (Pages 17 to 20)

1 Grenfell Tower was such that the fire protection 1 passive fire protection measures in buildings of this 2 2 measures which should've been in place in layers of kind has not contemplated a total building evacuation. redundancy, and upon which fire services and residents 3 3 That is not to say, of course, that a full evacuation of 4 rely, were substantially absent. 4 such a building in certain circumstances -- it's 5 5 The importance of the statutory fire protection happened before -- might not be possible, given time and 6 measures was emphasised by Dr Lane when she gave 6 with favourable conditions, particularly where residents 7 7 evidence all the way back in June. She said, are aware of an evacuation strategy provided by the 8 8 importantly -- I am going to quote from a passage of the building owner. But the challenges faced by the Brigade 9 9 on the night of the fire were significant, rendering the evidence which she gave in June: 10 "The fire protection measures must be constructed 10 possibility of simultaneous and immediate full 11 and then maintained to ensure they are fit for purpose 11 evacuation virtually impracticable. 12 in the event of fire. The stay-put strategy is provided 12 The following factors are important in that: 13 through design construction and ongoing maintenance. 13 1. The building, as we have said -- forgive me for 14 All building occupants, including the Fire Brigade, rely 14 repeating it -- wasn't designed or constructed to 15 on it in the event of a fire. It is the single ..." 15 facilitate such evacuations. 16 I come back to what she says about this: 16 2. There's an absence of any practical mechanism by which to effectively communicate with occupants of the 17 "... safety condition provided for in the design of 17 18 high-rise residential buildings in England. 18 entire building. 19 "The statutory guidance makes no provision within 19 3. There is an available single staircase only, 20 20 which is also to be used by firefighters in breathing the building for anything other than a stay-put 21 strategy. There is no means of warning nor a means to 21 apparatus and so on. 22 22 communicate the need to increase the areas to be 4. This is important: in buildings of this kind, if 23 evacuated as is currently regulated for other building 23 there is widespread failure of active and passive fire 24 uses." [Day 5, 18 June 2018, page 39 to 40] 24 protection measures, the likelihood that rapidly 25 25 That's one lesson that we can learn quite early on. changing conditions in the building as the fire Page 21 Page 23 1 1 Forgive me for just trying to touch upon some of the developed might create toxic and potentially lethal 2 key principles of building design, but it was important 2 conditions through which residents would be required to 3 3 to do so, so as to understand what firefighters and pass without respiratory protection. 4 4 commanders were doing on the night. That last point, the fourth, is of particular 5 We know, understandably, and properly said by some 5 relevance here. A year and a half after the fire, and 6 6 following extensive analysis of multiple issues, the core participants, that the principles upon which 7 7 buildings like these are designed and the reliance inquiry's experts, at least some, say that a detailed 8 8 consideration of the spread of smoke within the building placed on them by fire services is all well and good, 9 9 but when they fail on the scale which occurred at is a very complex undertaking which is yet to be done 10 10 Grenfell Tower, what is the planned alternative? That's fully. 11 a legitimate question which has to be answered. 11 The Brigade is carrying out its own extensive 12 The answer to many of those questions in relation to 12 analysis of it and is far from being able to conclude 13 the night of the fire can be found in the sheer scale 13 with any certainty yet, though that time will come, 14 and the rapidity of what happened and the fact that it 14 precisely what was happening in terms of the spread of 15 was unprecedented. But to understand what the 15 smoke. 16 alternatives might have been, even with hindsight, it is 16 Witnesses, both firefighters and residents, have 17 important to recognise how the statutory design 17 given their own valuable accounts which, among other 18 18 things, demonstrate that the pattern of smoke spread was principles actually impact upon what are option the fire 19 services may have in the event that a building fails in 19 variable from an early stage. 20 20 Professor Purser, who recently gave evidence, its safety design to the extent seen at Grenfell Tower. 21 I just want to touch upon some of the practical 21 conducted his own assessment, but said he hadn't yet had 22 issues that arise for fire services arising out of the 22 an opportunity to consider the firefighter evidence, 23 design principles that I've touched upon. 23 which is obviously essential before coming to any 24 First of all, simultaneous evacuation. 24 conclusion. 25 Since the early 1960s, the design of active and 25 Sir, I'm going to be about an hour and a quarter, Page 22 Page 24

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1	an hour and 20 minutes, so I'm not going to take my	1	been that the rainscreen cladding did its job insofar as
2	whole two hours, you may be relieved to hear.	2	it repulsed water applied from the exterior.
3	SIR MARTIN MOORE-BICK: All right. Not relieved, Mr Walsh!	3	But assuming that it would have been reasonable at
4	MR WALSH: Perhaps it is me!	4	the early stages to anticipate that the fire in the
5	SIR MARTIN MOORE-BICK: Before you go on, can I assume you	5	external cladding would spread as far and as rapidly as
6	would rather complete the whole of your statement	6	it did, it would've been a fundamental and unprecedented
7	without a break?	7	departure from high-rise firefighting procedure to
8	MR WALSH: I think so. I'll certainly conclude before the	8	abandon internal firefighting, because it would've
9	mid-morning break.	9	allowed the internal fire to develop further, breaching
10	Sir, I want to turn now, then, to the statutory	10	compartmentation and potentially impacting on access and
11	requirements and the impact on firefighting on the	11	egress routes.
12	night, as opposed to general principles.	12	Sir, there have also been understandable suggestions
13	Internal firefighting.	13	that the fire might have been fought externally in the
14	The statutory requirements are predicated on the	14	initial stages using an aerial ladder. We can provide
15	basis that fires in compartments must be fought	15	more analysis of this at Phase 2, but the inquiry is
16	internally, and that that is the principle which	16	aware that the Brigade's initial predetermined
17	supports fire service policy and training for such	17	attendance, the PDA, to high-rise fires in June 2017 did
18	fires.	18	not include an aerial ladder. But even if an aerial
19	The inquiry has heard that the deployment of	19	appliance had been on the PDA, it is unlikely highly
20	external jets of water into an internal compartment	20	unlikely that it could have positioned and set up in
21	through a window cannot be done safely in high-rise	21	sufficient time to have been used to undertake
22	residential premises or others, actually because	22	firefighting operations that could have stopped the
23	of the risk to which firefighters or residents within	23	external fire spread because of the short window of
24	the compartment would be exposed. It can cause boiling	24	opportunity that was available if that was going to
25	steam and all sorts of other difficulties, so great care	25	happen.
23	steam and an sorts of other annealities, so great care		
	Page 25		Page 27
1	has to be taken in relation to putting water straight	1	Turning now to the extent to which firefighting on
2	into a window in which people are already there.	2	multiple floors is provided for in the Building
3	In the course of the hearings, though, it has been	3	Regulations.
4	suggested that it may have been an option to abandon	4	While we have said that the statutory requirements
5	internal firefighting it's a perfectly legitimate	5	for the design of high-rise residential buildings
6	suggestion, and it has been made altogether in the	6	provide for internal firefighting, they do not
7	early stages of the fire, so as to allow an external jet	7	contemplate that fire services may be required to fight
8	to aggressively attack the fire on the cladding above	8	fires on multiple floors. It is just not contemplated
9	and below the window in flat 16 without risks to	9	by the regulations.
10	firefighters within the compartment.	10	At Grenfell Tower, of course, firefighting on
11	Now, of course, that window of opportunity, because	11	multiple floors was essential, notwithstanding the fact
12	of the rapidity with which the fire spread, was very	12	that the building wasn't designed to facilitate it.
13	short. But it is also a fact that several attempts were	13	This meant that doorways from numerous lobbies to the
14	made to attack the fire externally in order to prevent	14	stairwell were required to be open for a significant
15	vertical fire spread. An external jet was applied to	15	period, thereby necessarily to some extent breaching the
16	the cladding in the vicinity of the window, as we have	16	protection provided for an escape route. Of course,
17	heard, of flat 16 in the early stages, but with care,	17	that would also have been the case in a full
18	for the reasons which I've explained, in the knowledge	18	simultaneous evacuation of the building.
19	that firefighters were within the compartment. Hoses	19	Whether a building is fitted with dry or wet risers,
20	were deployed externally from within flat 16, at	20	whether there should have been dry or wet risers in
21	considerable risk to the firefighters who lent out of	21	Grenfell Tower, in either case, the provision provided
22	the window to do it, and later, aerial appliances were	22	for is for firefighting jets to be connected to the
23	used. But in all cases, these efforts were without	23	rising main, which is sufficient to deal with a single
24	material effect to the vertical spread of the fire, and	24	compartment fire. That's how the Building Regulations
25	it is a cruel irony that one reason for that may have	25	plan for these things.
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	Page 26		Page 28
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The use of further hoses -- you're talking about two hoses on each floor -- connected to riser outlets, whether wet or dry, to fight fires on other floors at the same time results in an exponential reduction, if I can use that word, in water pressure to a degree which renders the ability to extinguish fires inadequate on multiple floors if they're all being used at the same time. That's the way in which the construction and design of a building is accommodated.

So, in short, the available water supplied by the rising main and the associated water pressures are insufficient to accommodate multiple hoses in the riser outlets on multiple floors. So the possibility that firefighting may need to be effected in such circumstances just isn't contemplated by the regulatory regime. That's another lesson that might well be learned.

Perhaps that's why the ventilation system in the building was designed only to extract smoke from one lobby at a time, and was not capable, as we understand it, even if it had been working correctly, of doing the same job on multiple floors.

So, sir, those are all factors which, together with the many others which are addressed in the Brigade's statement, which I won't slavishly go through, spread, usually vertically -- practically every case vertically, as the experts have pointed out. Certainly the inquiry's experts have said that the information about those other fires is not as well documented as they would wish in order to make comparisons and draw specific conclusions. The Brigade agrees with that, but also points out that they were very different fires, in different buildings around the world, with very different regulatory design regimes. We set out some examples of those in the statement which I won't repeat here

But, importantly, the Brigade entirely recognises the fact that the fires in other buildings around the world which involve cladding materials are important factors to consider when assessing the collective knowledge of fire services in the UK about rapid fire spread on the exterior of buildings and the lessons which can be learned from them.

The extent to which the Brigade was fixed with this knowledge and the manner in which it was used and disseminated and might have assisted in contingency planning will obviously be a significant issue at Phase 2, when those with the relevant responsibility and expertise about these issues will have an opportunity to provide a detailed explanation.

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contribute to what was the Brigade firmly maintains was a unique and singular event. But, importantly, they demonstrate how difficult it is to develop contingencies for firefighting and rescue where there is a widespread failure to adhere to the design principles in residential high-rise buildings.

I say it was a singular fire, and it was, but the

I say it was a singular fire, and it was, but the Brigade is very conscious of the fact that the inquiry has heard about other fires and the Brigade's knowledge of other fires around the world. I just want to deal with that, if I may.

In this case, the fire safety measures in the building, which for more than 40 years had served its occupants well from a fire safety perspective, were, on the evidence of the inquiry's experts, so compromised to such an extent that the events of the night of the fire occurred as they did, but they were not yet fully understood by mid-2017.

Should the Brigade, should fire services, fixed with the knowledge of fire spread in other buildings around the world, have been alerted to something which might have assisted in developing contingency plans?

Now, the references in Phase 1, as we know, to other fires around the world demonstrated that there were fires which broke out in external cladding and which

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But for the present, the Brigade has taken actions -- many actions -- and in this case it includes a new procedure through the National Operational Learning User Group -- it's a process -- with the Institute of Fire Engineers to extract learning from international events and disseminate the relevant learning coherently on a nationwide basis, and that work is in train and is ongoing now.

But on the evidence of, sir, the inquiry's experts, what was unusual about the fire at Grenfell Tower was the extent of the lateral and downward spread in the external envelope and the extent to which internal compartmentation was compromised. That fire behaviour was, according to the experts, the function of a combination of factors, including the nature of the materials used in the cladding and their complex arrangement -- which is a fundamental and important factor -- the involvement of the architectural crown and the manner in which the new window sets had been installed. This, combined with the range of internal active and passive fire protection measures, created what the Brigade really maintains was a unique set of circumstances. But they're not unique now, because they've happened, and that's why lessons are urgently being learnt about them.

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8 (Pages 29 to 32)

1 1 Given those facts and what was happening in that way the opportunity to spread. In cases involving multiple 2 on the night of the fire, I just want now, sir, to touch 2 fires in the premises, it's equally important to 3 3 upon certain issues which arose and gave firefighters continue firefighting efforts, notwithstanding the 4 and control staff difficulties on the night. 4 difficulties created by the building design, not only to 5 The primary cause of the problems faced by them was 5 prevent further fire spread, but also to protect escape 6 described by Dr Lane as: 6 routes and to allow rescue attempts to be made. 7 7 "... the rainscreen cladding assembly together with As the fire developed through Grenfell Tower, it was 8 the insulation fitted to the existing external wall and 8 essential that firefighting operations continued, for to g the missing or defective barriers became part of the 9 abandon them would have further prejudiced the 10 successful combustion process. This created a condition 10 possibility of escape from floors on which the fires had 11 (in the event of an internal fire, cavity fire or 11 broken out and from other floors both above and below by 12 12 external fire) which connected every flat on a storey; reason of the smoke and heat which the fires generated. 13 and every storey from level three to the roof, which 13 It was essential, so long as there might be savable 14 supported the spread of external fire back into the 14 life within the building, that firefighting operations 15 building, through windows, and created a series of 15 continued so as to check the continued development of 16 internal fire events." [page 13] 16 the fire internally and to maintain the structural 17 17 That's how she summarises it. integrity of the building. 18 But, importantly, she went on to say this: 18 As one example, we can all remember that that is 19 "2.19.1 I do not consider it reasonable that in the 19 precisely what firefighters did to protect Mr Bonifacio 20 event of the installation of a combustible rainscreen 20 in his flat, who was partially-sighted, as he explained. 21 cladding system on a high rise residential building, the 21 He couldn't get out, but that's how the firefighters 22 fire brigade should be expected to fully mitigate any 22 behaved in protecting his position until he was rescued 23 23 resulting fire event." by firefighters as late as 8 o'clock in the morning. 24 That's her view: 24 Just coming to the rescue operation. 25 25 "That is particularly so in circumstances where the The inquiry now has taken both oral and written Page 33 Page 35 1 fire brigade had never been informed that a combustible 1 evidence from firefighters telling of multiple dilemmas 2 rainscreen cladding system had been installed in the 2 they faced when they were committed to the interior of 3 3 the building. As I think is very well known by now, first place. Further, there are so many combinations of 4 4 events, that could fall entirely outside the reach of more firefighters in breathing apparatus were deployed 5 external firefighting activity. This is important when 5 into the building than in any other single incident in 6 only internal firefighting arrangements are made for 6 the collective memory of the Brigade. More than 700 7 high-rise residential buildings by Regulation at this 7 fire service personnel were engaged in the emergency 8 time." [page 14] 8 response. Firefighters with breathing apparatus carried 9 So those were among the issues that the firefighters 9 out many rescues of residents from within flats and 10 and commanders faced on the night. Inevitably, it was 10 assisted many other residents who they encountered 11 necessary that policies and procedures which had been 11 elsewhere in the building to make their own escape down 12 established by the Fire Brigade for many long years had 12 the stairwell. In many cases, they removed their own 13 to be departed from. 13 masks from their own faces to give clean air to 14 Now, it has been suggested during the course of 14 residents, to protect them from the toxic conditions. 15 Phase 1 that there must have come a time when it was 15 Those have all been described in vivid terms, clear to firefighters that the fire could not be 16 16 I know, but one of the most important purposes of their 17 controlled, and that there should've been a decision to 17 evidence was to describe the conditions in the building. 18 abandon firefighting completely in favour of the rescue 18 That's why we say, again, that a full analysis of the 19 effort. That's the suggestion that some have made. 19 descriptions which they made must be undertaken. 20 It's an understandable suggestion. 20 One of the issues which has arisen is the extent to 21 But in addressing that suggestion, it's firstly 21 which firefighters always made it to the flats that they 22 important to point out that firefighting and rescue 22 were deployed to get to. The instinct of firefighters 23 operations are not mutually exclusive. In all cases, it 23 who encountered residents in the common areas and within 24 is of paramount importance for firefighters to attack 24 individual flats was to effect rescues wherever 25 and extinguish an initial fire so that it is not given 25 possible, often at significant risk, as I have said, to Page 34 Page 36

1	their own safety. But that in itself presented	1	the system of communication to and from the fire ground,
2	a significant problem for the bridgehead commanders,	2	did not provide for an incident on this scale. That is
3	because when firefighters are committed to a particular	3	one of the most significant lessons which must be
4	flat and they are heading to that flat and they	4	learned from the Grenfell Tower fire, and the Brigade is
5	encounter residents in distress on the stairway as they	5	learning from it. I will come back to what is being
6	come down, they could not pass them by, and so they had	6	done about that in due course.
7	to direct them down the stairs or in some cases take	7	As has been stated on a number of occasions, the
8	them down the stairs themselves. That presented	8	Brigade control room at Stratford was required to handle
9	bridgehead commanders, when committing crews to specific	9	more calls this is the scale of it from residents
10	flats, with significant difficulties. In the moment, in	10	requiring fire survival guidance within Grenfell Tower
11	the dynamic and changing situations that occurred on	11	on the night of the fire than the total number of such
12	that night, those were very, very difficult	12	calls in the previous ten years from the whole of
13	circumstances to address with any kind of certainty.	13	London. That is the difference in the level of scale
14	Accounts were given by firefighters during the	14	and the unprecedented nature of what happened on the
15	hearings of difficulty choices they were required to	15	night. That is in the context that certain of the
16	make, involving the viability of immediate rescue, the	16	control officers, with decades of experience, had only
17	number and the vulnerability of the residents they	17	been required to handle a handful of fire survival
18	encountered and whether to advise residents to remain in	18	guidance calls in all of their service.
19	relatively clean air or to encourage them to venture	19	We have also learnt that so voluminous were the
20	into a hazardous and toxic environment and attempt	20	calls to the Brigade that it was necessary for a number
21	escape down the stairs.	21	of other fire services and other emergency services to
22	I want to pause here briefly just to recognise the	22	assist in dealing with them using the established mutual
23	reality of the firefighters' situations. They're	23	aid arrangements. The demand on the control room on the
24	wearing heavy breathing apparatus. They've got masks	24	night of the fire and the number of calls far
25	over their faces. Sometimes they're on the second or	25	outstretched anything which the Brigade or, indeed, any
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1	third time into the building. They are sometimes	1	other fire service in the country has ever had to deal
2	literally feeling their way up and down the stairs or in	2	with. That is a significant consideration, of course,
3	the lobbies because the smoke is so thick that there is	3	in trying to understand what happened on the night, but
4	zero visibility. Many of the residents, of course,	4	the Brigade entirely accepts that it doesn't impact on
5	describe the same conditions. They are having to	5	the fact that lessons must now be learnt in light of
6	balance competing demands, and they are keeping an eye	6	that experience.
7	on their own air supplies at the same time. In some	7	But in learning those lessons, it's essential to
8	cases, they are drawing on the very limits of their	8	acknowledge the real difficulties which control rooms up
9	physiological capabilities.	9	and down the country will always face in these
10	So, sir, when assessing or judging the manner in	10	circumstances, no matter what changes are made. That is
11	which decisions were made by firefighters and commanders	11	not to say that something cannot be found to overcome
12	in those circumstances, it is our submission that those	12	those difficulties, but it is very far from being
13	factors must be borne in mind.	13	a simple fix.
14	I want to come now to the control room.	14	Among the many issues explored, the inquiry looked
15	Taken as a body of evidence, it is clear in the	15	at the extent to which control room operators should
16	accounts given by control room operators of their	16	interrogate callers to ascertain the conditions within
17	experiences on the night that the Fire Brigade control	17	the immediate vicinity outside their flats, rather than
18	room was overwhelmed by the scale of the incident from	18	simply relying on what they say. That is an issue which
19	an early point in the fire. The operators, the control	19	has always presented real difficulties in the training
20	room officers, faced equally difficult and distressing	20	of control staff nationally. Remote from the fire
21	dilemmas to those faced by the firefighters inside the	21	ground, they have no means of carrying out an objective
22	building.	22	assessment of the conditions immediately outside the
23	The Brigade acknowledges in relation to the control	23	caller's flats or beyond, and they are reliant to a very
24	room that its policies and procedures for the handling	24	large extent on what they're being told by a caller.
25	of calls, the provision of fire survival guidance and	25	That's one of the key problems which has been described
	Submittee and		
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1	by many of the control officers who gave evidence in	1	As we know, the inquiry has heard that many of those
2	this inquiry.	2	who made calls during the fire felt extremely and
3	But the problem, the issue, is perhaps most clearly	3	understandably reluctant to leave their flats,
4	articulated by a resident of Grenfell Tower on the night	4	Mr Bonifacio being one.
5	of the fire. It is vividly described by Mr Roncolato,	5	So the lessons which must be learned from control
6	who lived on the 10th floor, who called the Fire Brigade	6	rooms within the UK, and particularly within London, of
7	on a number of occasions on the night. He made two	7	course, must be considered in the context of the
8	attempts to leave his flat and found it impossible to do	8	enormous scale of the Grenfell Tower fire, and the fact
9	so by reason of the conditions that he faced.	9	that the decision to suspend the stay-put strategy
10	The Fire Brigade called him back at 4.49 am. That	10	provided by the building design and the Building
11	was because the control room had spoken to his	11	Regulations for an entire building was made for the
12	sister-in-law. So there was a callback. Mr Roncolato	12	first time in history in the UK.
13	said "I can't leave the flat because of the thick, black	13	Sir, in the final section before concluding, I just
14	smoke". He was asked by counsel to the inquiry, Mr	14	want to highlight, if I may, the actions which the
15	Millett, what he would have done if the control operator	15	Brigade has taken since the fire and the significant
16	had told him to leave and get out even though he said he	16	effort which is being put into the process of learning
17	couldn't get out, and he said this:	17	lessons.
18	"Well I would have assessed again if I was in	18	First of all, interim safety measures.
19	the condition to go out. But obviously she would've	19	Immediately after 14 June 2017, the Brigade was in
20	taken a big responsibility to do so on her behalf,	20	close liaison with the National Fire Chiefs Council, the
21	because she wouldn't know how bad the conditions outside	21	NFCC, for the purpose of recommending interim control
22	were. I knew, she didn't. She wouldn't know." [Day 52,	22	measures for fire services nationally to mitigate
23	3 October 2018, page 68]	23	failings in high-rise buildings demonstrating the
24	Those are the words of Mr Roncolato.	24	failings that were seen at Grenfell Tower.
25	Then in his call to the Brigade control again at	25	The resulting guidance was a document produced by
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1	5.05, an hour later, during which the control operator	1	the NFCC which recommends a process by which certain
2	did instruct him to leave, even though he said he cannot	2	types of high-rise residential buildings should be
3	get out, he said that he could not do so and decided to	3	subject to a risk assessment and analysis by a suitably
4	remain where he was. But he went on to say this in	4	qualified person, and, in short form, those buildings
5	evidence:	5	particularly with ACM cladding and systems similar to
6	"Now let's say I would be convinced by this person	6	the Grenfell Tower fire are now subject to a system,
7	to go out, and if something had happened to me, how	7	certainly in social housing, by which it is necessary to
8	would that person feel if I had not made it out,	8	develop the possibility of evacuation even before the
9	basically? So that's why I said"	9	Fire Brigade get there. That is achieved by trained
10	In fact, what he said was in that call, "Someone	10	persons in these buildings, who are on duty 24 hours
11	will have me on their conscience if I leave":	11	a day as waking watchers, who, in the case of fire,
12	"So that's why I said, you know, I don't want to	12	alert the occupants of the building, the building
13	think of someone thinking, 'Oh, because I gave him that	13	occupants are made aware of the evacuation process, and
14	advice, look what happened to him'. How would that	14	that is how that is achieved. It's the only way it
15	person then live for the rest of their life?" [page 77]	15	actually can be achieved when there aren't fire alarms
16	Mr Roncolato was in fact rescued from his flat by	16	all over the building and an evacuation process.
17	firefighters at around 6 o'clock in the morning, but in	17	So that is the position for buildings which have
18	that short passage, just that last short passage, he	18	been identified as being high risk, and that's the
19	captures the essence of the challenge which fire	19	policy which the NFCC recommends and which the London
20	services must face in developing policy derived from	20	Fire Brigade itself adopts. But it makes it clear that
21	lessons learned by the Grenfell Tower or earlier fires.	21	a simultaneous evacuation strategy for any fire should
22	This is not the Brigade's suggesting, "Well, we can't do	22	only be a temporary measure until all the risks have
23	any more about it"; it is merely highlighting the	23	been rectified.
24	genuine and difficult human difficulty that arises in	24	In addition, in London, the Brigade has provided, as
25	developing policy and training on issues of that kind.	25	an interim measure, an increase in the predetermined
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attendance required for such buildings for an interim period, which increases the number of personnel and fire appliances which will attend a fire in the first instance. Further details of that can be found in a document called the "Organisational Overview", which has been disclosed by the inquiry.

Importantly, though, more recently, the Brigade has now introduced fire escape hoods that are designed to be used by members of the public where they need rescuing through smoke-filled environments. They provide 15 minutes' protection from four of the main fire gases and can be worn by conscious or unconscious persons. They're now carried on all firefighter breathing apparatus sets, and there is also a reserve available if it becomes necessary in a more major incident.

Importantly, the Brigade, together with the Kent Fire and Rescue Service, are the first fire and rescue services in the country to adopt the use of them. In fact, they have already proved useful, and have been engaged most recently in a fire in which a child was able to leave a 2nd floor property through the building with the smoke hood, rather than run the risk of being rescued by a ladder. There are many instances in which they're useful. So that has been done.

Now, there are further actions which I am not going

being able to capture all of the information identified in various policies, in particular those which are relevant to section 7(2)(d) visits, familiarisation visits.

Perhaps just very briefly touching upon all of those issues, those which are perhaps most important.

Having acknowledged that position, sir, in relation to the operational risk data, the Brigade is now in the process of reviewing the way in which familiarisation visits under section 7(2)(d) are conducted in relation to policy, including the system which governs the way in which risk information is gathered, recorded and disseminated; including also a review of the way in which buildings are assessed; the introduction of a scheme by which fire station staff are provided with increased fire safety knowledge when carrying out 7(2)(d) visits, and also when carrying out premises risk assessments and operational database visits. So there is a new scheme in development to improve that system. And, of course, a full review of training to reflect all of those issues.

The statement, for those who wish to read it in more detail, also looks at the issues concerning the evacuation of buildings with a stay-put strategy and the measures which are put in place in relation to that, and

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to go through in detail, but they appear in paragraphs 75, sir, to 110 of the Brigade's statement. But I do need to touch upon some of them.

There are several actions and several projects which are now underway to learn the lessons which have been learned from the night of the fire. The accounts which are given in the statement frankly acknowledge where procedures and policies and training fall below the standard required by the Brigade and the actions taken to address them. It details further actions concerning the use of equipment for firefighting and rescue, and an analysis of the work undertaken to improve fire ground-control communication.

Operational risk information, the ORD. It is necessary that I say something about that.

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The Brigade accepts that the quality of the operational risk information recorded for Grenfell Tower at the time of the fire fell below the standards expected by the Brigade, as was acknowledged by the London Fire Commissioner during her oral evidence. It also points to a wider concern the Brigade has in the way that this type of information is gathered, recorded and disseminated across the organisation. The Brigade's witnesses have highlighted certain issues and practical challenges, particularly for fire station personnel, in

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the recognised need that policy note 633 does not provide specific guidance to commanders and firefighters on how evacuation might be achieved. Amendments are being looked at for that. But I repeat what I said earlier, that that is not a simple matter because of the nature and design of buildings.

On incident communications, the Brigade is reviewing the whole of the communications issue in relation to fire ground and control, and it is proposed to upgrade those communications, both for fire ground radios and for breathing apparatus radios, obviously together with training.

In relation to Brigade control, it is right that
I repeat that the Brigade accepts that its policies and
procedures for handling calls, the provision of fire
survival guidance and the system of communication to and
from the fire ground just didn't provide for an incident
on this scale. Therefore, measures are now being
addressed to include the exploration of a new dedicated
Airwave talkgroup to enable different fire services and
different control rooms to communicate with each other
and to effectively exchange communication in case of
a major disaster.

There is to be a revision and is a revision in place of the fire survival guidance policy, 790, fire survival

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1 1 which arise from the lessons learned in the guidance refresher training is being undertaken, and 2 2 a range of other measures in connection with that. Grenfell Tower fire, they cannot extend to overcoming 3 3 Other issues which those who read the statement will the shortcomings in the system of building regulation. 4 see are that there are reviews of policy concerning 4 That is the primary basis upon which the fire safety is 5 5 maintained in high-rise residential buildings. Sir, high-rise policy firefighting itself, that's all being 6 these are challenging issues which must be scrutinised looked at. Incident command training is also being 6 7 7 looked at, particularly in relation to the in Phase 2. 8 8 re-enforcement of the FSG co-ordinator role on the fire But the Brigade is well aware that it has its own 9 9 lessons to learn. We're not pointing fingers, we're ground, and in relation to the search co-ordinator, 10 Brigade control and the incident commander. All of 10 simply saying that's the reality of the position. Some 11 those issues came sharply into focus in the evidence in 11 of the evidence at Phase 1 has demonstrated that. 12 12 So, for the present, the Brigade repeats its Phase 1. 13 Sir, in conclusion, can I say that the Brigade will 13 continuing commitment to the bereaved, survivors and 14 continue to pursue the actions which it has identified 14 residents of Grenfell Tower to do everything in its 15 in the statement that I've just summarised, those last 15 power to meet their justifiable demand for answers to 16 few issues, and, where practical, will adopt measures to 16 their questions, and that meaningful lessons, by the 17 address the lessons which can be learned from the 17 Brigade, some of which have already been identified, 18 18 Grenfell Tower fire. which I've outlined, must be learned from the night of 19 It is expected that the inquiry will wish to examine 19 20 many of those issues further in Phase 2, and the Brigade 20 Sir, I don't think I can help you further unless --21 will continue to provide every assistance it can to that 21 SIR MARTIN MOORE-BICK: Thank you very much indeed, 22 22 end. But the Brigade does return to the question it Mr Walsh. You've been very economical, for which you 23 23 posed in its opening statement back in June, as should always be thanked, but I hope you feel you've 24 an expression of the issues with which fire services 24 covered everything you want to cover. 25 25 MR WALSH: I feel I've been given a very full opportunity. nationally must wrestle. I'm not going to read out that Page 49 Page 51 1 1 I'm grateful for it, sir. question again, but in essence, it poses the simple 2 question, whether it is in the public interest to make 2 SIR MARTIN MOORE-BICK: Thank you very much. 3 3 That might be a convenient point to have a short fundamental changes to the building regulation regime, 4 4 the design, construction and building control regimes, break. We'll break now for 10 minutes and resume at 5 5 so as to ensure that residential premises, particularly 11.35, please. Thank you. 6 high-rise premises, are safe so that residents and the 6 (11.25 am) 7 7 public can be confident that they are safe, and so that (A short break) 8 8 fire services, when they attend to deal with fires, can (11.35 am) 9 9 be equally confident; or whether -- it might be "and", SIR MARTIN MOORE-BICK: Now, the next person I'm going to 10 but for the moment I would say "or" -- fire services 10 invite to give us a closing statement is the 11 should plan across the country to fight fires and carry 11 representatives of G4, which I think for this purpose is 12 out rescues in buildings which are wholly non-compliant 12 Ms Barwise; is that right? 13 with safety provision. If that is so, so be it, but 13 MS BARWISE: Yes. 14 there are very significant challenges in planning for 14 Closing submissions on behalf of G4 by MS BARWISE 15 that. Some of those challenges I've highlighted today. 15 MS BARWISE: Sir, I propose to address you, if I may, on 16 Those questions are obviously not mutually 16 five matters but, before doing so, must put my 17 exclusive, sir, but it is finally important to bear in 17 submissions into context. 18 mind that fire and rescue services undertake their 18 On 14 June 2017, a devastating fire raged through 19 functions in the built environment on the assumption 19 the homes and lives of the Grenfell Tower residents. 72 20 that it is governed by rigorous regulations, robust 20 people died as a result, and many more found themselves 21 testing, competent individuals making choices about 21 bereaved and homeless. The effects rippled yet more 22 methods of construction and the materials used to ensure 22 widely as communities across the UK and overseas, 23 buildings are safe. 23 reflecting the diversity of the Grenfell residents, lost 24 Whatever changes may be made in fire service 24 friends and relatives. 25 policy -- and there will be, that is a commitment --25 I appear before you, sir, on behalf of the bereaved, Page 50 Page 52

those who survived and local residents, all of them 1 1 The first stage is breach of the compartment of 2 seeking answers as to how a fire such as this could 2 flat 16 between 00.54 to 01.05 or 01.13. 3 happen in 21st century London. They seek the truth and 3 First, how was the compartment of flat 16 breached? 4 place their trust in you and your team to find it. 4 The two most probable routes by which fire escaped 5 5 My five topics are (1) how an inevitable fire flat 16 and entered the cladding are either through the 6 overwhelmed the tower; (2) the seminal events of the 6 window surround, once the uPVC has fallen away, or 7 7 night in the context of the building; (3) root causes of through the extractor fan or window. All three fire 8 rapid fire spread; (4) active and passive protection 8 spread experts agree that the most probable route is by 9 9 systems; and (5) toxic conditions on the night. I will the defamation or falling away of the uPVC surround. 10 conclude with findings we invite the inquiry to make. 10 The uPVC, which Professors Torero and Bisby agree loses 11 Turning first to the inevitability of the fire and 11 its mechanical strength at low temperatures within 5 to 12 12 the tower's ability to withstand it. 11 minutes, served as a single barrier between the 13 The travesty of Grenfell is that the fire which 13 interior of the tower and the components of the cladding 14 14 system. The experts agree that the falling away of the overwhelmed it is one which its design contemplated and 15 could easily have resisted due to its concrete 15 uPVC likely occurred first, exposing a complex system of 16 compartmentation, which was originally complemented by 16 combustible materials to heat and smoke, facilitating 17 17 a concrete facade. ignition. 18 Professor Torero described the fire, which he 18 Beyond that, we are unlikely ever to know the 19 calculates was no bigger than a frying pan fire, as 19 precise sequence in which the materials burned. As 20 an inevitable, perfectly foreseeable event, with 20 Professor Torero said, the importance to the overall 21 a probability of 1; in other words, bound to happen. 21 outcome of what was the first thing to catch fire is 22 From the moment Grenfell Tower was enveloped in 22 probably not that significant. 23 23 patently non-compliant cladding materials, which would Dr Lane considers the fire exited the top of the 24 both ignite easily and burn rapidly, its fire safety 24 window by the column. Professors Torero and Bisby also 25 25 strategy, which depended on the stay-put principle and, favour this route, although they approach it by Page 53 Page 55 1 1 in turn, on compartmentation, became invalid and different but complementary analyses. Professor Torero 2 dangerous. All three fire experts agree that once the 2 uses fire dynamics and Professor Bisby analyses images 3 3 to determine the sequence of ignition of the cladding. building was clad in this particular cladding system, 4 4 Professor Torero stressed that both analyses are to be a stay-put policy was no longer appropriate. It is 5 clear from the experts' evidence that the installation 5 considered. 6 of this particular cladding system, so complex that its The alternative route of ignition by smoke venting 6 7 performance cannot be properly, precisely assessed, 7 from the window is not a likely scenario. 8 8 Professor Torero is satisfied this was not the means of inexorably led to the disaster that followed. 9 9 As Dr Lane forcefully put it, Grenfell Tower should escape since the temperature of smoke venting from the 10 10 never have been handed over after the refurbishment with flat 16 window was insufficient to cause fire in the 11 11 aluminium panels. this rainscreen system given the stay-put policy. The 12 12 tower represented a health hazard so egregious it should The properties of any given material do not indicate 13 never have been occupied. Given the combination of fire 13 which would ignite first. Whilst those with low thermal 14 inevitability, coupled with a stay-put policy, it is no 14 inertia will ignite much faster, it depends where each 15 15 exaggeration to describe the tower, as refurbished, as material was in relation to the flame. Further, the 16 a deathtrap, as indeed our clients did describe it. 16 contribution of exposed polyethylene edges of the 17 17 My second topic is the seminal events of the night, Arconic aluminium cladding panels will have changed the 18 Professor Torero's four stages. 18 outcome, in that they will ignite faster than other 19 Before I outline each stage, we should bear in mind 19 areas of the panel; but, given the proximity of other 20 Professor Torero's observation that the defining 20 materials, it is impossible to identify the significance 21 characteristic of a high-rise building is that the 21 of that, except perhaps at the crown. 22 timescales of allowing people safe time to exit will 22 The experts are agreed that in the event of any fire 23 converge with the time in which parts of the building 23 starting near a window, there was a high probability of 24 will fail, and that the fire safety strategies assume 24 fire spread into the cladding. 25 parts will fail, but that the escape route remains safe. 25 The second question during this first stage is: when Page 54 Page 56

1	was the compartment breached?	1	needed. On her view, compartmentation had been breached
2	There are two competing views. Whichever view is	2	at 01.13, but stay put did not substantially fail, as
3	accepted as correct, all three experts agree that the	3	she put it, until 01.26, which she chose because by then
4	fire had breached the compartment between 01.05 and	4	20 flats were visibly on fire.
5	01.13, and had very obviously breached the compartment	5	Dr Lane appears to have had in mind the point at
6	by between 01.11 and 01.13.	6	which the firefighters ought to have perceived the
7	Taking the two alternative definitions of	7	failure of stay put. In fact, the firefighters
8	compartment breach in turn, the first is that it occurs	8	perceived that defend in place, on which stay put
9	the moment the fire leaves the compartment and enters	9	depends, had failed by 01.13, since at that time the
10	the cladding. Professor Torero's view is that the	10	Brigade ordered a hydraulic platform, which is only
11	compartment is breached at a defined moment in time;	11	consistent with external firefighting. As Dr Lane said
12	namely when the fire is within the cladding outside	12	in her evidence, that was a recognition that unplanned
13	flat 16, which he says occurred between 01.05 and 01.08	13	for external firefighting is becoming necessary.
14	and was fairly obvious by 01.11.	14	I now move on to stage 2, vertical fire spread up
15	Professor Bisby was willing to accept, at Grenfell,	15	the east face, 01.05 or 01.13 to 01.29.
16	because of the inevitability of fire spread, that the	16	Vertical spread at Grenfell took approximately 12 to
17	compartment was breached at the moment when the fire was	17	15 minutes and averaged 4 metres per minute. That rate
18	in the cladding outside flat 16, so, on his reckoning,	18	of spread puts Grenfell among the slowest of 12
19	01.09.	19	international cladding fires examined by
20	The alternative definition of compartment breach is	20	Professor Torero. From the early stages so 01.13 to
21	that it occurs only when the fire enters another flat.	21	01.16 the fire had spread along the tip and edges of
22	Dr Lane's view is that from the perspective of ADB,	22	column B5. During vertical flame spread, the flame
23	compartmentation is not assumed to have been breached	23	propagated laterally northwards but not southwards.
24	until the flame is in the next compartment. On this	24	Between 01.18 and 01.28, the vertically propagating fire
25	basis, compartmentation is breached at 01.13. Dr Lane	25	had already ignited internal fires on the 5th, 12th and
	Page 57		Page 59
1	relied on diagram 33 of ADB, but ADB implies that	1	22nd floors.
2	compartmentation is breached simply on spread beyond the	2	Combustion within the cavity in the column and in
3	compartment of origin. Once the fire is in the	3	the cavity behind the spandrels is considered by the
4	cladding, it is, by definition, no longer within the	4	experts to be complex, and we may never know the precise
5	compartment of origin.	5	mechanism. What we do know is that the flames elongate
6	Once compartmentation is breached, evacuation is the	6	as they seek oxygen and fuel, leading to flame extension
7	only viable option. Professor Torero was clear that	7	of five to ten times that of the expected lengths of
8	once compartmentation is breached, evacuation is	8	an unenclosed fire, and the fuel-rich cavity is kept hot
9	necessary to secure the safety of the residents and is	9	by the insulation. The complexity of the way the
10	the only viable option at that point. That is because	10	insulation interacted with the polyethylene within the
11	stay put depends on early extinction of the internal	11	cavity is also significant, as I will explain shortly.
12	fire, namely the tactics known as "defend in place",	12	Professor Torero tells us that the width of the
13	which Dr Lane defined in her first report as meaning	13	cavity is fundamental to determining the extent to which
14	early extinction of the fire. Once that early effort	14	the cavities acted as chimneys. If the width of the
15	has failed, the stay-put strategy must change to	15	cavity is either too great or too small, then the fire
16	evacuate. The fact that, in the past, as Mr Walsh told	16	dies out.
17	us this morning, the Brigade has ignored a breach of	17	During the second phase, residents fled the flat 6s,
18	compartmentation by sectorisation and has managed to	18	and in this phase the lobbies and stairwell appear to
19	extinguish the fire does not alter these fundamental	19	have been relatively smoke-free.
20	principles.	20	The second stage was what Professor Purser describes
21	While Dr Lane was unwilling to say that stay put had	21	as the golden early period during any fire when people
22	failed at the moment compartmentation was breached, she	22	can make a safe escape, and after which the fire gets
23	accepted a high degree of compartmentation was needed to	23	exponentially worse.
24	support a stay-put strategy, and, if that cannot be	24	The third stage is compromise of the interior
25	achieved, a total evacuation is highly likely to be	25	between 01.09 to 01.50 or 02.00. This stage began when
	acine rea, a total evacuation is highly fixely to be	L 43	octation of to on oz.ou. This stage began when
23			
23	Page 58		Page 60

1 the extract fans and the uPVC window surrounds, allowing 1 the fire reached the top of the east face and began to 2 spread laterally by means of the crown. 2 flame to re-enter. 3 The crown was responsible for one of the very 3 During this third phase, evolution of conditions in 4 unusual features of the Grenfell fire; namely that 4 the stairs and the lobbies is very dynamic. Communal 5 horizontal spread enveloped the entirety of the building 5 stairwells and lobbies on levels 10 to 14 and above 6 within less than 3 hours. The crown, described by 6 level 20 intermittently become actually or seemingly 7 Professor Bisby as essentially a fuse around the top of 7 impassable to occupants by about 01.50. 8 the building, was a wholly unnecessary architectural 8 Another key feature of this third phase is that 9 9 feature, whose sole function was aesthetic. Its smoke spread from the east to the west face of the tower 10 contribution to lateral fire spread was, however, 10 relatively early on at 01.57. At this time, the flame 11 devastating, taking 24 lives from the 23rd floor alone, 11 front had not yet reached the west of the tower, 12 to say nothing of the many lives lost on the floors 12 suggesting a breach already of two layers of 13 below caused by fires starting by dripping materials 13 compartmentation. 14 from the crown. 14 The opening of doors and the doors' failure to close 15 The crown was made purely of Arconic cladding panels 15 appears to have played a key role in the loss of 16 shaped into fins and without insulation behind them. 16 compartmentation and smoke spread during this phase, but 17 The rate of lateral spread at the crown was half a metre 17 further investigation is required. 18 per second, setting the pace for lateral propagation. 18 The convergence of timescales that I talked about 19 Lateral spread at the crown was significant for two 19 earlier also becomes particularly acute in this third 20 particular reasons. 20 phase, as the tower's safety systems are failing, 21 First, it effectively compromised the flats above 21 limiting the opportunities for residents to evacuate. 22 level 20. The rate at which those flats were penetrated 22 The stairs and lobbies are affected by firefighting 23 23 was at a similar rate to the progression of fire in the activities bringing firefighters into conflict with the 24 crown. These flats suffered from heating, melting and 24 residents' need to escape. 25 25 dripping of polyethylene from the crown. Finally, Professor Torero identifies his fourth Page 61 Page 63 1 Second, the crown drove horizontal and vertical 1 stage, the untenable stage, until the extinction of the 2 spread elsewhere over the building. Melting and burning 2 fire. Professors Torero and Purser define untenability 3 3 polyethylene and molten debris from the crown fell to as a combination of physiological and behavioural 4 4 lower levels, igniting fires which propagated vertically conditions. Both observe that although conditions in 5 upwards. The phenomenon of falling, burning debris was 5 the stairs were often perilous during this period, they 6 also the key mechanism of horizontal spread at the lower 6 were variable, such that escapes were possible, even 7 7 after 3.00 am. 8 It is tempting to think that solely the Arconic 8 My third topic is the causes of failure of the 9 panels were responsible for the devastating effects of 9 10 rapid lateral spread caused by the crown, since there 10 The root cause of the failure of the tower is the 11 was no insulation behind the fins. It must be 11 facade and the window assemblies. 12 remembered, however, that the melting, dripping 12 I turn first to the question of how compliance of 13 polyethylene fell into the insulation and other 13 the facade and windows is to be achieved under the 14 materials in the cladding, so whilst the speed of 14 Building Regulations. 15 lateral spread at the crown clearly implicates Arconic 15 Functional requirement B4.(1) of the regulations 16 panels as being the most significant cause of rapid fire 16 requires that: 17 spread, in terms of lives lost as a result of the crown, 17 "B4.(1) The external walls of the building shall 18 the other materials also played a role. 18 adequately resist the spread of fire over the walls ... 19 The arrangement of materials around windows is also 19 having regard to the height, use and position of the 20 important in this phase, as in other phases of the fire, 20 building." 21 as it provided a means for the external fire to re-enter 21 Non-mandatory guidance on how this functional 22 the flats. Heat fluxes generated by the fire would 22 requirement can be achieved is given in the form of 23 impose thermal loads an order of magnitude greater than 23 Approved Document B, which I'll call ADB. There are two 24 the components were designed to tolerate, and which 24 principal routes for compliance suggested by ADB: either 25 would inevitably cause a failure of the window glazing, 25 the large-scale test or the so-called prescriptive Page 62 Page 64

route. The third route is a holistic fire safety 1 1 industry as petrol. 2 2 assessment of the building, and industry suggests Dr Lane considers that not one of the materials in 3 3 a fourth route might be a desktop study. the facade complied with ADB or was compliant with the 4 As there is no evidence of any route to compliance 4 Building Regulations. Professor Bisby is equally 5 having been followed, the prescriptive route was adopted 5 adamant that functional objective B4 was clearly not by default by the Grenfell contractors and design team. 6 6 achieved at Grenfell Tower. 7 7 That route sets requirements for insulation and outer The consequences of this non-compliance was that the 8 surfaces of external walls by reference to national and 8 fire would spread, the spread would be rapid and, once g 9 European standards, and requires proof of compliance by in the cladding, nothing could impede the spread of 10 product certificates. No certificates were, however, 10 smoke and fire. As Professor Bisby said, if a fire is 11 provided. 11 ignited in a cladding system such as this, made from 12 Dr Lane has identified the reaction to fire 12 materials such as these, under any circumstances, we 13 classification which the product should have met by 13 have to expect it to spread quickly and catastrophically 14 reference to the European standard BS EN 13501, which 14 because of the nature of the materials involved. 15 classes products as A1, described as non-combustible; 15 I turn next to the windows, starting with the uPVC 16 A2, known in the national system as products of limited 16 linings of the sill, head and sides of the windows on 17 combustibility; or, below A1 and A2, classes B down 17 the interior of the tower. 18 18 All three experts acknowledge the alarmingly low 19 As can be seen from Dr Lane's table at figure F.4 of 19 temperature at which uPVC loses mechanical stiffness. 20 her report, there are similarly low limits of thermal 20 These uPVC surrounds demonstrate the complexity of fire 21 energy output imposed on both A1 and A2, but there are 21 engineering design. On the one hand, the material is 22 22 no such limits on classes B to F. Both A1 and A2 can fire retardant with a high ignition temperature. On the 23 pass the non-combustibility test, BS 1182, though to 23 other hand, it deforms at very low temperature. Whilst 24 achieve A2, that is not necessarily required. 24 Dr Lane will be more concerned about what lay beneath 25 25 The relative flammability of A1 and A2 as against the uPVC than the material itself, Professor Bisby noted Page 65 Page 67 if you are relying on this material to provide any sort 1 classes B to F products undoubtedly matters in terms of 1 2 the ease of ignition and rate of burning. 2 of performance in a fire, you ought to be deeply 3 3 suspicious of the ability to provide it. At Grenfell, the insulation should, by reference to 4 4 The uPVC surrounds acted by default as cavity ADB, have been minimum A2-s3 d2. The insulation 5 products in fact used were not in the same league, and 5 barriers between the interior of the window and the 6 cavity of the cladding. UPVC is wholly unsuitable as 6 ranged from European classes D down to F, where test 7 7 a cavity barrier given its propensity to melt and should evidence was even available. 8 not have been used. No proper cavity barrier was 8 The ACM cladding panel surfaces should've been 9 designed, even though they are required at windows. 9 class 0, national system, or European class B-s3 d2 or 10 Accordingly, the window assembly was not compliant 10 better, but there is no valid certificate supporting any 11 with ADB, nor functional requirement B3.(4) of the 11 such grading. 12 12 regulations, which requires that the building shall be Arconic's Reynobond PE 55 cassette system was 13 European class E, but even then, only when tested with 13 designed and constructed so that the unseen spread of 14 fire and smoke within the concealed spaces in its 14 a class A2 substrate. That means being tested up 15 15 against a piece of A2. Absent that protection -- and at structure and fabric is inhibited. 16 The BRE report of 1992 to government following the 16 Grenfell, that protection was absent -- one assumes that 17 Knowsley Heights fire cautioned against the use of uPVC 17 Reynobond would have achieved a yet lower classification 18 near polymeric materials such as the polyethylene or 18 than class E. 19 insulation. Given the known toxicity of uPVC, 19 As I said in opening, G4 will submit in Phase 2 that 20 sufficient at Grenfell to intoxicate within 20 the core of the panels should have been of limited 21 combustibility, given the functional requirement of the 21 approximately 13 minutes, according to 22 Professor Purser's estimation, it is remarkable that 22 Building Regulations and ADB. 23 they are used at a recognised point of fire re-entry, 23 At Grenfell, the core of the panels equated, as 24 namely the windows. What is clear at Grenfell is that 24 Professor Bisby in his first presentation showed us, to 25 the material was being relied on as a cavity barrier, 25 diesel or lighter fuel, and is openly referred to by Page 66 Page 68

1	even though incapable of being one.	1	since the 1980s. Its behaviour cannot be considered
2	There were five key failings in the design of the	2	surprising by any competent fire safety professional.
3	window assemblies according to Dr Lane:	3	Professor Bisby considered the role of the polyethylene
4	1. The window were pushed outward compared to the	4	as particularly important, overshadowing the effect of
5	originals. This brought two specific gaps within the	5	the insulation.
6	internal wall construction, both of which were	6	Professor Torero observed that due to the
7	a potential path of fire spread.	7	polyethylene being thermally thin, once ignited, it will
8	2. The infill panels between the windows were clad	8	spread at a much faster rate than PIR insulation. The
9	with Aluglaze insulating panels containing Styrofoam.	9	aluminium skins, which melt in typical fire
10	Given that this is insulation, it should have been	10	temperatures, provided no protection against the
11	limited combustibility, or A2. The evidence suggests,	11	polyethylene within it, due to the extensive exposed
12	in fact, it was as low as class E.	12	polyethylene edges and given that polyethylene melting
13	3. A void was left between the original concrete	13	causes splitting of the aluminium.
14	and the Aluglaze infill panels, which provided a route	14	When considering the behaviour of the Reynobond
15	for fire spread.	15	panels, it's important to consider the role of the PIR
16	4. The windows were reduced in size, leaving a 30	16	insulation. There were two types of insulation used on
17	to 120-millimetre gap between the sides of the windows	17	the facade: Celotex RS5000, class D, and Kingspan
18	and the column, which was covered with an EPDM membrane	18	Kooltherm K15, for which there was no test evidence.
19	backed with insulation. The insulation materials were	19	The Celotex product was PIR. The Kingspan product was
20	classed E and F instead of limited combustibility. The	20	phenolic foam, but Professor Bisby considers its
21	EPDM led directly onto the insulation in the cladding	21	behaviour in flames similar to PIR. Neither were
22	cavity and could be burned rapidly through.	22	anything approaching limited combustibility.
23	5. The window surrounds contained highly	23	While the experts were clear on the primacy of
24	combustible materials, including the original wooden	24	polyethylene as a means for fire spread, the insulation
25	sills and internal wood lining, and the purlboard above	25	clearly did have a contribution, but the extent is more
	Page 69		Page 71
1	and below the windows.	1	difficult to measure. Professors Torero and Bisby were,
2	In summary, as Dr Lane said, the type of reveal	2	however, clear that the low thermal inertia of PIR,
3	lining materials and how they were arranged provided no	3	which was lower than the other elements of the cladding,
4	means to control the spread of fire and smoke. They had	4	will lead to much faster ignition of the PIR.
5	no or, at best, very little fire-resisting performance.	5	The PIR also performed a very effective supporting
6	Turning back to the facade as a whole, it's	6	role to the polyethylene. First, because its mass was
7	important to bear in mind that the components of the	7	greater than the polyethylene or the other combustibles,
8	facade function together. The materials interact in	8	hence it represented a large amount of fuel and could
9	ways that are not predictable, and this may be	9	burn for longer than other materials. Second, the
10	exacerbated further by geometry, to create what Dr Lane	10	combustion of polyethylene and PIR is mutually
11	described as a perfect combustion process. This means	11	supportive through a process called radiative feedback.
12	that, when considering the facade, we cannot view the	12	That meant the PIR's insulating capability prevented
13	materials in isolation. It does not, however, absolve	13	heat loss, and its release of pyrolysis products
14	any of the materials; each played their role.	14	assisted acceleration of upward flame spread, even
15	I now consider the role of Arconic's Reynobond PE 55	15	though polyethylene was the main driver of upward
16	smoke silver aluminium panels.	16	spread.
17	The polyethylene within Arconic's aluminium panels,	17	In short, whereas polyethylene determines the speed
18	which, as I have said, equates to lighter fuel, had	18	at which the fire propagates, the role of the PIR
19	devastating consequences for vertical and horizontal	19	dictates speed of ignition and duration of burning.
20	flame spread around the crown. The experts agree on	20	While both products pose their own particular dangers,
21	particular dangers posed by this product.	21	these dangers were amplified by their interaction with
22	Dr Lane considered it contributed to the most rapid	22	each other.
23	of the observed fire spread. Professor Bisby noted the	23	As I have said, the insulation should all have been
24	reaction to fire of thermoplastic polymers, including	24	A2, or limited combustibility, but in fact ranged
25	polyethylene, is well known and documented and has been	25	between classes D down to F.
	1 - yy, and and detailed and has been		
	Page 70		Page 72

1	Given the extent of the inferno which ensued, it may	1	an existing building. The regulations only apply if the
2	be suggested that, as a matter of causation, it was	2	works are a material alteration, namely either they have
3	irrelevant whether the insulation was of limited	3	the effect of making work non-compliant where previously
4	combustibility because it would've burned anyway. That	4	it complied, or making a previously non-compliant system
5	argument overlooks the fundamental point of	5	yet more unsatisfactory.
6	Professor Torero's convergence of timescales. Had the	6	Starting with the doors, there is clear evidence
7	insulation used been of limited combustibility, it would	7	that doors may have failed to provide the degree of
8	not have ignited or burned as quickly, particularly at	8	compartmentation required, since very significant smoke
9	the outset, potentially enabling the Brigade to	9	spread was experienced at a relatively early stage,
10	extinguish the fire before it took hold in the facade	10	including the possible movement of smoke through two
11	and/or enabling residents to evacuate in time.	11	compartments.
12	The particular properties and classification of	12	Dr Lane has assessed both flat and stair doors. As
13	materials, not merely the binary question of whether	13	to flat doors, 106 were replaced in 2011, but 14 were
14	they are combustible or not combustible, is important.	14	not. These 14 were all lost in the fire and Dr Lane is
15	This is obvious in many ways. For example, materials	15	unaware of their specification, so cannot confirm
16	such as aluminium are not combustible, but they do melt.	16	whether they complied with the applicable requirements.
17	So you cannot design safely for fire merely by focusing	17	The 2011 replacement doors were Masterdor Suredors,
18	on combustibility.	18	but Dr Lane finds they didn't comply with the then
19	An example of that point is the cavity barriers.	19	current standard because the test did not demonstrate
20	While there were a number of defects in the way the	20	30 minutes' integrity.
21	SIDERISE cavity barriers were installed, evidencing	21	A critical failing of the doors was the lack of
22	appalling workmanship, that is a secondary issue to the	22	functioning self-closers. The DCLG sleeping guide and
23	real problem; namely fundamentally flawed design.	23	LGA guide both require self-closers. Yet Dr Lane
24	Cavity barriers would never have assisted in a facade	24	identifies a systemic problem of malfunctioning
25	system of this nature given the outer wall of the cavity	25	self-closing devices. The evidence suggests an alarming
	Page 73		Page 75
1	contains combinatible reducations and the aluminium	,	fallow has the TMO to make a more land and a land
1	contains combustible polyethylene and the aluminium	1 2	failure by the TMO to repair or replace door-closers.
2 3	itself will deflect and melt.	2 3	Dr Lane will investigate the precise nature of smoke
4	What is worse, in an illustration of the complexity of fire engineering in facade systems, cavity barriers	4	spread through the flat doors per flat and lobby to ascertain the contribution of each door.
5	could actually have been a mechanism of fire spread, in	5	Turning to the stair doors, these are the originals,
6	that they created ledges on which the fires could sit.	6	but Dr Lane has established that they were not the
7	I now turn to my fourth topic, the internal active	7	type 2 door required by CP3 1971. Instead, they were
8	and passive safety measures.	8	British Standard fire check doors, which provided only
9	The purpose of active and passive safety measures	9	20 minutes' integrity as opposed to the 30 minutes
10	was to protect the stairs and lobby and the residents of	10	required of type 2 doors.
11	other flats. As we've heard from the residents, the key	11	Fire risk assessments carried out in 2016 identified
12	passive and active systems failed drastically, even when	12	instances of self-closing devices on stair doors not
13	one considers that they were only designed to mitigate	13	functioning. Dr Lane has seen no evidence that such
14	a fire on a single floor. The abject failure of the	14	issues were resolved before the fire.
15	design of Grenfell Tower is evidenced by, first, the	15	The second issue I'm going to consider is the smoke
16	doors which failed to close or prevent smoke spread,	16	ventilation system.
17	thereby undermining compartmentation; second, the sheer	17	Dr Lane hasn't yet reached a conclusion on whether
18	perversity of a ventilation system which appears	18	the system was compliant or not, but will do so in
19	designed to suck smoke into the lobbies, the very thing	19	Phase 2.
20	it is supposed to protect; third, a lift which bore the	20	The system was a depressurisation system which
21	hallmarks of a fire lift, but which in fact was, to all	21	should've extracted smoke from the flats themselves. In
22	intents and purposes, an ordinary lift.	22	fact, it appears the design would pull smoke from the
23	In each case, it should be remembered that the	23	flats into the lobbies.
24	Building Regulations do not automatically apply to the	24	Thirdly, the lift.
25	carrying out of replacement of such systems within	25	The original lifts were required by CP3 1971 to be

1	fire lifts. These were replaced in 2005, by which time	1	He concludes that polyethylene at Grenfell did not
2	ADB 2000 required the provision of firefighting shafts	2	produce sufficient carbon monoxide to be toxic, but
3	with firefighting lifts in buildings over 18 metres. It	3	would generate dense smoke, so being able to see only
4	is only firefighting lifts which can be used for	4	25 centimetres ahead of you in the flat and, by
5	evacuation. Fire lifts do not have the requisite	5	inference, in the lobbies.
6	emergency power source or protection.	6	2. Professor Purser considers dense, toxic smoke
7	Despite the requirements of ADB 2005, the lifts were	7	followed by flames from the exterior PIR around the
8	not upgraded to firefighting lifts. Furthermore, they	8	windows would rapidly penetrate flats through voids.
9	were not even fire lifts, they merely masqueraded as	9	The PIR would've produced large quantities of carbon
10	fire lifts, because Dr Lane has found no evidence that	10	monoxide and hydrogen cyanide, and likely resulted in
11	the lifts were ever connected to fire control switches	11	collapse after 23 minutes.
12	in 2005, when upgraded, and neither of the two fire	12	3. The uPVC window surrounds might have yielded
13	control switches functioned on the night.	13	sufficient carbon monoxide and hydrogen cyanide to cause
14	This is all the more astonishing given the TMO's	14	collapse within 13 minutes.
15	policy expressed in its fire safety strategy of	15	This sequence leads Professor Purser to conclude
16	upgrading lifts to fire lifts. Equally shocking is the	16	that toxic gases penetrating a flat in the minutes
17	misdescription in that document of the Grenfell lifts as	17	before the flat contents became involved presented
18	firefighting lifts.	18	a substantial hazard. Although Professor Purser's
19	Dr Lane makes no conclusive finding of	19	evidence is necessarily tentative, it is rooted in data
20	non-compliance of the lift. But her provisional view,	20	applied by him conservatively. It is reasonable to
21	given the failure to provide firefighting lifts under	21	conclude that conditions in flats, lobbies and stairs
22	ADB 2000 is that functional requirement B5 was not met.	22	were highly toxic, and that toxicity in the first
23	My final topic is toxic smoke conditions generated	23	few minutes of each flat fire was driven by the
24	by the burning of the polymeric materials or flat	24	materials from the cladding and window surrounds.
25	contents.	25	As Professor Purser tells us, even if smoke is not
20	Comence	=	1 to 1 1016 soot 1 talsot tells as, even 11 smoke to not
	Page 77		Page 79
1	First imitant and archamicat area liberate bear	,	torio at all it inflyances haborious and datassiss
1	First, irritant and asphyxiant gases likely to have	1 2	toxic at all, it influences behaviour and determines whether people live or die.
2	been produced. As Professor Purser stressed, his		
3	analysis is muraly indicative at this store. There is	2	- ·
4	analysis is purely indicative at this stage. There is	3	To conclude, the facade which included the crown
4	limited data from the fire beyond the fatalities,	4	To conclude, the facade which included the crown patently did not adequately resist and, on the contrary,
5	limited data from the fire beyond the fatalities, including the toxicology records from 15 of the	4 5	To conclude, the facade which included the crown patently did not adequately resist and, on the contrary, promoted flame spread, and so was in breach of the
5 6	limited data from the fire beyond the fatalities, including the toxicology records from 15 of the deceased, all of whom showed high levels of	4 5 6	To conclude, the facade which included the crown patently did not adequately resist and, on the contrary, promoted flame spread, and so was in breach of the Building Regulations. The facade, including its crown,
5 6 7	limited data from the fire beyond the fatalities, including the toxicology records from 15 of the deceased, all of whom showed high levels of carboxyhaemoglobin described as COHB. COHB levels in	4 5 6 7	To conclude, the facade which included the crown patently did not adequately resist and, on the contrary, promoted flame spread, and so was in breach of the Building Regulations. The facade, including its crown, lack of cavity barriers around windows, which could've
5 6 7 8	limited data from the fire beyond the fatalities, including the toxicology records from 15 of the deceased, all of whom showed high levels of carboxyhaemoglobin described as COHB. COHB levels in human tissue evidences inhalation of carbon monoxide.	4 5 6 7 8	To conclude, the facade which included the crown patently did not adequately resist and, on the contrary, promoted flame spread, and so was in breach of the Building Regulations. The facade, including its crown, lack of cavity barriers around windows, which could've prevented initial fire escape, together with the doors,
5 6 7 8 9	limited data from the fire beyond the fatalities, including the toxicology records from 15 of the deceased, all of whom showed high levels of carboxyhaemoglobin described as COHB. COHB levels in human tissue evidences inhalation of carbon monoxide. Professor Purser considers those who died at	4 5 6 7 8 9	To conclude, the facade which included the crown patently did not adequately resist and, on the contrary, promoted flame spread, and so was in breach of the Building Regulations. The facade, including its crown, lack of cavity barriers around windows, which could've prevented initial fire escape, together with the doors, and lifts are all contributors to the scale of the
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1 1 evacuation when compartmentation fails. There was the discharge of its functions by any likelihood of 2 2 liability being inferred from facts that it determines national guidance, known as Generic Risk Assessment 3.2, 3 3 or recommendations that it makes." and the London policy number 633, and Mr Weatherby QC, 4 From that we take that just because the inquiry is 4 who follows on from me, is going to deal with the 5 5 background and content of these two policies, including not a trial does not mean that matters of law are 6 irrelevant to the justice it delivers. Importantly, for 6 what we all say, that there was a terrible gulf between 7 7 Phase 1, if there are breaches of public law and paper and practice. 8 regulatory duties that are relevant to the terms of 8 What can undoubtedly be concluded by 2017 is that 9 9 the LFB was aware of the prospect of a high-rise fire reference, then the inquiry must declare them. Nothing 10 in section 2 indicates otherwise; in fact, it would 10 involving breach of compartmentation as a risk to life 11 frustrate the public interest not to do so, because 11 to be prepared for, including specifically as a result 12 12 of flammable facades. Parliament and others need to know where the causative 13 conduct, acts and omissions, was compatible with the 13 The inquiry now knows very well the signposts on the 14 existing law and policy or not. 14 way. The LFB's response to the Lakanal House coroner in 15 We have provided you with the relevant test for 15 2013 said it would prepare for fires that behaved 16 16 causation and the flexible standard of proof that inconsistently with the compartmentation principle, 17 17 operates in this investigatory context. Based on that develop contingency plans for when it did and review 18 legal framework for these proceedings, can I make clear 18 inspection regimes and information-gathering to identify 19 at the outset that our overarching submission is that 19 risks before they arose. The two big policies that 20 20 the inquiry is in a position to say now that multiple I just mentioned were updated in 2015. A training 21 and fundamental breaches of legal duty contributed to 21 package on at-risk buildings was produced to educate on 22 22 this disaster, and that all of these deaths were cladding fire between the summer and autumn of 2016, and 23 23 RBKC, with other councils across London, were preventable. 24 Our submissions on the proposed findings are set out 24 specifically warned by the LFB in a letter of April 2017 25 in detail at the end of the relevant sections of the G4 25 that cladding panels could be in breach of Building Page 85 Page 87 1 1 written submissions. In short, we say that the inquiry Regulations. 2 can and should say now: 2 The state of corporate knowledge gives rise, we say, 3 3 First, the patent failure to comply with Building to five conclusions from the Phase 1 evidence that are 4 Regulations materially contributed to all the deaths. 4 inescapable and which various counsel will follow on to 5 Second, the London Fire Brigade unreasonably failed 5 address you about. 6 to take steps that offered a realistic prospect of 6 First, this knowledge had not filtered down to 7 7 preventing these deaths. It breached its policies and station level through basic update or even operational 8 legal duties under the Fire and Rescue Services Act and 8 training. No Phase 1 firefighter witness could recall 9 9 Human Rights Act in failing to plan or train for the being specifically trained about the risks of external 10 10 foreseeable event of a fire of this nature. It should cladding fires, the revision of a stay-put policy or 11 11 what to do in the event of a failure of compartmentation also have pursued immediate full evacuation on the night 12 once it was clear that compartmentation of the building 12 in a high-rise building fire. 13 had so comprehensively failed. 13 Second, despite acknowledging the need for partial 14 14 Third, the emergency response of the category 1 or full evacuation of a high-rise building, the inquiry 15 15 responders fell short of the joint operation has received no evidence of any doctrine or training on 16 requirements of the Civil Contingencies Act 2004. 16 this, and no witness was able to give any operational 17 Now, Ms Barwise has just dealt with the building; 17 insight into how to achieve it beyond unplanned, 18 let me now outline the position on the emergency 18 door-to-door deployments as the need arose. 19 response. 19 Third, the first firefighting responders gave 20 The evidence that the LFB failed to adequately train 20 evidence that demonstrated a drastic failure to 21 and plan for a fire like the one at Grenfell Tower is 21 appreciate the breach of compartmentation occurring 22 overwhelming. On paper, its policies and executive 22 before their eyes. They failed to comprehend that 23 statements embrace the need to keep pace with common 23 immediate evacuation was the only option and that entire 24 construction methods and the risks they pose, including building failure was inevitable. 24 25 departing from stay-put advice and implementing 25 Fourth, certain senior personnel, including the Page 86 Page 88

incident commanders who arrived before 2.00 am, 1 1 systematic evacuation. That is why we describe their 2 continued to mischaracterise the nature of the fire, 2 operational failures as more institutional than 3 despite the obvious risk of mass fatality. 3 personal. Put simply, the evidence shows that this was 4 Fifth -- and I know that Mr Stein and Mr Mansfield 4 a devastating episode of looking without seeing and 5 will look at this closely -- before the fire, 5 hearing without listening. 6 notwithstanding the obligations under section 7(2)(d) 6 As to looking without seeing, Dowden was unable to 7 7 and the various policies, Grenfell Tower was register the obvious implications of breach of 8 a chronically underassessed building. 8 compartmentation across the building. However, his 9 9 The evidence of Commissioner Cotton in response to actions indicate more than he was ultimately willing or 10 these matters brought her and her organisation into 10 able to concede in evidence. 11 disrepute. Everyone who has followed this inquiry will 11 You do not start to deploy a covering jet and order 12 recall the woefully ill-judged and defensive statements 12 the more aggressive hydraulic pump all before 01.13 13 that she wouldn't develop a training package for a space 13 unless you know you are fighting an external fire of 14 shuttle to land on the Shard and that she wouldn't 14 substance. His movements to pumps six before 01.14 and 15 change anything about what her firefighters did on that 15 pumps eight at 01.19 say the same. By 01.26, he made 16 night. Not only were those comments insulting to the 16 pumps 10 and at 01.28 he made pumps 15, requested aerial 17 BSR, but they were irresponsible. They send a wholly 17 times 2 and declared persons reported. He did this 18 negative message about the LFB's capacity as 18 because the fire was, in his own words to the peer 19 an organisation to acknowledge its shortcomings and to 19 review, "halfway up the building and now getting into 20 make any real change in the future. 20 flats". This was as early as 01.28. What he saw and 21 Cladding fires are rare but notorious, because they 21 what he did reflected an obvious breach of 22 bear the highest prospect of catastrophe in a high-rise 22 compartmentation. This was not a sector fire. Yet none 23 23 of this translated into the full evacuation that was building. On that basis, they plainly should have been 24 planned for, but were not. 24 required. 25 25 This is also no time to patronise, either the As to hearing without listening, Watch Manager Page 89 Page 91 1 Dowden was quickly informed that the smoke and fire had 1 organisation by consoling it that there were 2 firefighters who acted heroically, or the BSR by 2 spread internally across the buildings at floors 5 to 7, 3 3 and then, we say importantly, onto floor 16. Yet very continuously reminding them that that was the case. As 4 4 little of this registered. This was absolutely one of our bereaved clients has pressed upon us 5 succinctly, "What my family needed was not heroes, but 5 a situation where audio and visual information could be 6 well-trained professionals working to a well-structured overwhelming. But that is why individual human 6 7 plan." 7 judgement and rules of thumb alone cannot command major 8 8 Ultimately, this is an issue of institutional fires. Dowden had no assistance from doctrine, training 9 9 culture. If the LFB is serious about making change, or experience to guide him to process the information 10 then it needs to learn from its errors on the night of 10 that was so overwhelming. 11 this fire. Its failure to do so is damning. At the 11 What he needed to do was evacuate. Instead, the 12 moment, its leadership remains in denial. If the 12 only available conceptual anchor that he could resort to 13 Phase 1 report does not disabuse them of that, who will? 13 was the concept of fire survival guidance, and that 14 The inquiry can and should, therefore, make findings and 14 proved to be fatally unhelpful. It meant individual 15 recommendations that identify the way in which the LFB 15 deployments to rescue particular occupants as the need 16 breached its own policies and failed to discharge its 16 arose, rather than a strategy to just get everybody out. 17 legal duties of training, resourcing and risk 17 The experts confirm what the BSR witnesses made 18 assessment. 18 clear, that before 2 o'clock, the means of exiting the 19 Without proper training or practice, Watch Manager 19 building still allowed people to get out. As a matter 20 Dowden and others were therefore left to approach the 20 of fact, the stairwell remained tolerably free of smoke 21 fire based solely on past experience, and that doomed 21 before 01.30 and, indeed, for some time thereafter. 22 them to error when faced with the unfamiliar. They 22 Even when most lobbies were filling up with dense smoke, 23 could not conceive of a fire that breached the 23 the staircase remained viable for 31 people to escape 24 compartmentation of the building in such a horrendous 24 from 01.31 to 01.47. They followed the 110 people who 25 way, and they were blind to the obvious need for 25 had escaped before that. Professor Purser calculated Page 90 Page 92

1	that simultaneous entry into the staircase of the full	1	diversions. Residents who had been told to stay put and
2	cohort of 293 people across 23 storeys could have	2	await firefighting assistance were left without any
3	resulted in evacuation within 7 minutes.	3	realistic prospect of being reached. Eventually,
4	The sceptics on this need to particularly consider	4	opportunity to access them was lost.
5	the evidence of Petra Doulova and her partner descending	5	Second, the bridgehead was starved of timely
6	from the 20th floor at 01.42 and passing multiple	6	information. To take powerful examples of delay from
7	firefighters in equipment on the way, just as they	7	among our clients, Mariem Elgwahry and Naomi Li both
8	should consider the case of Branislav Lukic carrying	8	called the control room at 01.30 to tell them that there
9	Clarita Ghavimi over his shoulder, followed by his	9	was a fire on the 22nd floor. The 22nd floor was
10	flatmate, as they came down from the 11th floor at	10	immediately mentioned in a radio service request at
11	01.47.	11	01.32. The 23rd floor, where Mariem and her mother,
12	The evidence points to what is no more than	12	Eslah, had now moved to, was communicated in the
13	common sense. From 01.15, the incident command ought to	13	telephone conversation between Operation Manager Norman
14	have confronted the clear dangers to occupants if they	14	and one of the CU staff at 01.35. The first known FSG
15	were to remain the building. Before 01.30, it ought to	15	list at the fire ground contained flat 195 on the
16	the have been obvious that this fire was going to	16	22nd floor and flats 205 and 204 on the 23rd floor.
17	jeopardise its entire occupancy. On this, Dr Lane has	17	Based on its detail, we can time that list being written
18	agreed. Evacuation should then have been instigated by	18	after 01.47.
19	sending firefighters to the top of the building and	19	Yet despite the red flagging of these flats and
20	immediately changing the control room advice.	20	floors, there was no FSG deployments to floor 23 until
21	Loudhailers could have been used in the stairwell.	21	02.08, and then no further deployments until 02.24 and
22	The intercom system could've at least been used to wake	22	02.51. Even worse, for a fire that was reported to have
23	some people up. Mr Weatherby is going to develop this	23	broken out on the 22nd floor as early as 01.30, no one
24	matter.	24	was deployed to the 22nd floor until 03.03. No
25	But let me make a point abundantly clear that hasn't	25	firefighter ever reached the 23rd floor, and although
	Page 93		Page 95
1	perhaps had the attention it should've had to date: the	1	Firefighter Roberts made it up to the 22nd, he searched
2	ensuring evacuation would not have involved a crowd of	2	neither the lobby nor the flats.
3	strangers in a public place, but neighbours and families	3	So reports of a fire at 01.30. No response at all
4	navigating the stairs of their own home.	4	before 02.08. Thereafter, no systematic approach.
5	Even after 2 o'clock, there was never a point when	5	The fires on those two floors claimed the lives of
6	it was impossible to descend without breathing	6	36 people, half the number of all the deceased in that
7	apparatus. Everything depended, therefore, on	7	fire.
8	maintaining and optimising the staircase and	8	Third, scarce resources to respond to FSG calls were
9	co-ordinated BA deployments. The failure of the	9	wasted. Two examples illustrate the point. There are
10	bridgehead throughout the night was that it dogmatically	10	several. But consider the Paddington FRU team, the
11	stuck to an ad-hoc rescue strategy and never	11	first specialist EDBA rescue unit to attend the scene,
12	contemplated facilitating escape in a systematic way.	12	sent on a hopeless mission to the roof at 01.56 to sling
13	Other counsel who follow will look at the markedly	13	ropes over the top of it to try and spray water down the
14	questionable results achieved by the BA deployments from	14	side.
15	the bridgehead that night, regardless of the effort that	15	They saved Fadumo Ahmed's life, but this was
16	was put in.	16	a specialist team, able to operate at the highest
17	We summarise this subject under five points:	17	floors, and had they been deployed in a co-ordinated
18	First, the bridgehead never evacuated residents. In	18	relay, without the extra weight of unnecessary
19	Watch Manager O'Keeffe's language, it tried to flood the	19	equipment, it must be likely that they could've done
20	building to undertake multiple rescues. This is	20	more to save others.
21	individual rescues from individual flats in response to	21	Most inexplicable of all is the delay in deploying
22	individual requests for assistance. In doing that, it	22	the available extended duration breathing apparatus
23	pursued a strategy that could not work. There was never	23	crews.
24	going to be time to evacuate the entire building by this	24	The statements of the EDBA crew members described
25	means; it involved too many flats and too many	25	being held outside to get bottles of water and general
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1	supplies of hoses and breaking-in devices. The sobering	1	the building.
2	schedules available to the inquiry show that the delay	2	The inquiry has evidence from officers Beale,
3	in deploying these desperately needed crews into the	3	Mulholland, Harrison and Leaver that this was completely
4	tower exceeded between one and one and a half hours.	4	obvious, as it was to a number of rank and file
5	Fourth, no one questioned the individual rescue	5	firefighters and, indeed, police officers.
6	approach. The majority of evacuations were either	6	Third, the lost first hour was compounded by the
7	without any assistance or only partially assisted	7	drifting decision-making in the second hour. Incident
8	towards the bottom of the stairs. The number of	8	command still did not establish the extent to which
9	successful assisted evacuations directly from a flat or	9	individual flats were in jeopardy, the failures of the
10	lobby throughout the night was few indeed, and on the	10	bridgehead were not appreciated, a major incident was
11	most generous interpretation, our estimate comes to 12	11	called without co-ordinating with the the other
12	flats and/or lobbies involving 28 people. The	12	emergency services still no one picked up the phone
13	bridgehead did not learn from the low return and	13	to Brigade command.
14	ineffectiveness of its own strategy.	14	Fourth, just after 2.00 am a watch manager,
15	Fifth, the bridgehead also did not learn from	15	Mr Harrison, intervened at the door to the command unit
16	successes. For instance, fewer deployments but with the	16	to press for revision of the stay-put advice and related
17	benefit of spare BA masks and sets for the use by	17	measures to aid evacuation. He referred to the matter
18	residents might have produced better results, like the	18	in his notes the next day. It is highly likely, we
19	evacuation of Sharon Laci and her daughter.	19	submit, having seen him give evidence, that this man did
20	Equally, no one apparently registered the	20	intervene at the door of a crowded, tense command unit
21	implications of significant numbers of self-evacuations	21	but was not heard.
22	after 3 o'clock in the morning. These survivors were	22	We say that this intervention and the officers'
23	not just young and fit adults, Mr and Mrs Macit came	23	reaction was symptomatic of something bigger, and it is
24	down from the 16th floor at 03.47. They were not young	24	a shame that it is not seen that way by the LFB. It
25	and, in the later case, suffered from mobility issues.	25	draws parallels with other sectors that had to address
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1	Ann Chance escaped with her 55-year-old mother and	1	the difficulty of the junior ranks pointing matters out
2	62-year-old aunt from the 10th floor at 04.20. One	2	to command when it really is a matter of life and death.
3	child was lost on the staircase in the worse possible	3	I'm talking about the experienced nurse in the operating
4	circumstances, and an unborn child died. But nine	4	theatre, the navigator in the jet plane and the junior
5	children aged 3 to 12 years old escaped from	5	officer and subaltern on the battlefield.
6	Grenfell Tower between 03.00 and 04.00 and many of them	6	Fifth, a specific criticism of Assistant
7	had to come down unaided.	7	Commissioner Roe is that he found no means to influence
8	Finally, there is no evidence to indicate that the	8	the drift of command once he was aware of the magnitude
9	Goulbourne system, introduced after about 03.20, made	9	of the fire, but prior to his arrival. From the picture
10	things particularly better. Under the direction of	10	of the fire sent by Station Manager Cook at 01.43, he
11	Group Managers Goulbourne and Welch, a substantial	11	understood that 100 per cent of the building was alight
12	number of EDBA crews were wastefully diverted to the	12	and that this was an undeclared major incident. But Roe
13	•	13	had no strategic input before it was far too late. That
14	lower floors instead of to the FSG calls on higher floors. These were crucial missed opportunities,	14	said, neither did his assumption of command result in
15	notably including for the remaining residents on	15	a change of the doomed strategy at the bridgehead or
16	floor 14.	16	improve communications with the control room.
17	I turn to overall command of the fire ground.	17	Now, the failure of incident command to brief the
18	Our headline point is that for much of the night,	18	control room undoubtedly impacted on the quality of
19	the incident had hierarchy but it lacked proper command.	19	advice given by its operators on the night. However,
20	First, Dowden should never have been left there that	20	the BSR view the control room as bearing its own very
20		21	significant failures.
22	long; he knew it, others knew it, DC O'Loughlin couldn't understand it.	22	During the Lakanal House fire, CROs had assumed
23		23	wrongly that compartmentation would not fail and that
23	Second, all three of the incoming commanders before	24	the fire crews would reach callers quickly. An adequate
25	2.00 am inexplicable failed to appreciate or discover that the fire had broken into individual flats across	25	post-Lakanal response needed to: (1) identify
23	that the fire had broken into individual flats defoss	===	r
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	1 revocation of the stay-put advice was not relayed
1 compartmentation failure as a paradigm shifting event in	• •
2 a high-rise fire; (2) speedily revoke stay-put advice;	2 effectively to some residents for whom English was not
3 (3) maximise intelligence to aid immediate evacuation;	a first language and, more generally, that some
4 and (4) operate effectively at overflow call capacity.	4 operators failed to communicate effectively with such
5 None of this happened for the callers from	5 residents and terminated calls with them rather than
6 Grenfell Tower.	6 staying on the line. Until there is organised access to
7 First, operators could again not conceive of breach	7 the tapes of the calls, we will not know.
8 of compartmentation within a tower block. Instead, they	8 Until then, we do say, as a matter of law,
9 repeatedly told callers that the fire was on the	9 section 149 of the Equality Act 2010 required the
4th floor or on another lower floor, even when the	proactive consideration by the LFB of how to remove or
11 caller was telling them that it was not.	minimise disadvantage connected to protected
12 Operators reassured people that they were safest	characteristics, including race and disability. We have
staying in their property, despite very early reports of	seen no evidence of the formal discharge of that duty
smoke and fire spread across the building, and they	yet, and the inquiry must get to the bottom of this
15 continuously told people that the firefighters were on	issue in Phase 2 in relation to the control room, just
their way when there was no way of knowing that this was	as it must consider the compliance of others.
17 the case.	Fourth, the residents' calls should have acted as
18 Second, there was no shared interpretation of what	an early warning of building failure, but the control
19 it meant to advise callers to remain in their properties	room and the incident command failed to grasp this. At
20 on the grounds that they were, in the words of	20 01.24, CRO Duddy heard a female caller, who it can be
21 policy 790, "not affected by fire, heat or smoke". Some	established to be Damiana Lewis on the 12th floor
22 operators thought the word "affected" required there to	shouting for help that the fire was in her kitchen and
be fire in the flat. Others thought smoke was enough.	that she could not breathe.
24 A fire outside or next door counted for some operators	At 01.25, OM Norman received a report from
but not for others.	Denis Murphy describing smoke-logging on the 14th floor
Page 101	Page 103
1 Third, as with the firefighters, these operators	lobby that was preventing him from leaving. She told
were denied proper training and, bluntly, therefore were	2 him that if leaving meant using the stairwells, which
3 not qualified to do the job they needed to do on the	3 she asserted wrongly were filled with smoke, he was
4 night. Experience of giving any type of FSG advice was	4 better off staying where he was.
5 rare. No one had practised or even contemplated the	5 At 1.26, Kasia Dabrowska from flat 95, also on the
6 role of counselling escape by telephone during	6 12th floor, informed CRO Fox that her neighbour had told
7 a high-rise mass evacuation. When the time came to give	7 her there was a fire in her kitchen and that smoke was
8 such advice, the operators had to improvise in what was	8 entering her own flat through the main door. When told
9 essentially an alien discipline.	9 that the fire was only in flat 16, she emphatically
10 Consequent problems included callers being offered	10 corrected the CRO, stating that the fire had already
the choice whether to stay or go when there was none;	11 reached her floor.
being told they needed to leave but simultaneously	There was then a series of calls at 01.30 that
advised that efforts were still being made to get to	indicated that the fire had internally reached the top
them; being unable to say in the plainest possible terms	floors of the building.
15 that pleas for helicopters and high ladders were never	15 At precisely 01.30, CRO Duddy was informed by
16 going to be met; and failing to carry out callbacks to	Mariem Elgwahry of the fire in her kitchen on the 22nd
17 inform residents who had been told to stay put in	17 floor. She had fled to the 23rd floor. She corrected
18 circumstances where the strategy had changed and they	his assurance that the fire was on the 5th floor and
19 now needed to get out.	made it plain that smoke was present in her new location
20 Despite provision in national policy GRA 3.2,	at the very top of the tower.
21 neither LFB policy or training required callers to be	21 At 01.30.02, Helen Gebremeskel from the 21st floor
22 asked about mobility or disability issues. There was	told OM Norman that there was fire in the floor below
23 also no training on how to build empathy and trust with	and that smoke was coming up into her flat.
24 people from different cultural, religious and language	At 01.30.08, CRO Russell began the call with Jessica
25 backgrounds. There remains significant concern that the	Urbano Ramirez, situated on the top floor, who
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1	immediately told her that there was a fire in the	1	night to address.
2	kitchen and smoke was coming through the floor.	2	Under the Civil Contingencies Act 2004, various
3	Also at 01.30.08, CRO Fox was informed by	3	so-called category 1 responders are required to plan for
4	Anthony Disson that the conditions on the 22nd floor	4	emergencies and work together when they arise. Our
5	were terrible and he could not see his hand in front of	5	basic observation, which we develop in writing, is that
6	him.	6	you cannot have major incidents separately declared by
7	At 01.30.38, Naomi Li, who had first identified	7	each service at different times, without the knowledge
8	smoke on the 22nd floor at 01.21, was now able to inform	8	of the other's declaration, with no co-ordination on
9	CRO Gotts that there was a fire in her neighbour's	9	critical changes of strategy, especially here the change
10	kitchen and they could smell smoke. She was told,	10	to the stay-put advice, and sensibly call it a joint
11	"Obviously I can't really advise you, but I'll let the	11	operation. Of some importance in this respect was the
12	firemen know you're there."	12	role of the police in giving FSG guidance and passing on
13	Thereafter, Biruk Haftom, a child, calling from the	13	to LFB information from members of the public regarding
14	top floor, told CRO Howson at 01.32 that there was lots	14	their family and friends still in the tower.
15	of smoke in the flat and the window was burning up.	15	Having said that, I want to address the role of RBKC
16	During the call, an adult could be heard saying "Oh my	16	and, therefore, by extension, the TMO.
17	God, the fire is coming through".	17	RBKC, as the local authority, fundamentally breached
18	At 01.33, a caller from the 11th floor could be	18	its duty under regulation 11(2)(b) of the regulations
19	heard shouting "Please, please, the fire is in my flat,	19	for the 2004 Act. It failed to provide reasonably
20	the fire is in my flat."	20	obtainable information to the LFB in relation to
21	We say the residents were the source of situational	21	residents, plans and known deficiencies in the fire
22	awareness that incident command so sorely lacked and did	22	prevention mechanisms of the building. On all these
23	itself not provide.	23	matters, it delegated to the TMO, which was not subject
24	Yet the first contact that OM Norman had with the	24	to clear, equivalent statutory duties under the 2004 Act
25	command unit at 01.35 passed on some detail, but did so	25	or its regulations. The management contract is silent
	Page 105		Page 107
	1 48€ 105		1 age 107
1	only as one-dimensional FSG calls, flats and doors	1	on the point, and we do not know yet what the
2	requiring individual search and rescue response.		- · · · · · · · · · · · · · · · · · · ·
	requiring murvidual search and rescue response.	2	understanding between the two organisations was, if
3	What was needed was a high-level intervention	3	understanding between the two organisations was, if there was any. On that, for the time being, I can make
3 4			
	What was needed was a high-level intervention	3	there was any. On that, for the time being, I can make
4	What was needed was a high-level intervention between control and incident command to identify and	3 4	there was any. On that, for the time being, I can make no further concessions.
4 5	What was needed was a high-level intervention between control and incident command to identify and dramatically act upon the clear overall picture of	3 4 5	there was any. On that, for the time being, I can make no further concessions. But there clearly is something to be concerned about
4 5 6	What was needed was a high-level intervention between control and incident command to identify and dramatically act upon the clear overall picture of building failure, and that did not occur.	3 4 5 6	there was any. On that, for the time being, I can make no further concessions. But there clearly is something to be concerned about when the evidence for the night shows that the local
4 5 6 7	What was needed was a high-level intervention between control and incident command to identify and dramatically act upon the clear overall picture of building failure, and that did not occur. Our final point for the calls is that although this	3 4 5 6 7	there was any. On that, for the time being, I can make no further concessions. But there clearly is something to be concerned about when the evidence for the night shows that the local authority was looking to the TMO and the TMO was looking
4 5 6 7 8	What was needed was a high-level intervention between control and incident command to identify and dramatically act upon the clear overall picture of building failure, and that did not occur. Our final point for the calls is that although this was a fire in London, the control room response needed	3 4 5 6 7 8	there was any. On that, for the time being, I can make no further concessions. But there clearly is something to be concerned about when the evidence for the night shows that the local authority was looking to the TMO and the TMO was looking to the local authority. In other words, there was
4 5 6 7 8 9	What was needed was a high-level intervention between control and incident command to identify and dramatically act upon the clear overall picture of building failure, and that did not occur. Our final point for the calls is that although this was a fire in London, the control room response needed to be nationwide. Despite having resources available,	3 4 5 6 7 8 9	there was any. On that, for the time being, I can make no further concessions. But there clearly is something to be concerned about when the evidence for the night shows that the local authority was looking to the TMO and the TMO was looking to the local authority. In other words, there was an operational gap, potentially facilitated by the
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1	appreciate the significance of the letter sent to RBKC	1	deceased needs to be given its due regard.
2	by the LFB in April 2017 warning about cladding not	2	It will also be necessary to investigate how so many
3	built in accordance with Building Regulations, and it	3	people with disabilities, rendering them unable to
4	must also mean that they had no knowledge of the litany	4	independently evacuate, came to be housed on upper
5	of patent defects identified by the inquiry's experts,	5	floors.
6	some of which, from a non-expert perspective, were	6	Sir, we say that all of these deaths were
7	posited and pointed out by residents before the fire.	7	preventable. By way of generic submission, can we end
8	Either these witnesses were not telling the truth	8	by emphasising four points.
9	about the extent of their knowledge, or they led	9	First, the events on floor 16 prior to 01.30
10	a dysfunctional organisation, incapable of ensuring fire	10	foreshadowed the prospect of disaster. By that time
11	safety, or, of course, both.	11	Firefighters Hippel, Stern and O'Beirne on the landing
12	The BSR look forward to the inquiry investigating	12	were able to convey to the bridgehead that a 4th floor
13	and making conclusive findings on this in Phase 2.	13	kitchen fire now posed a mortal danger 12 floors up.
14	Finally, the residents.	14	Acting on that information could and should have changed
15	The evidence of the BSR, both oral and written, were	15	everything.
16	significant in multiple respects.	16	Second, the lift could not be controlled via
17	First, it commemorated the loss of Grenfell Tower	17	a firefighters' override switch and was not otherwise
18	and its community, just as the opening hearings	18	disabled to prevent it from being called by residents.
19	commemorated the loss of its people.	19	One person definitely, but probably three, died because
20	Second, it provided critical detail and insight into	20	of that lift: Ali Yawar Jafari, Mohamednur Tuccu and
21	the problems with the building, the spread of the fire	21	Khadija Khalloufi.
22	and the response to it. Prior to the fire, residents	22	Third, the four deaths on floor 14 Denis Murphy,
23	identified many of the causes of the disaster to	23	Mohammad Alhajali, Zainab Deen and Jeremiah Deen
24	come: doors that did not close, windows and cladding	24	involved a catalogue of failures. Four people were left
25	with gaps, a smoke ventilation system that likely did	25	to die who had been reached by firefighters three times.
	Page 109		Page 111
1	not ventilate, and significant shortcomings in preparing	1	The fact that eight residents had been congregated into
2	residents to respond to a fire and, if necessary,	2	The fact that eight residents had been congregated into one room was written into multiple places, but the teams
3	self-evacuate.	3	that went up on the final occasion were not briefed that
4	Third, the near-death experience of survivors	4	they needed to rescue eight people. In breach of
5	provides a further human rights context. They, too,	5	policy, the flat was not properly searched. Four
6	require an investigation into truth that will respect	6	residents were left.
7	their human dignity and restore their sense of security.	7	We will return at the subsequent hearing to outline
8	But it doesn't stop there. By courageously giving	8	why we say that Firefighter Herrera's account is untrue
9	evidence, oral and written, regarding their harrowing	9	and, in any event, unreasonable. But then two further
10	experiences, the survivors have added vastly to the	10	EDBA teams were deployed to 14 with slips in their
11	understanding of human behaviour in fire, as well as	11	hands, only to be told by officers to divert to
12	acting as the informed eyes and ears of the fire's	12	firefighter duties on the lower floors. Taking all
13	progress. Their invaluable testimony must educate	13	these factors together, floor 14 stands as a paradigm of
14	further thinking on design, evacuation, search and	14	preventable death.
15	rescue, disability access and so much more.	15	Fourth, the higher floors were never a lost cause.
16	If one looks, then, to those who died, we should	16	The accounts of the late escapes, both sole and
17	mention, first, that the inquiry has stated that it will	17	assisted, indicate that death was preventable for some
18	not deal with the details of individual deaths today,	18	time, which is why the continuing delays and confusion
19	but that special hearings will take place in the New	19	over the stay-put advice, even after its change at some
20	Year.	20	point between 02.35 and onwards, are matters of grave
21	When we do get to Phase 2, it will also be important	21	concern to the bereaved families of those higher floors.
22	to reflect on how and why and the implications of the	22	Finally, the fate of those higher floors is bound
23	fact that a very high proportion of black and minority	23	out with migration of people from lower floors. Several
24	ethnic Londoners came to be housed together and died at	24	people went onto the staircase just before 01.30, when
25	Grenfell Tower. That figure of 90 per cent of the	25	safe evacuation was entirely possible, but ultimately
	Page 110		Page 112

SIR MARTIN MOORE-BICK: Well, now it's time for me to invite 1 1 went upstairs. We cannot stress enough that there were 2 2 enough firefighters in the building to unequivocally Mr Weatherby to speak on behalf of what we call the G3. 3 Yes, Mr Weatherby. 3 call them down, call out, prompt, pursue and usher them 4 down. That is what was available at that time. 4 Closing submissions on behalf of G3 by MR WEATHERBY 5 5 MR WEATHERBY: Thank you very much. Our conclusion, then, from six months of hearings 6 and 18 months of your work, the interim report of this 6 I am going to address you on three areas, if I may: 7 7 inquiry needs to contain a clear finding that none of Firstly, some general comments on the disaster, and 8 these deaths from the fire at Grenfell Tower were the 8 the high-level general conclusions that the Phase 1 g 9 product of accident. They occurred because the building expert evidence unquestionably points towards in terms 10 as refurbished was made into a deathtrap. 10 of fundamental non-compliance with Building Regulations, 11 The inquiry can work out in due course the hierarchy 11 and the reckless disregard for human lives that is 12 of causation, as well as other contribution. But the 12 represented by the multiple failures in design, 13 way the building was refurbished, including its patent 13 materials, fabrication, build, oversight of the 14 non-compliance with the Building Regulations, cost 14 refurbishment and the maintenance of the building 15 lives. All of that can and should be said in the 15 16 Phase 1 report. 16 Secondly, I'll pick the baton up from Danny Friedman 17 Of course, if that is what you have discovered, then 17 regarding the London Fire Brigade and candour, and the 18 I am bound to observe that just one other reason why 18 comments of Dany Cotton in particular, and the nature 19 this inquiry is so important going forward to Phase 2 is 19 and prevalence of institutional defensiveness more 20 that it is investigating the potential unlawful killing 20 generally and how we say the inquiry should deal with 21 of 72 people. 21 22 Additionally, the inquiry should find that the LFB 22 Thirdly and most substantially, I'll turn to the two 23 failed to take steps that could've changed matters in 23 main themes regarding the LFB emergency response: the 24 the way that I have summarised and my colleagues are 24 lack of any contingency planning, in particular the 25 going to now develop. 25 failure to have or to improvise a plan B to evacuate the Page 113 Page 115 1 Finally, it is important to record the facts and 1 tower, and the failure of the FSG process actually on 2 explain the reasons for the non-compliance with the 2 the fire ground itself. These were, in our submission, 3 3 Civil Contingencies Act. The great value of this the key systemic failures on the part of the LFB, which 4 4 process is that it is a once in a generation opportunity almost certainly led to a greater loss of life. 5 to consider how to better prepare for urban disasters. 5 In doing so, I'll endeavour to remain within my one 6 But in order for that to happen, the various agencies, 6 hour. I hope you won't be too annoyed if I stray 7 especially the LFB, have to confront the truth of how 7 slightly over it. 8 8 As has already been stated, the Grenfell fire was they could have done better on the night. 9 9 These findings are required to fulfil the inquiry's certainly a preventable calamity -- designed, 10 10 statutory duties, they are inescapable on the evidence manufactured and built, not accidental -- and we join 11 with others in urging you to make that clear in the 11 and there is an overwhelming societal interest in 12 12 publicly declaring them as soon as possible. interim report. There was no natural cause, no "Act of 13 Sir, as to those we act for, only time may heal what 13 God". No matter how many times certain witnesses and 14 14 core participants repeat terms like "unprecedented" and you have heard about. But people are here today because 15 15 they want justice. They look to your first report as "unique", which we've heard this morning, or "perfect 16 16 storm", it's impossible to get away from the catalogue the beginnings of that endeavour. 17 17 of failures that the inquiry experts, in particular, Thank you. 18 18 SIR MARTIN MOORE-BICK: Thank you very much, Mr Friedman. have already spoken to. 19 19 I'm not going to repeat that evidence; Well, that's a point at which I think we should 20 Stephanie Barwise has already addressed you 20 break for some lunch. We'll stop now and come back at 21 2.15, please. 21 comprehensively on that. But a particular feature of 22 the expert evidence is the fact that there is such 22 Thank you. 23 a high degree of agreement between the various experts 23 (1.15 pm)24 with only minor shades of difference. 24 (The short adjournment) 25 Also, although there is some challenge to the 25 (2.15 pm) Page 114 Page 116

Grenfell Tower Public Inquiry 1 1 Phase 1 expert evidence in written closings by one or 2 two of the corporate CPs, the areas of challenge are 2 3 relatively narrow, and there does not appear to have 3 4 been any provision of contrary expert opinion, as no 4 5 5 doubt that would have been disclosed more generally. 6 The expert evidence provides a long list of 6 7 7 failures, gross failures. Not just the combustible 8 cladding, both outer rainscreen and insulation, but the 8 9 9 altered window position, creating dangerous voids packed 10 with combustible foam, membranes and insulation, uPVC 10 11 window surrounds, polystyrene infill panels -- all 11 12 12 highly combustible. The lack of cavity barriers, front 13 doors without closers, different from those tested for 13 14 fire resistance, the lack of firefighter lifts, no plans 14 15 for evacuating vulnerable residents and no mitigation of 15 16 those risks -- just some of the obvious and gross 16 17 deficiencies with the building and its management. 17 18 A building, let no one forget, with one staircase, 18 19 no sprinklers and no general alarm, a building populated 19 20 with many elderly people and children, those with 20 21 disabilities and mobility issues, those particular 21 22 features being well known to relevant public 22 23 23 authorities, such as the owner and landlord, RBKC and 24 the TMO, and also those who designed and undertook and 24 25 2.5 signed off the refurbishment and those who were supposed Page 117 1 to regulate it. And, indeed, the fire service for 1 2 today's purposes. 2

should be brought into play in considering life safety, not a blueprint for safe design. To view ADB otherwise is to ignore the complexity of modern cladding systems and the obvious known risks they posed.

Although there will be much more work to do in Phase 2, you have commissioned and published, called and heard considerable and detailed evidence about the comprehensive and gross non-compliance with any reasonable standard, and we join with all of the other bereaved and survivors and displaced residents' teams in urging that you set out headline conclusions in the interim report so that Phase 2 can focus on just where those gross failures were, who is accountable for them and why it was all allowed to happen, a community turned into a war zone, in prosperous Kensington and Chelsea, in a country in a position to have high regulatory and health and safety standards.

The detail of the failures and who did what, just when and why, may be the subject of close consideration of e-mails and contracts and technical drawings. But the broad picture is clear for all to see. As I address you now, many bereaved and survivors, the victims, suffer severe psychological effects of the night. Many lost family and friends and all lost community. Many of my clients, no doubt others too, are still to settle in

3 Let me pose a shorter list, and I do it as 4 5 On the evidence, what parts of the refurbishment were done to anything approaching a reasonable fire 6 7 safety standard? Which active or passive fire safety 8 provisions were appropriate and functioning on the q night? 10 That is a very short list, if it's a list at all. 11 Dr Lane referred to fundamental non-compliance with 12 BR B4 in her report. We would take that opinion further 13 and submit that such a catalogue of failure shows 14 a reckless disregard for human life by those involved in 15 the design and build of the refurbishment project, those who manufactured and marketed the products and those who 16 17 undertook the works, and those who failed to qualify 18 assure and properly sign it off. 19 We would also add, and a point we'll press in 20 Phase 2, that while there was fundamental non-compliance 2.1 with building regs and shocking disregard for the guidance in ADB, no reasonable designer or procurer in 22 23 our submission would, in any event, see ADB is providing

all the answers. Properly viewed, it's a risk

assessment tool, a list of the considerations that

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new homes. They're looking for answers. 18 months has passed. No one has taken any

responsibility for the disaster. That is a major open sore for the bereaved and the survivors.

All of the corporate and public authority institutions are big on condolences and sympathy but, as a generality repeated in the recent written closings, they say, in effect, it was all a series of unfortunate and unforeseen events. It was not their fault because their product was not used correctly. It was for someone else to check the specification, the build quality, to sign the work off, the regulations weren't clear. So far the inquiry has only had a book of excuses. I've made this point before, but I need to repeat it.

The written closing arguments are more of the same. Arconic point at the insulation, not the ACM. They state the Phase 1 expert evidence:

"... establishes it was a confluence of unfortunate circumstances, and not the mere presence of ACM PE, which created the conditions for the Grenfell Tower fire."

Kingspan point at the configuration but, since the fire, they've been marketing the same product for use on high-rise residential buildings.

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30 (Pages 117 to 120)

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2 Smito is and Harley's the cladders, actually say a nothing, no closing at all. 4 Whirpool say there's not enough evidence to find the fire started in their applaince, fridge freezer. 5 Rydon say the fire must have escaped only through the open window, not via the menu of combustible products that they arringed in be packed around the sundows or the voids. 8 products that they arringed in be packed around the sundows or the voids. 9 Phase 2 will not be concerned so much with what a causally hopened—the fire and the dangerous state of the building on the night —but why it was allowed to happens, who was responsible for the overarithing fullures of design, procurement, compliance, build quality, and it is accountable for the particular aspects of the building of the particular aspects of the London Fire Brigade and the disappointing view of the London Fire Brigade and the disappointing time of the London Fire Brigade and the disappointing time of the London Fire Brigade and the disappointing time of the London Fire Brigade and the disappointing time of the London Fire Brigade and the disappointing time of the London Fire Brigade and the disappointing time of the London Fire Brigade and the disappointing time of the London Fire Brigade and the disappointing view of a page 121 1 Jiust want to pick that purticular baton up and run with it a little further. 2 with it in little further. 2 with it in little further. 2 with it in little further. 3 Firstly, though a very important clarification, and so important lar make no apology whatsoever for appetitum of the Brighters who risked their lives to save others. And thai sin't just a tire statement. 4 London Fire Brigade and the disappointing view of page 121 1 Jiust want to pick that purticular baton up and run with it a little further. 2 with it is little further. 2 with it and the purticular baton up and run with it a little furthe				
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1 1 need for regulation in that area. reports, but I've made my point. 2 July 2015, the Harris review, report of the 2 There's a widespread clamour for transparency and 3 Independent Review into self-inflicted deaths in custody 3 candour to be addressed through substantive changes to 4 of 18 to 24-year-olds, the theme again arose, specific 4 the law. Parliament has already considered one such 5 5 mention of "institutional defensiveness". bill, and there is cross-party support for such change. 6 The Bishop's report into Hillsborough, with which 6 But in the context of these proceedings, the rules and 7 7 processes already allow for this problem to be taken on I'm sure you're familiar, recognised repeatedly the 8 problems of institutional lack of candour and 8 head on to a significant degree. 9 9 promulgated the charter for public authorities to sign You've listened to our submissions at the outset of 10 to promise to act with integrity and candour. That 10 the inquiry and you've begun to utilise position 11 report was, of course, with respect to a process that 11 statements and required Rule 9 statements. In the light 12 12 took nearly 30 years to achieve a just outcome. of the lack of meaningful responses setting out 13 Incidentally, whilst most people remember the role 13 acknowledged failings, we submit that those requirements 14 of the police at Hillsborough, it's worth remembering 14 must now be ramped up. 18 months down the line, the 15 that a substantial secondary issue in that disaster 15 inquiry, the survivors and bereaved, the community, are 16 concerned the emergency response, both by the police and 16 all entitled to expect full and unequivocal assistance 17 the ambulance service. The context of Grenfell is, of 17 from institutional and corporate CPs. And now, not in 18 course, very different, but the parallels are there for 18 a year's time or even later than that, with the repeated 19 all to see. No one sought to criticise the individual 19 indication that this is a matter for Phase 2 and that's 20 police and ambulance staff battling to save lives, but 20 a matter to be reviewed down the line. 21 the new inquest jury concluded that the failures 21 One of the imperatives in undertaking a public 22 promptly to declare a major incident, to establish 22 inquiry is cost and efficiency. The reason some public 23 23 command and control, to co-ordinate and communicate, in inquiries and iconic inquests have taken so long isn't 24 effect to follow long-established major incident 24 because of complicated subject matter, it's because of 25 25 principles, delayed an effective response and an inability or unwillingness to confront this endemic Page 125 Page 127 1 1 contributed to the death toll. lack of institutional or corporate candour. 2 The other parallel is that, throughout the process, 2 I started by saying that this was a disaster made by 3 3 the police and the ambulance service flatly refused to human beings. The inquiry has powerful weapons at its 4 4 accept that their command and control failures had disposal to require candour. If it develops them, this 5 materially affected the emergency response. 5 process will reach robust conclusions far more swiftly 6 to the benefit of all. 6 Institutional defensiveness that we say is being 7 Both the public authority and private corporation 7 repeated here by the LFB. 8 8 In these proceedings, RBKC have signed up to the CPs here have had disclosure of the detailed expert 9 reports. They've had the opportunity of posing 9 Bishop's charter, as indeed has the Mayor, but we're 10 10 unaware of any other public authority CP having done so questions through CTI to those experts. Although 11 11 or, indeed, private corporations promising to act within there's more investigation to be done, additional expert 12 opinion to be obtained, none of the public or private 12 its spirit. Although RBKC have publicly announced their 13 commitment to the charter and, indeed, discussed 13 institutions and corporations can be in any doubt 14 whatsoever what the issues are that affect them, the 14 adherence to it with us, we make clear that we still 15 await, 18 months down the line, anything approaching 15 issue with which this inquiry, all of us, requires 16 16 a full statement regarding their role in the disaster. 17 They should be unequivocally asked to set out what 17 We make clear to them that candour must be demonstrated, 18 went wrong in the areas of product promotion, design 18 not announced. It's not a public relations tool. 19 procurement, fabrication, build, site work, maintenance, 19 RBKC, owner, responsible person, responsible for the 20 management, regulation for which they were responsible 20 planning committee, responsible for building control, 21 21 or in which they were engaged. involved at all levels, and they know many of the legal 22 As Mr Friedman made clear this morning, this isn't 22 responsibilities stop with them, they must have a lot to 23 a process of determining liability, but it does involve 23 tell us. The bereaved and survivors do not understand 24 getting to the truth, and that includes accountability 24 the 18-month delay in RBKC coming forward. 25 and it includes judgemental conclusions. In approaching 25 I could go on referring to other inquiries and Page 126 Page 128

1 1 the investigation in this way, the inquiry will be able plan, rather than a plan B evacuation, then outcomes 2 to focus its work far more efficiently. 2 would doubtless have been different. Many more lives 3 We urge you to address candour in the Phase 1 3 would've been saved. 4 report, not only with respect to what we say is the 4 In the written closing, LFB has a whole section 5 5 institutional defensiveness of the LFB, but also with headed "Evacuation" and at paragraph 85 makes the 6 an eye to the public authorities and corporate CPs, who 6 following assertion: 7 will enter the spotlight more in Phase 2. This is a key 7 "85. While it is still the Brigade's position that 8 issue and, respectfully, it should not be ducked. 8 the statutory guidance makes no provision within the 9 9 The LFB -- systemic failings. type of building design used in Grenfell Tower for 10 For the rest of my submissions, I'm going to focus 10 anything other than a 'stay put' strategy, the Brigade 11 on the LFB, because that's where the evidence has mainly 11 is considering amendments to these policy notes to 12 been, and what we say are the systemic failings that 12 provide additional guidance to crews, officers and 13 contributed to the disaster. 13 control room operators. That said, the Brigade wishes 14 14 to emphasise that there is no simple and expedient Given the imperative to try and complement rather 15 than repeat submissions, I'm directing my approach to 15 'Plan B' for implementing a full scale simultaneous 16 contingency planning and response to emergency calls, 16 evacuation plan when a catastrophic failure of a evacuation and FSG calls respectively, because they're 17 17 building's fire safety provision occurs ..." 18 central to the failures. 18 The perplexing thing about this assertion is that 19 In its recent 24 October position statement, where 19 the statutory guidance, of course, relates to the 20 it purports to set out lessons learned or, more 20 Building Regulations. The real issue for the Fire 21 precisely, the actions it's taken since the fire, and 21 Brigade shouldn't be whether that guidance helps, but 22 today in oral submissions, LFB says it's an organisation 22 whether the national guidance for fire and rescue 23 23 committed to improvement and learning. It asserts that services on firefighting in high-rise buildings mentions 24 its review team has 30 dedicated staff. 24 evacuation when stay put breaks down, and unremarkably, 25 25 There are some sensible nods, which we applaud, to it most certainly does. Page 129 Page 131 1 practical changes, such as the rolling out of smoke 1 However, not only do the Fire Brigade fail to 2 hoods, consideration of the greater use of drones, smoke 2 mention GRA 3.2 in the section on evacuation, they fail 3 3 to mention it at all in the whole of their closing curtains, for example. But other than fleetingly, LFB 4 4 failed to address the two central issues we focused upon submissions. 5 and to which I'm going to turn: the lack of contingency 5 I'm going to come to GRA 3.2 in a moment, but first 6 planning for when stay put breaks down or, in the 6 contingencies more generally. 7 language of the national guidance I'm going to turn to 7 What do we mean by contingencies and contingency 8 in a minute, became "untenable", and the fact that the 8 planning? As a general proposition the stay-put 9 9 FSG process was not fit for purpose for a significant strategy has been effective, as we've heard, in 10 10 incident with more than a handful of FSGs and, high-rise residences. Whereas certainly there's 11 critically, that this was a fact that was known to LFB 11 a discussion to be had as to whether stay put has had 12 before the fire. 12 its day, it was not unreasonable as at 14 June to have 13 Why are these central issues notable really by their 13 stay put as a strategy for many high-rise residences, so 14 absence from the position statement of the LFB? Of 14 long as they didn't have dangerous cladding and 15 15 course they refer to reviews to their policy 633 and effective fire safety layers. However, emergency 16 790, high-rise firefighting and FSG policies 16 services, by their nature, do not live in the world of 17 respectively, but if they're included in those reviews, 17 the general, the normal and the ordinary. 18 18 why are these issues not expressly highlighted and taken Of course, there are many types of fire that fire 19 on head on? They are obvious and they've been 19 brigades will see as a matter of routine: chip pan 20 repeatedly referred to by us on behalf of the bereaved 20 fires, kitchen fires, fires in bins. But, equally, the 21 and the survivors and taken up in questions by your 21 emergency services know they must deal with the 22 counsel. 22 unexpected: the plane or train crash, explosions, 23 Let there be no misunderstanding, I mean that had 23 suicide bombings, sink holes, bridges collapsing, 24 there been proper contingency planning in place, had it 24 natural disasters, extreme weather -- all of these 25 not adhered to an obviously failed stay put and rescue 25 require not just default planning, but contingency Page 130 Page 132

1	planning, and versatile and rapid imposition of control	1	to expect the unexpected, react to the particular
2	and command decision-making.	2	circumstances and that's why they have tools like the
3	Although stay put has been an effective strategy in	3	decision-making model, which trains/guides commanders to
4	many high-rise residences, breakdown in compartmentation	4	gather, evaluate, set objectives and tactics,
5	and large-scale facade fires are hardly unheard of.	5	communicate them, continually re-assess and re-evaluate.
6	Lakanal and a host of other disasters and near disasters	6	It's equally clear in this context, high-rise
7	have been referred to already, fires both in the UK and	7	residential buildings, that national policy requires
8	internationally.	8	actual operational contingency planning in advance, and
9	Indeed, in the evidence, we've seen the tall	9	expressly contemplates that there will be a circumstance
10	building fires presentation provided by LFB itself,	10	where stay put is "untenable" and the fire and rescue
11	distinguished, we might add, by its lack of circulation.	11	service will have to move to actual full or partial
12	But it certainly recognised the phenomenon of dangerous	12	evacuation, whether simultaneous or staged. That's
13	high-rise fires and fire spread across facades with new	13	expressly set out in this national guidance document.
14	building materials.	14	The possibility of stay put becoming untenable was
15	Of course, we can all distinguish, as has been	15	real, contemplated, expressly referred to in guidance,
16	attempted, between these fires and Grenfell, and, of	16	not some fantasy so far from reality that no one could
17	course, the loss of life here was, indeed, unprecedented	17	reasonably expect to countenance it, not some spacecraft
18	in UK terms. But that stay put was not infallible was	18	crashing into the Shard.
19	well known. We don't need the LFB presentation on that,	19	GRA 3.2's matrix included and itemised the
20	on spectacular high-rise fires, or even Lakanal for that	20	eventualities that in fact materialised on 14 June. It
21	fact, we just need to look at GRA 3.2.	21	provided control measures, mitigation in relation to
22	GRA 3.2 is national guidance for the fire and rescue	22	them. Let me pick up some of the key points.
23	services from central government. The generic risk	23	Firstly, page 8, the caution that poor maintenance
24	assessments are produced to minimise inconsistencies of	24	may mean that fire engineered solutions might not
25	approach and outcome across different fire and rescue	25	actually work. At Grenfell, this was the case, although
	Page 133		Page 135
1	services, and to assist in meeting the requirements of	1	we might add poor compliance to poor maintenance,
2	the Management of Health and Safety at Work Regulations	2	specifically with relation to the lifts and other
3	1999. That's expressly asserted in the document I'm not	3	installations, fire doors for example.
4	sure we've looked at, but it's the GRA introduction	4	Secondly, page 9, clear reference to rapid fire and
5	document on open source. It introduces the whole	5	smoke spread, virtually up and down and horizontally,
6	series.	6	and breach of compartmentation with fire spreading to
7	More than that, page 6 of GRA 3.2 acknowledges that	7	multiple floors. That's exactly what happened on the
8	the guidance was issued consequent to a number of	8	night and that's a factor that we referred to this
9	improvement notices, issued by the health and safety	9	morning as if it was something that couldn't have been
10	executive to fire and rescue services regarding	10	foreseen.
11	high-rise firefighting systems and I emphasise the	11	Thirdly, page 10, mention of smoke stacking and how
12	word and equipment.	12	this can mislead as to location and size of the fire.
13	word and equipment		
	Thus, these central government generic risk	13	Fourthly, pages 16 and 17 of the guidance, both the
	Thus, these central government generic risk assessments are key documents underpinning and informing	13	Fourthly, pages 16 and 17 of the guidance, both the
14	assessments are key documents underpinning and informing	14	need to understand the evacuation protocol for the
14 15	assessments are key documents underpinning and informing local services and policies.	14 15	need to understand the evacuation protocol for the building, and also to have an operational evacuation
14 15 16	assessments are key documents underpinning and informing local services and policies. From Assistant Commissioner Roe's evidence, it's	14 15 16	need to understand the evacuation protocol for the building, and also to have an operational evacuation plan as a contingency where stay put becomes untenable,
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14 15 16 17 18	assessments are key documents underpinning and informing local services and policies. From Assistant Commissioner Roe's evidence, it's clear that the LFB were key stakeholders in the drafting of GRA 3.2.	14 15 16 17 18	need to understand the evacuation protocol for the building, and also to have an operational evacuation plan as a contingency where stay put becomes untenable, as clear a reference as could be to the known possibility of the default strategy becoming
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	C CA E 11 1 177 1 11 1 171	,	
1	evacuation of the disabled, mobility challenged, ill,	1	equip incident commanders to evaluate the necessity for
2	injured residents.	2	abandoning the stay-put policy and invoke any
3	FSG arrangement must include consideration of how	3 4	contingency plan to evacuate. Indeed, LFB do not have
5	advice will be reevaluated in the light of calls and how the information loop between caller, control and	5	any contingency planning policy for high-rise residential blocks where there's a breach of
6	incident command will be achieved, something I'll return	6	compartmentation at all.
7	to in a moment.	7	Policy 633 repeatedly refers to rescue and multiple
8	On the night, of course, there were multiple FSG	8	rescue, and only at paragraph 7.45 does is refer to the
9	calls, but, as we'll submit later, arrangements were	9	possibility of evacuation, and then only to point at the
10	neither effective nor did they lead to any re-evaluation	10	difficulty of so doing. No contingency plan, no plan B,
11	of tactics until far too late. Furthermore, no plan, no	11	no guidance on how an incident commander should evaluate
12	policy to assist vulnerable residents to get out and no	12	abandoning the default position, no guidance on how
13	firefighter lift by which to do so. Of course, you've	13	evacuation might be achieved, what factors would assist,
14	heard first-hand evidence from some of those mobility	14	such as immediately informing control so that advice can
15	and disabled, challenged residents, including my client	15	be changed, and the specific measures referred to in
16	Maher Khoudair.	16	GRA 3.2. As we've heard in evidence, compounding the
17	Sixthly, at page 20, express mention that incident	17	lack of policy around contingencies, absolutely no
18	commanders should be trained to identify when evacuation	18	training on evacuation from high-rise blocks.
19	should prevail where stay put is the default strategy.	19	In our submission, paragraph 85 of the written
20	It's apparent from the evidence that this didn't happen	20	closing by LFB is somewhat disingenuous when it states
21	at the London Fire Brigade.	21	that the statutory guidance makes no reference to
22	Seventh, page 21, incident commanders should review	22	evacuation as a required contingency to stay put when it
23	and change the plan when new information becomes	23	fails. The LFB know full well that the national
24	available at the incident or from control. Vital that	24	guidance most applicable is GRA 3.2, not least because
25	incident commanders utilise functional commanders to the	25	of the part they played in drafting it.
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			Tage 197
1	full.	1	The lack of reference to GRA 3.2 in the submissions
2	Eighthly, incident commanders must recognise where	2	speaks volumes. Is this a public authority which is
3	building design and materials may be impacting on fire	3	trying to assist the inquiry, or is this a public
4	spread. Specific mention made of plastic or aluminium	4	authority which is avoiding obvious and serious failings
5	window frames and panels.		
6		5	in its systems and in its operations on the night? Yes,
_	It's apparent that there was no awareness on the	6	there's reference to welcome positive changes and some
7	night.	6 7	there's reference to welcome positive changes and some policy reviews, but nowhere does LFB properly grapple
8	night. Ninthly, section 2 of the summary to the guidance	6 7 8	there's reference to welcome positive changes and some policy reviews, but nowhere does LFB properly grapple with the key issues.
8 9	night. Ninthly, section 2 of the summary to the guidance document at point 23, reference again made to the	6 7 8 9	there's reference to welcome positive changes and some policy reviews, but nowhere does LFB properly grapple with the key issues. Given that the GRAs are not only national guidance
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8 9 10 11	night. Ninthly, section 2 of the summary to the guidance document at point 23, reference again made to the evacuation of the building made necessary by reason of stay put becoming untenable due to unexpected fire	6 7 8 9 10 11	there's reference to welcome positive changes and some policy reviews, but nowhere does LFB properly grapple with the key issues. Given that the GRAs are not only national guidance to assist in the saving of life, but they were expressly promulgated to assist fire and rescue services to
8 9 10 11 12	night. Ninthly, section 2 of the summary to the guidance document at point 23, reference again made to the evacuation of the building made necessary by reason of stay put becoming untenable due to unexpected fire spread, and control measures raised, including	6 7 8 9 10 11 12	there's reference to welcome positive changes and some policy reviews, but nowhere does LFB properly grapple with the key issues. Given that the GRAs are not only national guidance to assist in the saving of life, but they were expressly promulgated to assist fire and rescue services to discharge their duties under health and safety
8 9 10 11 12 13	night. Ninthly, section 2 of the summary to the guidance document at point 23, reference again made to the evacuation of the building made necessary by reason of stay put becoming untenable due to unexpected fire spread, and control measures raised, including "utilis[ing] other emergency services to aid movement of	6 7 8 9 10 11 12 13	there's reference to welcome positive changes and some policy reviews, but nowhere does LFB properly grapple with the key issues. Given that the GRAs are not only national guidance to assist in the saving of life, but they were expressly promulgated to assist fire and rescue services to discharge their duties under health and safety regulations, the failure of LFB to follow through with
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8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	night. Ninthly, section 2 of the summary to the guidance document at point 23, reference again made to the evacuation of the building made necessary by reason of stay put becoming untenable due to unexpected fire spread, and control measures raised, including "utilis[ing] other emergency services to aid movement of casualties/public to safe areas" and relying upon "all means of contacting persons within the building, such as intercom telephones, loud hailers etc". Interestingly, GRA 3.2 raises just the points we've looked at in evidence and to which I'll return, but which are dismissed by the London Fire Brigade. The approach envisaged in GRA 3.2 is classic contingency planning. It contemplates a practical workaround to a default safety strategy which has failed. In contradistinction, LFB's high-rise residential	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	there's reference to welcome positive changes and some policy reviews, but nowhere does LFB properly grapple with the key issues. Given that the GRAs are not only national guidance to assist in the saving of life, but they were expressly promulgated to assist fire and rescue services to discharge their duties under health and safety regulations, the failure of LFB to follow through with appropriate policies and training is, in our submission, a clear breach of the general article 2 duty to have a reasonable policy to minimise the life threatening risks of a known dangerous scenario. Both G4 and G3 have referred to this in written submissions, and we've footnoted a whole host of authorities regarding that proposition if it's thought to be in any way controversial. We urge you to clearly identify the systemic failures in the interim report. The LFB position and that of some of its senior officers is that evacuation was not possible or

1	an attempt to avoid the question. We've heard that the	1	course, opines that stay put was untenable from at least
2	building was "not built for evacuation". No means of	2	this point.
3	communication, conditions deteriorating. Difficult it	3	But the key is when, subjectively, the incident
4	might have proved, problematic a single staircase and no	4	commanders should've realised that the building was
5	general alarm might have been, but facing the inferno	5	compromised on different levels, and the fire was out of
6	that the tower rapidly became, there was simply no	6	control. In our submission, this was not a binary
7	option. The success of evacuation would've been	7	moment. The realisation should've begun to form soon
8	directly related to how soon it was put into effect and	8	after 01.08, as the fire rapidly spread and as
9	how efficient it was. But can it really be disputed	9	the minutes went by. Incident command should've had
10	that early evacuation would've saved many lives? We	10	well in mind that the fire was reaching a stage where it
11	asserted as much in opening. We underline that	11	was not safe for residents to remain, and should've
12	submission following the evidence.	12	formed a decisive plan which would've commenced
13	Before I turn to the evidence, I note in passing the	13	a determined evacuation at the very least by 01.26.
14	recent opinions of Professor Purser, supporting the work	14	Every minute thereafter is relevant when we speak of the
15	of Dr Lane regarding evacuation times. Would it have	15	LFB's institutional failure to get residents to safety.
16	been possible and how long would it have taken?	16	Sure enough, we've heard evidence that, with
17	Mr Friedman has referred to the 7-minute point. At	17	a facade fire, it might burn off without re-entering.
18	another place in a slightly different context,	18	Given this was a densely populated high-rise residential
19	Professor Purser refers to 15 minutes.	19	block, one stairwell and the height of summer, when
20	We fully understand the difficulties of	20	windows would naturally be open, with a fire rapidly
21	an evacuation of Grenfell Tower. The single staircase,	21	spreading, with information available coming from
22	the conditions, would not have been ideal. But there	22	firefighters inside the building that fire and smoke has
23	was no absolute safety issue with simultaneous	23	spread internally, and with calls starting to come in
24	evacuation. It was not impossible to do. And it	24	from imperilled residents, the point when it should've
25	would've been unlikely to have impacted or been impacted	25	been obvious that stay put was no longer tenable must
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1	by the operations of the firefighters.	1	have been very early. If that wasn't 01.15 or
2	Obviously the firefighters would've played	2	thereabouts, when the fire was plainly spreading out of
2 3	Obviously the firefighters would've played an important role in facilitating the evacuation,	2 3	thereabouts, when the fire was plainly spreading out of control it was most certainly by 01.26.
2 3 4	Obviously the firefighters would've played an important role in facilitating the evacuation, particularly of the elderly and the vulnerable. It was	2 3 4	thereabouts, when the fire was plainly spreading out of control it was most certainly by 01.26. We reject the suggestion that this is based on
2 3 4 5	Obviously the firefighters would've played an important role in facilitating the evacuation, particularly of the elderly and the vulnerable. It was a matter of organising it. It's an unattractive	2 3 4 5	thereabouts, when the fire was plainly spreading out of control it was most certainly by 01.26. We reject the suggestion that this is based on hindsight. It should have followed from observation,
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1 1 arrival, which meant that a watch manager was left in thought evacuation would follow. 2 charge for almost the whole of the golden hour of 2 On assuming command, Mr Roe took no convincing at 3 emergency response opportunity. 3 all that it was "absolutely unsustainable to continue 4 Indeed, as has been stated, it was not until Mr Roe 4 with stay put". 5 5 arrived at 02.43 when any proper command control was So much for what happened, but what could've 6 established. Why, therefore, no mention in the LFB 6 happened? 7 7 Are the LFB correct that evacuation was virtually closing statements of how they intend to ensure they 8 never put a watch manager in that position again? Why 8 impracticable? Given the reality that there was really 9 no alternative, had the default position been abandoned 9 indeed. 10 10 by or around 01.26, and determined evacuation imposed, Policy, including 424, did provide for a monitoring 11 officer, and although that post was assumed, no support 11 attention would then have been focused on how to 12 12 overcome the difficulties of a single staircase and no was in fact given by Mr Walton, who was the monitoring 13 officer designate until he arrived at the incident 13 general alarm and a raging fire, not if. 14 ground around 01.50. 14 First, the bridgehead would've been informed all 15 With rapid escalation directed by Mr Dowden, a DAC 15 efforts would be made to evacuate. This would've meant 16 assisted by an AC should've taken over at ten pumps, but 16 resources would not have been wasted trying to get onto 17 17 nothing of the kind happened. In the meantime, no the roof and moving firefighting media around. Every 18 effective command and control support, no contingency 18 effort could've been made to maintain the integrity of 19 policy or training, the default strategies of stay put 19 20 and defend in place were continued in the face of 20 BA crews would've been deployed to systematically 21 overwhelming evidence that they weren't working. Why? 21 clear floors as soon as they'd arrived, using high-rise 22 22 Because as we've seen, policy and training did not equip kit to mark those flats and floors cleared rather than 23 23 awaiting debriefs for ad hoc rescues. the responders to consider or change to a contingency 24 evacuation because no external command control support 24 Secondly, control would've been informed to change 25 25 was provided to Mr Dowden and because a watch manager advice to callers, "Get out if you can", and to bang on Page 145 Page 147 1 was left in charge of a fire that was so far beyond his 1 neighbours' doors if possible. 2 capability that he didn't want to do. 2 Control could've been asked to ring previous callers 3 3 back and tell them too, to immediately contact RBKC and We've set out the facts relating to Mr Dowden at 4 paragraph 19 of our written submissions and I don't 4 the TMO to see whether they could recruit some sensible assistance with lists of vulnerable residents in 5 repeat them here. 5 6 The two incident commanders following Mr Dowden, 6 particular. 7 Mr Walton and Mr O'Loughlin, fared little better. Until 7 Thirdly a firefighter or a police officer could've 8 relieved at 02.43, Mr O'Loughlin indicated that he had 8 been stationed on the intercom. I appreciate the 9 9 no expectation that flats other than on the north-east problem with falling debris has been raised, but the 10 10 side would be affected or that compartmentation had reality is the immediate area near the entrance had no 11 11 such falling debris for a considerable period, but it failed. He turned his Airwave off as he approached the 12 tower and he didn't consider he needed details of the 12 was covered by a canopy. It wasn't compromised for 13 FSG calls to formulate a plan. Indeed, shortly before 13 a considerable time into the night. From CCTV camera 4, 14 the position was taken by Mr Roe, Mr O'Loughlin noted 14 this was certainly after 02.30. From Professor Bisby's his surprise at being told the number of persons 15 15 video number 5, it was probably after 02.40. So plenty 16 reported. 16 of time, in our submission, to have a person safely 17 17 It was for the incident commander to change from stationed at the buzzers. 18 stay put to evacuation and to determine that FSG callers 18 Firefighters or police officers could've been 19 were to be advised to get out if they could. A further 19 stationed around the block with loudhailers or, as 20 45 minutes were wasted because Mr O'Loughlin failed to 20 Mr Friedman's already mentioned, inside the block too. 21 get situational awareness such that he could properly 21 Despite some assertions to the contrary, there is 22 evaluate what to do. 22 open source YouTube footage from the night illustrating 23 Of course, other officers, as has been mentioned, 23 that a loudhailer at the base of the tower could be heard from the 23rd floor. We've referred to that in 24 did have such awareness: Mr Harrison, Mr Egan, 24 25 Mr Goodall, all of whom, on arrival, expressed that they 25 our written submissions at paragraph 35. It indicates Page 146 Page 148

1	that loudhailers could've been effective, at least to	1	facilitate individual rescues. Policies 539 and 790	
2	some degree.	2	deal with the handling of 999 calls and FSG calls	
3	Incidentally, the YouTube clip is apparently picking	3	respectively.	
4	up the loudhailer used by Firefighter Murray,	4	As we know, where the building evacuation strategy	
5	a firefighter that has been read but not called to give	5	is stay put, the caller will be told to get out if they	
6	evidence, and at a time of 01.40. So, in our	6	become directly affected by fire or advised to stay put	
7	submission, it was perfectly possible from an early	7	otherwise, underpinned by confidence in compartmentation	
8	point to use tools such as loudhailers.	8	and the ability to put the fire out.	
9	Furthermore, NPAS evidence about aerial support	9	But the FSG policy is to feed information from 999	
10	indicates that helicopters were equipped with PA systems	10	callers where residents believe they're trapped as well	
11	which could also have been deployed for this purpose.	11	to the fire ground to facilitate rescue, whilst advising	
12	At least such efforts would've alerted residents to the	12	callers to consider escape routes or otherwise remain	
13	fire before it directly affected them, even if they'd	13	safe.	
14	had trouble hearing the particular advice itself.	14	So the aims of the policy are to provide the best	
15	Fifthly, the bridgehead or a small group of	15	informed life safety advice on the one hand and, on the	
16	dedicated officers could've been tasked to identify	16	other, to provide optimum details to the fire ground to	
17	which floors were clear, who had been evacuated and	17	facilitate rescue.	
18	where remaining residents, particularly the vulnerable,	18	Neither of those aims was achieved on the night nor	
19	might be.	19	was any information loop. On the one hand, resources	
20	Sixthly, a major incident declaration and consequent	20	were being wasted on other efforts which only	
21	co-ordination with the blue-light services, the police	21	exacerbated the problems, whilst many residents who	
22	and ambulance service in particular, could've been	22	still had a window of opportunity to self-evacuate were	
23	deployed to identify who had evacuated but remained from	23	being told to stay put.	
24	enquiry at the base of the tower, even corralling	24	Had stay put been abandoned at or before 01.26, all	
25	evacuees to confirm their position and who was left in	25	the callers between then and when the advice actually	
	Page 149		Page 151	
	1 age 147		1 age 131	
1	the tower.	1	was changed sometime after 02.35, would've been advised	
2	As I noted earlier, the intercom and loudhailer	2	to get out if they could.	
3	points are specifically mentioned in the national	3	From our schedules the schedules we provided last	
4	guidance.	4	week, this translates in our submission to around 57 999	
5	The statistics show that half of the residents of	5	calls relating to 25 different flats.	
6	the tower self-evacuated by 01.42. Dr Lane reviewed the	6	Instead, what happened? Residents were told to stay	
7	evidence and indicates that the stairs were largely	7	put because no one had told control room of a change of	
8	clear prior to that time. Although there may have been	8	policy and no one had told them compartmentation had	
9	some difficulties passing the "hot zone" between 13 and	9	been breached. Inquiries were not consistently made as	
10	16, between 02.00 and 02.30, there were multiple	10	to whether residents were becoming affected by heat fire	
11	self-evacuations and assisted rescues up to and beyond	11	or smoke and whether they could leave.	
12	4 o'clock, including from above level 16 until around	12	The operation of the process was, on any rational	
13	03.55.	13	view, hopeless. Control operated blind from the	
14	Although conditions undoubtedly deteriorated and, at	14	incident command, scraps of paper, whiteboards	
15	times, particular levels became more difficult to pass,	15	a mishmash of radio messages, mobile phone and landline	
16	evacuation was possible for several hours. What was	16	were used to communicate with the fire ground.	
17	missing was a co-ordinated plan or, indeed, a plan at	17	At the fire ground, messages were not initially	
18	all.	18	picked up by the incident command appliance and they	
19	FSGs.	19	were diverted to a fire appliance en route.	
20	As incident command persisted with firefighting and	20	The first FSG messages were received at the fire	
21	failed to re-evaluate or abandon stay put, a parallel	21	ground by the CU8 at around 01.43. But just how they	
22	and almost unconnected process dealt with the 999 calls.	22	were collated there assuming they were remains	
23	Without steer from incident command the control room	23	unclear. And, likewise, how they were passed on.	
24	continued blind with a process based on advice to stay	24	Mr Meyrick in CU8 gave evidence that he communicated	
25	put and providing information to the fire ground to	25	messages on to Mr Kentfield and it may be some messages	
	D 450		D 452	
	Page 150		Page 152	

1 Where there's one or a small number of calls, the 1 were forwarded directly to Watch Manager De Silvo by 2 2 control room will liaise with the incident command 3 3 There's scant physical record of what was happening appliance and, no doubt, the incident commander direct 4 to the information at this time, save for the notes made 4 and remain on the line. At a multi-call incident, 5 5 by Mr Meyrick apparently as he received them. a dedicated unit to deal with calls will have to get to 6 We know -- and I reference the G3 BA deployment 6 the incident, will have to set up, communication will 7 7 have to be established between the commander, the schedule here -- that no BA crew was deployed to any 8 flat as a result of a 999 call or the FSG process while 8 bridgehead, the command unit, control. The policy 9 9 Mr Dowden was incident commander, nearly an hour into requires a loop where information comes from the caller 10 the fire. The average delay through the night in 10 to the incident ground, it's acted upon and a debrief 11 deploying crews to flat to which crews actually were 11 12 12 deployed on our analysis was an hour and 10 minutes from As we've seen from the evidence, the FSG process on 13 the time of the first 999 call. I stress to flats to 13 the incident ground was shambolic. It took nearly 14 which deployments were actually made, because almost 14 20 minutes from the first FSG calls for them to be 15 half of them, there weren't such deployments. 15 notified to the incident ground. No information was 16 At 02.13, Mr Sadler apparently started his car 16 ever fed back to the control room. If, as policy 17 bonnet staging post, literally with notes made on the 17 intended, the IC was reliably kept informed as a pivot 18 back of an envelope. We time that because of the 18 point within the loop of information, this in turn 19 picture he took of the envelope so he could pass it onto 19 would've brought earlier and clearer focus upon the need 20 the tower. It's not until 02.23, an hour and a half 20 to abandon stay put. But, in reality, the incident 21 into the fire, that the dedicated CU7 became operational 21 commanders remained quite independent of the process, at 22 for FSG management, far, far too late. By that point, 22 least until Mr Roe took over, far too late. 23 about 24 of the 33 flats from which FSG calls were made 23 On our analysis of the evidence up to 04.15, in the 24 had called 999 at least once. 24 schedules, again, which we provided to the inquiry team 25 2.5 Standing back from all of this, what was happening last week, we indicate that only three deployments of Page 153 Page 155 1 1 was efforts being made, best efforts being made, but firefighters resulting directly from FSG calls led to 2 chaos resulting. Staging posts popping up at car 2 fully successful outcomes, with another two which were 3 3 bonnets and the entrance to the tower by Mr Williams and partially successful. Out of 33 flats from which 999 4 on the mezzanine, scraps of paper, backs of envelopes, 4 calls were made, no rescue deployments at all were made 5 walls, whiteboards used at these points and at the 5 in almost half of them. 6 bridgehead to record information that then had to be 6 Of course, in some of those cases residents 7 moved about. 7 eventually self-evacuated, and some were met and 8 The fact that the FSG process failed should not be 8 assisted by firefighters in the lobbies and on the 9 9 a surprise to anybody. It certainly shouldn't have been stairwell. The point made is that the FSG process on 10 10 a surprise to the LFB. We know that from the evidence the night was successful in only a handful of cases. 11 of Mr Johnson, who told senior policy officers whilst he 11 The fact that firefighters assisted residents in lobbies 12 12 served on the dedicated command unit section, what and on the stairs supports the proposition that 13 better place could he have been, at Islington in 2014, 13 deployment to search and clear floors would've been far 14 that policy 790 was not effectively fit for purpose for 14 more effective. 15 multi-call incidents, and he demonstrated it through 15 Neither does there seem to have been any correlation 16 a training package. 16 between calls which were noted as priorities in CU7 on 17 But, regrettably, his criticisms and proposals for 17 the grid that you may recall, where the LFB had 18 change were not heeded. Babcocks declined to take the 18 information that trapped residents were elderly or 19 training forward. The package demonstrated that it 19 children, immobile or ill, and the deployments. Among 20 would be impossible to pass information on within the 20 the 16 999 calls where there were apparently no 21 timescales of what was felt to be a realistic 21 deployments at all, 11 were noted as priorities on the 22 progression of a high-rise incident. In effect, the 22 grid. 23 training package showed that it was impossible to meet 23 Finally, in terms of the statistics, we note that 22 24 reasonable timescales and, of course, that was proved by 24 emergency calls had been received from 15 flats where 25 the incident itself. 25 the caller identified the flat number by 01.45. 21 of Page 154 Page 156

Grenfell Tower Public Inquiry 1 1 those were passed to the fire ground as FSG calls. The appear on the second floor bridgehead wall. We can be 2 significance of that is by 01.25, all 999 calls 2 clear about that extent of time because that's when the 3 3 identifying particular flats were being passed on to the bridgehead was moved to the 3rd floor, so it's 4 fire ground, and by 01.45, there were a huge number of 4 a reasonable conclusion that, somehow, the information 5 5 had gone from control to CU8 to the bridgehead before 6 The fire was out of control, the control room was 6 that time. 7 overrun, the FSG policy was not producing results, and 7 There's no evidence that the flat 142 information 8 that continued through the incident. There was 8 passed through Mr Sadler's car bonnet staging post or, 9 9 a disconnect between command and the control room. indeed, Mr William's post at the entrance to the tower. 10 Critically, information flow was one way, from 10 There's no evidence at all that the information went 11 control to the fire ground, and much of the information 11 12 12 out of date by the time it got to the bridgehead or 13 because of a lack of feedback from the tower. Some 13 14 information fell between the cracks and was not passed 14 15 on, despite callers being told that rescue was on its 15 16 way. Incident command failed to appreciate the volume 16 17 of calls. 17 18 I'm conscious of time, but I would like to finally 18 19 move on to an example, and that's the example of 19 20 flat 142 on level 17. Just how unfit for purpose the 20 21 FSG policy was is illustrated by reference to flat 142. 21 22 As I stated from Mr Johnson's evidence, we know LFB 22 23 23 were aware of how it wouldn't cope with multiple calls. 24 Whether it's possible to have a workable FSG process to 24 25 25 deal with multiple calls remains in question, but its Page 157 known deficiencies should've underlined the need for 1 1 2 a general evacuation. 2 3 The residents of flat 142 were the family of my 3 4 client Mohammed Hakim. You may not be immediately 4 5 familiar with 142 as there has been so little evidence 5 6 6 about it. It will feature in the next phase when we 7 deal with what happened to each deceased, because the 7 recorded on a CIF. 8 five members of the family in the flat perished in the 8 9 9 fire. But I'm not referring to 142 now for that 10 10 purpose, but to illustrate how information fell between 11 11

from the 2nd floor to the 3rd floor when the bridgehead moved, and it appears that the information passed on from this first call was lost. So had been the best chance of rescuing the family. When no one came, the family made a second call, almost an hour later at 02.27. At 02.30, the control room officer who took the call passed the information to CU7. Mr Peckham noted the radio transmission on a control information form, so we know that was received. We know it was added to the laminated board in CU7. There's no evidence, however, that that second call was communicated to the tower until much later on, when Mr Furnell took a photograph of the laminated board to the tower sometime after 03.15. Again, the family waited and no one came.

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the cracks. There were three 999 calls from flat 142: at 01.29. reporting smoke coming into the flat; at 02.27 reporting

by then the fire was right next to the window; and at 03.18. I just want to spend a moment tracing the evidence that we know about that.

The first call was actually taken by the police at 01.29, and they passed it on to the Fire Brigade at 01.38. Control passed the information to the fire ground as an FSG by radio. The incident command appliance didn't respond and the information had to be intercepted by CU8 in the process of setting up at 01.43. There doesn't appear to have been any system, as I've said, at CU8, certainly at that point. But at some time before 02.17, the legend "17th fl, 142, FSG", did

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At 03.18, the family made the third call, spoke to the same CRO. A control information form again was generated at 03.23, so we know the information was passed on. CU7 were also informed independently by the police, PC Jacobs, that five people were trapped in flat 142 just after this time at 03.35. That too was

> This information did appear to go to the tower because it ended up on the bridgehead on the ground floor, but by the time of this third 999 call, it was too late, because the last crew to successfully reach level 17 had been deployed there somewhat earlier.

Despite three 999 calls, information being passed to CU8, twice to CU7, independent police information going to CU7, no rescue crew was ever deployed to flat 142. Lost between the cracks.

Conclusions.

Long before the firefighters could've been deployed onto the fire in flat 16, it had escaped onto the cladding. From a very early stage, it was obvious that no means of firefighting was going to extinguish or slow the progress of the fire. The Fire Brigade failed to react appropriately because of a series of systemic errors.

We urge the inquiry not to confuse effort with

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40 (Pages 157 to 160)

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1	outcome. Very brave attempts were being made to save	1	SIR MARTIN MOORE-BICK: Now, Mr Stein, your turn to make
2	lives, but commanders were following the wrong plan,	2	a statement.
3	with policies that were plainly not fit for purpose.	3	Before you start, can I just say that we're probably
4	633, mention made of the possibility of the need to	4	starting at an hour which you hadn't originally expected
5	evacuate where stay put was the default policy, but no	5	to start at. I don't want you to feel rushed. It would
6	contingency or operational plan for how that could be	6	be probably good for us and for you to hear the whole of
7	approached. This compounded by the complete absence of	7	your statement at once, but if we get to a time when you
8	training.	8	feel it's not going to work, you tell me.
9	Given the scale of the disaster, it's apparent that	9	MR STEIN: Sir, I understand that. I've already spoken to
10	the FSG system never got off the ground, at no stage	10	our stenographer about the need to keep to a reasonable
11	worked efficiently and was ineffective in saving lives.	11	pace as well, so I'll bear those matters in mind.
12	In fact, in adhering to a plan that was plainly	12	SIR MARTIN MOORE-BICK: All right. We'll see how we go,
13	inappropriate from the outset, the FSG process hindered	13	shall we?
14	rather than helped.	14	Closing submissions on behalf of G3 by MR STEIN
15	The LFB are right to highlight the courage of	15	MR STEIN: Sir, the London Fire Brigade let down the
16	individual firefighters, but they do them a disservice	16	firefighters who attended the Grenfell Tower fire, as
17	when they fail to acknowledge the obvious systemic	17	well as the residents of the Grenfell Tower. Quite
18	errors which placed those firefighters as well as	18	simply, the LFB was not able to take on a fire of this
19	residents at greater risk to life and limb. Those	19	magnitude, as it had had insufficient training,
20	systemic failures are all the more serious because LFB	20	inadequate equipment and no leadership capable of
21	had been involved in drafting the national guidance. It	21	tackling this fire. The London Fire Brigade was
22	knew post-Lakanal the policy fix with the FSG policy	22	a disorganised organisation.
23	simply didn't work for an incident with more than	23	The evidence before this inquiry has demonstrated
24	a handful of trapped persons.	24	that the London Fire Brigade has a cultural inability to
25	We urge you to carefully consider the following	25	plan for a major disaster in any high-rise block,
	Page 161		Page 163
	O		Ö
1	findings:	1	whether residential or office or any large building. It
2	Firstly, that there was a systemic failure to have		
	3	2	has completely failed to train or test equipment such as
3	any contingency plan to safeguard life where a stay-put	$\begin{bmatrix} 2 \\ 3 \end{bmatrix}$	has completely failed to train or test equipment such as radio and other communication systems under true-to-life
3 4	•		
	any contingency plan to safeguard life where a stay-put	3	radio and other communication systems under true-to-life
4	any contingency plan to safeguard life where a stay-put strategy became untenable or training to evaluate or	3 4	radio and other communication systems under true-to-life conditions. The majority of the equipment which is
4 5	any contingency plan to safeguard life where a stay-put strategy became untenable or training to evaluate or operate such a plan.	3 4 5	radio and other communication systems under true-to-life conditions. The majority of the equipment which is meant to allow the London Fire Brigade to communicate,
4 5 6	any contingency plan to safeguard life where a stay-put strategy became untenable or training to evaluate or operate such a plan. Secondly, there was a systemic failure to properly	3 4 5 6	radio and other communication systems under true-to-life conditions. The majority of the equipment which is meant to allow the London Fire Brigade to communicate, analyse and assess a fire ground did not work, and the
4 5 6 7	any contingency plan to safeguard life where a stay-put strategy became untenable or training to evaluate or operate such a plan. Secondly, there was a systemic failure to properly gather, collate, make available sufficient information	3 4 5 6 7	radio and other communication systems under true-to-life conditions. The majority of the equipment which is meant to allow the London Fire Brigade to communicate, analyse and assess a fire ground did not work, and the London Fire Brigade has demonstrated an inability to be
4 5 6 7 8	any contingency plan to safeguard life where a stay-put strategy became untenable or training to evaluate or operate such a plan. Secondly, there was a systemic failure to properly gather, collate, make available sufficient information concerning Grenfell Tower to allow for such contingency	3 4 5 6 7 8	radio and other communication systems under true-to-life conditions. The majority of the equipment which is meant to allow the London Fire Brigade to communicate, analyse and assess a fire ground did not work, and the London Fire Brigade has demonstrated an inability to be able to grasp and learn from mistakes.
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1	Grenfell Tower.		replace training and bravery is no substitute for
2	I refer to quotes now from two of those brave	2	equipment. Nor should any of us forget the astonishing
3	firefighters.	3 4	courage of the residents of the tower, both those who
4	C 1		made it out and those who died in the fire.
5	In his evidence, he referred to the struggle to get	5	In the last part of the evidence read before this
6	out of the bin store. He was hot, disorientated and	6	inquiry on 3 December, the words of Mrs Emanuela Disaro,
7	stressed:	7	the mother of Gloria Trevisan who lost her life
8	"Eventually we got out and got to stairwell. The	8	alongside her boyfriend Marco Gottardi and two others in
9	smoke was thick in the stairwell and I could not see my	9	flat 202 on the 23rd floor, should be remembered.
10	hand in front of my face. We had all lost our energy.	10	Gloria's mother said:
11	We struggled to get down the stairs and it was a mixture	11	"You could tell she was having problems talking.
12	of stumbling, falling and crawling trying to get down.	12	Her throat was burning, she was starting to feel unwell
13	After coming down 3-4 floors I realised we had lost FF	13	and she wanted to go quicker. At a certain point she
14	Chris DORGU. I asked for FF BADILLO to shout for FF	14	told me fire was coming through the window.
15	DORGU because I had no energy to do it. Neither did he.	15	A moment later she said:
16	We sat there. I looked at my gauge and saw I only had	16	" she couldn't breathe. She told me again what
17	15 bar left; I was in big trouble. I put myself in a	17	she felt for us and that we have to say goodbye and we
18	corner of the stairwell because I did not want to be in	18	had to be strong. At that point Gloria said she was
19	anyone else's way if I didn't make it out."	19	cutting off the phone because she didn't want me to hear
20	In fact, Firefighter Dorgu appeared, grabbed his	20	anything and she said goodbye to us"
21	arm, and was able to help him out.	21	Firefighters and residents have no doubt about the
22	Let's not forget the evidence from Watch Manager	22	bonds that have been made amongst themselves. They know
23	Louisa De Silvo. You'll recall she was deployed at the	23	what they saw, what they witnessed and they have built
24	bridgehead. Faced there with the job of making sure	24	up strong relationships of friendship and respect.
25	that firefighters were going correctly into the tower,	25	That is why, when the residents and survivors march
	D 465		D 445
	Page 165		Page 167
1	the question was asked of her by counsel to the inquiry,	1	on the 14th of a month, the firefighters line the march
2	referred to two West Hampstead BA wearers, Martin Hoare	2	and they meet and greet each other with dignity, warmth
3	and Matthew Tanner, being deployed at roughly 02.55.	3	and respect.
4	She was asked what her recollection was about that	4	But there are difficulties for residents and family
5	particular deployment, and she said this:	5	members from the tower. Residents and family members
6	"What I remember about that is I recognised them,	6	from the tower and survivors from this fire, even when
7	like I say, because of my time at Kentish Town. So they	7	they don't always believe that individual firefighters
8	were firefighters who were familiar to me.	8	either did their best or have even given their evidence
9	"What I do remember is Firefighter Tanner asking me	9	honestly because of the dire peril everyone was in, they
10	if there would be water there when he gets there. Any	10	thank firefighters for the saving of lives. An example
11	firefighter going near or into a fire will take water;	11	of this is Seun Talabi. He said:
12	that is our baseline for our own safety. And I remember	12	"As well, I'd like to speak about the Fire Brigade,
13	him asking and I remember having to say that it was	13	if I can.
14	unlikely that there would be any water for him to take	14	"No one should ever have to go to work and not
15	with him into those conditions.	15	return back to their family, no one, whether you're Fire
16	"These are firefighters who have seen the building	16	Brigade, whether you're a firefighter, whatever job you
17	that they're entering, and I remember having to say to	17	do. But at the end of the day, it will be easier
18	him that it was unlikely there would be water and that	18	sometimes if you just say the truth, because that way
19	he was to try and effect rescues" [Day 30, 26 July	19	people will forgive you. It will be easier for people
20	2018, page 36]	20	to forgive you." [Day 59, 16 October 2018, page 153]
21	Ms De Silvo was sending firefighters into an inferno	21	He went on to say:
22	and she and they knew it.	22	"But you shouldn't lie on residents that are going
23	But this inquiry needs to avoid the mistake being	23	through enough as it is and say you did rescue missions
24	made by the London Fire Brigade, which is to confuse	24	that you didn't do."
25	bravery with adequacy of response. Bravery cannot	25	Of this position, which is difficult for Mr Talabi,
	Page 166		Page 168
			

1 disaster, multiple FSG calls and high population risk, 1 we suggest, he says: 2 2 "I would like to thank Peter Herrera for opening then we await the next disaster, which will yet again 3 3 that door, because if he didn't open that door, lead to casualties and death without an adequate 4 I probably would've gone through the window and 4 response from the LFB. 5 I probably would've died. Maybe, maybe not. But at the 5 But the truth from other submissions made today, and same time, Peter Herrera made loads of mistakes that 6 6 from the background history from other fires, is that 7 7 night. far from the Grenfell Tower being an unrealistic 8 8 "... All he had to say was, 'I tried my best, I was scenario, the risk of a cladding fire was well known to g scared'." 9 the LFB. In 1999, after the Garnock Court fire in 10 Where we suggest that the London Fire Brigade has 10 Irvine, the Environment, Transport and Regional Affairs 11 failed as an organisation, from a starting point, is in 11 Committee examined the potential risk of fire spreading 12 12 failing to assess the potential for risk, in planning to in buildings via external cladding systems. This is 13 deal with the risk and, therefore, in failing to train 13 1999. 14 or equip to cope with such risks. 14 The Fire Brigade Union, in their submissions, 15 The London Fire Brigade is assisted and sets out by 15 observed that there are a number of risks posed by the 16 the London Safety Plan, which was approved and as yet 16 use of combustible or badly installed external cladding 17 unamended on 30 March 2017. It refers to the question 17 systems, and went on to make further submissions that 18 of risk management, setting out matters in this 18 the primary risk, therefore, of the cladding system is 19 way: what does London Fire Brigade mean by risk, it 19 that it provides a vehicle for assisting uncontrolled 20 20 asks? And it answers its own question: the London Fire fire spread up the outer face of the building, with the 21 Brigade's understanding of risk is based on the 21 strong possibility of the fire re-entering the building 22 22 likelihood of an incident occurring and its at higher levels, via windows or other unprotected areas 23 23 consequences. Well, the most likely incidents that may in the face of the building. This is, in turn, a threat 24 occur may be a fire in a house, a fire that does not 24 to the life safety of the residents above the fire 25 25 breach compartmentation, and if you base your planning floor, 1999. Page 169 Page 171 1 upon such level of risk, you'll never have adequate 1 In her evidence, Commissioner Cotton was asked --2 resources capable and able of helping people in such 2 this is on 27 September -- whether she'd been shown the 3 3 a fire as at the Grenfell Tower. LFB slideshow with the title "Tall building facades". 4 4 On 27 September of this year, Mr Millett QC, counsel Her answer was no, despite her background, being the 5 to the inquiry, asked Commissioner Cotton whether there 5 director of safety and assurance at the time. Whilst 6 had been a structural or cultural failure by the LFB to 6 the circulation list contained her senior fire safety 7 7 respond to new hazards. The response from the officers, she did not know if any had actually seen the 8 commissioner was to deny that there had been such 8 presentation. She accepted eventually that the 9 9 a failure. During the course of the commissioner's conclusions from the slideshow demonstrated that there 10 evidence, she stated that training about fires on 10 had been an emerging consciousness within the LFB that 11 building facades would not have helped, and I quote, she 11 facades of high risk buildings created risks of fire 12 12 spread. 13 "But I truly don't think it would've benefited 13 Now, the key question is whether and how that 14 14 anyone to have had any more detailed knowledge about information had been disseminated to front-line 15 cladding to respond to the fire at Grenfell because it 15 operational firefighters. Well, we know repeatedly, 16 wouldn't have enabled them to extinguish the fire." 16 from the questions asked by counsel to the inquiry, that 17 [Day 50, 27 September 2018, page 69] 17 the answer from the front-line firefighters is they had 18 We suggest that it is imperative for the safety of 18 no knowledge, other than one or two who referred to 19 Londoners that the LFB review their management of risk. 19 having seen it themselves online or on television. 20 The consequences of not planning within an emergency 20 The commissioner's response to the document in 21 21 service to deal with a known risk is precisely why the relation to whether the information had been given out 22 London Fire Brigade was outclassed by the Grenfell Tower 22 to the operational firefighters, she said this: 23 23 "I don't think it has been because I wasn't familiar 24 Without making sure that the London Fire Brigade has 24 with this document beforehand. But the normal procedure 25 25 the resilience and resources to cope with a major would be if there was deemed to be something that was Page 170 Page 172

1	a risk that needed to be shared, it would be developed	1	Natural curiosity.
2	into a training package that could be shared more	2	Forgive me if this seems judgemental, commissioner,
3	widely." [page 50]	3	but does this seem the right way for the London Fire
4	Asked if she knew why such a training package had	4	Brigade commissioner to be reviewing documents about
5	not been undertaken:	5	cladding fire risk, or is there something we are
6	"No, I don't." [page 51]	6	missing? We have the largest ever civil disaster since
7	Asked why the presentation was only provided to	7	World War II, the largest call-out of firefighters and
8	a limited number of specialists and not been seen:	8	appliances that anyone, it seems, has ever heard about,
9	"No idea."	9	and we have the deaths of 72 people from the vertical
10	It was suggested by counsel to the inquiry that her	10	community that was the Grenfell Tower building. But
11	evidence indicated both structural and cultural failings	11	when does the commissioner decide to look at documents
12	within the LFB, a failure to more widely disseminate key	12	that relate to high-rise blocks and cladding fires?
13	elements of fire safety. Her response:	13	Well, it seems only when it is shown before this
14	" nobody would expect an incident like Grenfell,	14	inquiry.
15	where the building would fail so spectacularly and be	15	We ask this question: why did the commissioner not
16	covered in such a highly flammable product, would be	16	say within hours if not days of the Grenfell Tower fire,
17	allowed to exist."	17	"I want to see everything the LFB has on high-rise block
18	Whilst ultimately accepting that the Grenfell Tower	18	fires and cladding fires"? Why did she not say, "Give
19	fire was not a negligible risk and that the risk of such	19	me every piece of academic research on cladding fires
20	a fire had been on the London Fire Brigade's radar for	20	and let me understand what happened and see how we can
21	at least nine months, the commissioner argued that	21	improve"?
22	training would make no difference.	22	The fact is that the commissioner for the LFB did
23	Of course, we have the memorable part of the	23	not ask for this material immediately. The fact is that
24	evidence from the commissioner addressing the	24	that defies belief. Why is the commissioner of the
25	unrealistic scenario that had unfolded at	25	London Fire Brigade not taking the lead in examining
	Page 173		Page 175
	Tage 173		Tage 173
1	Grenfell Tower, as she put it, where she explained:	1	what happened and why?
2	" I wouldn't develop a training package for	2	But it's worse than that, because it also tells us
3	a space shuttle to land on the Shard, we would respond	3	that her senior management team did not brief her on
4	to it and deal with it in the same manner we do. That	4	what was available in the months leading up to the
5	is an incident of that scale, so I wouldn't expect us to	5	inquiry. London has approximately 1,600 high-rise
6	be developing training or response to something that	6	blocks, both residential and office. The London Fire
7	simply shouldn't happen." [page 52]	7	Brigade has not trained to fight a compartment breaching
8	But does not the commissioner understand that	8	fire in any of these blocks. This cultural blindness to
9	aeroplanes fly into towers, concerts in large buildings	9	risk means that the very organisation which we rely upon
10	are bombed and towers are vulnerable to fire?	10	and pay for, which we all believed before the
11	But in her evidence, we also learnt one further	11	Grenfell Tower fire was in the business of disaster
12	thing about the "Tall building facades" document. She	12	management and solution, is quite incapable of dealing
13	explained that the only reason she had looked at the	13	with a fire ground of this complexity.
14	"Tall building facades" presentation is that she was	14	This is like the army and navy saying, "We're pretty
15	going to be questioned before this inquiry. Asked by	15	good at dealing with a minor skirmish, but we have no
16	counsel to the inquiry:	16	plan and we've given no thought to fighting a battle."
17	"Question: Have you studied this document since	17	Because of the abject failure by the LFB to plan for
18	Grenfell?	18	this known risk, no one single person was capable, it
19	"Answer: The tall building facades one?	19	seems, of appreciating the growth of this disaster.
20	"Question: Yes.	20	Mr Weatherby has examined the GRA 2014 and its
21	"Answer: I've looked through it, yes. I have not	21	contents. I only say this: it is clear that the London
22	studied it in detail. I have looked through it.	22	Fire Brigade has failed to comply with its duty under
23	"Question: Who asked you to do that?	23	GRA 2014.
24	"Answer: Once you'd shown it here in this inquiry,	24	Therefore, without such planning, the firefighters
25	my natural curiosity led me to go and look at it."	25	were left with inadequate equipment and no overall
	Page 174		Dago 176
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1	ability to make an assessment of all of the information	1	emergency service is reliant on runners with pieces of
2	available from FSG calls, 999 calls, from people at the	2	paper, this is fit only to just about on occasions
3	scene, CCTV photographs or other images sent down,	3	convey emergency rescue information. But as regards the
4	drone, helicopter, television, Airwave, mobile phone, or	4	equally important need to use that information to assess
5	the handheld radios. Nor was there the equipment	5	the situation, it is simply not fit for purpose.
6	available which might have supported communications,	6	I'm going to move on to the radios and the problems
7	such as the Vector computer-based simulation system	7	with those at the tower.
8	described by SM Johnson as not working for nine years,	8	The handheld radios used by the firefighters at the
9	or the other not working or useless equipment, such as	9	Grenfell Tower fire operated on
10	the striker camera, Toughbooks, mesh nodes and CSS.	10	a most-powerful-signal-gets-through line-of-sight
11	The FSG call centres were blind to the events of the	11	principle, which means that a standard high-rise
12	fire ground, and the command units didn't have reports	12	building, with an inevitable iron steel structure,
13	from the firefighters within the block and no way to	13	reinforced concrete components, will block radio waves
14	bring together an assessment of the FSG information.	14	attempted by communication to be made up and down the
15	So no wonder we have the discrepancy in time and the	15	tower. The limitations of that equipment used resulted
16	communication of the abandonment of stay put. Because	16	in very significant failings on the night.
17	there were no information feeds, and no real	17	You'll recall the evidence of Firefighter O'Beirne,
18	communications, we in fact have two separate	18	one of the first firefighters to arrive. Mr O'Beirne
19	determinations that the stay-put policy should be	19	witnessed flats on fire one and two levels above the
20	changed to an evacuation.	20	fire. He spoke to individuals coming from flats. He
21	On 26 September, in the questions asked by counsel	21	also noted heavy smoke-logging in flats on the 6th
22	to the inquiry of AC Andy Roe, he was asked about his	22	floor. He attempted to radio Mr Dowden using his
23	decision to abandon stay put. Two important pieces of	23	handheld radio and he heard nothing back. He said this:
24	information arose.	24	" I radioed down to WM DOWDON[sic], using my
25	First, Mr Roe's ignorance as to Watch Manager	25	handheld radio, and said something along the lines of
23	That, we would ignorance us to water wantinger	23	nandicid radio, and said something along the lines of
	Page 177		Page 179
1	The second of the second of the second of the	,	
1	Johnson's pilot exercise which had demonstrated the	1	'the flat above the fire floor is on fire, their kitchen
2	operational difficulties which arose once fire survival	2	is alight. We need a BA crew and breaking in gear.' I
3	guidance call numbers rose above seven.	3	only radioed once.
4	Second, that whilst Mr Roe had abandoned the	4	"I don't remember hearing any other radio traffic at
5	stay-put policy as of 02.47, in fact, by 02.35, Jo	5	that time. I didn't get a reply but I believed my
6	Smith, within one of the FSG centres, was advising that	6	message had been transmitted and that I had spoken
7	callers evacuate, get out, this could be the last	7	clearly."
8	chance. How is it that we have a situation where the	8	Again, once on the 6th floor:
9	call centre assessment, without sight of the tower on	9	"I radioed down to the Governor, WM DOWDON, again
10	fire, is that stay put has to be abandoned, yet this has	10	but I didn't get any reply. I didn't get a reply to any
11	not managed to communicate itself to Mr O'Loughlin, who	11	of the radio messages I sent to the governor but I
12	had been in charge at that time, and, therefore, not	12	assumed he was still very busy but that he could hear
13	onwards to Mr Roe?	13	me."
14	Wouldn't lives have been saved if someone in	14	But was this vital evidence from Mr O'Beirne, who
15	a command position to make the call to abandon stay put	15	was the individual that had decided that it would be
16	could have had an understanding of the volume and	16	a good idea to go up the stairs of the tower and see how
17	factual content of the FSG calls, as well as effective	17	farce were progressing, received and acted upon or
18	communications with firefighters in the tower, plus	18	understood at these early stages?
19	sight of the tower?	19	Mr Dowden's evidence in this regard was given on
20	Marcio Gomes put it this way:	20	27 June of this year. He said that he received no
21	"The decisions, or better yet the lack of decisions,	21	information from Mr O'Beirne as to what Mr O'Beirne was
22	at the time cost lives, and I truly believe that a lot	22	discovering concerning the conditions on the floors
	more lives would've been saved if things were done	23	above the 4th floor.
23			
24	quicker." [Day 71, 9 November 2018, page 151 to 152]	24	The evidence from Mr O'Beirne and Mr Dowden is
		24 25	The evidence from Mr O'Beirne and Mr Dowden is entirely compatible. Mr O'Beirne recalls trying to
24	quicker." [Day 71, 9 November 2018, page 151 to 152]		

1	transmit the messages but received no acknowledgement or	1	crew, as well as where they are firefighting, where they
2	reply. Mr Dowden does not recall getting these	2	think they are, where they are finding casualties, what
3	messages, and given that we know where he was standing,	3	rescues are taking place. We're not able to get any of
4	which was close to the base of the tower, it is likely	4	that information back either." [Day 29, 25 July 2018,
5	that he simply didn't receive the radio traffic as the	5	page 233]
6	tower structure itself would've been blocking the radio	6	Firefighter Morrison, Amanda Morrison, she put it
7	transmission.	7	this way:
8	If these calls had been made by a mobile phone, as	8	"For me the comms is a massive issue as a game
9	was demonstrated by the harrowing long call, yet another	9	changer for that job. Not having comms is a bit like
10	testament to courage and bravery by Marcio Gomes as he	10	being disabled in the job. You can't talk to each
11	spoke to Ms Fox at the call centre, then in all	11	other, you can't tell each other what you need, you're
12	likelihood, the call and information to Mr Dowden	12	trying to grab peoples helmets and talk to each other
13	would've got through.	13	through our sets, you can't talk to downstairs to see if
14	Now, the ability to use a mobile telephone in fire	14 15	they've got anyone coming up, whether they've got any
15	conditions without question is difficult and it requires		news on us getting water."
16	an individual phone call to be made. The point is that	16 17	Firefighter Foster, Katie Foster:
17	type of technology will allow a call to be made in and	18	"I attempted to use my radio to pass on the
18	out of a tower. It may be that you can't just or should	19	information that we had found and especially as there were residents inside."
19	not rely upon your personal mobile phones, but the		
20	technology is there.	20 21	In fact, she and her colleague had come across
21	Perhaps it's obvious that communications are vital. But let's remind ourselves of some more of the evidence.	21 22	a male who told us there were five people inside a flat.
22		23	She remembered trying to radio through around seven
23	Ms De Silvo at the bridgehead.	23	times but was unsuccessful. Greg, the partner she was
24	"The sheer volume of FSG calls coming in meant I was	25	with, also tried but was also unsuccessful.
25	receiving information by small pieces of paper	23	Now, all of this evidence was given before the
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1	runners and also by radio with just the floors and flat	1	commissioner gave her evidence. Do they not have
2	numbers. The volume of FSG calls was very high."	2	someone within the London Fire Brigade that might have
3	She went on to say:	3	been tasked with listening to what was being said before
4	"Another problem was the BA crews normally use	4	this inquiry? How can the commissioner say that she
5	channel 6 to communicate with entry control. However	5	wouldn't have changed a thing? Floor 14, we suggest, is
6	this channel was proving difficult throughout the	6	a demonstration of these communications problems leading
7	incident. There was so much feedback on the channel	7	to loss of life.
8	that it was very difficult to use. Someone tried to lay	8	Inability of firefighters to communicate within the
9	a repeater on the ground floor bridgehead which is a	9	tower, both amongst themselves and with the bridgehead,
10	kind of booster to help with the signal, but that didn't	10	led, amongst other things, to the tragic failure to
11	help at all. I've never experienced communications	11	rescue occupants of flat 113: Omar Alhajali,
12	problems on that scale before."	12	Denis Murphy, Zainab Deen and Jeremiah Deen.
13	She went on:	13	Firefighters Cornelius, Merrion, Murphy and Sanders
14	"The BA channel wasn't working well so crews	14	were the first crew to visit floor 14. They were unable
15	couldn't tell me what they had or hadn't done through	15	to notify anyone by radio about the number of residents
16	that means either. Some were committed to a specific	16	at flat 133 and the need for additional crews to rescue
17	FSG, but before they got there they came across	17	them with secondary BA kits. It was only on return to
18	casualties who they needed to help there and then."	18	the bridgehead that Firefighter Cornelius was able to
19	In her evidence on 25 July, again asked about	19	convey that information.
20	communications:	20	Back at the bridgehead:
21	"So for a lot of the time we were unable to get any	21	"I informed him that we needed more BA set wearers
22	communications from them [firefighters] at all, which is	22	and more people to go up there and rescue the 8 people."
23	worrying in terms of safety, because we want to monitor	23	He added:
24	their air, we want to know their location, if they get	24	"I tried constantly to contact the bridgehead,
25	in trouble, we need to know where to send an emergency	25	anyone downstairs, telling them that we needed second
	Dago 192		Dago 194
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1	sets and what we had found, and that we wasn't going to	1	required for a particular floor. Well, we suggest	
2	be able to bring the people down the stairs. This is on	2	that's right, but an understatement of the	
3	both of my radios. And Firefighter Murphy tried as	3	participation.	
4	well. But at no point we had anything we didn't hear	4	Since the fire, where have we got to?	
5	any chatter over the radio or anything at all." [Day 38,	5	The absence of substantive change following this	
6	6 September 2018, page 81]	6	incident gives rise to concerns that the same will	
7	They tried again, there was no ready communications	7	happen post-Grenfell. Has the communication equipment	
8	with the BARIE sets or with handhelds, says Firefighter	8	failure been addressed since the fire? Sadly, we	
9	Cornelius.	9	suggest that the LFB's response has been piecemeal at	
10	Firefighters Herrera and Firefighter Orchard	10	best. Sir, you'll have noted our submissions in this	
11	ultimately effected a rescue of only four of the eight	11	regard at pages 24 and 25 of the written submissions.	
12	residents from flat 113. Firefighter Herrera recollects	12	The London Fire Brigade's 24 October 2018 updated	
13	being tasked to rescue three people, Firefighter Orchard	13	position statement in other words, updating what	
14	to rescue six.	14	they've done since the fire entitled "Actions since	
15	Firefighter Herrera said he was tasked to look for	15	the Grenfell Tower document", made reference to some	
16	a family, an adult male, female and child. Firefighter	16	steps to address some of the communication issues	
17	Orchard:	17	identified. Reference made to the, as an example,	
18	"She called us forward and told us that there are, I	18	introduction of improved BARIE equipment to be	
19	think she said six people in Flat 113 on level Fourteen.	19	undertaken there referred to, but not until 2020 or	
20	She said, 'They were alright, they're not alright now.	20	2021. Also referring to the command unit replacement	
21	We need to get them out."	21	project, acknowledging the ongoing issues regarding the	
22	Now, we know that Firefighter Herrera contends he	22	reliability of the CSS, is still over two years from	
23	was told this is his evidence by Omar Alhajali	23	completion.	
24	that there were no more occupants in the flat and that,	24	Now, of course, such steps as those are welcome, but	
25	while he conversed with Mr Alhajali in the lounge of	25	notable omissions include the failure to address the	
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1	flat 113, he, Mr Herrera, states he was not aware of the	1	following:	
2	residents in the first bedroom. The credibility of	2	(a) the problems of communicating using the existing	
3	those assertions is strongly challenged, and the chair	3 4	handheld radio system within a concrete, steel and glass	
4	is invited to determine this matter.	5	building and at incidents where there is a significant volume of radio traffic.	
5 6	Notwithstanding those issues, it is plain that the inability of Firefighters Herrera and Orchard to	6	(b) the apparent lack of effectiveness of the	
7	communicate with the bridgehead denied them the	7	repeater and/or leaky feeder equipment.	
8	opportunity to confirm the expected numbers of persons	8	(c) the need for realistic training to overcome	
9	in the flat.	9	communications in what are known to be challenging	
10	Firefighter Cornelius. Asked the question:	10	circumstances.	
11	"Question: One question that's arisen is: what	11	(d) the failure to instruct an expert in the field	
12	difference would radio contact have made for you at that	12	of communications to overcome problematic communication	
13	stage?	13	within buildings and built environments.	
14	"Answer: For me, it was a big factor. It would	14	(e) the need for funding and policy change to enable	
15	have given me confidence in what I was telling the	15	the deployment of Airwave Firelink radios directly on	
16	people, that we could send another crew of firefighters	16	the fire ground.	
17	up, or more crews, multiple crews, with second sets.	17	This piecemeal approach, undertaken at a glacial	
18	That to me would've been a key element in saving them	18	pace, is typified by the fact that the London Fire	
19	"	19	Brigade's written closing submissions simply state that	
20	The Fire Officers Association submissions set out by	20	the Brigade is aware of a range of incident	
21	Mr Browne QC and Mr Wall, dated 6 December 2018,	21	communication challenges, both in relation to the fire	
22	understandably observe at paragraph 103 that	22	ground radio and the breathing apparatus equipment, and	
23	communication problems were one of the factors impacting	23	capacity that occurred at Grenfell Tower.	
24	upon ability to undertake an evacuation, since it meant	24	Going on to say in respect of the Brigade's fire	
25	that crews could not communicate how many BA were	25	ground and BA radio equipment provision, both systems	
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1	are scheduled for replacement in the financial year	1	building.
2	2019/20.	2	In summary, the ability to communicate, receive and
3	Moving on, the LFB there sets out the lessons learnt	3	process information within the London Fire Brigade
4	and experienced from the Grenfell Tower fire will be	4	structure was appalling. The firefighters response to
5	considered as part of the development of the technical	5	the fire and overall attitude was a commendable "keep
6	specification for these replacement radio projects.	6	going regardless", but it was undermined by the
7	So instead of setting out in detail for this inquiry	7	inability to pass communications from firefighter to
8	what the LFB has done and proposes, we are left to look	8	firefighter and firefighters to decision-makers.
9	through their announcements. The London Fire Brigade	9	The reaction from the London Fire Brigade has been
10	document titled "Replacement of incident ground	10	far too slow, and we suggest that the LFB's leadership
11	communications update" dated 21 May 2018 sets out in,	11	remains incapable of making decisions that adequately
12	frankly, a confused document a decision that has been	12	react to the dangers faced by the people under its care.
13	named to consider the purchase of radio sets, and it	13	Sir, if I may, I would suggest I have another
14	looks like the purchase is from a company called Intel,	14	10 minutes.
15	the cost assessment being 1.6 million.	15	SIR MARTIN MOORE-BICK: You keep going, if you're content.
16	But if that is what the London Fire Brigade is	16	MR STEIN: I am.
17	setting itself out as needing to do, as we understand	17	Let me move on to then the views of people from the
18	it, the problem is that such radios from Intel will be	18	tower regarding equipment failures, because some have
19	simplex only, simplex meaning only one person can talk	19	addressed this.
20	at a time. This means that even if a firefighter is	20	Rosemary Oyewole, 15 October.
21	communicating a relatively routine message, so long as	21	She says:
22	this is more powerful, this will block the communication	22	"I would also like to say that we lost beautiful,
23	from another firefighter on the same channel or cut out	23	beautiful, beautiful people that night, innocent
24	that call. The person with the strongest signal will	24	children. Everyone that passed away that night was
25	generally be the person closest to the receiver radio or	25	innocent and nobody deserved that. And if events might
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1	with the least obstructions. Radios of this type are	1	have played out differently, then I probably wouldn't be
2	also low powered and, therefore, signals will be easily	2	sitting here today myself.
3	obstructed by reinforced concrete.	3	"So I just think the people that came back that
4	So we doubt whether the LFB is on the right track.	4	night, or the firemen that came back that night, they
5	As these types of handheld radios will not penetrate	5	were you know, on many occasions people came back,
6	a building such as the Grenfell Tower itself, the issue	6	people had the chance to see how many people were
7	is not just whether there was too much radio traffic,	7	brought into our flat, people had the chance to see the
8	but whether communications can be established up and	8	state of the people that were brought into our flat, and
9	down a building.	9	for there not to be any precautions taken into place
10	We know a radio that is contained within a mobile	10	and, you know, the right equipment being given to people
11	telephone, as demonstrated by Marcio Gomes, will call up	11	to come and get people out of our flat I think if
12	and down a tower, and that is because it is transmitting	12	they did have the correct equipment, then I personally
13	a signal outside of the tower to a cell site mast and	13	think that the people that passed away in our flat
14	then back to a recipient.	14	possibly wouldn't have passed away.
15	A simple radio can transmit to an outside signal	15	"And that's all I'd like to say." [Day 58,
16	repeater and then back into the building, as long as	16	15 October 2018, page 90]
17	they are line of sight, one to another.	17	Helen Gebremeskel, 6 November:
18	The New York system could be adopted, which allows	18	"We've seen failings and failings I've been
19	for a hardwired it's called an arc system which could	19	failed so many times you know, failings and failings
20	be installed in high-rise buildings that allows there	20	and failings with other fires and other lessons not
21	inter-floor communications.	21	learnt.
22	The London Fire Brigade and this inquiry need to	22	"So Grenfell has to stand for something, and it's to
23	have the assistance of a communications expert to advise	23	stop here about how people are treated and how the
24	us what the best solution is to these types of	24	loopholes in the system need to be closed, you know.
25	communications issues within a fire ground in a large	25	"
	Page 190		Page 192
	- "6" - " "		- "80 - 1/2

		1	
1	"Justice for me is that, you know, this never	1	Thank you all very much, 10 o'clock tomorrow,
2	happens again, you know, we have a fair system. We've	2	please.
3	got a lot to deal with, especially in this environment	3	Thank you.
4	at the moment, but it has to stop here." [Day 68,	4	(4.30 pm)
5	6 November 2018, page 89 to 91]	5	(The hearing adjourned until Tuesday, 11 December 2018
		6	at 10.00 am)
6	The London Fire Brigade needs a shake-up from the	7	INDEN
7	top down. The Grenfell Tower fire marks a point in	8 9	I N D E X Closing submissions on behalf of1
8	history where the Brigade should have said, "We need to		London Fire Brigade
9	change, we need to review our resources to be able to	10	by MR WALSH
10	undertake realistic planning for what are the known	11	Closing submissions on behalf of G452
11	risks to high-rise towers from cladding fires". We do		by MS BARWISE
12	not see that the commissioner or her office have	12	
13	recognised this need to change.	1.0	Closing submissions on behalf of G3115
14	Within days if not weeks of this fire, the London	13	by MR WEATHERBY
15	Fire Brigade should have been calling for a radical	14	Closing submissions on behalf of G3163 by MR STEIN
16	change to resources and a dedicated discussion with the	15	by MR STEIN
17	Mayor's office and the Cabinet Office regarding funding	16	
18	to cope with major disasters.	17	
19	That discussion should have been directed at the	18	
20	question: what value do we place on the lives of our	19	
21	citizens, and how far are we prepared to pay for the	20	
22	protection of our people? In essence, that is the same	21 22	
23	discussion which lies at the heart of this inquiry and	23	
24	we will be examining in Phase 2.	24	
25	The question there, as we continue into Phase 2,	25	
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١,	:		
1	is: what price are we prepared to pay as a society to		
2	protect our own people from commercial greed, local		
3	authority cost-cutting and institutional apathy?		
4	Unless we change our approach to the assessment of		
5	risk, and include within that risk assessment the very		
6	people who will suffer the risk, when we come to the		
7	question of the expenditure of resources on equipment		
8	and training within such organisations as the LFB, then		
9	no doubt we will be here again at some point in the		
10	future, confronting these same issues.		
11	The families we represent say stop and change. On		
12	their behalf, we say stop and change. No more fires		
13	that the LFB cannot deal with, fund the emergency		
14	services properly, and have leaders of these services in		
15	place that can exercise leadership, not denial.		
16	Sir, those are our submissions.		
17	SIR MARTIN MOORE-BICK: Well, thank you very much, Mr Stein.		
18	You have done very well to finish by 4.30.		
19	MR STEIN: Thank you, sir.		
20	SIR MARTIN MOORE-BICK: Thank you very much.		
21	Well, that's obviously a good point to finish for		
22	today, so we'll break in just a moment.		
23	We resume tomorrow with some more closing		
24	statements. According to my running order, we shall be		
25	hearing from Mr Menon first thing in the morning. Good.		
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