Grenfell Tower Inquiry

Day 176

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(10.00 am)

SIR MARTIN MOORE-BICK: Good morning, everyone. Welcome to today's hearing.

Today we're going to embark upon Module 5 of Phase 2, in which we're going to investigate aspects of training and management of the London Fire Brigade which we were not able to investigate in Phase 1.

Today we're going to hear opening statements from various core participants, but, before we come to them, we're going to hear first from Counsel to the Inquiry, Mr Richard Millett Queen's Counsel.

Yes, Mr Millett.

Module 5 opening statement by COUNSEL TO THE INQUIRY

MR MILLETT: Mr Chairman, thank you very much. Good morning to you, good morning to members of the panel, Ms Istephan and Mr Akbor.

Today's opening addresses mark the start of Module 5, during which we will investigate the remaining matters concerning the London Fire Brigade's response to the Grenfell Tower fire on 14 June 2017 that could not be addressed in Phase 1.

We will also investigate three other specific topics that arise from the Chairman's findings in the Phase 1 report. Those specific topics are as follows:

1. The adequacy and effectiveness of visits carried out by the LFB under section 7(2)(d) of the Fire and Rescue Services Act 2004 to obtain information which is necessary to discharge the LFB's statutory function to extinguish fires.

2. Training, and with particular focus on the training provided by the LFB to incident commanders and in relation in particular there to evacuation.

3. Alternative firefighting strategies in high-rise buildings.

As to the structure of Module 5, we are going to start with opening statements by certain of the core participants today. Starting from tomorrow, we will hear evidence from past and present senior LFB officers on the topics that I've mentioned.

You will recall that, at Phase 1, the Inquiry called evidence from some 88 LFB employees, and the statements of a further 262 LFB witnesses were read into the record. In this Module 5, the Inquiry will not therefore be calling any further factual evidence about the events on the night of the fire on 14 June 2017. Those events have been the subject of detailed analysis and findings in the Phase 1 report.

The Inquiry currently expects the factual evidence of this Module 5 to take 14 or so sitting days.

Following the factual evidence, we will then hear from three of the four experts retained by the Inquiry for the purposes of this module. Those experts are as follows: (1) Professor Chris Johnson who has examined the effectiveness of the LFB's communication systems; (2) Mr Steve McGuirk, who will deal in broad terms with firefighting on the night; and (3) Professor Jose Torero, who will consider general issues arising from the firefighting response.

We expect that that evidence, the evidence of each expert, will take one day apiece.

Dr Ivan Stoianov has addressed certain issues relating to water on the night of the fire. In the light of some of the points made by Thames Water and the LFB very recently in their opening submissions, the Inquiry team has decided to call Dr Stoianov's evidence later, in Module 7, to allow him to consider the points that have been raised.

Finally, I should make it clear that the first part of Module 6 will be concerned with further questions for the LFB and others, such as: the sufficiency of the LFB's policy arrangements for the management of fire survival guidance calls; MHCLG's policy document GRA 3.2 and evacuation; the translation of knowledge within the LFB of risks presented by cladding fires in high-rise

buildings into operational policy and practice; and the lessons learned and arising from the Lakanal House fire and other relevant fires in this country and abroad. We intend to examine those matters in Module 6, but also to some extent in this Module 5.

I should also make it clear that in Module 6 the Inquiry will hear present from the present London Fire Commissioner and his two immediate predecessors.

Mr Chairman, that is all I propose to say by way of opening statement.

SIR MARTIN MOORE-BICK: Good, thank you very much, Mr Millett.

Well, now, the first of the core participants' legal representatives to address us is Mr Friedman Queen's Counsel, and since he is in the room, he is ready to go slightly earlier than we suggested we might be able to hear him.

Module 5 opening submissions on behalf of BSR Team 1 by MR FRIEDMAN

SIR MARTIN MOORE-BICK: Good morning, Mr Friedman.

MR FRIEDMAN: Good morning, Sir Martin.

SIR MARTIN MOORE-BICK: Good to see you. Are you ready to make your statement?

MR FRIEDMAN: I am, and we are grateful for the arrangements that have been made for the remote hearings, but also

happy to see you here this morning, and good morning to Ms Istephan and Mr Akbor too.

Firefighters don't cause fires. They respond to the threats of other people's making. But that does not insulate fire services from the need to achieve competency in what they do, and at Grenfell Tower, the London Fire Brigade confronted the limits of its competency. The depth of its deficiencies exposed an organisation that could not cope with an emergency beyond the normal or standard fire. Although unusual, the catastrophic consequences of high-rise building failure were foreseeable and foretold. Still, the LFB remained dangerously unprepared.

The inescapable function of fire services is to compensate for the errors of architecture, design and other control systems which, once failed, will lead to disaster if not responded to effectively. That is why we say to all the firefighting parties at this Inquiry that the gross negligence of the contractors, the hijacking of regulations by companies, and the economics of successive governments cannot serve as full excuses. There are aspects of the LFB's undoing at Grenfell Tower that were caused by the culture of the organisation. Caught in its traditions, fiercely cared for by its unions, its heroic status makes it rare for it to face

public criticism, but that in turn makes it hard to honestly assess its deeper limitations. All these things have burdened the LFB in making change, and, for reasons I now turn to, the LFB is unlikely to re-imagine itself to correct the deficiencies exposed by this disaster without outside intervention.

Our starting point is management capability. The generation that led the LFB in its period up to Grenfell Tower had largely entered as young adults at watch station level, mostly during the 1980s, and worked their way up through the ranks to middle and senior officer roles. It was normal for them to have no relevant university qualifications, and they appear to have had little training in leadership and management skills. With some notable exceptions, like Paul Grimwood and Sabrina Cohen-Hatton, who the Inquiry is about to hear from, few leaders of operational firefighters had developed understanding of management, fire engineering or behavioural psychology. In turn, these managers promoted those coming up behind them without what would now be regarded as transparent and fair procedures, with little fast-tracking of talent or competitive lateral hires from other services or sectors.

In our written document, we have summarised the

findings of 20 years of independent reviews that have repeatedly said the same thing. From the Audit Commission in 1995, the Bain review in 2002, the Knight review in 2013 and the Thomas review in 2015, the constant refrain has been that fire services are heavily managed but insufficiently led, because its leadership does not have the training, development or competitive recruitment to do better. These criticisms are relevant to the LFB.

The Brigade had advice from Babcock in 2014 to introduce mandatory formal management accreditation into each level of leadership. A peer review by representatives from other services in 2015 underscored the need for a change in leadership style and better connection with staff at all levels.

After the Grenfell Tower, the internal people services review, completed in December 2017 by then Assistant Commissioner Roe, acknowledged for the first time in anything that we have seen that the Brigade lacked "a clear, structured programme of change, encompassing in particular leadership and performance management". This would need, it said, external, multidisciplinary support and better leadership development and recruitment to combat what it described as stagnation and a lack of new thinking.

For more than a decade, central government had ceased inspection of fire services, but when Her Majesty's Inspectorate investigated the LFB in 2009, it found that processes for selecting, developing and promoting middle and senior management lacked effective recording and openness, and there were few opportunities for staff to develop leadership capabilities.

When the inspectorate returned to assess the LFB in 2020, just after your Phase 1 recommendations, sir, it still found that the basic building blocks of programme and change management are only now being established. If that was the finding in 2020, the LFB not only lacked those basic arrangements to manage, lead and assure its service in June 2017, but we say no one in the organisation's leadership had urgently identified how lacking it was in its capacity to do so. The consequence was a management system that was highly resistant to change.

The Inquiry will need to consider how funding reductions contributed to lack of innovation, especially after 2010. Yet the shortcomings of the LFB at Grenfell Tower have roots long before austerity, and are to do with a considerable consensus across all ranks of fire services that are unwilling to transform the nature of what they do.

Firefighting, despite its courageous values and high level of comradeship and public service, remains a conservative vocation. It has a problem with progressive organisational thinking at various levels, and not just at the top. Firefighters find it difficult to transform when transformation is due.

In terms of understanding what went wrong at Grenfell Tower, a pertinent focus is that both the management and the crews grew out of the watch and shift culture and its drilled approaches to particular forms of standard firefighting responses and very significant demands for peer group conformity. Indeed, those who climbed to the heights of leadership will often have excelled within that culture and part of its self-reinforcing cycle.

Again, since the turn of the century, reports have repeatedly focused on this problem. In 1999, Her Majesty's Inspectorate found that:

"The watch is a closed culture which takes on the character of a family rather than a team, where the emphasis is on fitting in, not on tolerating diversity."

20 years later, the renewed HM Inspectorate still describes some watches as having created their own subcultures which are contrary to service values and have proved impenetrable for new staff, and where teams

have worked together for many years, working practices haven't yet modernised.

The LFB has a well documented difficulty in this area. Its peer review in 2015 described a "them and us" culture affecting trust, openness and respect that went well beyond the division between management and union. Adrian Thomas, in the same year, felt that distance from London was by no means a rule, but distance did seem to allow a greater degree of independent thinking, more flexible thinking, an acceptance of change from the employee representatives.

The HM inspection of the LFB in 2019 equally found that changes understood to be required after Grenfell Tower were:

"... slow to implement ... which is typical of the Brigade's approach to organisational change."

And:

"In recent years, innovation has been stifled ... [and] staff report a lack of organisational desire for change ..."

Sir, all of that begs the question why this conservative and quite fearful workplace culture continues to prevail in what is otherwise a courageous community of people?

There is an insider's answer to that question in

Dave Baigent's study entitled, "One more last working class hero: a cultural audit of the UK fire service". The author is an academic sociologist who was previously a member of the LFB and the FBU. He describes three features of firefighting life: first, the heroic and still highly male-gendered need to get into the fire; second, the need to get on and fit in with watch colleagues; and, third, the tendency to see an "us and them" divide between management and station, but also between the heroism of the notional frontline and those non-operational theorists who focus on prevention and policy.

Baigent's work is no doubt going to have its opponents, but Dr Cohen-Hatton has spoken about the toxicity and fearfulness of the dominant male heroic model that both men and women who work in the services feel that they have to live up to. This analysis also strongly resonates with those BSR who told the Inquiry at the end of Phase 1 hearings that what they wanted was not heroes, but well trained professionals working to a well structured plan. What occurred instead was the flooding of the building, and firefighters and equipment all going in without conceptual tools or adequate training to do things differently.

For the BSR, there were agonising failures of

training on the night of the fire. So many firefighters, with so much experience, could not recognise an event of complete building failure unfolding before their eyes, and consequently when and how to evacuate it. We know that evacuation happened in Melbourne in 2014, and it happened just recently in Milan. Why didn't it happen in London in 2017? The difficult truth is that previous experience of firefighters turned out to be their greatest impediment. They could not see what they did not know. They could not do what they had never experienced.

Professor Torero's root cause explanation for their knowledge deficit is that operational firefighters are intentionally trained to achieve proficiency in planned or set firefighting methods as opposed to encouraging developmental learning, skill and psychology. They cannot work effectively beyond unexperienced events.

Torero's key point is that training is currently underdeveloped for anything other than what he calls design anticipated fires. The essential features of the design are (1) the presumption that compartmentation will hold; (2) a default position to favour direct interaction with fire as opposed to considering other options, such as evacuation; and (3) the predisposition to act out the internal heroic image of the responder

who fights the fire. In Torero's view, the presently trained personnel can discharge firefighting plans, but they are not proficient in formulating new ones. The presumption of regulatory compliance, including having stay put as the emergency plan, has caused the training to deliver standardised operational tactics and excused firefighters from needing any proper understanding of building behaviour. All of that came unstuck at Grenfell Tower.

Torero primarily puts the cause down to the fact that in all areas, government, private and fire service, competency in fire engineering has not kept up with the complexities of modern design. That, he says, is to do with the lower status of fire engineering as an academic and vocational discipline as against other forms of engineering, causing it still to resemble a regulated trade as opposed to a profession.

The lack of competency of those who led on fire engineering within the fire services is particularly damaging twice over. It cannot hold the responsible persons under the Fire Safety Order to account, and at the same time cannot obtain enough influence within the fire services to qualify the operational protocols relating to standardised design firefighting.

Whatever the grounds to criticise the outsourcing of training to Babcock, that issue should not detract from the primary blockages caused by the educational traditions in which the LFB operational responders are trained. They are still taught by instructors who are largely previous or current serving members of the Brigade, who were themselves firefighters in the traditional image and mould, and LFB managers are the ones that commission and audit the training, and they also tend to be from the same background.

The BSR will look to the Inquiry to establish whether the training provided by Babcock was worse than its predecessor, but their major concern is that it didn't get any better. Despite the industrial relation sensitivities, we are also bound to observe that, whatever the continuing advantages of a strict watch shift system, it is inconsistent with delivering training that will fundamentally transform the competency of the service. The shift, with its two days and two nights on and four days off, limits available time, it ill fits co-training with non-operational experts, it is particularly difficult to quality assure, especially if the watch managers have to be trainees, trainers and supervisors of the training during shift hours without the training to do so. Overall, it makes

significant changes in the way things are done particularly cumbersome to achieve.

Taking all these matters together, the LFB remained a depressed learning environment before Grenfell. It was not an auspicious forum for change makers or particularly welcoming to blue sky thinking. You saw that in Phase 1 with Peter Johnson's exercise that tested the readiness of command units to deal with multiple fire survival calls. You will see a similar problem in this module with regard to research on the psychology of incident command.

Modern organisations need to be places of ideas. That is the case even when, and indeed especially when, those organisations manage risk to life. Projects for change were not so much rejected as default, dampened down or stalled in the system.

The BSR therefore invite consideration of these impediments of culture and training. They provide important root cause explanations as to why the LFB defaulted in its competences in such a significant way at Grenfell Tower, and it is those deficiencies as established in Phase 1 that I now turn to.

The first deficiency: operational firefighters could not identify a cladding fire even though it was long understood to pose potentially catastrophic risks.

The evidence suggests a genuinely perverse disconnect between the identification of cladding systems being recognised as a high-rise fire danger for more than 30 years, but no one ever seriously suggesting that operational firefighters ought to be trained on the subject. Witnesses, core participants and a note of Counsel to the Inquiry have set out the multiple references to the issue over time. We particularly mention the select committee report in 1999; the various versions of Generic Risk Assessment 3.2 in 2008 and 2014; the guidelines on the provision of operational risk information, otherwise known as PORIS, in 2013, and the 2014 National Operational Guidance programme paper on fires in the built environment that highlighted external wall finish cladding and described the potential for external fire spread with combustible cladding systems.

Sir, it could be debated whether more should have been done by central government, but the hazard of cladding and other forms of external fire spread was identified in the national documents, but were never mainstreamed into LFB capability.

Phase 2 disclosure shows that discussion of cladding fires took place in different sections of the LFB, but was never transferred to operational firefighters, whose

knowledge of the risk counted most. Chief amongst those failings was the various slide presentations on tall building façades that were adapted by members of the fire safety and enforcement department in 2015 to be delivered in training only to themselves, without anyone apparently thinking to translate the slides into a station-based package for fellow firefighters.

During 2015, the leaders of operational policy, having completed GRA 3.2 in its revision and its translation into an updated local policy 633, attended various high-rise building sector conferences and emailed one another during which the terrible examples of cladding fires were mentioned, but still not circulated to the organisation.

This is an awful indictment of a fire service, that its training and dialogue was so disjointed that this pocketed awareness of bad case scenarios was never joined up. The explanation of officers who knew about these cladding fires but did not educate their workplace about them is equally disappointing, even if revealing. They say that the detail of the fires were too limited to learn anything from. But in an age of internet, emails and video conferencing, they did nothing to research their facts. They then say that they assumed, without actually knowing, that the regulatory framework

and compliance cultures in these other countries would be less exacting than the UK and therefore little was thought to be gained.

If these explanations are genuine, they amount to an admission of unacceptable closed-mindedness and constitute a fatal breach of health and safety obligations to inform, train and prepare. The LFB repeatedly presents itself as a world leader, but on this, the largest Brigade in a significant global capital city, it is incongruously isolationist and parochial.

The second deficiency at Grenfell Tower was that the LFB visits to the building before the fire woefully under-assessed the risks it posed and the basic features of layout that needed to be known.

Since 1947, fire services have been under a statutory duty to make arrangements to (inaudible) gather information to enable the discharge of their function. The terms of section 7(2)(d) of the Fire and Rescue Services Act 2004 do not change that requirement, albeit that for the first time they explicitly state that the duty relates to both the putting out of fires as well as the protection of life and property from fire. Nevertheless, the duty erroneously remains downgraded in firefighting parlance as " familiarisation

visits ". In fact, it ought to combine two things: first, preventative risk assessment; and, second, the preparatory stage of operational response such as to enable incident command and crews, if ever deployed, to have access to the right information when they need it.

The content of the operational risk database, or ORD, filled in by North Kensington station for Grenfell was so inadequate that it is difficult to believe that its flaws were not more widespread. The Inquiry has already established the various gaps in the database, as well as the follow-up actions that were never completed. The incident command at Grenfell Tower duly had insufficient, wrong or no information as to the number of floors, building plans, riser mains, lifts control, ventilation, radio testing, emergency contacts and residents. The recent Inquiry expert report on water has disclosed that available fire hydrants, which would have made a difference in water flow, were missing from the ORD and never used. Based on the standardised LFB risk assessment system that prevailed at the time, Grenfell Tower scored the lowest possible category. This absolutely should not have been the case.

After the Lakanal House fire in 2009, the LFB became aware that the organisation was exposed. Its research acknowledged that degrees of building failure were

relatively common and that the protection of building control under the Building Regulations and risk assessments under the Fire Safety Order were insufficiently robust.

In 2010, a national study known as Future Fires described securing compliance with fire safety as the biggest single concern to the sector. The LFB leadership therefore knew that the instability of the regulatory system was itself a generic hazard, particularly in relation to high-rise firefighting and arguably its greatest threat.

A report of December 2013, commissioned to comply with the Lakanal House action plan, showed stations to be lacking in training or commitment to comply with the requirement of either the national or internal premises risk assessment policies. The problem was so great that the study advocated alteration of the service standards in order to sufficiently compel greater station compliance with the statutory duty.

The Brigade's third officer in command, Assistant Commissioner Brown, effectively shelved that report and its recommendations, despite having previously informed the Lakanal House working group that the LFB was compliant with the relevant policies and had met its Lakanal House action plan commitments relating to

section 7(2)(d) of the Act. It obviously had not.

On this issue, the LFB demonstrates a profound ambivalence about what it expects of its members. The various LFB policies acknowledge the necessary connection between competent prior inspection and construction literate incident command.

However, Commissioner Cotton's Phase 1 evidence chose to disallow the expectations of the policies because, in her words, "frontline firefighters don't have the technical knowledge or ability to be able to do those things", to which the obvious responses are: if not, why, and whose fault is that?

Whatever the success of preventative and preparatory measures in London, witnesses will tell this Inquiry that premises assessment remained a perceived paperwork chore to be tolerated rather than lauded as an essential feature of the firefighting job.

Firefighters likely got by without better information and knowledge because during standard fires they did not need it. Radical solutions, including altering the shift system to prioritise inspection or transforming the structure of the organisation to trouble re-align its prevention function, was seen as too controversial to be pursued.

Can I turn then to the third deficiency in the LFB

response on the night, and that is the insecurities of the incident command system.

We agree with others that, without sufficient training, preparation and policy, the failings of the individual incident commanders were the failings of the organisation. But there is one particular aspect of those failings that demands real attention, and it concerns the extent to which the unusual but not unexpected features of the fire overwhelmed the commanders who looked at it.

We want to suggest that the attempt by the LFB and other fire service core participants to find only technical explanations for that failure will never work, and the reason for that is that the errors partly lie in human psychology and the over-tendency of the brain to compute what is experienced and recognisable and to overlook information that is not.

For more than 50 years, behavioural psychologists have described this essential editing feature of the mind. It causes error when making decisions, especially under extreme pressure. It has been studied for the preparation of military battlefields and launchpads, airline cockpits, surgeons' operating tables and other high-risk stress-related disciplines. It has become essential to the North American armed services'

doctrine, especially since the mistaken shooting down of an Iranian commercial airline flight by the USS Vincennes in 1988, and some of its central insights were achieved by research done on US fire ground commanders in the 1990s.

And yet the LFB is still reluctant to recognise this as a core part of its own incident command training and doctrine. Instead, it stands by the decision-making model, or DMM, contained in its policy 341. The model assumes that, in the heat of the moment, a commander is able to analyse in a form of straight-line reasoning that gathers and thinks about information, identifies objectives, plans their execution, communicates and controls the plan, evaluates the outcome upon execution and then starts the cycle again.

The problem with the model is that is just not how people think under pressure, especially during emergency incidents. In real-world settings, experimental research shows that their thinking is more reflexive than reflective. They rely on generalised appraisals and biases rather than optimum or exact judgements in their situational awareness, and especially so when the situation is dynamic, complex and stressful. Consequently, they do not generate and compare options.

Asking WM Dowden to rely on this orthodox model of

decision-making, that was designed by business consultants in the 1940s for people sitting at desks with the luxury to contemplate solutions, set him up not only to fail, but disabled him in his capacity to succeed.

The evidence of Chief Officer Dr Sabrina Cohen-Hatton will show that, by 2015, national guidance had come to accept that the older decision-making model was dangerous because it was counterintuitive and wrong. It advocated thereafter a new approach that controls the human tendency to simplify and prompts against our natural bias towards the familiar. Hence its name: the decision control process, or DCP.

The DCP contains three questions: (1) why am I doing this? (2) what do I think will happen? And (3) is the benefit proportionate to the risk?

The DCP has been the subject of internationally peer reviewed published research studies by Cardiff University that show it to produce five times greater effectiveness in command decision-making than the traditional LFB model. The authors of that research include Cohen-Hatton and Group Manager Phil Butler. Both of these people were pioneers in this country. To the great benefit of the LFB, both these career

firefighters were working for the organisation in the years before Grenfell Tower. Still, their nationally adopted ideas were deemed by the Brigade leadership to be too transformational. Too much too soon.

The LFB is the only fire service in the country that did not adopt the DCP model. It is now used by all other London blue light services. Even when it has national guidance and the country's leading experts available to make change happen, this is an organisation that still finds it extremely difficult to do anything other than remain the same.

The fourth deficiency: evacuation.

The basics still warrant repeating. Stay put is a principle of construction designed to limit the need to evacuate residents from tall buildings when it is unnecessary to do so. No more, no less. However, the Phase 1 report found that the principle had been allowed over time by the LFB to transform into an article of faith. The Inquiry has now seen the foundation documents of the 1960s and 1970s through to the present BSI and PAS guidance.

As long as stay put has existed as a concept, so has its limitations. It is reliant on effective compartmentation and envisages in any event that once affected by fire or smoke, residents need to get out

through unencumbered means of escape. BS 9991 also makes clear that the numbers, profile and disabilities of the resident population will be relevant to how long it takes to get out. It is ludicrous to operate under a default assumption that this will never happen. Compartmentation fails, doors don't close, works are not competent, contractors break the law, and so smoke and fire spread.

The Inquiry has already seen that the requirement for incident commanders to consider the need for evacuation was contained in national and local policy, but that the efficacy of the requirement was fatally compromised by the fact that there was no guidance as to how, in practical terms, this should be done. As far as the LFB was concerned, the how remained a chronically undeveloped doctrine and practice.

The Inquiry will hear from Dr Grimwood about the alternative approach that was taught by Kent Fire Services to incident commanders from 2010 onward, which included the so-called ICE, later RICE technique. RICE stands for rescue, intervention, containment, escape. Its central premise is that it does not assume that compartmentation will hold or that residents will not self-evacuate. It also counsels against default engagement with the fire, deploying straight to

intervention, before establishing by rapid reconnaissance of the staircase that compartmentation can be operationally relied upon.

By 2014, a group of southeastern regional fire services had developed joint operating procedure that identified four factors to consider when re-evaluating the pre-planned stay-put strategy. These are: (1) fire development; (2) smoke travel; (3) self-evacuation; and (4) compromised staircase, all of which were witnessed, we should add, within the first minutes of the Grenfell fire by the commanders. The Kent trainer also envisages that the stairwell can split into sectors so as to facilitate conveyor belt staged evacuation.

LFB has been developed since the Grenfell Tower fire to incorporate aspects of the Kent/southeast approach, including stairwell protection and dedicated monitoring and identifying a set of triggers that would justify considered departure from stay put. The question is: why was that thinking not there previously?

A broader way to look at it is: why was a technique that had been developed in training, assessment and firefighting in Kent since 2010, and before that in Malaysia, and then shared across other services, so under-appreciated by the LFB before the Grenfell Tower fire, given that it could have made a significant

difference on the night?

The evidence in Phase 1 included repeated assertions that evacuees would have been in panic and endanger themselves and firefighters. Several years on, no evidence has been disclosed to establish the solid empirical foundation to justify that fear. The likely reasons for that is that for several decades, those who have studied crowd psychology during disasters, including during fires and explosions such as the Summerland resort, the King's Cross fire and the collapse of the World Trade Center, have established that, in moments of crisis, people tend to act in an unusually collaborative and bonded way, even with strangers, but especially when they are in familiar surroundings and with people who are known to them. We have cited a range of articles that emphatically make these points clear, including a research study of World Trade Center survivors led by Professor Ed Galea that was footnoted at the end of GRA 3.2 on high-rise firefighting.

What is striking is how the Phase 1 evidence adds to that body of research. Even in great fear, people did not exhibit extreme, uncontrollable reactions. Despite the conditions, neither residents nor firefighters were physically hurt as a result of the evacuation. They may

not have thought it at the time, but the evidence of survivors and even the recordings and texts of those who died overwhelmingly show them as prone to creative, co-operative and life-saving initiative. This is the body of data that the initiative in this process has collected, and it is extraordinarily ad idem with the conventional wisdom that now exists in the academic research on behavioural psychology.

Underneath its technical construction, origins and policy justifications, we therefore want the Inquiry to test an ostensibly more difficult contention about stay put, that this article of faith has developed as such because it is underpinned by a continuing fear and mythology about the panicking crowd. The consequence is that the firefighters see themselves as the rescuers in the story, rather than facilitators of residents being the co-respondents in their own escape.

Now, it is inevitable for a range of reasons that some buildings will need to be evacuated. On that, there existed a further unacceptable gap in doctrine, as Steve McGuirk accepts, that there has never been any dedicated thinking around how to evacuate residents whose mobility is impaired, and there is still nothing of meaningful substance contained in the amended policies. That is the case even though the overall

significant percentage of mobility impaired people in high-rise social housing buildings is well known, and it's also well known that it's growing, given the ageing population.

Without wishing to dilute the responsibility of the landlord to profile and better arrange for resident evacuation from its building, it cannot be right for the fire service to remain aloof from planning how they will facilitate a building evacuation if the emergency need arises. By virtue of their duties under section 7(2)(d), fire services must also establish what plans the responsible person has made for vulnerable residents and consider taking enforcement action when there are none.

The further deficiencies in the response to Grenfell Tower concern the communication system. The problem was not just the equipment, but the way in which it was used and the manner in which incident command, the fire ground sectors and the control room communicated. All parts of the system were overwhelmed. The issues relating to the control room and fire survival guidance will be dealt with in Module 6. Professor Johnson has also provided the Inquiry with an in-depth description of the technical deficiencies of the available radio equipment, especially the BA radios.

We want to draw your attention to Professor Johnson's emphasis that the effectiveness of communications is not about the equipment alone, but the overall quality of the communication system and the organisational culture that procures and utilises the equipment.

What is at stake for a communications system at a fire ground is the achievement of situational awareness. Johnson provides a general definition as the ability of individuals and teams to perceive information in their environment, to interpret and comprehend the meaning of that information, and then use it in a way that helps anticipate future events and hence informs their subsequent actions.

The conclusion of the expert is that the LFB put up with and makes do with the defective radio equipment because most of the time they don't need it. Crews are deployed, they put out the fire, and they say what they've done. That is until the incident becomes huge and complex.

Those who witnessed the Phase 1 evidence will recall the profound lack of situational awareness, especially by incident and sector commanders, throughout the night. The problem lay in part with the equipment, but it also lay in the quality of the interpersonal communications

at the fire ground and with the control room.

There is an important emergency concept called crew resource management, or CRM. It places a premium on interpersonal communications amongst teams in high-stress situations. The absence of developed CRM organisational culture within the LFB is relevant to the failure at the Grenfell incident ground. There were points especially in the window of opportunity before 2.00 am when experienced firefighters like Station Manager Egan did not speak up when they believed that the building needed to be evacuated, and when they did speak up, they were not heard, as appears to have been the case with Watch Manager Harrison.

Speaking up for those in support roles and listening up for those in leadership are skills. The failings in this area, including that the LFB doesn't teach these skills, are likely to relate to the extent to which the organisation remains inflexibly against speaking up in its hierarchies, even though other disciplined vocations, including the cockpit and the operating room and military launchpads, have made it professionally safe and indeed a duty to do so.

There is now a real question as to whether the final deficiency in the LFB response concerns the competency in the use of water. It is important that the BSR wait

for the informed explanation of others, and yet it is equally right that they should articulate their concerns at this stage.

Until the recent service of Dr Ivan Stoianov's report, it was thought that the non-availability of the taller 42-metre ladder was the critical issue as to the absent water equipment during most of the fire. It is now suggested that there was equipment present that might have made a difference, but for the lack of institutional knowledge on how best to use it.

If the expert is correct, then water from the ground monitor situated on Grenfell Walk was capable of reaching the 15th floor, and all the available aerial pumps were capable of launching water to the top of the building. Both of these things are said not to have happened because of a fundamental misunderstanding of the technical features of water supply, and a consequential failure to alter incident strategies to secure greater water flow. This is an extraordinary possibility for the BSR to have to contemplate four years after the fire.

The Phase 1 evidence tragically indicates that it is unlikely that greater water supply and more aerial pumps and monitors would have prevented the upward vertical spread of the fire or its horizontal spread across the

crown at the top of the building. Yet the evidence of the success achieved by the ground monitor on the raised section of Grenfell Walk does suggest that there was a strong correlation between water supply and containment of downward fire spread.

This is what happened with the partial containment of the fires on floor 10 and 11. It enabled the late rescues of Antonio Roncolato from flat 72 at 6.05 in the morning and Elpido Bonifacio from flat 83 at 8.07. The fact that the families of Natasha Elcock from flat 82 and Anne Chance from flat 73 also survived until rescue in the later hours of the fire attests to the combination that external water provided as a containment function until BA crews arrived.

That is why we are bound to raise again the fate of flat 113, three floors above on the same side of the building, where there was proof of life until 4.06 am, just before the flat became engulfed in flat at 4.09. The Inquiry is well aware of missed opportunities earlier in the night to rescue those who took shelter in flat 113. This new evidence on water adds a potential additional reason as to why this flat and this floor stand out as the paradigm of preventable death.

Panel, we are moving into the final modules of this Inquiry. There is considerable evidence now that

Britain currently has an unstable fire regulatory system. But it also has a fire service that is incompetent to meet contemporary challenges. Both of those matters need fixing, and until that happens, those who live in high-rise social housing will continue to be at significant risk. Grenfell Tower showed them least likely to be protected from fire and most likely to be dependent on effective fire service response.

The LFB was brave at Grenfell Tower, but it was not effective. There is a time and a place in this Inquiry to deal with deregulation and austerity, but the fire service leadership and the Fire Brigades Union need to be rather more introspective than they currently are in acknowledging how they can be more part of the solution than the problem.

Professor Torero's opinion is that without a radical change in structure, culture and competency, then things will remain the same. What he says brings into question that the present model of fire response is an unqualified heroic good. In particular, he contests society's traditional comfort in neighbourhood fire stations and the retention of an orthodox frontline shift system. The evidence of decades of reviews tells us that the sector will never lead itself out of these current deficiencies, and therefore what is required is

a long-term, ongoing, multidisciplinary national transformation process. It should include fire service personnel but must be led by others.

For the BSR, the question of reform can no longer be a closed conversation. The panel will have to decide how much it will prompt these endeavours, but as with other aspects of this once in a generation inquiry: if not now, when?

SIR MARTIN MOORE-BICK: Thank you very much indeed, Mr Friedman.

Now, the next statement is going to be made by Professor Thomas Queen's Counsel on behalf of other bereaved, survivors and residents.

Good morning, Mr Thomas.

Module 5 opening submissions on behalf of BSR Team 2
by PROFESSOR THOMAS

PROFESSOR THOMAS: Good morning, sir. Good morning, panel.

It's been said that you rise above your fears by facing them, not ignoring them. In our society, we have been brought up to respect and to be grateful for firefighters for what they do for us. It does not come naturally to us to criticise their actions. They are held in high esteem by the public as frontline workers who bravely put their lives at risk for others and who are here to protect and serve us. They act with

impressive selflessness. So, our criticism of the London Fire Brigade does not detract from the individual acts of bravery of firefighters, nor does it detract from the solidarity of individual firefighters with the bereaved, survivors and residents of the Grenfell community. But Grenfell is not just a story of individual heroism and bravery. It is a tragedy fraught with systemic failings, neglect and a culture of organisational obfuscation.

Individuals may have been brave, but was the LFB wise? The LFB, as a public body, has a duty of accountability and should act with candour in its responses to this Inquiry. Indeed, it is only through acknowledging the causes and consequences of its failings that the LFB can make meaningful change.

The London Fire Commissioner's opening submissions on behalf of the LFB lack the contrition and introspection needed to truly rise above and learn from the LFB's failings on 14 June 2017, which, as we have seen and heard during Phase 1, are reflective of systemic failings. The failure of the LFB to appropriately be critical of its response to the fire at Grenfell Tower constitutes a great disservice to those who lost their lives, those who lost loved ones, those who lost their homes, and indeed the wider Grenfell

community. The LFB's failure to adequately address their organisation's failings is disappointing to the BSRs, who view this as an attempt to ignore fault.

Sir, how can I assist you?

We ask the questions. As Grenfell Tower burnt before the world's eyes, action, and in some quarters radical action, was needed and well overdue. We hope that during the course of this module, this Inquiry will investigate how it came to be that the LFB was so ill equipped to respond to the fire at Grenfell, and why the LFB abjectly failed in its dynamic risk assessment.

We say that there are at least -- at least -- eight questions that need to be answered by the LFB:

1. Why was there a failure to learn lessons from Lakanal House?

2. Were there deficiencies in the training across the LFB and was this systemic?

3. What was the impact of austerity, cuts and deregulation on the LFB in the years preceding the Grenfell fire and the LFB's response to this?

4. Why were the section 7(2)(d) visits to Grenfell Tower so deficient?

5. How did essential communications fail at Grenfell Tower, and why was the technology so inadequate?

6. Why did the London Fire Brigade fail to follow its own policies?

7. Were there systemic failings within the LFB that impacted on their response to the Grenfell Tower fire?

8. Why did incident commanders fail to recognise that the Grenfell Tower was a failing building and that the stay-put advice was untenable?

Now, those are eight broad questions we've come up with. I'm sure your team will have questions of its own.

The structure of our submissions.

In these oral submissions, we intend to address the points raised by the other CPs in their opening written submissions. You will be pleased to know that we do not intend to repeat our written submissions. I might touch upon them, just on occasion to refer to their content.

As we outlined in our written submissions for this module, there are central themes that pervade all the topics to be addressed, most notably the LFB's culture, the LFB's failure to learn lessons, austerity and deregulation.

In our submission, it is essential to fairly contextualise the LFB's failings at Grenfell, prior to and on the night. The spectre of austerity and massive cuts to the LFB's budget, retrenchment and closures of

fire stations loomed large over the organisation and undoubtedly negatively impacted on resources, training and equipment and the failures to learn lessons from previous fires and incidents. Matters were further compounded by a deep-rooted and pervasive culture of intransigence and an unwillingness to change and develop.

Culture.

My learned friend Mr Friedman Queen's Counsel has spoken at length about the issue of culture and the manner in which it affected the LFB's ability to prepare for a fire like the one at Grenfell Tower. Sir, we agree wholeheartedly with those submissions, and we agree that the LFB's culture permeates all strands of its unpreparedness. Its blinkered response to the fire resulted in the failure of the incident commanders prior to, now Commissioner Andy Roe, to consider the earlier abandonment of stay put and the failure to engage with or consider an evacuation plan. This is, in our respectful submission, evidence of the Brigade's cultural resistance to change and technical knowledge and innovation, as well as an embedded weakness in the organisational training and structure.

It's of no surprise that the Brigade's response was woefully deficient, both on the incident ground and in

the control room. We agree and adopt Professor Torero's opinion on the issue, namely that at the heart of the inadequate dynamic risk assessment conducted during the Grenfell Tower fire was a "fundamental misunderstanding" among all command ranks that the primary role of the fire and rescue services is to fight fires, and that if a fire cannot be fought, there is no alternative path of action or role. Professor Torero notes that this misconception is a "key weakness" of the training and structure of the London Fire Brigade.

It is important to note that our clients and the public do not expect perfection. We are not perfect beings. We make mistakes. We make mistakes all of the time. But all we can do is try to learn from our mistakes, take responsibility for them, and do a better job tomorrow. The question here is whether the fire service is exempt from that standard which we hold to ourselves. I fear the answer is a resounding no.

Deflection of responsibility.

Vikas Runwal once said, "Honest self-reflection opens the door to reprogramming, change, success and freedom". Dear panel, the written submissions of the LFB make for very disappointing reading in this regard. The LFB repeatedly state in their written submissions that ultimately it was not responsible for the causes of

the fire or the manner in which it developed. The LFB points the finger at the building contractors, product manufacturers, as well as the TMO and building control. Of course we do not dispute responsibility of those involved in the refurbishment and the management of Grenfell Tower. The evidence from Modules 1 to 3 has indeed been shocking and damning. Nor do we say that the LFB in any way caused the fire. However, the fact that others played the primary role in the causes of the fire does not absolve the LFB of its responsibilities and obligations. Its response to the fire and its preparation for a fire at Grenfell Tower have to be held up to the cold light of scrutiny and, where wanting, those deficiencies must be exposed and thereafter acknowledged and rectified by the Brigade. Joining in the chorus of disapproval of the egregious behaviour of the corporate core participants does not make the LFB's failings disappear. The organisation must apply some critical thinking and introspection in order to ameliorate its own ills.

Lest we forget, as we start this module, that the Inquiry's Phase 1 report was incredibly critical of the LFB for the manner in which it prepared for and its response to the fire at Grenfell Tower. Yet almost two years on from that report, the London Fire

Commissioner's opening statement contains limited acknowledgement and acceptance of the LFB's failings.

One would have thought that an organisation whose actions were so heavily criticised would be humbled and be prepared to take ownership of mistakes. The LFB's deflection of responsibility, despite the weight of the evidence to the contrary, further illuminates how the LFB came to not implementing any substantial lessons from previous fires in high-rise buildings. It also raises real public safety concerns about the willingness of the London Fire Brigade to learn lessons from the Grenfell Tower fire, as well as its commitment to the safety of Londoners. The lack of contrition is frankly insulting to the bereaved, survivors and residents of the Grenfell community.

We know that the LFB is not a monolith. There were some alternative voices raised that challenged the orthodox and accepted LFB positions, as evidenced by some in the firefighting testimony in Phase 1. However, the prevailing lack of self-reflection and self-awareness of the LFB is quite frankly a kick in the teeth to the rank and file firefighters who risked all to go up several flights of smoke-filled stairwells as the fire raged and enveloped the tower.

The stance adopted in the LFB's opening submission

risks long-term damage to the reputation of its organisation. It is because of the goodwill and the high regard in which the London Fire Brigade is held in the public consciousness that we expect better from them rather than empty platitudes. How can the public have faith in the institution if it's unwilling to accept responsibility for widely acknowledged mistakes and failings?

Accepting and understanding mistakes is a key feature of learning lessons, and we agree with the Mayor of London, who said in his opening submissions, namely:

"The most important outcome for the bereaved, survivors and residents, and indeed for all Londoners, is that the lessons of Grenfell are learnt and progressed quickly so that they can be reassured that the terrible events of that night will not be repeated."

Can the BSRs be confident that lessons are being learnt? Once again, the answer must be a resounding no.

The written submissions of the London Fire Brigade alarmingly demonstrate that it is not an organisation that is undertaking meaningful introspection in response to the fire and the Phase 1 findings. Notwithstanding the fact that the LFB in their written submissions say that they have been involved in the process of "assessing LFB policy, procedure and training to reflect

the learning from the Grenfell Tower fire", and that this has been done recognising the need to demonstrate that the LFB's a learning organisation committed to continuous improvement, their unwillingness to accept their own failings renders this hollow. That passage could have been cut and pasted from the myriad declarations, policy documents, circulars generated post-Lakanal. However, the hand-wringing, the mea culpas, are no substitute for decisive action.

You see, our clients and the Grenfell community have not forgotten the evidence of ex-Commissioner Cotton, who infamously stated that, even with the benefit of hindsight, she would not have done anything differently on the night of the fire, and that she would not train firefighters for a cladding fire any more than she would train them "for a space shuttle landing on The Shard".

Many of the BSRs said in their evidence to this Inquiry that they wanted change to make sure that what happened to them and their families never happened again. Hanan Wahabi, whose brother and his wife and three children died in the fire, said:

"It was very upsetting to hear Dany Cotton say that she would not have done anything different on the night. This is like saying that there are no lessons to be learned. I know that people tried their best but

mistakes were made. Saying that they would not do anything differently cannot be an acceptable response if we are serious about learning. 72 people passed away and we can't bring our loved ones back."

That public bodies are unwilling to engage in meaningful retrospection is not surprising to us lawyers who work in this field. There is a long history of public bodies resisting such introspection until forced to do so, and when forced to do so, dragging their feet to meet recommendations. It is for this very reason that families have pressed for public officials in those organisations acting in the public interest to act with candour. The reticence is emblematic of a culture that Professor Torero describes as incapable of reform from within.

We know that change can sometimes mean venturing into the unknown and leaving behind that which is comfortable, familiar and routine. The fear of the new. This can be problematic in an individual, but catastrophic in a large public organisation. Culture inertia within a public organisation such as the LFB is shortsighted and dangerous.

As Professor Torero astutely and succinctly opines:

"The creation of a culture that rebalances priorities is necessary to promote acquisition of the

skills and attributes essential for the Fire and Rescue Services to operate in the modern built environment. The new culture requires a profound reformulation of hierarchy within the LFB that enables those with the appropriate skills and attributes to conduct plan formulation, to progress in the command structure. Currently, this culture does not exist and the LFB command shows a strong bias towards those individuals who have demonstrable skills and attributes when it comes to consistent repetition of pre-defined protocol."

That lessons will be learned is a phrase so often used and abused after tragedies and disasters when the public gaze is still bright and hand-wringing and platitudes are plentiful. However, its meaning has become diminished and treated with often justifiable scepticism. It is a phrase which sadly history has often shown to be hollow. Far from being learnt, lessons are ignored, disregarded and failings ultimately repeated.

Lakanal.

One of the most shocking aspects of the LFB's failure of preparedness for the Grenfell fire is that lessons should have been learnt from the Lakanal House fire in 2009, which, if addressed properly and taken seriously, may have prevented this disaster. Although

not like for like, the similarities between the two fires are striking. On 3 July 2009, a faulty television caused a fire to break out on the 9th floor of Lakanal House in Camberwell in South London. The building was a high-rise residential block, some 42 metres tall, containing 98 flats and maisonettes, spread over 14 floors. The fire spread via the exterior cladding made up of HPL composite panels which were found to be non-compliant with Building Regulations.

Six people died in that fire, including three children. Inquests were held and, at their conclusion in March 2013, Assistant Deputy Coroner Her Honour Frances Kirkham CBE, sent recommendations in a Rule 43 letter to Mr Ron Dobson, the then fire commissioner. These recommendations covered section 7(2)(d) visits, fire safety awareness for the public, incident commanders, Brigade control, and communications at major incidents.

The Inquiry's Phase 1 report found:

"The evidence heard in the Inquiry at Phase 1 shows that, despite changes to certain LFB [organisational] policies and the introduction of new training packages, few if any lessons were learnt by the LFB."

The evidence concerning the LFB's failure to learn the lessons of Lakanal House will be heard across

Modules 5 and 6. In Module 5, the Inquiry will hear how the LFB failed to implement the recommendations relating to the section 7(2)(d) visits, incident command policies and procedures and radio communications. The Inquiry will explore the failure to disseminate knowledge of these changes through appropriate training. In Module 6, the Inquiry will hear evidence about the changes to national guidance following Lakanal and the LFB's failure to fully incorporate these provisions into their own local policies; about the introduction of the fire survival guidance policy and the failure to regularly refresh the training of control staff on handling of important calls; and the missed opportunities to introduce fire safety measures in high-rise buildings through the retrofitting of sprinklers.

The common themes in the failure to learn these lessons are a defensive culture within the LFB's top-tier management, who had battened down the hatches when faced with criticisms from the coroners court and the DCLG following Lakanal, and a fire and rescue service whose workers are stretched to breaking point by chronic underfunding, staff shortages, ineffective training and threats of privatisation.

Stay put and the failure following that.

Given that around 150 people self-evacuated during the Lakanal House fire, a review of the attachment to the stay-put doctrine was necessary. Further, given that the vast majority of the occupants of Grenfell Tower who self-evacuated on the night of the fire did so before the stay-put advice was abandoned at 02.47, and that the vast majority of those who died at Grenfell did so after being advised directly or indirectly to stay put, it is rather astonishing and to compound insult to the families and the Grenfell community that, in their written opening submissions, both the LFB and the FBU defend the decisions of the first incident fire commanders not to revoke stay put. This is despite the finding of you, sir, in Phase 1 to the contrary. This position reflects a lack of appreciation that sometimes the tried and tested methods need to be changed. It also reflects organisational inertia and stagnation that the LFB has not accepted the failings of the incident command on the night which contributed to the loss of life.

In effect, instead of facing its fear, it's chosen to ignore it. It is clear that stay put remains an article of faith for the London Fire Brigade. It is unclear, though, how this marries up with the LFB's supposedly new-found appreciation of the risk of

compartmentation failures and the risk of combustible cladding in high-rise buildings. There is a disconnect here.

On 12 February of 2020, Andy Roe agreed the revised high-rise firefighting policy 633 for the LFB, stating:

"The LFC has a legal obligation to equip and train its firefighters so far as reasonably practicable for what is now a foreseeable risk, as well as an obligation to Londoners to provide a service that will make all reasonable attempts to save lives, including in circumstances as extreme as those experienced on the night of the Grenfell Tower fire."

The risk of external fire spread was a foreseeable risk by 2017, before 2017, which the London Fire Brigade was fully aware of. However, they failed to make or have any adequate plans or training in place to respond to cladding fires. Once again, the LFB comes across as an organisation reluctant to take ownership of its own lack of preparedness for the Grenfell Tower fire, this time in relation to its own knowledge of the risk posed by the cladding and the failures of compartmentation. The saying goes that failing to prepare is preparing to fail. One simply cannot hope for the best without planning for the worst.

Once again, the findings of the Lakanal House

inquests are prescient. On 28 March 2013, the Lakanal House coroner wrote to Mr Ron Dobson and emphasised, amongst other things, that consideration be given to training of incident commanders to enhance their performance in relation to the following: the dynamic risk assessment model; other management tools to enable commanders to analyse the situation and recognise and react quickly to the changing circumstances to anticipate that the fire might behave in a manner that is inconsistent with the compartmentation principle.

In 2007, before the findings of the Lakanal House inquest, the Home Office document, "Fighting fires in high-rise buildings", version 1.8, referred to the development of contingency plans for a range of foreseeable events, including fire spread beyond the compartment of origin, communication failure, and lift failure.

You see, there is evidence to suggest that the London Fire Brigade knew that there was more than a negligible risk of a serious fire in a high-rise building with a cladding system. At the very least, the London Fire Brigade ought to have known about the risks posed by combustible cladding due to an awareness of cladding fires in the UK and abroad.

Sir, you concluded in Phase 1:

"Notwithstanding this history of fires involving cladding systems, the LFB's experience and assessment of the Shepherds Court fire in August 2016 and the letter to the Chief Executives of the London boroughs, very few (if any) of the incident commanders or senior officers who attended the fire at Grenfell Tower were aware of the risks posed by exterior cladding. Certainly, none of them received any training in recognising or assessing risks of that kind or in the steps that should have been taken in response to a fire in the envelope of a high-rise building."

Professor Torero reinforced your view, sir, by stating:

"... given the recent history of large façade fires, the evolution of the fire at Grenfell Tower was foreseeable and that there was an awareness within the London Fire Brigade of these fires and their potential consequences."

Dear panel, this Inquiry heard evidence during Phase 1 about the tall building façades presentation which was discussed with previous cladding fires, mechanisms of external fire spread, regulations, the Shepherds Court fire and the need to understand what products were used in the cladding system. The oral evidence in this module needs to explore why, why this

presentation was only shown to a few senior officers? Why wasn't this information shared across the board?

At the time of the Grenfell fire, the London Fire Brigade's standing policy on high-rise building firefighting number 633 had not been amended to take into account BRE 135, nor was it amended to take into account the Brigade's own tall building façades presentation or the Lakanal House coroner's report. This is a failing on the part of the LFB as an institution to equip its firefighters with the knowledge of the risk of cladding fires and training on how to identify and respond to cladding fires.

Cladding fires and external fire spread from cladding was not a new phenomenon. I repeat: not a new phenomenon. Indeed, there had been cladding fires in the UK and around the world before the Grenfell fire. Commissioner Roe's comment that cladding fires are "now a foreseeable risk" after Grenfell is inaccurate and misleading.

Alarmingly, a note appended to the revised policy 633 said that "clearly a more detailed and dedicated thinking is still required within the Brigade". It's astonishing that even after the deaths of 72 people in the Grenfell Tower fire, the LFB cannot clearly set out a detailed and unequivocal policy about this issue.

Why?

While the London Fire Commissioner acknowledges the need for the LFB's policies and procedures to be informed by international fires in modern high-rise buildings on the one hand, it continues to justify its failings at the Grenfell fire by asserting that these fires were in different jurisdictions and operated under different regulatory regimes, and you heard Mr Friedman Queen's Counsel on that point earlier on.

This qualification once again rings hollow. It is possible to appreciate that different regulatory contexts exist across different jurisdictions whilst simultaneously appreciating the obvious dangers posed by multiple cladding fires. In the face of overwhelming evidence, the London Fire Brigade cannot in good faith argue that it was unaware of the cladding fires in the UK and abroad, so that the only reasonable conclusion is that the London Fire Brigade did not deem it necessary to amend its existing policy and training in response, and we ask you to question: why was that?

Let me come on to training.

Phase 1 highlighted deficiencies in the LFB's training prior to the fire, perhaps most egregiously in the case of the incident command training. The Phase 1 report was highly critical of the absence of any

training for incident commanders on how to recognise the need for evacuation, which in turn reflects a failure to recognise the risks of the fire taking hold on the outside of modern buildings. The Phase 1 report found that there was "a failure to educate firefighters on the dangers associated with combustible cladding systems", which was surprising given the long history of fires involving cladding on high-rise buildings, both in this country and abroad, the history of which some senior figures within the LFB were aware.

The LFB have argued that essentially the lack of training in relation to the evacuation for its incident commanders was partly due to:

"Despite the provisions of GRA 3.2, there has never been any national operational guidance as to how to manage the full or partial evacuation of a building with a stay-put strategy or to deviate from any other planned evacuation strategies which might apply to high-rise buildings."

Whilst there may indeed have been inadequate guidance from central government, this absence of guidance cannot justify the absence of internal training. Surely the London Fire Brigade should have attempted to guide their own staff on the matter. After all, GRA 3.2 did contemplate evacuation. Did the London

Fire Brigade raise their concerns with central government about the lack of guidance? If they didn't, why didn't they?

The issues associated with training were not limited to evacuation of high-rise cladding fires. The Phase 1 report and the expert evidence since have found significant deficiencies in training in the control room, section 7(2)(d) visits, and communications. However, in their opening submissions, the London Fire Brigade argue that:

"Following its refurbishment, Grenfell Tower was a tragedy waiting to happen. The stay-put strategy was fatally undermined as soon as the rainscreen cladding system was installed. Building control and the London Fire Brigade should have been informed of the increased fire risks associated with rainscreen cladding systems, and ultimately there should not have been any residents living in the resulting death trap. Firefighters and control staff should never have had to respond to a fire in the Grenfell Tower ignorant of these increased fire risks without the necessary policy, preparation and training."

We couldn't agree more. It relates to what the experts, Steve McGuirk and Professor Torero, have identified as human error psychology, namely the

inability to deal with something adequately that you do not recognise. Again, Mr Friedman has already touched upon this. But the Brigade bears significant responsibility for putting their own employees at considerable risk without the necessary knowledge and training to do the job, because they had the information.

We know that Dr Cohen-Hatton faced resistance within the Brigade as she attempted to make improvements to the incident command training. Our clients would like to know the reasons behind this and whether the missed opportunities to learn from her best practice contributed to the failures of command and control on the night of the fire.

Ultimately, this Inquiry will have to ask the question: given the failures, were there deaths which could have been avoided? Were there lives that could have been saved?

Cuts.

The link between cuts and austerity and the fire safety being compromised and eroded is real. If an organisation is understaffed and underfunded, its ability to act efficiently is likely to be compromised. Our clients find common ground with the Fire Brigades Union on this point, whose warnings went unheard in the

decades before the disaster as the London Fire Brigade experienced the worst cuts imposed on any fire service in modern history.

One of the impacts of the cuts was the reduction in staff in the control room. On the night of the fire, there were fewer control room officers on duty to handle the 999 calls and the fire survival guidance calls. There were fewer supervisors able to monitor how these calls were being handled and to ensure that the information was passed on the ground. In some cases, this meant that vital information about people who were trapped and could not self-evacuate was not passed on to firefighters at the tower with fatal consequences. We echo the call of the Fire Brigades Union that the Inquiry must investigate the decisions made by the former Mayor of London to impose stringent cuts on the Brigade during Module 6. Our clients are clear in their assertions that Prime Minister Boris Johnson, when he was the Mayor of London, had a cruel agenda of cutting the Fire Brigade's budget, firefighters' numbers and stations.

Let me remind you, this was a man who showed contempt for fire safety and the lives of Londoners when, in the face of legitimate political debate and criticism of his reckless policies, he told Labour

assembly member Andrew Dismore to "get stuffed". His agenda directly impacted on the London Fire Brigade's ability to discharge its statutory duty. Sadiq Khan commissioned a review in 2016 when he became Mayor. The review was unequivocal that the Fire Brigade could not sustain any more cuts if it was to have sufficient resources to meet the challenges of the future to keep Londoners safe.

The Mayor's Module 5 written submissions state that he has been funding the London Fire Brigade at levels higher than those to which he is resourced by central government. We say it is alarming that he felt the need to use his own submissions to plead for further investment in the London Fire Brigade.

The fact is we have serious concerns about the attitude of central government. The written submissions of the Home Office, while acknowledging its overall responsibility for fire and rescue service policy in England, is silent on the issues of funding, cuts and deregulation. We urge this Inquiry to return to this important issue in Module 6 and to make recommendations to address what we consider to be an urgent issue.

Further cuts of 15% of the London Fire Brigade's budget to 2020 were set out in the local government settlement. Despite the Grenfell Tower fire, no

additional funding has been found for fire and rescue services. We fear that the London Fire Brigade will not be in a position to learn lessons from the Grenfell Tower fire without the resources to implement the necessary changes. Above all else, our clients don't want other families to go through what they have been through, but without proper funding, we fear the past may repeat itself.

I have nearly finished.

Communication.

Communication is another aspect of the Brigade's response that, among other things, was arguably impacted by lack of resources. Communications within the Brigade broke down at the Grenfell Tower fire. The ability of the firefighters to speak to each other, the bridgehead and/or the incident commander, were severely compromised. Vital information from the FSG calls was left to the vagaries of paper notes being passed to runners to the bridgehead and presumably back to the incident command. This is in spite of the LFB policy 488 on incident communications which states:

"Effective communications are the key to success. A reliable communication network is essential for safe operation at incidents and fundamental for securing the level of command required to manage operational

resources effectively."

In the opinion of expert witness Professor Johnson, the significant communication problems on the night of the Grenfell fire placed lives both of the firefighters and of the residents at risk.

It seems impossible to avoid the conclusion that cost saving and cutting influenced the Brigade's decision not to upgrade its communications equipment earlier. In Phase 1, Ricky Nuttall said:

"I know there's better equipment out there, and I understand it's all about costs, but in this situation cost shouldn't come into it."

We endorse Professor Johnson's recommendation for the LFB, namely the need for cultural change from making do with the legacy of information technologies to technical excellence.

With other aspects of the LFB's inadequate response to the Grenfell Tower, the failure of communications seems to be one affected by culture that is resistant to change and innovation. We endorse Professor Johnson's recommendation to understand why so many innovative proposals from the Brigade's staff were dismissed, and more generally the resistance to technical innovation by the Brigade. Communication failure featured in the Lakanal House fire. Problems with radio coverage,

interference and congestion also affected the Brigade's response to Lakanal House. These problems were repeated on the night of the fire at Grenfell, and our clients would like to know why.

So let me conclude.

We welcome the London Fire Brigade's submissions that they have been looking into evacuation and stay put since the Grenfell Tower fire, and we too are alarmed by the continued lack of national guidance and consensus. This is a matter that is urgent and needs to be addressed at a national level. Central government must not drag its feet any longer.

The overall message we would wish to convey on behalf of our clients is that the evidence and disclosure to date in this Inquiry demonstrates that the Brigade is an institution in urgent need of reform. Our clients are concerned that the London Fire Brigade is an institution incapable of reforming itself from within. Professor Torero argued that, "The current culture of the fire and rescue services does not allow for the required level of self-criticism and introspection". As such, our clients ask that you, sir, and your panel keep under review the need for the overhaul of the London Fire Brigade from the outside.

Given the implications for public safety, this

overhaul cannot wait. Our clients want to ensure that others do not experience what they went through. We all want and need a fire service that is fit for purpose in the 21st century. This is not an insurmountable goal, but it is one that requires more than just goodwill and paper policies. There must be a genuine sea change in the culture of the LFB.

At governmental level, there must be a realisation that bodies such as the London Fire Brigade are public services, not just businesses. Safety and lives cannot be sacrificed at the altar of austerity. The London Fire Brigade must be properly funded and resourced in order to underpin those changes in training, learning, practice development, that are so desperately needed. The structure and makeup of the leadership must change. They need to listen, to be humble, to understand the righteous indignation of those who suffered as a result of this disaster.

The London Fire Brigade must and can do better for the sake of its members and the wider society. The safety of Londoners requires it. The residents and survivors of Grenfell Tower demand it. The memory of the deceased deserve it.

I started this address, sir, with these words: you rise above your fears by facing them, not ignoring them.

The LFB chose to ignore them.

So let me finish with these words: Conan Doyle once said it is easy to be wise after the event, but this quote has absolutely no place or applicability here, because this is not a case of critics being wise with hindsight. The LFB should have been much wiser before the Grenfell Tower fire, but this organisation chose or was incapable of doing otherwise. We state clearly and unequivocally that, in this case, accordingly, this Inquiry should not allow the excuse of hindsight to be used when everything that we have said was foreseeable all along.

Thank you.

SIR MARTIN MOORE-BICK: Well, thank you very much, Professor Thomas.

At this stage we will take the morning break, and we will resume at midday with the next statement.

Thank you very much.

(11.45 am)

(A short break)

(12.00 pm)

SIR MARTIN MOORE-BICK: Good, thank you.

Now, the next statement we're going to hear is going to be made by Mr Imran Khan Queen's Counsel on behalf of those whom he represents.

Yes, Mr Khan.

Module 5 opening submissions on behalf of Imran Khan & Partners by MR KHAN

MR KHAN: Good afternoon, sir. I'm recovering from a sore throat, so if my voice fails me, my apologies.

SIR MARTIN MOORE-BICK: Take your own time. There is water there, and if you need any more, please just indicate and we will get some for you.

MR KHAN: Very grateful.

Good afternoon, sir, and good afternoon, panel. Pleasure to be here. I make opening submissions on behalf of our clients represented by Imran Khan & Partners.

Chair, it's often said that when tragedies occur, they could have been avoided had we known then what we know now. In relation to the tragedy of the Grenfell Tower fire, our clients invite the Inquiry to ask the question: what did the London Fire Brigade know before and at the time of the fire at Grenfell that took the lives of 72 people, and could that knowledge have saved lives, even one life?

In our submission, we set out what we understand, through the disclosure, that the London Fire Brigade knew and should have known which might have assisted in saving the lives of those on the night of the fire. We

set out information which we consider was available to the London Fire Brigade, the LFB, before the Grenfell Tower fire, and we set out what the LFB failed to implement despite the information available to them, and where possible how this related to the night of the fire.

Sir, the training of firefighters and what they need to be trained on is identified by a commissioning department within the LFB, or by a third-party training provider, Babcock. From 2012, the majority of LFB firefighters received their training from Babcock. Borough commanders, watch managers and station managers retained the responsibility for ensuring that firefighters within their borough had sufficient training.

Regardless of who identified the requirements for training, it would proceed via the training commissioning alteration process, known as TCAP, which was then followed. Up to and including June 2017, once a training requirement had been identified, a TCAP form was completed. The operational directorate co-ordination board -- a bit of a mouthful -- also known as ODCB, identified and agreed what further training was required for LFB operational staff, and those needs would be communicated to staff through their

Operational News publication. So, sir, panel members, that was, in very brief, the system in place for the training of firefighters.

So I go back to the original question: what did the LFB know through its training?

Well, it was established in Phase 1 of the Inquiry that senior staff within the LFB were aware of previous fires involving combustible cladding systems, but, it would seem, it failed to adequately train operational staff to recognise or assess the risks that they posed and the steps that should have been taken by way of response.

My learned friend Mr Thomas Queen's Counsel has already mentioned the Lakanal House fire. The Lakanal House fire and the subsequent recommendations made by the coroner in that case will be dealt with in detail in Module 6. However, the fire illustrates a specific example of the failure of the LFB to educate and train its operational staff on the hazards of external cladding systems on high-rise buildings, despite its knowledge on the subject.

The LFB were aware of the role of the external panels in the fire and we have seen considerable evidence to indicate this. We have addressed it in detail in our written submissions and we don't intend to

repeat it here. We know that Mr David Crowder of the Building Research Establishment prepared a presentation on the Lakanal House fire which referred to the use of composite external wall panels. The presentation was produced in collaboration with former Deputy Assistant Commissioner Gary Reason, former Commissioner Ron Dobson, and Assistant Commissioner Steve Turek of the LFB. Ms Rita Dexter, who was Deputy Commissioner of the LFB, stated in her witness statement to the Inquiry that the presentation made "a very significant impression" on her as it detailed refurbishment projects which had "the unintended consequence of diminishing fire safety protections of the building".

In 2014, as part of the LFB's response to the Lakanal House coroner's recommendations, they raised a TCAP, number 0153. It was called the Lakanal House training case study. The LFB draft PowerPoint presentation, however, made no reference to the cladding or exterior wall panels. The Babcock training guide entitled, "Lakanal House case study" does not refer to cladding or exterior wall panels, and the LFB PowerPoint presentation does not refer to them either.

In addition to Lakanal, there were national and international cladding fires of which senior staff in

the LFB were aware, as demonstrated through a consideration of their correspondence. These fires took place after the Lakanal House fire in 2009, and before the Shepherds Court fire in 2016, which we deal with separately.

In our written submissions, we have dealt in detail with the following cladding fires: Madingley, Dorrington Point, Sainsbury's distribution centre, Balearic Capital East Apartments, Andrew Reed House and the fatal fire at Atherstone industrial estate. We don't intend to repeat it here and now.

The LFB was also aware of the following international cladding fires: the Lacrosse Docklands in Melbourne, as well as The Address and The Torch, both of which were in Dubai. These fires are also referred to in greater detail in our written submissions and we don't intend to repeat it here.

We now come to the extent of training to the operational staff on the risks associated with cladding systems.

Despite the LFB's knowledge of the previously stated fires, we submit that there was only very limited training delivered to operational crews on the hazards of cladding systems and combustible sandwich panels, particularly in high-rise residential buildings.

It was established in Phase 1 of this Inquiry that the following senior firefighters present on the night of the fire did not receive training on how to fight cladding fires: Watch Manager Dowden, Watch Manager Brien O'Keeffe, Crew Managers Charles Batterbee, David Davies, Charles Secrett and Jamal Stern.

The following is a list of training materials that has been disclosed to the Inquiry of training materials which were available to operational crews before the night of the fire, and this of course excludes the Lakanal House case study.

An article in the LFB publication Operational News entitled "Insulating sandwich panels" did refer to insulating sandwich panels, but not in relation to high-rise buildings. The article stated, "The incident commander must react very quickly and be responsive to new information and evidence of changing conditions", but did not provide any further guidance.

A firefighter training programme entitled, "OP002 building construction" was disclosed to the Inquiry by third-party training provider Babcock. It was part of the core skills firefighter development programme in November 2014. The programme had a single page entitled "Sandwich panels used in construction", but it did not relate to use in high-rise residential buildings, nor

the specific hazards associated with compartmented high-rise buildings. It stated:

"They are often used in conjunction with lightweight steel to provide exterior walls and roofing for large retail outlets and warehouses."

It listed some hazards to firefighters, including rapid fire spread, toxic smoke and the possibility that "sandwich panels involved in fire may fail suddenly".

The firefighting training programme entitled "OP23 firefighting in buildings 1" was also part of the core skills development course in February 2015. Under the heading "Construction", it stated:

"Age, materials used and system of buildings will greatly affect fire development and influence the firefighting tactics used. OP001 Building Construction deals with this subject in more detail."

We note, however, that OP001, "Building construction", did not refer to cladding materials or sandwich panels.

An overview of a back-to-basics firefighter tactical decision exercise produced by the LFB in 2016 included a scenario for a high-rise training exercise. This involved "intense fire conditions in the flat of origin with vertical smoke and fire spread up exterior cladding or fascia in a residential high-rise building".

The Inquiry legal team has already noted that the scenario did not look for firefighters to identify the cladding as a means of fire spread, nor did it address the risk associated specifically with cladding or combustible materials.

At paragraph 38 of his second witness statement, LFB's current assistant director of training, Peter Groves, referred to training document TCAP 0212 entitled "Highly insulated buildings". This was intended to raise training which would address hazards associated with combustible insulation rather than sandwich panels and cladding. This was raised in October 2015 and related to computer-based packages linked to the LFB publication Operational News, issue 30. We refer to training document TCAP 0212 in greater detail in our written submissions, and again we don't intend to repeat that detail here.

What we do note here is that TCAP 0212 requested training that ensured that firefighters should "be aware of the implications on their firefighting tactics of the increase in use of highly insulated sealed compartments, fire development in these compartments and the hazards associated with modern methods of construction".

Under the section entitled "What do you want this training to achieve?", the TCAP training document stated

that the computer-based training package intended to reference "technologies that are used to make this happen". Celotex and Kingspan, et cetera. It noted that, "This technology is highly interdependent. If one aspect fails, it can undermine the entire design solution", and it recommended that the training should address "what a perfect response should look like, consideration of compartment failure and effects crews can anticipate on the compartment fire conditions".

In his second witness statement to the Inquiry, Mr Groves of the LFB stated that the computer-based training which arose from this training document was withdrawn due to IT issues, and it was intended that it would be relaunched in Operational News issue 40, which was to be issued after the Grenfell Tower fire. Mr Groves does not mention why the training was not relaunched until after the fire.

In her witness statement to the Inquiry, Ms Cara Kelly of training provider Babcock says that Babcock did not receive any TCAP request from the LFB in relation to the same. This is important because it was the only TCAP training document exhibited which addressed the specific hazards of combustible insulation in such a level of detail and it was not relaunched until after Grenfell.

On 19 August 2016 the LFB attended an external cladding fire in a 20-storey residential block in Shepherd's Bush. Approximately 50 occupants were evacuated. On 30 August 2016, the cladding panels from the Shepherds Court fire were tested by testing company Bureau Veritas with staff from the LFB's fire engineering department. The consequent report produced by Bureau Veritas indicated the panels were "likely to have assisted the fire in spreading up the outside of the building".

In April 2017, some months later, LFB's senior communications officer, Martin Simpson, emailed the Brigade's current head of fire safety, Assistant Commissioner Daniel Daly, as well as the head of regulatory enforcement, Andrew Jack, and Assistant Commissioner Andy Hearn about an article from Inside Housing, the publication. This article addressed the role of external cladding in the Shepherds Court fire. Mr Simpson's email highlighted a quote in the article from a chartered surveyor and fire safety expert which stated:

"This kind of spread can be catastrophic, particularly where flames can get through windows and if a stay-put policy is in place for residents."

The LFB produced a PowerPoint presentation setting

out information about the Shepherds Court fire and the conclusions of the Bureau Veritas' cladding panel testing. According to the witness statement of LFB fire engineer Mr David Green who produced the presentation, it was given to LFB fire engineering liaison officers and senior fire safety officers in October 2016.

The LFB did not disseminate the presentation to operational crews. In her oral evidence to the Inquiry, former LFB commissioner Ms Cotton was not familiar with the presentation and could not explain why the circulation of the presentation was only restricted to a limited group of LFB fire engineers.

In addition, in his witness statement to the Inquiry, Assistant Commissioner Daly stated that, in his view, the incident has similarities with the Lakanal House fire and, as such, "it did not appear to be a new hazard", as an awareness of external fire spread is referenced in LFB high-rise firefighting policy. He stated that the effectiveness of firefighting actions in arresting the fire spread of the building led him to believe that "there was no need for additional messages to operational crews".

In his statement to the Metropolitan Police, Assistant Commissioner Daly explained that he raised the Shepherds Court fire as an issue internally for

inclusion in the LFB's publication, what I have already referred to, Operational News. He stated that he was fairly certain that the issue did not feature in Operational News until after Grenfell. He explained:

"In fairness, I imagine that there is always a long queue of material waiting to be featured. You can't send out a document with every bit of learning required as people can only absorb so much in a period of time."

He noted that there was, in his words, "something" in Operational News in August 2018 about high-rise firefighting which addressed the withdrawal of stay put in favour of evacuation.

The LFB were aware of cladding fires that resulted in the evacuation of residents, often from buildings with a stay-put policy in place, in particular the fires at Madingley, Dorrington Point and Shepherds Court. Evidence has also been disclosed to the Inquiry of other high-rise fires the London Fire Brigade attended which resulted in evacuation, and in our written submissions we refer to the following fires: the Adair Tower fire, a fire at Grenfell Tower in 2010 and a fire at Tideslea Tower. Again, we don't intend to repeat the submissions here today.

In addition to those fires, policy note number 633, the LFB's internal policy on high-rise firefighting at

the time of the Grenfell Tower fire, stated this:

"It may be necessary to undertake a partial or full evacuation in a residential building where a stay-put policy is in place."

But despite this statement in the LFB's high-rise policy, and their knowledge of the high-rise fires where evacuation took place, either as a result of a cladding fire or otherwise, at the time of the Grenfell Tower fire the LFB had "not provided personnel with explicit guidance as to when and how it should be withdrawn". This is according to the witness statement of the current LFB commissioner, Mr Andrew Roe, who was an assistant commissioner, as we know, in January 2016 and was in that role on the night of the fire.

Commissioner Roe was the fourth incident commander on the night of the fire from 2.44 am to 12.35 pm, and he disapplied the stay-put strategy at 2.47 am. In his first statement to the Inquiry, he stated:

"LFB openly recognise that there are no clear parameters in its policies or training for when and how a stay-put strategy should be disapplied and what alternatives should be put in place."

According to the Phase 1 report, LFB incident commander Watch Manager Dowden did not evacuate Grenfell Tower, and:

"... by 01.50 at the latest he should have realised that the fire had begun to enter the interior of the building and that compartmentation, which underpins the 'stay put' advice, had been breached."

The report stated that Watch Manager Dowden should have spoken to the LFB's control room and "should have decided to evacuate the building".

In his oral evidence to the Inquiry, Watch Manager Dowden stated that he could not recall receiving training on when a partial or full evacuation may be necessary. He stated that he had no input from any individual on understanding when it may be necessary to have a full evacuation and he only referred to internal high-rise policy. He also said that he could not recall training on this and only had experience of theory-based scenarios for training on evacuation from high floors.

Firefighter Michael Pole, the firefighter whom our client Mr Paulos Tekle, who is here today, wished to call as a Module 5 witness, commented in his statement to the Metropolitan Police that he had not received any training about what to do if a building compartment fails. This is despite receiving high-rise training and training on compartment firefighting.

Sir, you will recall that at 2.00 am on the night of

the fire, Mr Tekle asked for himself and his family to "be helped out of the flat", but was told by a firefighter that "we [that is Mr Tekle's and his family] were safe in the flat and that we should just cover the front door with a blanket".

In his witness statement to the Inquiry, Mr Tekle stated:

"If we had been given proper instructions by the firefighter, we would have attempted to leave at that time."

Mr Tekle in fact left his flat on the 18th floor at around 2.56 am, nearly an hour later. Mr Tekle has asked us to remind you, sir, and the panel members that tragically his five-year-old son, Isaac Paulos, did not make it out of the tower. Mr Tekle firmly believes that had the firefighters carried out their duties correctly, his son would still be alive today.

The evacuation of residents, evacuation strategies and the stay-put policy are referenced in the LFB's high-rise training, but they focus on the idea of evacuation rather than practical guidance of when and how to undertake an evacuation of residents following the withdrawal of stay-put advice from a high-rise building, in particular where there is no pre-existing evacuation plan. The training disclosed also referred

to the stay−put policy but did not refer to the possibility of changing the advice to evacuation, or the possibility of emergency evacuation or mass rescue of occupants.

The (inaudible) Babcock PowerPoint firefighting training presentation on high−rise incidents referred to self−evacuation. It stated:

"Firefighters entering a building may find themselves travelling against the flow of people evacuating from the building."

The presentation also referred to residential buildings but noted that:

"In residential buildings, occupants should only evacuate if the fire or smoke is in their property. Firefighting operations can be hampered by the number and type of people being evacuated."

A 2011 LFB training PowerPoint presentation entitled "High−rise buildings and dealing with high−rise fires" state in its slides that:

"In residential buildings, occupants should normally only evacuate if the fire is in their flat or maisonnette, and if the fire is located in another part of the building, occupants should normally be advised to stay in their home unless they are being affected by heat or smoke."

A July 2016 Babcock high−rise procedure course called OP007, which was part of the core skills firefighter development training, referred to fire spread from one compartment to another and the possibility of external fire spread. The PowerPoint slides also referred to evacuation, but in relation to commercial high−rise buildings rather than residential, and in relation to pre−planned evacuation procedure.

In his expert report to the Inquiry, firefighting expert Mr Steve McGuirk stated:

"I have seen some training documents that mention the possibility of changing stay−put advice and/or evacuating residents, but this is not addressed in any detail and nothing that I have seen would indicate that the training provided actually addressed when and how this should happen."

One example of this is the Blackwall terror exercise, and the Holcroft House command decision exercise that is exhibited to the statement of Cara Kelly is similar in this respect.

In addition to this, in Mr Groves' statement to the Metropolitan Police, he commented that there was "no standalone training on mass evacuation but that was the intention going forward", that a standalone package would be created, and is "a direct result of the

Grenfell Tower fire".

We have not had sight of any policy as to how the LFB executed or assisted evacuations in premises with a get−out and stay−put policy. We have also seen very few references in their disclosure to evacuating anyone other than fire service personnel. For example, a July 2011 Babcock training presentation that was disclosed to the Inquiry concerning firefighter emergency evacuation and tactical withdrawal focused on firefighter evacuations.

In his expert report, Mr McGuirk stated:

"The overall impression is that LFB's incident command training did not prepare personnel for the possibility of needing to evacuate a high−rise building with no pre−existing evacuation plan, specifically when this decision should be taken, and how an evacuation should be carried out."

In his report, Mr McGuirk agreed with your findings, Chair, that the capacity of the stairs was sufficient for mass evacuation and remained substantially free of smoke until 1.50 am. He also agreed with your finding, Chair, in relation to the need to attempt mass evacuation.

In addition, in her statement to the Metropolitan Police, Firefighter Jessamine Bates

criticised the strategy for emergency search and rescue and evacuation on the night of the fire. She said:

"Firefighters were being told to go to individual flats when there were actually people in every flat and maybe we should have been checking and clearing floor by floor."

Sir, it has already been mentioned by Mr Friedman Queen's Counsel about the Kent Fire and Rescue Service firefighting policy, the alternative. The LFB was aware of an alternative firefighting strategy for high−rise residential buildings. It was developed by Dr Paul Grimwood of Kent Fire and Rescue Service. He developed a strategy known as RICE: rescue, intervention, containment, evacuation. It was bespoke to high−rise buildings, developed by Dr Grimwood in 2008 and focused on the philosophy of "protect the escape route at all times" and stairwell protection. The strategy also addressed the reversal of stay−put advice and, according to Mr McGuirk's report, the following four triggers are used by Kent Fire and Rescue to assist an incident commander to reverse stay put: fire development, smoke travel, self−evacuation and a compromised escape route.

We have considered Dr Grimwood's work on stairwell protection and RICE in further detail in our written

submissions and we don't intend to repeat it here.

Dr Grimwood stated that he was invited as part of a small team of representatives from the Chief Fire Officers Association southeast regional high-rise task group to meet with Deputy Assistant Commissioner Peter Cowup of the LFB. The discussion during the meeting centred on the southeast region's approach to developing procedures to mitigate smoke entering stairwells and the use of RICE.

In his report, Mr McGuirk assessed Kent's standard operating procedure, SOP, and accepted that RICE:

"... would have potentially made a difference at Grenfell, even taking into account the practical difficulties outlined in the Phase 1 report, and would have been preferable to the approach followed by LFB on the night of the fire."

He explained that the four triggers to reverse stay put were all present at Grenfell at an early stage, and "would have given the signal that evacuation needed to be considered".

If the LFB had trained its firefighters in the use of Kent's SOP, he says, it is certainly possible, even likely, that more lives could have been saved. However, a note of caution: Mr McGuirk emphasised a need not to jump to the conclusion that using Kent's SOP would have

prevented fatalities.

Module 5 of this Inquiry will address the adequacy of what is known as the LFB's training on section 7(2)(d) visits. In brief, section 7(2)(d) of the Fire and Rescue Services Act 2004 places a responsibility on the fire and rescue authority to make arrangements for obtaining information needed for the purpose of extinguishing fires and protecting life. The information collected by the LFB during the section 7(2)(d) or familiarisation visits is recorded on the operational response database, ORD.

In our submissions, we say that the London Fire Brigade did not adequately train its operational crews to be aware of the risk of cladding systems and combustible sandwich panels when conducting these familiarisation visits. This is despite its considerable knowledge of cladding fires and the guidance set out in LFB internal policies, for example policy note number 800 and policy note number 663 at appendix 1. I'm not going to take you through those today.

In his expert report, Mr McGuirk argues that the London Fire Brigade policies adequately met the requirements of section 7(2)(d) in reference to those policy documents. However, policy note 663 did not

refer to cladding explicitly, but it did include "the likelihood and impact of any fire spread beyond the compartment of origin and the potential for multiple rescues", and "any building design features which may promote rapid or abnormal fire spread, such as sandwich panels or voids".

However, Mr McGuirk concludes that the London Fire Brigade had a superficial approach to management systems to ensure these policy notes were complied with on the ground and failed to train and educate operational staff to understand the requirements of section 7(2)(d).

In his Phase 2 expert report to the Inquiry, Professor Jose Torero states this:

"... in regard to Grenfell Tower, the [LFB] failed to obtain the necessary information through inspections, to enable them to conduct an adequate Risk Assessment.

"An adequate Risk Assessment would have identified the potential for the June 14th, 2017 scenario and would have determined two possible paths of action, rectification or a change in response tactics."

It was also established in Phase 1 of this Inquiry that Watch Manager Dowden and the North Kensington crew who were responsible for the visit to Grenfell Tower did not discover that combustible materials were used on

Grenfell Tower. This, we say, should have been obtained from Kensington and Chelsea TMO. They were also not trained on how materials used in exterior façades might behave in a fire and therefore could not have been expected to have assessed risks created by the cladding system.

In terms of the training material on section 7(2)(d) visits which has been disclosed to the Inquiry, the LFB publication Operational News issue 24 indicated that a training package was available to London Fire Brigade operational crews. Neither the article itself nor the associated PowerPoint presentation referred to the consideration of building design features or the relevant hazards.

We now address the quality and advocacy (sic) of section 7(2)(d) operational response database entries.

In general, concerns regarding the quality of section 7(2)(d) visits and adequate guidance to crews were known to the London Fire Brigade, particularly following the Lakanal House inquest in 2013.

In December 2013, Borough Commander John Elwell was tasked with discharging action 18(b) of the coroner's Rule 43 recommendations, namely to create an inspection regime targeted at high-priority buildings. Borough Commander John Elwell sent both

Assistant Commissioner David Brown and Deputy Assistant Commander Tom George his briefing paper which was entitled, "Action 18(b) LFB consolidated action plan" on 13 December 2013. The briefing paper noted "a number of substandard examples were found. This could indicate a poor understanding of the rationale and a lack of competency", and recommended "further training is provided to all personnel with a role in the ORD process".

Despite this, the LFB's preliminary report of the head of the Grenfell Tower review team produced in 2019 following the Grenfell Tower fire said this:

"Operational risk information provides no practical guidance for undertaking 7(2)(d) visits and focuses on the process for identifying premises which may become subject to such visits."

It also stated:

"It has been observed that the information provided in the Brigade's policies and associated training packages in relation to undertaking 7(2)(d) visits is not completely aligned with policy referred to in Operational News 24."

Sir, panel, we deal with the issue of communications.

The LFB, we say, were aware of problems surrounding

communication equipment and its use in high-rise concrete buildings, and this has been addressed in detail in Professor Chris Johnson's report to the Inquiry. He concluded that failures in communication on the night of the fire, whilst caused by various factors, caused a risk to life to both firefighters and the residents of Grenfell Tower, and reduced situational awareness of firefighters on the night of the fire. He provided the example of the loss of life on floor 14, when firefighters were unable to request additional support to assist in the rescue of residents found there.

We have considered in some detail the issue of communication in our written submissions and we summarise those in this way.

Firstly, the age and adequacy of the LFB's communications equipment and their failure to update this equipment. We note that in her statement to the Met Police, Firefighter Jessamine Bates stated:

"I feel that better communication would have helped. The actual equipment was poor and I was aware that equipment literally fell apart."

Secondly, the LFB's awareness of communication problems with high-rise buildings, particularly following the Lakanal House fire, and their failure to

provide policies or training on recovery from widespread communications failures.

Thirdly, we note the LFB's consideration of methods of mitigating communication problems in high-rise buildings.

Finally, we raise the issue of testing for communication black spots during familiarisation visits.

We know that Professor Johnson stated that communications tests carried for the Grenfell Tower fire did not test for potential communication problems sufficiently. He recommended the LFB adopt "validated test procedures to assess radio coverage in high-rise buildings".

Sir, that brings us to what conclusions we might draw from all of this.

It seems to our clients that, with the evidence that we have seen, that our clients have considered, that has been adduced thus far in this module, and what comes before you in the next few days, if it reflects the material disclosed and referred to previously, the tragedy of the Grenfell Tower fire should not and cannot be considered in the context of hindsight, as Mr Thomas Queen's Counsel so eloquently put it. It is not a situation in which it can be said that had we known then what we know now, lives could have been saved. The

simple fact is that the LFB did know. They knew, and lives could have been and should have been saved, for a number of reasons.

Firstly, senior staff at the LFB had considerable knowledge of national and international exterior cladding fires, and yet they failed to disseminate this information to its firefighters, those on the ground. With this knowledge, the LFB should have trained firefighters about the dangers of external cladding and armed them with techniques to fight such fires. Had the crews and the incident commanders on the night of the fire been trained to fight external cladding fires, they would have been better prepared, and, sir, lives could have been saved.

Secondly, senior staff at the LFB were aware of the hazards of flammable cladding. Despite this knowledge, they did not provide sufficient training to firefighters conducting pre site familiarisation visits to recognise the risks of the use of cladding in high-rise buildings. Had the crews who inspected Grenfell Tower received this training, they could have discovered that dangerous cladding was used during its refurbishment. As Professor Torero stated, had the London Fire Brigade obtained this information, firefighting tactics in relation to Grenfell Tower could have been rectified in

the light of this information. Sir, lives could have been saved.

Thirdly, in relation to pre site familiarisation visits, the LFB were aware that information available to firefighters during incidents was often incomplete due to the lack of information collected by firefighters during pre site visits. Despite knowledge of these concerns, the LFB only provided minimal training and practical guidance to the firefighters who carried out those visits. Had the firefighters who conducted the pre site visit at Grenfell Tower received adequate training and guidance, they would not have omitted vital information from their entries. In turn, this would have aided firefighters on the night of the fire in their efforts to save the residents of Grenfell Tower. Sir, lives could have been saved.

Fourthly, the LFB had knowledge of previous high-rise fires which resulted in the evacuation of residents despite having a stay-put policy in place. The LFB's own high-rise policy contemplated that stay-put advice may be abandoned in favour of evacuation. Despite this, the LFB failed to provide firefighting crews with guidance as to when and how this should be carried out. Had the LFB provided this training to its firefighters and incident commanders,

then incident command would have known to abandon stay-put advice in favour of evacuation far earlier on the night of the fire. This in turn would have prevented further fatalities on the night of the fire. Sir, I repeat: lives could have been saved.

Fifth, senior staff of the LFB were aware of alternative high-rise firefighting strategies which would have aided incident commanders and their crews to recognise when stay-put advice should be abandoned and how to carry out an evacuation. As Inquiry expert Mr McGuirk stated in his conclusion, had the LFB trained firefighters to use these strategies, more lives could have been saved.

Sixth, as Inquiry expert Professor Johnson noted, communication problems on the night of the fire caused a significant risk to lives of the residents of Grenfell Tower. The Inquiry might consider that the communication problems experienced by firefighters on the night of the fire may have been exacerbated by the LFB's neglect to update its equipment and its failure to train its operational staff on how to mitigate communication black spots and failures. Sir, panel members, we invite you to explore this, and the methods by which the LFB could have mitigated communication failures, and whether, as a result, any lives could have

been saved.

Sir, we end, finally, on the issue of training on diversity, and we note amongst the many thousands of documents that have been disclosed to us, there is only one mention of training on diversity in all the disclosure that we have had.

As a result, we wrote to the Inquiry on 10 June this year and we asked, we said this:

"We have found only one reference to any form of equality and diversity training in the material disclosed. This is at paragraph 5 of Ms Rita Dexter's witness statement, which states that she managed and led the equalities team."

We asked, sir, a number of questions, ending in this way. We said this:

"In short, we are trying to ascertain whether there was at any point leading up to the fire at Grenfell any form of equality and diversity training given to the LFB or any such policies in existence."

The Inquiry responded:

"The Inquiry has not specifically sought disclosure from the LFB on its equality and diversity training and policies as such matters fall outside the Inquiry's terms of reference. To the extent that you consider such matters to impact the issues set out in

the Inquiry's terms of reference and list of issues, we would invite you to include this in your proposed questions for witnesses and in any representations you may wish to make to the Inquiry during the course of Module 5 and/or 6."

Sir, we must say that our clients were incredibly disappointed, to say the least, with this response.

You will be aware that, on behalf of our cohort of clients, we have at the outset -- and I remember the first opening submissions that I made at Holborn Bars -- consistently been submitting that the Inquiry needs to consider the issue of the makeup of the residents of the tower and how they were treated before, during and after the fire. You don't need reminding, sir, what we said in our opening statement in relation to Phase 2. We said this:

"Whilst we have identified these 15 key missed opportunities on the part of those involved in the refurbishment of Grenfell Tower, we note that there has actually been a missed opportunity for this Inquiry, and that is to recognise the issues of race and social class which we on behalf of our clients argue should be an integral part of this Inquiry."

Sir, we yet again urge the Inquiry to examine whether treatment of those who occupied the tower was

any different because of their background. This is especially so when the head of the LFB itself, Mr Andy Roe, has gone on record in The Guardian newspaper of 19 March 2021 to state this:

"A culture of casual racism and misogyny remains so prevalent within pockets of the [organisation] that ... [he] feared his mixed-race daughter might not be treated with 'dignity and respect' at some fire stations."

The article went on to state:

"[Andy] Roe paid tribute to the kindness and bravery of his colleagues who risked their lives regularly and 'have reached in to rescue people regardless of background'.

"But he added this: 'In my experience the same people might then come back to the fire station and express themselves casually in racist terms, in misogynist terms, use crude language around faith and sexuality. We are awash with really great people who are really kind and will be there for anyone at their point of crisis, but we still have elements of our culture that we need to transparently face up to and unpick.'"

We say this, sir, members of the panel: we submit that any organisation in which there is clear evidence of racism and misogyny, as accepted by its chief

officer, must at the very least consider whether it is capable of delivering an appropriate service to a population as diverse as that which exists in London, and whether it did so specifically to those that lived in Grenfell Tower. There is then an even greater necessity for this Inquiry to examine this issue for itself, particularly when the proportion of black and minority ethnic firefighters in the London Fire Brigade stands at around 15%, whilst serving a city with a black and minority ethnic population of around 40%.

The Guardian article referred to the LFB's own data, which shows that employees from African, Caribbean and Asian backgrounds or with English as a second language were less likely to be promoted, more likely to be subject to formal or informal discipline, and more likely to be made to retake training modules.

To assert that the LFB's equality and diversity training and policies fall outside the Inquiry's terms of reference, sir, in the light of Mr Roe's admission, the LFB's own data and our clients opinion, is, and we don't say this lightly, a dereliction of the Inquiry's duties and obligations which serves only to cause our clients greater injustice. On their behalf, and Mr Tekle's behalf, we ask that this be immediately rectified.

Thank you very much.

SIR MARTIN MOORE-BICK: Good, thank you very much indeed.

Well, the next statement is due to be made on behalf of the Mayor of London by Ms Studd Queen's Counsel, but she is not going to appear in person, she is going to make that statement remotely at 2 o'clock.

So I think at that point we must rise for the moment, and we will resume with Ms Studd's statement at 2 o'clock.

Thank you very much.

(12.48 pm)

(The short adjournment)

(2.00 pm)

SIR MARTIN MOORE-BICK: Good afternoon, everyone. We're now going to hear an opening statement from Ms Anne Studd Queen's Counsel on behalf of the Mayor of London, and I can see Ms Studd on my screen, so I hope you can see us, Ms Studd, and hear me. Is that the case?

MS STUDD: I can see you and hear you.

SIR MARTIN MOORE-BICK: Good, thank you very much. Well, now, it's time for you to make your statement on behalf of the Mayor, and would you like to go ahead, please.

Module 5 opening submissions on behalf of the Mayor of London by MS STUDD

MS STUDD: Thank you very much.

In his report of Phase 1 of the Inquiry delivered on 30 October 2019, the Chairman made recommendations which included identifying significant institutional and systemic issues that required change by the London Fire Brigade. The London Fire Brigade had been driving forward those necessary changes under the Mayor of London's oversight to ensure identified risks are being managed, the recommendations from Phase 1 are being implemented, and the improvement measures achieve their intended outcomes.

The evidence to be called in relation to Module 5 will examine the operational response of the LFB on the night of the fire, and will include an examination of where that response might have been lacking in co-ordination and effectiveness. The Mayor does not need to comment on that evidence, nor on the expert reports in any detail, but he does wish to emphasise two points.

First, the most important outcome for the bereaved, survivors and residents, and indeed for all Londoners, is that the lessons of Grenfell are learnt and progressed quickly so that they can be reassured that the terrible events of that night will not be repeated.

Secondly, as the Chairman was careful and right to emphasise, the issues that arose at Grenfell in relation

to the operational response of the London Fire Brigade were systemic and institutional, rather than individual.

Since the fire at Grenfell, the governance of the London Fire Brigade has changed. At the time of the fire, the LFB was overseen by and accountable to the London Fire and Emergency Planning Authority, LFEPA. LFEPA has since been abolished and, from 1 April 2018, the London Fire Commissioner was established as a corporate sole, legally responsible for exercising the functions of the LFB. The London Fire Commissioner is a functional body of the Greater London Authority. The role of the deputy mayor for fire and resilience was also created. Under the new governance arrangements, the Mayor appoints the deputy mayor and the London Fire Commissioner, sets the London Fire Commissioner's budget, and agrees its integrated risk management plan.

Following the Phase 1 report, the Mayor appointed Andy Roe as the fire commissioner. The Inquiry will recall that Andy Roe has first-hand knowledge of the issues that arose at Grenfell, as he served as one of the incident commanders and was responsible for revoking the stay-put advice and ordering the evacuation of the building.

One of the benefits of the governance change is that there is a more direct oversight by the Mayor. While

the London Fire Commissioner has operational independence, the Mayor is responsible for agreeing key London Fire Brigade strategies, monitoring performance, and setting the budget.

The deputy mayor has established a fire and resilience board attended by senior staff from the LFB to support her in her duties. This enables monthly scrutiny of LFB's performance, and provides an opportunity to challenge the LFB on its improvement work, and for the deputy mayor to be consulted on major decisions. It also meets for deep-dive sessions on particular issues that require particular scrutiny.

Additionally, the GLA's oversight has been increased by the formation of its fire team, which supports the deputy mayor with his governance and assurance work. 18 months following the Inquiry's Phase 1 report, the deputy mayor is reviewing effectiveness to identify further possible improvements. The aim is to ensure that LFB's learning does not come only from external inspections and enquiries, but rather from the review and assurance processes which should identify potential issues and instill a culture for continual improvement.

The London Fire Commissioner, with the support of the mayor, has published a transformation delivery plan to address the findings of the Phase 1 report and to

transform the London Fire Brigade in terms of policy, procedure, culture and training. It addresses not only the recommendations of the Phase 1 report, but also takes into account the December 2019 inspection report from Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services and considers the priorities for wider reform.

To assist in this transformation, the London Fire Commissioner has reorganised the leadership of the London Fire Brigade, which includes, but is not limited to, the appointment of Richard Mills as deputy commissioner to oversee operational matters; Fiona Dolman as director for transformation, to lead delivery of the London Fire Brigade's transformation programme; and Tim Powell as director for people, to lead improvements in training, organisational culture, and diversity.

To date, the London Fire Brigade has confirmed that it has completed 18 of the 29 recommendations aimed at the London Fire Brigade in the Phase 1 report, and the Mayor continues to ensure that the London Fire Brigade is taking timely action to implement the remainder of the Inquiry's recommendations.

While not commenting on the specifics, in preparing for Module 5 the GLA and the deputy mayor have reviewed

the relevant expert evidence. London Fire Brigade has been undertaking a range of improvement work relating to but not as a result of the issues raised by the experts as follows.

Professor Chris Johnson has highlighted the need for a systemic approach to ensure resilient communications for firefighters on the ground. The LFB is in the process of procuring new radios and breathing apparatus, having identified this as being necessary on its own learnings from the Grenfell Tower fire and reviewed in the light of the Inquiry's Phase 1 report. The GLA has requested assurance to be undertaken to ensure that new systems fully address the need for an integrated and evidence-based approach to communication to ensure the safety of the firefighters and the public.

Furthermore, and in accordance with the issues raised by Steve McGuirk on alternative approaches to firefighting in high-rise buildings, the London Fire Brigade have developed a new high-rise firefighting policy which has now been implemented. Discussion about this policy demonstrated the challenging position the London Fire Brigade is in, as its consultation document included a procedure for firefighters to go beyond the bridgehead in breathing apparatus sets not started up, aiming to extent the opportunity to rescue residents

affected by fire or smoke. Concerns expressed by the Brigade union led to an extended consultation on the new policy and the establishment of an independent health and safety advisory panel, whose recommendation to remove the procedure was implemented in the final policy. This highlights, Mr Chairman, the difficulty of balancing firefighters' and residents' safety in the current built environment.

Central government have indicated that they will promulgate national guidance to support all fire and rescue services in relation to these changes in policy. However, in the continuing absence of a governmental or nationally agreed position, whether through the NFCC or the national FBU, the London Fire Commissioner has taken the steps he can to identify and implement measures intended to equip crews to undertake effective action or rescue in such exceptional and extreme circumstances where there is savable life.

The final topic concerns Professor Torero, who has identified areas of concern in relation to fire safety inspections and the capabilities of operational commanders within the London Fire Brigade. These issues are being addressed by London Fire Brigade, for instance in its revised policy on the management of operational risk information produced after the Inquiry's Phase 1

report. The deputy mayor has recently received a report from the London Fire Brigade's new independent operational assurance adviser on the revised policy, who has endorsed it both as a policy and how it's being applied. These issues are complex and multi-layered, and the Mayor is confident that the London Fire Brigade will build on the significant steps they've already taken to improve the planning and response to emergency incidents in high-rise buildings.

Much has changed at the London Fire Brigade since the events being considered in this module. However, the Mayor is not complacent. Through his deputy mayor, and with the assistance of the GLA fire team, London Fire Brigade performance is being scrutinised and challenged to ensure that it progresses the recommendations made as a result of the Phase 1 report and is responding appropriately to the need for improvement.

The Mayor is also clear that there is more to do to strengthen assurance work both within the LFB, where a new assurance framework is being implemented, and at the GLA.

The Mayor publishes monthly Phase 1 recommendation progress reports to ensure that the London Fire Commissioner, and other organisations at which

recommendations were directed, remain transparently accountable to Londoners for making the improvements identified by your Inquiry.

The test of the transformation programme at LFB is how it works in practice, and a recent incident in London allowed for this to be examined. On 7 May 2021, the LFB attended a serious fire in a 19-storey block at the New Providence Wharf development in the London Borough of Tower Hamlets. While investigations into the fire are continuing, it appears that a fire breaking out in one flat spread to others via the building exterior. Around 125 firefighters attended the incident, with the first fire engine arriving at the scene approximately four minutes after the call to the London Fire Brigade. An evacuation of the block was carried out early in the incident, rescuing 35 people, with smoke hoods used to aid the evacuation and aerial appliances in attendance.

London Fire Brigade's new fire survival guidance and evacuation and rescue policies, developed since the Inquiry's Phase 1 report, were implemented during the incident, ensuring, for instance, effective communication between the control room, the incident command and the bridgehead. The fire was under control within around two and a half hours, two people were hospitalised, but there was no loss of life. This

incident demonstrates London Fire Brigade's ability to act on the lessons from Grenfell, but it also demonstrates that there remain significant fire risks in London's built environment.

Although a tragedy on the scale of Grenfell was avoided in this case, the recurrence of a fire in similar circumstances clearly illustrates that there has undoubtedly been a failure of regulation and its implementation. London has many buildings which have been built or modified using unsafe materials, and there are additional problems with unsafe installations. The risk present in London's built environment remains high. Many buildings are subject to interim safety measures, such as waking watch. The latest figures available at the time are that over 1,000 buildings have changed from a stay-put to a simultaneous evacuation strategy. The evidence that has been obtained as part of this Inquiry has clearly demonstrated that the issues that arose at Grenfell are far from unique to that building.

Unfortunately, the greater understanding of increased risk gained in significant part as a result of this Inquiry has not been sufficiently reflected in increased resources for fire and rescue services. Following the Phase 1 report, the LFB received £5.5 million to carry out fire protection activity from

the government. For 2021 to 2022, the funding was reduced to 3.9 million, with no guarantee that the funding will continue in future years. The Mayor is calling for this to become a permanent annual increase in funding from government until such time as London's built environment is safe.

The period between 2009 and 2016 saw significant reductions in funding for the London Fire Brigade and the closure of 10 fire stations and the reduction of 27 appliances. An independent review commissioned by the current Mayor, shortly after his election in 2016, found that no further reduction could be considered. It is clear that there can be no further reduction to operational capacity while parts of the built environment in London continue to carry with them such significant risks.

Ultimately, this is dependent on funding decisions made by central government. The Mayor has prioritised the London Fire Brigade and funded it at levels higher than those to which he is resourced by central government, notwithstanding the financial constraints faced by him as a result of the COVID-19 pandemic.

It is by demonstrating a commitment to the learning from Grenfell that we continue to place the BSRs central to the Inquiry and its work, and to reassure them that

much has changed and that change is continuing. Where there are more lessons to learn, the Mayor will do his best to ensure that those too are addressed diligently.

Thank you, sir.

SIR MARTIN MOORE-BICK: Thank you very much, Ms Studd.

Now, the next opening statement is going to be made by Mr Martin Seaward on behalf of the Fire Brigades Union.

Mr Seaward, I can see you, I think, and you can see us, I hope.

MR SEAWARD: Yes, indeed.

SIR MARTIN MOORE-BICK: Well, then, if you're ready to make your opening statement on behalf of the FBU, we shall be pleased to hear you.

Module 5 opening submissions on behalf of the Fire Brigades Union by MR SEAWARD

MR SEAWARD: Thank you, sir, and fellow panel members and assessors.

You have our written submissions and we will not repeat these today. We have already, and you are anyway fully aware of the issues that are going to be canvassed in Module 5. I won't read out the list, but they all concern the fire and rescue services.

This renewed focus on the fire and rescue services should be kept in proper perspective. The

Grenfell Tower disaster was an extreme event. It was caused by the failures of government, organisations and persons who were nothing to do with the fire and rescue service, although this was regrettably facilitated by the failure of those in leading positions within the service to challenge or make the case for public and firefighter safety. This was a major failing of chief fire officers and their organisations and of those who advise government on fire policy.

I will list the five main causes as the FBU sees it.

Firstly, the not fit for purpose regulatory regime that left the door open to the failed design and build of the refurbishment, eg removing fire certificates, the demeaning of health and safety in favour of business interests, and the constant pressure to cut red tape, the one-in, one-out and then one-in, two-out.

Secondly, the refurbishers. The owners, RBKC and TMO, the design team, fire engineers, manufacturers of cladding materials and the construction industry which variously gamed the system and failed to think fire, and between them installed a new rainscreen cladding system which rendered the tower a combustible death trap and failed to provide correlative fire safety measures.

Thirdly, stay put. This is a feature of building design and is not the creation of the fire and rescue

service. It should never have been applied to Grenfell Tower after the refurbishment destroyed its compartmentation, mainly by installing a combustible rainscreen cladding system. In light of what we now know, the building should not have been occupied at all with a stay-put evacuation strategy.

Fourthly, the LFB was not advised of the increased fire risk presented by the new rainscreen cladding system on Grenfell Tower following the refurbishment, and was unaware of its capacity to cause rapid insidious fire spread over the whole of the building, inside and out. The total building failure at Grenfell Tower put firefighters in an unprecedented, impossible situation on the night of the fire that we know as the Grenfell Tower disaster.

If I can turn, sir, to the order of modules, the intense focus on the emergency response in Phase 1 and now again in Modules 5 and 6 of Phase 2 risks losing its perspective. The FBU asks the Inquiry to look at the underlying systemic causes of the Grenfell Tower disaster, avoid condemning individuals in the LFB, and recognise that the LFB was trying its best to provide a service to keep the public safe from fire in the face of acute challenges from the government.

These challenges include: firstly, deregulation,

which limited the extent to which new building materials and methods could be understood, regulated and taken into account for firefighting purposes; secondly, austerity cuts, which reduced staff numbers in key public sector departments, including building control, fire safety departments, operational crews, and control; thirdly, attempts at privatisation, draining already limited resources; fourthly, the government's fragmentation of the fire and rescue service and then providing insufficient national leadership, guidance and scrutiny from ministers, the DCLG and chief fire officers in the Chief Fire Officers Association, which later became the National Fire Chiefs Council, the NFCC.

These failings originate because of the failed government policy and the failure of the then Mayor of London, now Prime Minister, and chief fire officers to stand up for the service, for public safety and for standards, resulting in a failure to identify emerging risks, a failure to plan adequately to respond to those risks, a failure to protect the service, see particularly the cuts imposed on the fire inspecting officers.

The FBU has believed from the outset that the Inquiry could better assess firefighting procedure and training after looking first at all the regulatory and

guidance context within which the fire and rescue services developed their policies and procedures. The lack of national guidance in respect of evacuation is well known to all those who listen to the Inquiry. The FBU asks note be taken also of the dearth of national guidance under section 21 of the Fire and Rescue Services Act 2004 or otherwise on other issues of importance to all fire and rescue services. Notably, there was no national guidance to local fire and rescue services, including London, on the requirement for responsible persons to prepare evacuation plans, especially PEEPs; the problems facing fire and rescue services in the fields of communications; the growing risk of new buildings materials and the increase in prevalence of rainscreen cladding systems on existing, often old high-rise residential buildings; the increasingly prevalent breaches of compartmentation in existing high-rise, despite universal dependence on stay put; and failing to advise on the recommendations to retrofit sprinklers.

Sorry, I seem to have lost my place here. I have pressed return and it has all disappeared. It'll come back in a minute.

(Pause)

Sir, I was looking at the lack of national guidance

and citing some examples. Sir, I had mentioned on the recommendations to retrofit sprinklers, and also on the requirements for responsible persons to prepare evacuation plans, especially personal emergency evacuation plans, and on the various recommendations made by coroners and other proper authority following earlier tragedies, as well as on when and how to evacuate in a fire.

The FBU has read the criticisms, some trenchant, of the London Fire Brigade which are made in other opening submissions and agrees there have been significant failings in the fire and rescue service. These failings do not lie with the firefighters in local stations, control room staff or with local fire safety teams, nor do they lie with the FBU, which has challenged these failings every step of the way. But module 5 will be heard before much of the relevant evidence, including oral examination of the experts and the senior fire officers, including the present London Fire Commissioner and his two immediate predecessors. The FBU urges all those listening to the Inquiry hearings, including especially the panel, not to pass judgment on the fire and rescue service, and particularly the individuals therein, before hearing all the evidence and considering the wider picture outlined above.

The LFB is not a failed service. It has continued to provide a good service in face of the destructive effect of ministers' deregulatory agenda, privatisation, eg in the control room, and austerity cuts.

The FBU reserves its position on all Module 5 issues until closing submissions. We ask the Inquiry to consider leaving closing submissions for Module 5 until the end of Module 6 so that the core participants can consider all the evidence adduced in these two modules when finalising their submissions on the overlapping issues to be covered.

The Inquiry does not currently propose to call the Prime Minister, Boris Johnson, to testify about his period as Mayor of London, nor to call Matt Wrack, general secretary of the FBU. We urge the panel to keep an open mind on the desirability of calling both these witnesses in Module 6. As to the former Mayor, he repeatedly overrode the London Assembly to impose swingeing cuts on the LFB. As to Matt Wrack, firefighters, particularly operational crews, would otherwise have no one to speak for them in Modules 5 and 6.

Moving on to the role of the FBU.

It may assist those listening to these submissions to explain briefly what the FBU does. The FBU is

a trade union, a voluntary organisation of workers funded entirely by member subscriptions. 90% plus of UK firefighters belong to the union, including control staff and officers. The union negotiates and collectively bargains with employers on their behalf on pay, hours, conditions, pensions, health and safety and discipline. It represents individuals who suffer injuries or have other problems arising out of their work, and the bereaved families of firefighters who die in the line of duty, whose numbers have tragically risen dramatically over the last 20 years. It also represents the voice of firefighters with ministers, mayors, other politicians, chief fire officers and their national bodies.

The FBU campaigns for investment in the fire and rescue service and for wider issues, eg on climate change. The FBU has campaigned to modernise and improve standards in the UK fire and rescue service for the benefit of its own members and of the wider public for more than 100 years. However, the FBU wants to make it clear, it's not in charge of the fire and rescue service. It ought not to be conflated with the management of the fire and rescue service in London or nationally. On the contrary, the FBU was formed in London precisely in order to defend and promote

firefighters' conditions against LFB management, and especially in recent years, the FBU has often been attacked, ignored, excluded by management and government.

For example, since 2004, the FBU has been excluded from participating in official bodies like the Central Fire Brigades Advisory Council and the Building Regulations Advisory Committee. It has been so excluded both by the restructuring of 2004, which deprived the FBU of its statutory right and duty to participate at this level, and by the attitude of those administering these bodies thereafter.

In particular, the FBU has had no legal responsibility to look out for emerging risks like cladding. That was the responsibility of the building owners and clients, those engaged in the cladding industry, the government, particularly the DCLG, the regulatory bodies under the Building Regulations, the Housing Act, and the Fire Safety Order, such as the BRE, the BBA, building control, housing authorities, and fire and rescue services, and the national bodies of the fire and rescue service, such as CFRA, CFOA and NFCC. Within the LFB, or any fire and rescue service, it was no part of any firefighter or control room staff's responsibility to look out for such emerging risks in

the built environment.

Turning if I may to the calls for the wholesale restructure of the fire and rescue service.

Core participants and some experts in their submissions to this module have called for the wholesale restructure of the fire and rescue service. The FBU wants to ensure that the lessons of Grenfell Tower are learned, that a similar horror never occurs again, and supports the work of organisations like Inquest that have called for a national oversight body to ensure that recommendations made at the inquest and inquiries are implemented. We agree such improvements are needed in the FRS and call for the highest professional standards in the service. That is what the FBU campaigns for daily.

As a trade union, it has consistently called for reforms, for improvements to standards and training. However, it is the experience of the FBU that so-called reforms in the fire and rescue service have, rather than improved, eroded the fire service, a process that has been echoed across the public services in the UK. We urge that these reforms imposed from above and not challenged by the leadership of the fire and rescue service ought to be fully investigated by the panel.

The last attempt at wholesale restructuring of the

fire and rescue service in 2004 resulted in, firstly, the abolition of national standards of fire cover and emergency response and their replacement with the locally determined integrated risk management planning process, which I'll refer to as the IRMP process.

Secondly, the failure of that IRMP process, which was hopelessly fettered by its link to budgeting and became inextricably tangled in the struggle of hard-pressed local authorities to make savings in the face of austerity cuts. Decisions about the provision of fire and rescue services across the country were driven not by risk assessment, as they should have been, but by the need to find savings in austerity. This has led to huge cuts to funding, leading to significant reductions in staffing, including in specialist fire safety teams.

Thirdly, the resulting and near constant attempts to cut the numbers of staff, equipment and stations, to alter terms and conditions of service, to avoid the payment of pension benefits, played out in 47 different brigades, have absorbed the efforts of local authorities, senior management and the FBU and distracted them from new challenges confronting the fire and rescue service.

Fourthly, sidelining and ignoring the FBU wherever

possible instead of engaging fully with representatives of the workforce.

Fifthly, the abolition of national appointment and promotion standards.

Sixthly, the abolition Her Majesty's Fire Services Inspectorate.

The FBU contends this led to the consequential dearth of research development and national guidance for brigades into common problems, some central to the GTI, including those listed above. The FBU contends that the new national bodies that arose have failed to speak truth to power and, as a result, have played a leading role in downgrading fire safety, leaving the public at risk.

CFRA, CFOA and NFCC did not address issues highlighted by fires where compartmentation failed for various reasons, including the need for national research and development of solutions to the national problems of how to evacuate a high-rise, how to communicate effectively when fighting fire in a high-rise and how to augment water flow to achieve a sufficient flow rate. Neither did they press the DCLG for the resources to carry out this work properly.

On communications, they failed to address the fundamental problems as set out by Professor Johnson,

and produced no national guidance to benefit all fire and rescue services, instead leaving the work to individual fire and rescue services to struggle ineffectively with this recurring problem.

They failed to advise government on the need to revise its guidance under section 21 of the Fire and Rescue Services Act 2004, the fire and rescue national framework, and on the failure of the IRMP process properly to assess risk. Instead, the IRMP was used, as I've said, purely as a budgetary device to make year-on-year savings.

In short, these reforms only made things worse, hindering the efforts of firefighters to tackle high-rise fires.

Moving on to Steve McGuirk.

The FBU opposed Steve McGuirk's appointment as the firefighting expert to the Inquiry and is critical of his report. His report says evacuation was possible, but he doesn't explain how it could have been done. He has side-stepped that difficult question, "How would you do it?", by agreeing with the Chairman that firefighters should have made it up on the night.

He is part of the problem. He was a chief fire officer from 1999 until 2015. He was also president of CFOA just before the Lakanal House fire in

2009. He was a leading national figure among chief fire officers and an adviser to the Local Government Association between 2009 and 2014, when it produced its guidance on high-rise building fire safety. He also chaired the practitioners forum during its brief existence.

Neither Mr McGuirk nor his two brigades developed learning on evacuation and stay put, or assessed risks of catastrophic building failure, or warned government of cladding risks, or challenged the deregulation of the fire safety and building control regime or alerted government of its dangers. He must therefore, submits the FBU, be held to account himself for the failure of CFOA and the NFCC to assess the risks of catastrophic building failure and to warn ministers of the dangers of cladding in relation to hazards. He should be asked why CFOA oversaw a deregulated fire safety regime and failed to warn ministers or the public that such a regime was likely to lead to a disaster.

On evacuation specifically, Mr McGuirk agrees with the Chairman's conclusion that, by 1.30 at the earliest and 1.50 at the latest, it was clear that revoking the stay-put strategy in place and moving to an attempt to evacuate the tower was the only realistic way of minimising loss of life and serious injury, and that

steps ought to have been taken to carry this out. He so agrees notwithstanding he acknowledges there was no national operational guidance or direction that provided advice as to how to evacuate a high-rise building, and he reports no practical guidance in the UK as to how evacuation should be carried out, saying:

"I have also considered a number of international procedures, but here too I have not located any explicit operational evacuation procedures."

Sir, there are still no agreed operational guidance four years after the fire. The firefighters on the night had no procedure and no training for such a situation. On the other hand, they did have a procedure and training in the defend-in-place strategy for high-rise with a stay-put evacuation strategy, and they carried it out. Therefore, the FBU contends the firefighters on the scene cannot be blamed or criticised for any failure to evacuate.

Turning now to Professor Torero on not blaming the fire service.

Professor Torero delivered a lecture at the Warren Centre fire safety engineering project in Australia on 24 July 2018, when he expressed why it is wrong to blame firefighters and the fire and rescue service for the Grenfell Tower disaster. I'm quoting

him directly now:

"What ended up happening in Grenfell was that the engineers delivered the building. Those engineers did not exercise competency adequately. Their competence was not consistent with the complexity of what they were doing, and they delivered a building on fire to the fire service that the fire service could not manage. It wasn't the fire service failure to address the problem of the building, it's our failure to actually deliver the building that the firefighters could actually work on. So the expectation that the fire service should have understood building performance, the expectation that the fire service should have been able to manage the fire, is a really unfair expectation. Nevertheless, today we're sitting in front of the television watching the testimonies of the firefighters at Grenfell, and we're blaming them for what they were not able to handle. We expected them to come and fix the problem for us. We created the mess, and they couldn't fix the problem, and now we want to blame them."

Professor Torero now calls for reforms of the fire and rescue service. The FBU agrees a change of culture is needed, particularly for ministers, policy advisers and chief fire officers nationally and at local level to confront, not avoid, difficult issues like

communications problems, and to learn from recommendations made by proper authority, usually following earlier tragedies.

The way to restore a fire and rescue service which lives up to these rightfully high expectations and retains public confidence is (a) to establish national institutions with meaningful trade union representation to assure appropriate guidance is developed and given to local fire and rescue services; and (b) to secure adequate resources for local fire and rescue services to discharge their functions.

Such national institutions might include, as has been recommended by Professor Johnson, for example, a national framework for fire safety research, a national framework for operational firefighting research, a national fire safety investigation board, a modern equivalent of the Central Fire Brigades Advisory Council, a national statutory body to include genuine trade union representation.

If reforms mean private sector takeover, attacking the workforce and blaming the victims, that will let those in power off the hook and fail to confront the building crisis.

Moving on, sir, to Dr Paul Grimwood.

The FBU respects Dr Grimwood's work and notes that

he himself recognises that the practical application of the RICE mnemonic to a situation such as Grenfell is necessarily limited. Dr Grimwood says it is important to emphasise that RICE is not a policy or procedure, but a command decision-making tool that is primarily an aide memoire used to alleviate command stress and prompt a pre-determined, rapid, analytical thought process. It was not an alternative evacuation policy.

The pro forma Kent standard operating procedure, known as the Kent SOP, bears no indication that it had actually been adopted by Kent or any other fire and rescue service by the time of the Grenfell Tower disaster, or even now. The national Fire Brigades Union were not consulted with the pro forma Kent SOP and received no information from any FBU representatives in the southeast region about it. If Kent or any fire and rescue service had sought to implement the pro forma Kent SOP, they would have been obliged to consult with the FBU because of the increased risk to firefighters if required to work above a fire in a high-rise residential building. Subject to evidence that might emerge in Module 5, it's unlikely that the pro forma Kent SOP was introduced as a procedure before the Grenfell Tower fire and more likely that it remained a pro forma.

Neither the Kent SOP nor RICE provides help for

vulnerable people with mobility problems and may lead to injuries and deaths of firefighters. In any event, firefighters and control staff whom we represent in this Inquiry and their FBU representatives, both in London and nationally, were unaware of the RICE mnemonic or the pro forma Kent SOP until long after the fire.

There are still no national guidelines on evacuation. Since the fire, the London Fire Commissioner has introduced a revised PN633 which Anne Studd QC referred to a few moments ago, which would have required firefighters to work above the fire in a high-rise without starting up their breathing apparatus sets, as has been the accepted safety practice for more than half a century. The FBU have highlighted the unacceptable risks to firefighters' health and safety which the new policy endorsed. The FBU's concerns were upheld by an independent arbitrator.

The London Fire Commissioner accepted the finding of the arbitrator and modified the proposed procedure which is now being introduced in London. This is to the credit of both the LFC and the FBU, both of whom have listened and learned from this Inquiry and are determined to improve the fire and rescue service, including the operational response to high-rise buildings.

Those who wish to demean health and safety may see the FBU's intervention as obstructive or being difficult, whereas it was in fact both reasonable and well-founded, and born out of the FBU's long experience of supporting bereaved families of firefighters who have died fighting fire, including in high-rise buildings, for example Shirley Towers and (inaudible) Court.

The LFB should not be blamed for failing to devise an evacuation policy. As we submitted in Phase 1 and as remains the FBU's understanding, no other fire and rescue service had an evacuation plan at the time of the fire, notably not greater Manchester Fire and Rescue Service, where Mr McGuirk was a chief fire officer from 2009 to 2015.

Even now, over four years after the fire, the national steering group set up by the Home Office, MHCLG and the NFCC to implement the Chairman's recommendation 12A has still not reported with national guidelines for evacuating high-rise. The Chairman recommended that the government develop national guidelines for carrying out partial or total evacuations of high-rise, such guidelines to include the means of protecting fire exit routes and procedures for evacuating persons who are unable to use the stairs in an emergency or who may require assistance, such as

disabled people or older people and young children. So far, very little detail has been provided about the work of this steering group, see for example the last update of March 2021.

Ensuring excellent standards in the fire and rescue service needs the sustained commitment and leadership of central government to set and maintain standards. In light of this delay, the four years' delay since the fire and two years since the Chairman's recommendation, the FBU asks: how can Watch Manager Dowden possibly be criticised for not having devised an evacuation plan for Grenfell Tower on that terrible night?

Turning then to the criticism in your Phase 1 report, sir, of Watch Manager Dowden for not deciding to revoke stay put and move to total evacuation of the tower by 1.50.

The FBU submits that some of the Chairman's findings in his Phase 1 report relating to the actions of firefighters on the night of the fire may need to be revisited in light of the evidence heard in Phase 2. One such finding is the criticism of Dowden for failing to evacuate the tower by 1.50, when he handed over control to Station Manager Walton. The Chairman found that it was or should have been obvious that only a supervised mass evacuation would minimise the number

of casualties, and he describes the same window. By 1.50 at the latest, found the Chairman, he should have realised that the fire had begun to enter the interior of the building and that compartmentation, which underpins the stay-put advice, had been breached. In those circumstances, he should have spoken to Operations Manager Norman in the control room and, having obtained the most recent information, should have decided to evacuate the building and set about ensuring through the control room that all calls from the building were told to leave, come what may.

This is a finding which the firefighting community whom I represent, both the FBU members who attended or who were on duty that night and the FBU and its wider membership, and so far as I'm aware the employer, the LFB or the London Fire Commissioner, which they cannot accept. It is not out of any disrespect for the Chairman or for the process of the Inquiry, but from their own knowledge and experience, they believe that Watch Manager Dowden and his senior colleagues around him at the incident ground should not be criticised for not ordering a full evacuation of the tower by 1.50.

We wrote to the Inquiry on 9 August 2019 itemising some of the difficulties with a supervised mass evacuation. I won't repeat those here. The FBU

respectfully submits that Watch Manager Dowden neither knew nor should have known some of the key factors which the Chairman considered should have triggered his revocation of stay put and started him planning to evacuate the tower. So, these key factors -- I'm about to run out of battery.

(Pause)

So turning to those factors, sir, Watch Manager Dowden did not know the cladding fire had spread out of control by 1.50. The spread of fire was unusual, since other fires of this kind had tended to burn out after reaching the top of the building. Watch Manager Dowden and his colleagues could not have predicted the rapid fire development, specifically that fire would race across the crown and accelerate lateral fire spread. Untrained in how to fight cladding fires, he continued to expect the fire would be extinguished by firefighting operations and was still planning to fight it at 1.50, when he handed over command.

Watch Manager Dowden could not reasonably have been expected to know his firefighting plan could not succeed until after he had at least seen the ineffectiveness of the aerial, which didn't start applying water until about 1.47 and continued thereafter until 2.05. If an aerial had been included in the PDA Mr Dowden may

have learned of the futility of trying to fight the external fire over 20 minutes before it became apparent on the night.

Moreover, Watch Manager Dowden and his colleagues on the night were not provided with the tools to enable him to make or them to suggest that decision which had never been made before in the fire and rescue service, let alone by a watch manager. The Chairman has found institutional failings. These cannot be laid at the door of Mr Dowden and his colleagues on the night for all the reasons I have outlined.

Additional to the systemic failings already cited, essentially the lack of an evacuation procedure, policy or training in it, there was no responsible person's evacuation plan prepared by RBKC or the TMO, not even vulnerable persons, nor any practical guidance or even information about who or in which flat such persons were, nor any training or drills for residents on how to evacuate the building which would have identified safe places to gather and practised special arrangements for vulnerable people.

There was no training on how to go about conducting a section 7(2)(d) visit, on how the materials used in exterior façades might behave in fires, and Mr Dowden could not be expected to assess the risks created by the

cladding system or how they might relate to other aspects of the building's fire safety measures, nor when to bring in the expertise of a fire risk assessor to assist with that task, nor how to assess the risks thereby uncovered. These were failings of the LFB's senior management, not of Mr Dowden. His training didn't equip him to understand the nature of the fire or how best to combat or contain it, nor did it equip him to decide whether to undertake an evacuation or how best to do so, nor how to evaluate the situation, revoke stay put, plan an evacuation and then implement it.

Mr Chairman has found the knowledge that high-rise buildings constructed on the basis of effective compartmentation itself created a barrier to thinking about evacuation, and so if he had considered revoking stay put and moving to evacuation, he would have had to improvise to carry it out, improvise in the face of formidable practical difficulties and despite the dangers that would arise, including a risk to life.

The reduced frequency which firefighters have been called upon to attend operational incidents was not compensated by any increased training, let alone realistic training. In addition to the formidable difficulties impeding evacuation, as found by the Chairman, for example there being no reliable way to

communicate with the residents, should be added the unavailability of a fire lift, which deprived crews of the chance to get to the upper floors quickly via the lifts and materially limited the height to which firefighters could physically travel to initiate or assist with evacuation.

Professor Johnson reports on the unreliable communication systems used on the night. The problems were already known to the Chairman and all who listened to the evidence in Phase 1, but Professor Johnson has explained how these communication failures led to reduced situation awareness. Importantly, BA crews up the tower were unable reliably if at all to communicate with the bridgehead, nor bridgehead with the incident commander and vice versa. There were adjustments that could have been made, eg to reconfigure the BARIE headsets to use the more powerful UHF radio, but the firefighters were not trained to do this. Watch Manager O'Keeffe pointedly lamented that he could have done with an Airwave radio.

Examples of early communications failures are legion, but a few illustrate the point. By early, I mean in the period up until 1.50. During the attempt to rescue Jessica on floor 20 between 1.34 and 1.57, Firefighter Dorgu tried unsuccessfully to radio the

bridgehead but couldn't get through.

Watch Manager Dowden did not know of any FSG calls until after 1.35, when the first admin call to CU8 started, and not until the first list of three FSG calls was thereafter taken by Watch Manager Kentfield to Dowden when he was talking to Station Manager Loft, and that's estimated at about 1.40. The initial service requests sent to the incident command pump had not been picked up and there was no digital record of them. The incident command pump wasn't manned because all the firefighters were busy elsewhere.

Firefighters Cornelius and Murphy, the first crew deployed by the bridgehead to respond to an FSG call at around 1.51, tried repeatedly to contact the bridgehead on their handheld radios to say that they would not be able to bring the people down, but they received no answer and heard no radio traffic. They didn't debrief to bridgehead until around 2.19, their end of wear time. Sir, Mr Dowden was unaware before 1.50 that the BA deployments to rescue FSG calls had been unsuccessful and they had been unable to reach the uppermost floors.

He reasonably tasked Station Manager Loft with co-ordinating the emergency response to FSG calls in line with procedure PN790 and as discussed with Station Manager Loft. He couldn't have been expected,

we submit, to obtain information about the success of search and rescue deployments in response to FSG calls before he handed over command at about 1.50. We respectfully say that's contrary to the Chairman's finding at paragraph 28.21 of the Phase 1 report.

Having tried but failed to radio the bridgehead, Crew Manager Stern and Firefighter Hippel later informed Watch Manager O'Keeffe at the bridgehead at about 1.38 of the poor conditions on floor 16 —— you will remember the vivid description, "It's fucked" —— and of the failed rescue attempt on floor 16, with one person still unaccounted for. Watch Manager Dowden denies learning this critical information, which was likely due to communications problems.

At his handover to Station Manager Walton shortly after 1.50, Watch Manager Dowden didn't have information about any of the operations inside the tower and there was too much traffic on the radio to get a message to the bridgehead. This is likely to be true because Watch Manager Dowden was a patently honest witness and because there were difficulties communicating from outside the tower to the bridgehead.

In light of all the circumstances, including the new factors identified above, the FBU respectfully asks the Chairman and/or the panel as he and they think fit

to review his criticism of Watch Manager Dowden for not deciding to revoke stay put and move to evacuate before 1.50. It was not obvious; on the contrary, it ran counter to all his training and experience.

Concluding comments.

Any future reform of the fire and rescue service must be the result of proper engagement with and consultation of the unions representing the workforce. The FBU fully supports upskilling people who do the work of the FRS from top down. It fully supports the greater integration of the fire safety department into proper pre—planning and preparation for operational response. It fully supports the proposals for achieving better communications at incidents, better use of existing water supplies, centralisation of fire service research, independent incident investigation and the collation of reports.

But the FBU warns that further structural reform of the fire and rescue service will be seized upon by central government as an opportunity for further cuts, for further privatisation of parts of the fire and rescue service and to bring in business leaders who may not themselves have been exposed to all the dangers of firefighting and who may therefore appear to or actually will underestimate the value of health and safety which

the FBU has fought for over 100 years to promote.

The public services sector is unsuited to privatisation, as seen in the probation and prison services. Yet it is repeatedly attempted in the fire and rescue service, eg the failed attempts to privatise the management of the LFB's fleet of vehicles, with AssetCo going into liquidation, or to privatise control rooms, which ended in chaos, wasting millions of pounds, taking up valuable control staff time along the way, as explained by Scott Haywood and Jo Smith in their witness statements in Module 5 and as exposed by the national Audit Commission.

The Fire Brigades Union calls on the Inquiry to assess the corrosive effect of the restructuring the fire and rescue service has been subjected to in recent years by investigating the effects of fragmentation of the dearth of national research and resulting guidance and of austerity cuts on the fire and rescue service over the last 15 years.

Those who oversaw these destructive changes cited above should not continue to be the architects of further reform. The FBU actively supports such positive change when possible. It has done so in the past, for example in developing generic risk assessments like GRA 3.2 for high—rise firefighting, in the development

of community fire safety work and dynamic risk assessments, in welcoming women and people from ethnic minorities into the fire and rescue service, encouraging equal treatment and challenging discrimination, and will do in the future. The FBU believes there is a need for major change and improvement in the fire and rescue service and has made this case for many years. The union is committed to such changes to improve public safety and the ability of firefighters to prevent fires and respond safely and effectively when fires happen.

Thank you, sir, and your colleagues, for allowing us to make this statement.

SIR MARTIN MOORE—BICK: Thank you very much, Mr Seaward.

The next statement is going to be made by Mr Louis Browne Queen's Counsel on behalf of the Fire Officers Association.

Mr Browne, do I have you there?

MR BROWNE: I am here, sir. I can see you and your colleagues and I can hear you.

SIR MARTIN MOORE—BICK: Good, we can see and hear you now.

So we are ready for you to make your statement, if you would like to do that now, please. Thank you.

Module 5 opening submissions on behalf of the Fire Officers Association by MR BROWNE

MR BROWNE: Thank you very much.

While it is recognised that the Chairman made findings in his Phase 1 report relating to the action of firefighters on the night of the fire, we respectfully submit that those findings may need to be re-evaluated depending upon the evidence heard in this module and in Module 6. Accordingly, and insofar as specifically relevant to the Fire Officers Association and Richard Welch, emphasis will again be placed on the wholly impossible situation firefighters and those in command faced on the night of the fire.

The following must be very carefully borne in mind: those in LFB command positions inside and outside the tower were motivated solely by taking decisions that would, in their honestly held view, facilitate the rescue of those trapped in the tower. In considering the actions of all LFB personnel on the night, it must at all times be borne in mind that this tragedy was wholly unprecedented in its scale and complexity and the enormous challenges it posed.

The fire was a multistorey external fire that caused a multistorey internal fire. Crucially, on the night of the fire, none of the firefighters, including those in command positions, had any knowledge that the tower was clad in such highly combustible rainscreen cladding. The evidence given by all firefighters who commented

upon it was that the fire at the tower was wholly outside the experience of all personnel who attended.

Turning then, sir, please, to the condition of the tower immediately before the fire.

Dr Lane's opinion is cogent on these issues. In her supplemental report, she states as follows. Based on the relevant test evidence, the construction materials forming the cladding, when considered either individually or as an assembly, did not comply with the recommended fire performance in ADB 2013 as applicable. The entire system could not adequately resist the spread of fire over the walls, having regard to its height, use and the position of the building. Specifically, the assembly failed adequately to resist the spread of fire to an extent that supported the required stay-put strategy for the tower. The assembly failed adequately to resist the spread of fire to an extent that supported the required internal firefighting defend in place firefighting regime.

The cladding presented an extreme and primary hazard. In the event of any internal fire starting near a window, there was a disproportionately high probability of fire spread into the cladding. The type of materials in the cladding and how they were arranged around the window in the kitchen contributed to the

speed at which the fire spread from the flat of fire origin to a multistorey external fire within the rainscreen system. The consequence of this was that any individual flat of fire origin was no longer in a separate fire rated box as required. The compartmentation required in the building was breached by the ability of the fire to spread on the external wall from that compartmented flat to the next. The required single safety condition, stay put, was not provided for as was required as a result of the system installed during the refurbishment.

Dr Lane did not consider it reasonable that, in the event of the installation of a combustible rainscreen system on a high-rise residential building, the Fire Brigade should be expected to fully mitigate any resulting fire event. This was particularly so where the Fire Brigade had never been informed that a combustible rainscreen system had been installed.

Her overall conclusion was that there were multiple catastrophic fire routes created by the construction form and construction detailing that was used. The cladding as configured at the tower rendered it unsuitable for a stay-put policy. Once fire was within the cladding, there was nothing to impede the spread of fire and smoke around the building and this, in her

words, created a condition for a catastrophic fire event to occur.

As stated, none of those were matters that those making command decisions on the night were aware of. The single stair, lobbies and the fire safety provisions therein were not ever designed to create a safe escape route or a safe working environment in a whole-building fire. The design approach for high-rise residential buildings is or ought to have been based upon inhibiting that from occurring.

The net effect of all of this is that those LFB personnel taking command decisions on the night had no prior opportunity to consider their firefighting and rescue tactics, as well as any evacuation guidance to the residents having regard to how the fire was likely to behave or spread once on the exterior of the building.

The impossible scale and nature of the task facing both residents and firefighters that night was encapsulated by Dr Lane in her supplemental report, when she said that it was her opinion that the conditions created difficult and at times life-threatening conditions for the LFB. The conditions greatly restricted their ability to implement the standard processes and procedures regarding firefighting once the

fire spread beyond flat 16. Further, the single escape stairs and its lobbies became the single most important life safety feature. The failure of this life safety feature meant that after 01.40, and in particular 2.00 am, worsening conditions limited the ability for rescue to occur and created more and more barriers, or perceived barriers, for residents to overcome in order to self-evacuate.

Since the stay-put strategy is a safety building design condition, the LFB and its officers in command reasonably relied upon this building design condition on the night of the fire. There is no building design function in a high-rise residential building provided to enable firefighters in the UK to communicate any change in their evacuation or rescue guidance from within the building.

Then please, sir, just some points concerning Mr Welch's role as fire safety commander on the night.

As you know, he arrived at the bridgehead at 2.16. At that time it was on the second floor. He spoke with Watch Manager O'Keeffe and Watch Manager De Silvo concerning the plans. He was concerned that the plans were the correct strategy and appeared to be operating successfully. Watch Manager O'Keeffe requested Mr Welch to obtain all available EDBA resources, and this he did

by communicating that via fire ground radio with CU8.

He ensured that when the bridgehead was moved to the third floor, FSG information which had been collated on the second floor, the results of FSG calls, were transferred to a wall on the third floor. He satisfied himself that FSG calls were being processed properly and, when sufficient information was to hand, prioritisation was given to the rescue of the young and the elderly.

According to Mr Welch, there was not a point when there was insufficient numbers of EDBA wearers to be deployed safely into the tower. At the point in time when he was fire sector commander, there were frequent difficulties in firefighters being able to reach higher floors, and it was for this reason that he did not consider that stay put should be abandoned. The reasons would have been, to use his words, unsurvivable, and further, conditions were, again using his words, getting worse by the minute.

The decision to abandon stay put was communicated by Mr Welch to GM Cook at a point when the bridgehead was on the ground floor and so after 3.08. At about 4 am or thereabouts, Mr Welch and GM Goulbourne devised and implemented a plan for systematic searching. This involved committing SDBA wearers for firefighting

starting on the floor of the fire and then pushing EDBA wearers to get as high as they could in the building. Despite the conditions, firefighters attempted to push as high up the tower as was possible.

In addition, Mr Welch attempted the use of positive pressure ventilation. However, that did not work. The use of secondary BA sets was not a viable option to assist residents who needed rescuing and assisting with evacuating the tower and that was for these reasons: firstly, they were not designed for that purpose; secondly, they are not for use in firefighter emergencies -- three were declared that night -- and, thirdly, there was an insufficiency of secondary sets.

Can I then move on, please, sir, to deal with some comments concerning Mr McGuirk's report, and in particular the comment that he makes at page 61, paragraphs 166 to 167, that there was no request to mobilise either a high volume pumping unit, HVP, or hose laying vehicle even as a precautionary measure.

It is our submission that, even had such a request been made, no operational advantage could have accrued due to the locations involved, traffic conditions and the following: the nearest HVP was stationed at Barnet, a distance of over 13 miles from the tower. Given the traffic conditions and speeds likely to be achieved,

this would imply 20 to 30 minutes' travel to the incident. Additional time would be required in locating and being briefed by the incident commander, identifying a suitable water source, planning the route and deployment to that water source. In the case of Grenfell Tower, the closest sustainable and inexhaustible open water supply was the Grand Union Canal.

Secondly, on deployments the pumping unit would be located by the canal. That would be approximately a mile from the incident. As the pump carries 2 kilometres of hose, a supplementary hose box would be required to secure the supply. Locating that unit would have been virtually impossible given the gridlock in surrounding roads and streets. That was extensive and impenetrable.

There can be no doubt, in our submission, that an operation to lay one mile of hose along the route would have proved impossible and necessitated a lengthy operation, potentially delaying any delivery of water to the tower by a further two hours at least.

Next, a hose laying lorry would encounter similar issues, as this vehicle also lays 90-millimetre hose from the back of the vehicle as it drives along, therefore needing a clear carriageway. This vehicle

could not operate effectively in gridlock conditions. Again, had an HVP been successfully deployed, the first delivery of water to the tower would have been delayed by hours.

As regards the Kent Fire and Rescue standard operating procedure, the SOP, as has been pointed out by Mr Seaward, RICE2 is simply a prompt or mnemonic; it is not a policy or procedure and offers no practical advice on how a full or partial evacuation is to be achieved in any situation. Certainly after 1.58, RICE was of extremely limited relevance to the situation at the tower, since in the initial stages of the fire, which began on the 4th floor, 80% of the occupants were above the fire ground. Adopting a RICE model, floors 5 and 6 might have been considered primary areas needing to be evacuated due to an imminent danger from the fire. However, in the time required to evacuate those floors, the speed and ferocity of fire spread was such that, in the meantime, many parts of the stairwell would have been compromised. The core activity underlying RICE is the maintenance of the integrity of the means of escape and that was not achievable.

Given the speed and ferocity of fire spread, it would not have been possible to determine, firstly, how the various parts of the stairwell, all subject to

fluctuating conditions, might be protected and by whom; and, secondly, how hoses might be deployed, at which selected levels, at which times and with what objective.

In 20 questions on RICE, it is estimated that it would take 20 to 40 minutes to evacuate 350 people from a 20−storey building in tenable conditions and average age and fitness, with evacuees in single file on the stairway. Thus, whilst it may have been theoretically possible and therefore it can be said that attempts should have been made to carry out an evacuation, the RICE evacuation model would be compromised due to (a) the absence of any effective means of communicating to residents any evacuation plan, (b) fire compartmentation had been subject to multiple failures, (c) conditions throughout sections of the stairway were not tenable, the integrity of the stairway had not and could not be maintained, and (d) while some occupants were of average age and fitness, there was no available information with regard to numbers who were not fit and whose disabilities might impact on an orderly evacuation in single file.

Sir, that's all we propose to say by way of our opening statements.

SIR MARTIN MOORE−BICK: Thank you very much indeed, Mr Browne.

At that point we shall take the afternoon break, and we will resume at 3.30, when we shall hear a closing statement from Mr Stephen Walsh Queen's Counsel on behalf of the London Fire Brigade.

So 3.30, then, please. Thank you.

(3.11 pm)

(A short break)

(3.30 pm)

SIR MARTIN MOORE−BICK: Welcome back, everyone. We are now going to hear an opening statement by Mr Stephen Walsh Queen's Counsel on behalf of the London Fire Brigade.

Yes, Mr Walsh, when you're ready.

Module 5 opening submissions on behalf of the London Fire Brigade by MR WALSH

MR WALSH: Thank you very much indeed, Mr Chairman. Good afternoon to you, Ms Istephan and Mr Akbor.

Just so you know for timing purposes, I won't be longer than 45 minutes.

SIR MARTIN MOORE−BICK: Well, we have allowed you an hour, so don't feel under any pressure.

MR WALSH: I don't, but I'm very grateful, sir.

Sir, by far the most important assertion I can make in these submissions as we move into Module 5 of the Inquiry, if I make no other submissions today −− although I will −− but the most important and the most

meaningful is that the primary focus of the London Fire Commissioner is concentrated on learning meaningful lessons from the Grenfell Tower fire. Indeed, the Commissioner's energy and that of the LFB as an organisation has been and remains fully committed to that process.

The tragic loss of 72 lives and the consequent impact which the events of 14 June 2017 have had on the bereaved, the survivors and the residents of Grenfell Tower, together with a wider public interest, remains daily −− and I mean daily −− the driving force behind the London Fire Commissioner's efforts. There is no doubt that the Brigade must and is doing everything in its power to learn the hard lessons from that terrible night.

And that is not a platitude, it is not a hollow statement, as the evidence which the London Fire Commissioner, Commissioner Roe, will demonstrate in Module 6, if he is given the opportunity to explain in much more detail what has been done, although I will summarise certain matters later on.

Sir, you won't be surprised to hear that, in common with many other core participants, I have no intention of repeating all of the facts and matters addressed in our written opening submissions, which are now in any

event publicly available. Instead, I would seek only to highlight certain key aspects which we believe will inform the understanding of the evidence which is to be heard now during Module 5.

From the very start of the Inquiry in early 2018, the LFB, the London Fire Brigade, and to an extent fire and rescue services generally, have rightly come under the microscope. Indeed, it has been subjected to minute scrutiny by a large body of experts commissioned by the Inquiry in multiple disciplines.

The intense questioning of more than 80 Brigade staff in Phase 1 of the Inquiry, which I think is accepted the LFB not only co-operated in but largely assisted in facilitating, combined with the scrutiny that the experts have undertaken since the Inquiry began its complex task, has revealed areas in which the Brigade has been the subject of criticism, and the London Fire Commissioner has made it clear that the London Fire Brigade must and does take full responsibility for its operational response to the fire and for ensuring that the knowledge gained from it is used to maximum effect for the future, while enhancing both public and firefighter safety.

Of course it is true that the LFB was not responsible for the causes of the fire or the manner in

which it developed or the failings which were exposed in Modules 1 to 3 of Phase 2 on the part of some who were connected with the refurbishment of the building, which resulted in the eradication of essential fire safety measures which in turn caused the devastating fire.

That is the last and only time in these submissions I will make that point, because among the vital lessons which must be learned from the tragedy is that the LFB and fire and rescue services around the country must plan and develop operational tactics in procedures, insofar as they possibly can -- which is the key issue which I will come to in a moment -- to meet the consequences, should they occur again, of the chain of events which led to the Grenfell Tower fire.

And, of course, much of the evidence to be considered in Modules 5 and 6, including the expert reports, concern matters and events up to the date of the fire in 2017. But one of the key factors to address as your Phase 1 report makes clear, sir, is the question whether the LFB can be said to be a learning organisation both before and following the fire. Those are matters, no doubt, which will be addressed through Commissioner Roe and others in Module 6.

For the purposes of these Module 5 submissions, it is right that the LFC provides an account of what it has

been doing and the challenges involved in it, because it has some bearing on the consideration of the challenges faced by fire and rescue services before 2017, which is relevant, of course, to the evidence to be given in Module 5, and I will come to that shortly.

Understandably, certain core participants in their Module 5 opening submissions have relied upon a number of the opinions of the experts, that is to say the experts which have been instructed as experts by the Inquiry, and extrapolate from them what are said to be hard facts about the manner in which the LFB has gone about its business. But with the exception of Mr McGuirk, none of the expert witnesses who have been instructed as experts, who are undoubtedly expert and knowledgeable in their own fields, claim to have expertise in firefighting or managing and operating fire and rescue services. Indeed, many expressly say so, in fairness to them. Obviously there is no criticism against them, either implied or overtly, because their reports actually have provided valuable information to the LFB, and I would think fire and rescue services nationally in the furtherance of their lesson-learning processes.

But insofar as those reports impact upon the operation of the LFB and fire and rescue services

generally, it's obviously necessary to hear from the present and former LFB senior staff who are to give evidence in Modules 5 and 6. Indeed, the submissions of certain of the core participants in their Module 5 openings concern matters which are of particular significance to the issues to be addressed in Module 6 because there is an unavoidable overlap between those two modules.

So far in Phase 2 of this Inquiry there has been no opportunity, until now, for those who are experienced in firefighting, the people who were and are responsible for key areas of fire and rescue operations, training, resourcing, managing budgets according to government expectations and so on, to address the issues which the Inquiry needs to explore, and for the experts to hear, actually, as well, in relation to the key issues for this Inquiry from the perspective of operational firefighting and rescue in the field. That's valuable evidence which will not, I hope, only inform the Inquiry, but also the experts' views. In order to take any informed view and in the interests of fairness, those witnesses must be allowed to have their say. They need to be given a fair opportunity to address issues which have arisen during the course of this Inquiry, and, sir, I know that you and your counsel team will

provide ample opportunity for them to do that.

So, with those factors in mind, we resist in these submissions the temptation to engage in counter-argument on numerous matters which are raised in certain of the core participants' opening statements until the evidence has been heard in both Modules 5 and 6, which we will address in closing submissions at the appropriate time, given that this is an opening submission and not a closing one.

Just briefly in relation to the extensive report of Dr Stoianov on water augmentation issues, which was disclosed at the beginning of last month or the very end of the month before, the LFB has looked at that, without a doubt requires further time to consider a range of matters before a fully informed view can be taken, and I know that Thames Water Utilities is continuing to review that report and take the view, quite properly, as does the LFB, that Dr Stoianov will require time to consider what they say about it, and indeed what we say about it. Because he is now giving evidence I think in Module 7, we will say no more about it now.

But there are one or two assertions which have been made by some core participants in their opening statements which I should briefly address now. Some of it was addressed I think orally this morning.

First of all, the question of trust. Can the witnesses for the London Fire Brigade be trusted to provide candid and transparent evidence to this Inquiry? We say that the answer to that question was provided in large part in Phase 1 of the Inquiry, when so many Brigade witnesses at all levels of command attended to give open and clear evidence about the night of the fire without hidden or overt agendas, and in the spirit of providing the bereaved, survivors and residents the truth of that tragic night as they saw it.

That evidence, of course, was backed up by multiple volumes of material which the LFB's GTIRT team compiled, which provided minute-by-minute accounts of what occurred throughout the night of the fire and which I think it's fair to say informed so much of your Phase 1 report, followed up with the London Fire Brigade's vast and transparent documentary disclosure exercise to the Inquiry.

Of course, no London Fire Brigade witnesses sought, and have not done so for Modules 5 or 6, the protection of an undertaking from the Attorney General not to use what they tell this Inquiry in any subsequent proceedings.

All that demonstrates, we say, that the evidence of London Fire Brigade witnesses has and will continue to

be open and candid in the full spirit of the duty which public authorities such as the London Fire Brigade owe.

Secondly, just very briefly, the issue of foreseeability.

I think it's fair to say that certain of the submissions of CPs are predicated on the assumption that the Grenfell Tower fire was an entirely foreseeable event. The experts differ in their views, as we know.

Sir, it would be crass for me or for anyone else to argue against the proposition that certain factors in this chain of events were foreseeable and within the knowledge of the LFB, for which in some cases the Brigade had policies and procedures in place. I want to make that clearer, because I paused halfway through that sentence: it would be crass to argue against that proposition, that there were elements which were foreseeable. But for the purposes of these opening submissions, we simply make the point that the question of foreseeability of the whole incident cannot be answered in simple, binary terms: yes or no. It is a complex issue, with multiple strands, which include the very significant issue of the sheer scale of the disaster at Grenfell Tower and the impact which the matters revealed in Modules 1 to 3 had upon it. Those shocking revelations by definition raise serious

questions about their foreseeability.

Sir, coming back then to the main thrust of these oral submissions.

Fire and rescue services are in a position where they have to consider the extent to which they can plan their operational response and procedures to fires in residential high-rise buildings by anticipating similar widespread failures to those which, sir, this Inquiry has found. Planning for such eventualities through operational procedures and training is, of course, highly challenging, not least because buildings such as Grenfell Tower, as we know, were never intended to allow firefighting and rescue on multiple floors, nor were they designed to facilitate a simultaneous evacuation of the full complement of residents. And, as I've said, the progress which has been made by the London Fire Commissioner in addressing the Phase 1 report recommendations, including new and revised policies, training and equipment, is summarised in the LFC's written statement, and I won't read all of that out again, but I will touch upon it. I will summarise the summary a little later on orally.

But to make sense of that work, the work that has been ongoing since the fire, and to better understand the LFC's approach to residential high-rise firefighting

before the Grenfell Tower fire, as well as to provide essential context for the issues which will be examined in Module 5, the LFC's written statement revisits the key factors which impact on the ability of fire and rescue services to conduct operations in dangerously unsafe high-rise buildings, and the hard challenges which they face in doing so.

We have also set out again in that statement the basic key principles of building design for buildings such as Grenfell Tower in those written submissions. They are, all of them, in any event, by now well known and I have no intention of repeating them here.

Perhaps it is sufficient, then, to summarise the position as follows: Grenfell Tower was designed, constructed and should have been maintained to support a well established fire strategy from a safety perspective, which is provided by law, and supported by a range of regulatory requirements. That's what should have been the case.

As Dr Lane put it, the strategy -- she is talking about the stay-put strategy, which I think everyone knows is not a fire and rescue service strategy, it's a design principle -- the stay-put strategy is provided through design, construction and ongoing maintenance, says Dr Lane. All building occupants, including the

Fire Brigade, rely on it in the event of a fire. It is the single safety condition provided for in the design of residential high-rise buildings in England.

The statutory guidance makes no provision within the building for anything other than the stay-put strategy. There is no means of warning nor a means to communicate the need to increase the areas to be evacuated, as is currently regulated for in other building uses, which have complex fire suppression systems, which have evacuation drills, strategies, alarm systems and so on.

Sir, it's no good the fire and rescue service saying, "Well, look, it's not designed so there is nothing we can do". That is not what the London Fire Brigade says. But what it means is that in developing operational procedures, which must be done to address fires in certain high-rise residential buildings, fire and rescue services must do so on the basis that the single safety condition may have been entirely compromised, and the provisions for fire and rescue operations which the building was designed to facilitate consequently rendered inoperable. To put it in stark terms, in short, fire brigades must now -- and they must -- plan for operations in residential high-rise buildings which, by reason of their design, actively thwart attempts to fight fire and to rescue and

evacuate residents.

Some of the consequent obstacles which must be overcome have been addressed in previous submissions which we have made to you, sir, and they shed light on the approach of fire and rescue services. They are also set out in the LFC's written submissions, which I don't intend to repeat now, though I will, if I may, but just by example, touch upon the problems surrounding firefighter safety and the challenges of internal firefighting rescue.

Can I make this clear: the identification in these submissions of challenges which fire brigades face in developing policy and procedure to address fundamentally failing buildings cannot be taken as a reluctance to meet those challenges. They are being met, as far as possible. But it is vital that the challenges and therefore the potential limitations on fire and rescue services are understood, both before the fire on 14 June 2017 and afterwards.

So, briefly, what are the examples of challenges to fire and rescue services that I just want to touch upon?

First, the very basic point: as far as can be discerned, all of the Inquiry's experts agree that for the purpose of developing fire safety measures for residential high-rise buildings of the kind this Inquiry

is considering, the following assumptions are made by the Building Regulations and the broader regulatory system which determines how these buildings are designed and built.

Only single unit fires are anticipated or allowed for. Multiple fires on multiple levels are not anticipated or allowed for. Vertical or lateral fires on the exterior are not anticipated or allowed for, and simultaneous evacuation on a large scale is not anticipated or allowed for. And clearly the viability of those assumptions and the integrity of the building's fire safety strategy are dependent upon adherence to the principles of fire safety contained in the Building Regulations and elsewhere when constructing, maintaining and refurbishing the building. If they are not -- if they're not -- the challenges to fire and rescue services in case of fire become extremely onerous.

In his Phase 1 report, Professor Torero made the point that the means by which the fire service can alter the strategy, that is to say the stay-put strategy, are very basic: by knocking on flat entrance doors, by operating sounders in residents' flats in the unusual circumstances in which they're available, and importantly, all of these approaches, says

Professor Torero in his first report, are inconsistent with a fire that has spread vertically or horizontally, as it did at Grenfell Tower.

Sir, that leads me to the question of firefighter safety, which is inextricably linked to the safety of residents and the people they strive to protect.

One of the primary challenges in planning and executing firefighting and evacuation in buildings like this, those which are failing, was identified, sir, by you, if I may say so, in your Phase 1 report, and I hope you won't mind if I just repeat one or two examples.

At paragraph 28.63 you:

"... recognise that the mechanics of carrying out an evacuation of any sort in rapidly deteriorating conditions would have presented its own risks to the lives of residents and firefighters."

And that's a fact, and we entirely agree with that, if I may say so.

Then at paragraph 28.80, sir, you characterise Assistant Commissioner Roe's, as he then was, strategy on the night of the fire as an intention:

"... to flood the building with as many EDBA wearers [that is extended duration breathing apparatus wearers] as were available and to provide as much assistance as possible to the remaining occupants. The strategy was

both bold and necessary. However, it meant that firefighters would be deployed into the tower without any firefighting equipment, which was both contrary to policy and created a very significant risk to their safety."

And one might add: and, consequently, to the residents they're there to try and protect and assist.

The London Fire Commissioner has previously expressed his appreciation to you, Mr Chairman, for your acknowledgement of the bravery and selflessness of firefighters who were deployed into Grenfell Tower, and your broad approval of the sentiments he expressed in his evidence to you when he acknowledged the fact that big organisations must always improve systems and training through learning, but at the same time paid tribute to the bravery of firefighters on the night who —— and these are his words, which met with your broad approval:

"... put themselves at enormous risk for hour after hour after hour, and were battling against what was frankly an absolute failure of the building system, and they had done their absolute best in intolerable circumstances. My junior officers performed well beyond what was acceptable in terms of their physical and mental capacity, and actually in some numbers have paid

the price consequently."

Well, of course, firefighting and effecting rescue, of necessity, is a dangerous occupation, even where the built environment broadly adheres to established fire safety measures. That's what firefighters take on when they take the job. But the potential obligation on fire brigades to assume when planning fire and rescue operations that such measures will be ignored or flouted to a substantial degree by building owners and others places substantially higher risks on firefighters and residents alike, and the perennial question for fire and rescue services is where the line should be drawn. At what point, notwithstanding the overarching desire and will to save savable life, does the risk to firefighters become too great to justify under health and safety legislation, given that serious injury or worse to firefighters has a direct impact on the safety of residents? How far can fire and rescue services push the risk envelope while maintaining its duty to protect the safety of its employees?

Now, that preparedness to push the risk envelope is one which —— there was an example of it, I suppose, during the course of the redevelopment of the high—rise firefighting and evacuation policy which the LFC was involved in very recently, and which Ms Studd

Queen's Counsel, on behalf of the Mayor, mentioned earlier on. That dilemma had been highlighted in the recent consultation in respect of the Brigade's new policy where the appropriate safe use of breathing apparatus by firefighters above the bridgehead was the subject of considerable debate, and frankly disagreement, between the London Fire Commissioner and the Fire Brigades Union. It is just one example of the ongoing consultation which, by the way, is required by law —— all fire and rescue services are required by law to consult with the unions —— and that was an example of just such a thing.

There is no criticism, by the way, of the FBU there, because it is part of their function to consider matters of that, and it is part of the LFC's function to look to savable life and to push that envelope as far as possible, but they are very difficult, very difficult issues to resolve.

In the years following the Grenfell Tower fire, the Commissioner has made strenuous efforts to address this challenging issue in liaison with many stakeholders, including the National Fire Chiefs Council and of course the Fire Brigades Union, among others, and very importantly —— I mentioned this in our Module 3 opening, but it is actually quite significant —— the LFC

has commissioned and led groundbreaking research with the University of Bath into the physiological effects on firefighters who are deployed into high-rise buildings, which has revealed significant results which have a direct impact on the capabilities of fire and rescue services in this country and in fact worldwide, what we're discovering.

That actually brings me to the relevant issue of internal firefighting in buildings of the kind that we are here considering.

As the evidence in Phase 1 made clear, the statutory requirement for the design of residential high-rise buildings are predicated on the basis that fires in compartments must be fought internally. There is no provision, at least in the regulations, for external firefighting. They just don't provide for it, the Building Regulations, although of course at Grenfell Tower strenuous efforts were made to attack the fire externally in extremely dangerous conditions on the night, and we'll be revisiting that I think again in Module 7.

However, during the Grenfell Tower fire, assuming that it would have been reasonable at the early stages to anticipate that a fire in the external cladding would spread as far and as rapidly as it did, it would have

been a fundamental departure from high-rise firefighting procedure to abandon internal firefighting, as some have suggested perhaps should have been done, and that would have been a departure from procedure for a number of reasons, chief among which, in a fire of that kind, is the absolute need to continue protecting internal escape routes for residents. While the statutory requirements for the design of high-rise residential buildings provide for only internal firefighting, as I've said, what they do not do is they do not contemplate that fire services may be required to fight fires on multiple floors at the same time. Of course, at Grenfell Tower there were simultaneous serious fires on multiple floors.

Importantly, whether a building is fitted with a dry or a wet riser, because that's how the water is provided to the internal part of the tower, the provision is for only two firefighting jets to be connected to the main, the dry or wet rising main, which is sufficient to deal with a single compartment fire envisaged by the Building Regulations. The important thing is that the system of the main, the rising main, and the mechanisms do not allow for their use on more than one or perhaps two floors at one time, whatever the available flow rates of water from the external hydrants, with the

consequence that fires cannot be fought on multiple floors. The regulatory regime simply doesn't contemplate the need for it. The challenge it presents to fire brigades is the major problem of how do you go about deploying firefighters into areas of a building without the means to protect themselves and residents from fire?

These are challenges that I'm pointing out. I say again, we're pointing out the challenges. We're not saying that they can't be done, but they are difficult.

On the question of evacuation more generally, sir, we have set out in our written submissions the challenges which fire and rescue services face in planning evacuation in high-rise residential buildings which are significantly failing, and which don't allow for simultaneous evacuation. Those challenges have been well documented in our previous submissions and in that document, and indeed by the experts to the Inquiry. They are very well understood and I don't propose to repeat them all for you now, but they're there in the document for anyone to see.

But the point is all of those challenges -- I've just given a couple of examples of them -- existed before the fire, before 14 June 2017, and still exist, so that the LFB's new policies and procedures are the

product of very careful thought in consultation with stakeholders on a national basis. They go as far as possible to addressing this extremely difficult issue and to a significant extent -- I use that phrase again -- pushing the envelope as far as is reasonably possible to meet the real challenges.

While I'm on the subject of evacuation, I just want to mention something which Professor Thomas Queen's Counsel discussed this morning in his oral opening submissions, and I just want to resolve what might be a misunderstanding concerning what can be learned from other fires around the world.

Let me just make it very clear: the London Fire Commissioner acknowledges absolutely that there is much to learn about fire behaviour in modern high-rise buildings from examples of other fires around the world, which can inform the development of policy and procedures to address similar fires in London and around this country.

Recognising the importance of this since the Grenfell Tower fire, the Brigade has reviewed the process by which information which is fixed in the Brigade's engineering and fire safety department is channelled to operational staff, so as to improve the mass of information available to incident commanders

about fire behaviour in high-rise buildings in the context of the increasing complexity of construction design and materials used in new builds and refurbishments.

However, the extent to which examples of other fires around the world can inform the development of evacuation procedures in the UK, particularly for stay-put buildings, is much more restricted, and that is because many of the fires were in differently designed buildings with different regulatory regimes, and many of those other fires were in buildings which were either designed or built to support simultaneous evacuation or which had other aspects of it. So an example was given this morning of the Lacrosse fire in Melbourne. Now, much learning can be had from the way in which that fire developed externally, but there is not a great deal of learning, it might be said, that could be derived in relation to how you evacuate a stay-put building, because the Lacrosse Building had very sophisticated fire suppression systems which were phased all the way down the building, alarm systems and so on and so forth, whereas stay-put buildings, as we know, have none of that at all.

So I just wanted to resolve what might have been a misunderstanding about our point on that.

Of course there are examples in this country, and the Lakanal House fire might be a near example of that, but just a slight warning to guard against equating that fire, the Lakanal House fire, too closely with the fire at Grenfell Tower, because the Lakanal House fire did not involve rainscreen cladding, and the primary issues were associated with internal breaches of compartmentation and fire loading in concealed spaces.

But, that said, there is no doubt that the Lakanal House fire in terms of lesson-learning had a significant bearing on the operation of Brigade control rooms, and we accept that, and we understand that the issues concerning the operation of the LFB control room on the night of the Grenfell Tower fire, in light of the learning from the Lakanal House fire and the provision of fire survival guidance by control staff to residents is to be addressed in Module 6, and in the circumstances we'll reserve more detailed submissions about that until the appropriate time. For the present, we remind you that, in Phase 1, the London Fire Commissioner expressly accepted in closing submissions that there are undoubtedly lessons which must be learned from the night of the Grenfell Tower fire in respect of control room policy and training.

On a different topic now, that of risk information

gathering, we need to touch briefly upon the most recent report but one of Professor Torero. When I say that, there was a very recent report; I'm talking about the one just before that. We had addressed one aspect of that report in our written Module 5 submissions, but then we understood he was going to give evidence in Module 6, so we took them out, so I'm putting them back in now orally only in summary form.

The LFC accepts that the gathering of information concerning risks to fire safety in the built environment is a vital factor in the planning of operational procedures to address them. Indeed, significant steps have been taken to improve the process of risk information gathering at the LFB since the Grenfell Tower fire.

One of the mechanisms for achieving this involves the effective use of the expertise which exists in the LFB's engineering and fire safety department which, among other things, monitors developments in modern construction and design techniques for the purpose of providing advice and guidance to building owners and to the Brigade itself, as the letters, as you may recall, from Assistant Commissioners Turek and Daly to local authorities did, that was the purpose of them, and they were considered in Module 2, I think. Dr Lane described

them as sensible approaches.

Professor Torero in his recent report considers the matter again, but if one goes back to his earlier reports and his published approach much more widely, he strongly advocates the need for much greater expertise and competence across all stakeholders, particularly designers, architects, engineers and so on, to keep pace with the exponential increase in recent years of the complexity of modern construction methods and materials. That's his basic position and it's a compelling one.

On that theme, it is Professor Torero's view that fire and rescue services throughout the country should dramatically increase the number of its staff who are trained to a suitable level of expertise, competence, in the technical principles of modern construction materials so as to be able to engage from an early stage in the design and construction phase of significant refurbishments and new-builds. The purpose, he says, is to enable fire and rescue services to identify failures which can affect the performance of a particular building prior to a fire event and to eliminate previously unforeseeable events through inspection and understanding of building behaviour in the modern and more complex context.

Compelling though such an approach might be for the

future —— and it is compelling —— in order for fire and rescue services to engage in the design and build process to that extent, there would not only need to be a change in culture involving industry, central and local government and the fire sector generally, but a significant change in the legislative structure with considerably increased support and funding to give effect to such changes.

I come finally, sir, now, as a topic, to a very brief explanation of the products of the London Fire Commissioner's intense learning programme over the last four years, which in many ways is a continuation of the process of learning which the LFC would maintain has always been a characteristic priority of the London Fire Brigade. Further detail can be found in the written submissions, which themselves amount to a summary, but we re—emphasise that a much fuller account, which I know many have expressed the desire for, will be provided by the Commissioner himself in Module 6, if he is permitted to do so, for the purpose of answering the question posed in the Phase 1 report whether the LFB has learned lessons and, if so, to what extent since the Grenfell Tower fire.

It is fair to say that it has been Commissioner Roe's priority since his appointment to

drive forward progress in relation to your recommendations, sir, following Phase 1, recognising the need to demonstrate that the LFB is a learning organisation committed to continuous involvement and improvement. Some of the new measures which have been introduced address the recommendations in your Phase 1 report, while others represent the Brigade's own ongoing process of learning and development, which is central to its ethos and is a key feature of its operational planning.

In very short summary form, a suite of new and revised measures has been adopted following wide consultation and careful consideration of the multiple challenges which fire and rescue services face when planning and executing fire and rescue operations in dangerously failing buildings.

Among the changes are a range of new and revised policies which address high—rise firefighting, evacuation as a separate topic, fire survival guidance as a separate topic, and each of these policies, which are in many respects very closely interlinked, provide guidance and procedures for incident commanders and control staff to follow including communication strategies in extreme circumstances of the kind experienced at Grenfell Tower.

In relation to high—rise evacuation, and evacuation issues, a —— I've called it here in my document voluminous, I hope you know what I mean by that —— voluminous face—to—face theory training programme was delivered to approximately 4,500 staff over the course of and within a year, during, in fact, the lockdown and the COVID—19 pandemic. Further policies address risk information gathering and incident command, while extensive work has been carried out to improve information sharing between the Brigade's specialist fire safety department and operational staff.

In the field of incident command training, the Commissioner has established a dedicated incident command training team to ensure that a golden thread of training is implemented from the control room officers through to command unit crews, facilitating more effective lines of communication between Brigade control and the incident ground.

Finally, from a summary perspective, in addition to the suite of new policies on high—rise firefighting, evacuating, fire survival guidance and operation risk gathering, the LFC has overseen real changes in a range of other areas, including control communications, fire ground and general communications, including equipment, and the acquisition of new and additional equipment,

including a fleet of new aerial appliances, groundbreaking remote drone capability and, of course, the use of smoke hoods across the Brigade.

In conclusion, the question whether the London Fire Brigade is a learning organisation will be informed by the evidence of those past and present officers who are to give evidence in Modules 5 and 6, when they are given an opportunity to explain the challenges and the realities of providing firefighting and rescue services in one of the most populous, complex and densely built cities in the world. For the present, the LFC reminds, sir, you and your colleagues on the panel of the assertion he made in his evidence towards the end of Phase 1. He has always been clear that large organisations must always develop policy and procedure through learning, from experience, and that culture must be embedded and it must be never ending. He is clear that the London Fire Brigade must be proactive in its approach, particularly with regard to the increasing complexity of modern construction and design methods and materials insofar as they impact on fire safety.

The fact that all fire and rescue services are —— well, they certainly are now —— alerted to the dangers which exist in buildings of this kind where a refurbishment or maintenance of previously safe

buildings has been conducted in a way to fundamentally undermine that safety, is a challenge. Those are the challenges which are facing the London Fire Brigade, but all other fire and rescue services in the UK, and those challenges are being met head-on.

The London Fire Commissioner's paramount consideration is and always has been to protect the safety of Londoners in case of fire and other emergencies. The same consideration was the imperative behind the determined efforts of firefighters on the night to do their best in the most dangerous of conditions, and this is always so in the mind of the commissioner, it is always so in the mind of the women and men who make up the London Fire Brigade.

The interests of the bereaved, survivors and residents of Grenfell Tower remain at the very heart of the LFB's continuing commitment to learn from the tragic events of 14 June 2017, and to effect meaningful change wherever possible.

Sir, I don't have anything further at the moment.

SIR MARTIN MOORE-BICK: Well, Mr Walsh, thank you very much indeed, that's been a very helpful statement.

MR WALSH: Thank you, sir.

SIR MARTIN MOORE-BICK: Thank you.

Well, that's all the opening statements we're

expecting to receive. Tomorrow we shall embark on the first of the witnesses in Module 5, that will be at 10 o'clock tomorrow morning, but at this point we shall close for the day.

Thank you very much. 10 o'clock tomorrow morning.

(4.20 pm)

(The hearing adjourned until 10 am on Tuesday, 21 September 2021)

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