IN THE MATTER OF THE GRENFELL TOWER INQUIRY

BEFORE SIR MARTIN MOORE-BICK

CLOSING SUBMISSIONS ON BEHALF OF THE G11

SURVIVORS, BEREAVED AND RESIDENTS AT THE CONCLUSION OF PHASE 1

INTRODUCTION

The 3 groups of BSR lawyers have endeavoured to consider different aspects of the evidence in their submissions. In this document Mr Mansfield QC will distil themes from phase I into a series of propositions which are derived from the concerns expressed by the families we represent and which have a basis in the evidence you have received from themes and the experts in this phase. He does not intend to read out what is written here because we appreciate it will be read by you the Chair and the public alike.

SUBMISSIONS

A. "I WOULDN'T CHANGE ANYTHING WE DID ON THE NIGHT"

1. We start our closing submissions on behalf of the BSRs represented by the G11 legal team with the end of Dany Cotton's evidence on 27th September 2018:

"I wouldn't change anything we did on the night, I think without exception my firefighters and my officers and my control staff performed in a fantastic way given the incredible circumstances they were faced against.."[1]

(i) This response from the LFB Commissioner laid bare the heart of the problem of the management and command of the LFB which impacted upon their emergency response to the fire that night.

(ii) These were her parting remarks after a day of quite extraordinarily tone deaf evidence, evidence which did a disservice to the bereaved families, residents and survivors of the fire. A disservice to those in London and beyond in the UK, living in blocks still clad with combustible materials, and a disservice to her own rank and file fire fighters; men and women who routinely risk life and limb as part of their job and who certainly did so that night.

---

[1] Dany Cotton Transcript 27.09.18: page 236

2. Whilst Commissioner Cotton's sincerity is not questioned, when she talked about "hugging" her Firefighters; it was not tea and sympathy that they needed in the immediate aftermath of the Grenfell Tower disaster; but leadership that was informed, knowledgeable and proactive. Further, in the months that followed and into this Inquiry, they needed leadership that was prepared to be reflective, candid and insightful enough to recognise where strategic decision-making was flawed, firefighting operations were compromised and risk assessments were neither dynamic nor up to meeting the challenges that were faced on the night of 14th June 2017.

3. The Commissioner could have chosen to take over as Incident Commander from AC Roe, but instead said this: ***"I was fully satisfied with his plan; I was fully satisfied with the level of control he had. Also, I was aware that had I assumed command, I would have been sucked into doing the tactical plan."*** [2]

(i) It is submitted on behalf of the G11 BSRs that her reasoning and justification appear somewhat trite. As the most senior Fire Officer at such a huge disaster, she should have seen it as her duty to be part of the tactical planning, to oversee it and review it.

4. Dany Cotton's role that night was that of monitoring officer. *"... **they can effectively critique the Incident Commander's plan, discuss it and have an overview."*** [3]

Despite having this role on the night of the fire, her evidence would suggest that the Commissioner has provided no reflection or evaluation of the performance that night, or areas for development.

5. There does remain however, one line of answers given by the Commissioner which we would submit, do carry far more weight.

(i) ***"I'd say you could see the risk of a cladding fire spreading on the outside of the building; I don't think we could have foreseen the risk of the full-scale building***

[2] Dany Cotton Witness statement dated: Page MET00012492_0003

[3] Danny Cotton witness statement dated: Page MET00012492_0003. *Because Monitoring Officers are not directly in charge of the incident they are able to step back and have that wider view of the incident. It' s a very useful role for information sharing and offers a means of double checking with people in terms of what's actually going on.* ***It's also enables the Monitoring Officer to provide feedback on performance and to talk through any areas for development***

failure that happened." [4]

(ii) ***"Equally, even if he had training on the cladding itself, what he wouldn't have anticipated were the significant building failures inside the premises that allowed the fire to travel through all the compartments"*** [5]

6. There are both systemic and individual failings on behalf of the LFB that night in their response to the fire. Further, the Inquiry's investigations under the Terms of Reference of Phase I has unearthed some highly damning aspects with regard to procedures and implementation of existing policies within certain parts of the service and at the heart of it all an almost complete absence of effective training and dissemination of information on the part of Babcock International.

7. Overarching all of this, and what must never be forgotten in this process, is the complete failure of Grenfell Tower, the building. We submit that this is both in terms of non-compliance with existing building regulations and breaches therein, and further significant breaches and defects during the refurbishment and beyond such as fire doors, windows, ventilation system and absence of fire alarms etc. These were matters within the purview of contractors, developers, RBKC and the KCTMO. These were also matters foreshadowed and fore warned about by the residents themselves, which fell on deaf ears.

8. **LFB Policies and Guidance**

Table No. 1: Relevant LFB Policies.

One thing that the LFB does not lack is policy documents. These are myriad, covering almost every conceivable issue and action. This vast library of documents and the directions contained therein, with their buzz words and phrases such as *dynamic assessments* and *situational awareness* are of no use, unless these policies are:

Read, Understood, Implemented and Monitored for effectiveness. The sad reality from hearing the evidence of firefighters of all ranks was that many of these policies remained unread and implemented and of no practical use.

[4] Dany Cotton Transcript 27.09.18 page 74
[5] Dany Cotton Transcript 27.09.18 page 133

B. SIX CRITICAL JUDGEMENT CALLS/DECISIONS THAT NIGHT

1. We submit that on the evidence the Chair can make findings in respect of key judgement calls/decisions that either should/should not have been made or were made poorly. Further, that the Incident Commanders that night fell short of their own extensive policies and guidance in respect of their roles and strategies deployed.

2. It is only by recognising what could and should have been done better, what underlying issues are in play such as training, resources and funding, how better to equip firefighters for all the challenges that they may face; that the LFB Leadership can properly protect those they serve: the population of the Capital and the individual firefighters.

DECISION No.1 INCIDENT COMMAND

1. **Table No. 2: LFB0169_0001: Incident Commander Procedure and Arrival of SMs and Comments on Command Issues**

SM Loft and WM Dowden discuss SM Loft taking over as IC but decided instead that he should manage FSG calls.

2. It is an absolute operational imperative for any organisation to have properly informed individuals in the right positions so that they can effectively make the often split second big decisions that are required. In giving his evidence Mike Dowden was at times reduced to tears and candidly stated that he was "***out of my comfort zone***" and he felt "***helpless***" when the fire began to spread in an "***unprecedented***" fashion. He stated he did his best and had good intent. No doubt that is correct, however he was not equipped for the role, taking into account its scale, its dynamics and catastrophic outcome. This would have pushed the most senior officer to his or her limits. For a junior officer, who has never operated at such a level before it was an impossible task. WM Dowden was placed into a position for which:

a) He was not trained, b) He was not equipped to make the split second decisions, c) He did not have the early realisation that the fire was one that could not be fought. This led to poor situational awareness and dynamic risk assessments.

3. **FINDING SOUGHT**:

(i) Senior officers of the rank of SM, should have been alerted and mobilised to the scene earlier and the first on scene taken over the role of Incident Commander.

(ii) WM Dowden was neither trained or sufficiently supported to remain in the role of Incident Commander in the crucial first hour of the fire.

DECISION No. 2 REALISATION THAT THIS WAS A FIRE THAT COULD NOT BE FOUGHT

TOR: - The Development of the fire and smoke. How the fire and smoke spread from its original seat to other parts of the building.

Evidence in support of these submissions:

(i) FF Evidence: FF Charlie Batterbee, Cornelius: **Table no. 3 Evidence of Flat 16/Early crews.**

(ii) Expert Evidence: Luke Bisby Presentation, Professors Lane and Torero's Evidence on fire spread.

1. Mike Dowden, like almost all firefighters of all ranks present that night held onto the belief for some considerable time that they could "fight" and win against this fire and that informed the strategic plan.

(i) What was absent from such a plan was any consideration, belief or even thought for the potential for:- Extremely rapid external fire spread and the reasons and consequences of that.- Compartmentation Failing.- How the consequential internal fire, heat and smoke spread would impact on residents' attempts to self-evacuate. – Firefighters' attempts to rescue them and internal firefighting generally. Therefore the initial dynamic risk assessments by WM Dowden were fatally flawed.

2. In his statement at **01:13** hrs Mr Dowden called for further resources as he felt comfortable that the fire was still contained. The footage and oral evidence of the firefighters and residents **inside** the building show that Mr Dowden's assessment was contrary to the reality of the fire, as did:

(i) The amount of FSGs at this point, which were already in double figures.

(ii) The internal fires and thick black smoke which were visible inside the Tower. See Floor 16 and the encounter between Sam Daniels and Justin O'Beirne and FFs Hippel

and Stern. **Table no.3**

(iii) Evidence of Dave Badillo, Justin O'Beirne, and Christopher Secrett. See **Table no.3**

(iv) At this point WM Dowden failed to modify his strategies. Instead he requested an aerial ladder at 1:13am, and asked water to be aimed from the outside of the building above and below Flat 16.

(v) WM Dowden notes that after appliance G331 arrived he requested that they aim water from the outside of the building, above and below the flat. He noticed that the fire in flat 16 was starting to affect the external facia of the building [1]. *No time given.*

3. At around **01:29** – WM Dowden realises that the jet is having no effect on suppressing the fire and he orders the crew to turn off the covering jet and report to the bridgehead wearing BA.

4. A striking piece of evidence, the 999 call of Jessica Urbano highlights that the fire was beyond containment, compartmentation was breached, stay put was untenable and contingency planning was now called for.

(i) **Phone call of Jessica Urbano Ramirez.**[2] CRO Russell calls back Jessica at 01.30.08. The Call lasts 00.54 minutes, so it finishes at 02.24. WM Dowden is not aware of this call, but it graphically illustrates the internal fire, smoke and heat spread. -Jessica is in flat 201 on the 23rd floor. CRO Russell tells her the fire is on the 4th floor.[3]

- She tells CRO Russell there are 10 people there (counting them).
- Smoke is coming through the floor and the CRO advises her to block the floor.
- Jessica said from the outset of the call (0130) that she couldn't breathe.
- CRO Russell tells her that the fire is on the 4th floor; she counters "there's a fire at the back". She explains that she had come out of her house because of the fire; and is on the top floor, around the back, in someone's house.
- She says, "***there's fire already***" and that it is out the window [4];
- Towards the end of the call, Jessica says "***there's a fire in here***"[5]. It is very

[1] Mike Dowden Witness statement dated: 23.02.18 Page 5
[2] Transcripts of Jessica Urbano Ramirez Telephone calls **LFB00004790_0023** and **LFB00000507**
[3] 999 Call Transcript page 3
[4] 999 Call Transcript page 9

difficult to get an answer from her. She is saying that she cannot breathe.

(ii) At the same time CRO Howson (in the same Stratford control room) is speaking to another child in the flat, Biruk Haftom, and later Moses Bernard; whilst CRO Jabin, in the Manchester control room is speaking to Debbie Lamprell also in the same flat. These calls clearly illustrate the extent of the fire, heat and smoke spread internally and also the abysmal lack of communication, even within the same control room, never mind between the control room to CU7 to the Incident Commander.

5. WM Dowden was "***totally consumed***" by everything going on around him and he describes this as "***sensory overload***"[6]**.** By the time Matt Leaver (who had no previous knowledge of a fire with this type of cladding) arrived he soon came to the conclusion that "***there is a chimney effect with the fire on the outside of the building due to the cavity between the cladding and the concrete structure.***"[7]

6. **FINDINGS SOUGHT:**

(i) That the initial dynamic risk assessments by WM Dowden were fatally flawed.

(ii) That the IC/ Senior Officers should have appreciated that by the time the fire had exited Flat 16 and rapidly spread to the top of the tower, this was a fire that the FFs would not be able to contain.

(iii) The early realisation of this should have led to a change in firefighting strategy and early considerations of the utility of maintaining the Stay Put policy and contingency planning.

DECISION No. 3 THE ABANDONMENT OF THE STAY PUT POLICY

1. The Stay Put policy was not abandoned until: 02:47 am. Before that, the Incident Commanders and Senior officers on the fire ground and those in the control room clung to the belief that the fire would be controlled and contained. Why did the LFB have such ardent adherence to this policy, even as the flames rapidly roared up the side of Grenfell Tower? They were convinced that multiple compartmentation failure would not occur and

[5] 999 Call Transcript page 58
[6] Mike Dowden Transcript 26.06.18: Page 81 line 25.
[7] Matt Leaver Transcript 11.09.18: Page 11.

that complete building failure was impossible. This was a misplaced belief predicated on an assumption and expectation that any building signed off for human habitation would be fit for such purpose. The fire brigade were to be sadly disabused of those assumptions and expectations in the most tragic and stark manner imaginable. Grenfell Tower was not fit for habitation. There was catastrophic and total building failure born out of a building industry imbued with a culture of complacency with regard to regulations, and where expediency and profit margins carry greater currency than the safety of people in social housing.

2. As Barbara Lane succinctly put it: ***"Grenfell Tower should never have been handed over with this rainscreen system, in circumstances where a Stay Put evacuation strategy was in place" … "It shouldn't have been occupied."*** [1]

3. There are two different fire-safety strategies which can be adopted for residential buildings. One is "simultaneous evacuation" where the aim is to evacuate residents as quickly as possible. The other is "stay put".

(i) Stay Put is a much more complex policy than evacuation and is based on the assumption that each flat is a self-contained, fire resisting compartment. It is not an absolute policy. Residents of other flats should leave if their flat becomes affected by fire or smoke, or if they feel threatened, or are instructed to leave by the Fire and Rescue Service.

(ii) In effect, it is a policy which depends on: (a) an initial risk assessment by the appropriate authorities so as to decide whether Stay Put is appropriate in the abstract; (b) an ongoing risk assessment by those authorities in the event of a fire; and (c) a personal risk assessment by each resident (both initially and during the course of any fire).

4. This Inquiry has clearly seen the limits of the policy:

(a) the assumption that the refurbishment works had complied with Building Regulations so that the flats were self-contained, fire-resisting compartments was wrong (albeit the fire fighters had no reason to know that initially);

[1] Barbara Lane Supplementary Report at 2.11.15 and Transcript: Oral evidence on 22.11.18 page

(b) the ongoing risk assessment by the appropriate authorities during the fire spread was too slow and only belatedly led to the abandonment of the policy; and
(c) the inconsistent advice given to residents by control room officers which impaired the decision making and risk assessment process by those residents.

5. It is now abundantly clear that a rigorous review of the use of the Stay Put policy in each building is long overdue. For many of the clients we represent, the emphasis has to be reversed to get out as it once was and now is with RBKC. At Grenfell Tower, "stay put" was not the only option. The evidence, in the form of the picture of the previous "leave the building" fire safety sign exhibited to the witness statement of Shahid Ahmed, demonstrates that for most of Grenfell Tower's history a different strategy was in place.

6. On the topic of stay put, Dany Cotton was as ever out of touch.[2] The evidence of the North Kensington crew members who initially tried to rescue Jessica Urbano Ramirez at the behest of her sister Melanie, and Justin O'Beirne who without a BA set on carried out reconnaissance, testify to the internal fire, heat and smoke spread on floors well above the seat of the fire. See **Table no 3.** WM Dowden was unaware of these conditions at the time due to the poor radio communications (as per Justin O'Beirne's account of the radio failure when he tried to contact the Bridgehead to inform WM Dowden of the internal fire and smoke spread).

7. **CM Norman Harrison** returned to CU8 at about 01:50 and in the presence of: Mark Kentfield, Dan Meyrick and Tony Peckham and 3 other senior officers he said the following: "Someone needs to take control to change the stay put advice" [3]

CLADDING AND COMPARTMENTATION FAILURE

ToR:- the evacuation of residents.

Table No. 4: FFs Knowledge of Cladding, Compartmentation Failure and Evacuation

[2] **Dany Cotton** Written Statement dated: **MET00010828_0054**: "*…. It should be that the responsible person has assessed their building and has decided whether or not a Stay Put policy is appropriate I think stay put was appropriate for the initial crews and I think it was still appropriate when I got there because at that time we thought we had a fire that was on the outside of the building. The fire that was in the compartment was out. The staircase had smoke in it and that would have affected people coming down the stairs under their own steam.*"
[3] Norman Harrison Witness statement dated: Page and Oral Evidence

8. The Inquiry has heard from over 130 Firefighters and Control Room Witnesses. **Very few witnesses knew about cladding, moreover had even a rudimentary working knowledge of the effects of cladding and combustible materials on compartment action, fire and smoke spread.** This dearth in knowledge was not universal e.g. Evidence of Norman Harrison. However, the stark question that must be answered is why was Norman Harrison, a WM, able to have such a perceptive view, yet more senior officers and commanders did not. Crucially this failing impacted upon the strategic decisions made and firefighting techniques employed on the night.

9. Cladding, combustible materials and compartmentation failure, were not new concepts for the LFB. Only two months before the fire at Grenfell, Dan Daly wrote a letter on the subjects. **LFB Tall Building External Spread LFB00085_0001.** [6]

(i) Witness after witness of all ranks, looked on incredulously as questions about cladding in high rise tower blocks were put to them. Those responses beg the questions where did Dan Daly's carefully crafted memo go? Who read it? Why did no one action it?

(ii) Once again Dany Cotton proved to be an information vacuum on these matters.

(iii) The LFB's own presentation document provides information and guidance: **Tall Building Facades**[7] **LFB000003521_0001**. **SM Pete Wolfenden**[8]**,** stated that he had seen this document as part of his training as a senior officer. Such evidence was a rarity.

(iv) **London Safety Plan_ MET00012563_0002** [9]

(v) **Compartmentation Fire Fighting LFB00000186_0001**[10]

---

[6] LFB Tall Building External Spread **LFB00085_0001:** *"My predecessor AC Steve Turek wrote to housing providers in March 2009 about a variety of matters relation to fire safety in residential housing blocks……Testing of the panels has found that the combustibility of the composition of the panels at Shepherd's Court did not meet the levels expected for conformity with the building regulations. On testing it was found that panels may deform or delaminate exposing any combustible core or constituent material resulting in the panel becoming involved in the fire and allowing the fire to spread and enter flats other than the flat of origin of the fire".*

[7] **Ref LFB000003521_0001**. It identifies the issues associated with External Fire Spread and uses the same diagram used in **BRE Trust Report *Fire Performance of External Thermal Insulation for Walls in Multi storey Buildings* [INQ0000092_11]** to describe the issues related to External Fire Spread; and the issues associated with façade external fire spread.

[8] SM Wolfenden Oral evidence Transcript 11.09.18: PM Page 99

[9] states: ***The Brigade will continue to work with industry bodies and sit on technical standards committees to gather data and promote firefighter safety as a key consideration in future developments.***

[10] Compartmentation Fire Fighting **LFB00000186_0001 : issued 03.01.12 and reviewed as current on 28.01.16.**

10. However, even without a knowledge of cladding and combustible materials, there was ***objective*** evidence to inform the Incident Commanders and senior officers on the fire ground.

(i) **Table 3 Evidence of North Kensington FFs internal fire and smoke spread.**

(ii) The FSGs were confirming that compartmentation had been breached:

a) FSGs **LFB00000304**, 01:24:57 999 Call- Nothing identify which flat - operator to operator call passing over to fire brigade - lady in background requesting fire service - caller comes through to operator and says GT - operator says already there - caller says I can't breathe – **fire in the kitchen** - loses caller LFB has call at this time Flat 96, 12th floor (Incident no 76047)

b) Callers at 01:26 flat 186, 21st floor and 95 12th floor, **fire in their flats.**

c) 01:33 11th floor caller, fire in their flat.

11. **FINDINGS SOUGHT:**

(i) The failure of WM Dowden and successive Incident Commanders to abandon the stay put policy was borne out of their ignorance of cladding and lack of training on compartmentation firefighting. Neither however are excusable as there is existing training policy: **Compartment Fire Fighting** [10] and these were topics and subjects known to the LFB.

(ii) There was a systemic failure on the part of then LFB, with regard to training, dissemination of information and implementation of existing policy on compartmentation firefighting, failure and related issues of cladding and combustible materials.

(iii) By 0126 compartmentation had been irrevocably breached.

(iv) The stay put policy was no longer tenable after this point.

12. Our submission is that only the highest standard of safety is acceptable. Anything else is unsafe. Accordingly, materials below A1 should be banned. Whilst questions remain as to the reliability of the testing regimes under which materials are afforded s1 d0 classification, their usage should be a subject to a moratorium.

13. **ACTIONS GOING FORWARD**

(i) LFB Position Statement. [11] Recognition that changes are required.

(ii) Even Dany Cotton seems to acknowledge a problem. ACM cladding and its removal.[12]

DECISION No.4 EVACUATION

Table No. 4: FFs Knowledge of Cladding, Compartmentation Failure and Evacuation

Tor the evacuation of residents.

1. **High Rise Building Evacuation and Contingency Planning**

(i) **Para 7.50 of Policy Number 633: LFB00001256** states as follows:

"*It may be necessary to undertake a partial or full evacuation in a residential building where a 'Stay Put policy is normally in place."*

(ii) **Fire and Rescue Services Act 2004 Appendix 1** states:

"1. During 7(2)(d) visit personnel should ensure they are familiar with the following and their impact on firefighting and search and rescue operations:

Evacuation arrangements which may include phased evacuation"

(iii) **GRA 3.2** *"Contingency plans for particular premises should cover: fire spread beyond the compartment of origin and the potential for multiple rescues, an operational evacuation plan being required in the event the "Stay Put" policy becomes untenable, alternative communication arrangements to overcome any radio 'blind spots'"*

2. It was self-evident that there was no evacuation plan for Grenfell Tower. The G3 group of lawyers will be examining this in some considerable detail so we make short submissions and comments in respect of this topic herein. Save for a few examples the vast majority of the firefighters were unaware of and untrained in evacuation procedure.

3. However, even without specific training around this topic, the question of evacuation at Grenfell Tower was not a new one and should not have taken so many by surprise. In any set of circumstances contingency planning would be both relevant and necessary. Indeed, the LFB, those responsible for the building RBKC/KCTMO and those who carried out the fire risk assessment, all anticipated the need for contingency planning.

[11] LFB Position statement dated:
[12] Dany Cotton Witness statement dated:

(i) **Fire Risk Assessment: Carl Stokes Associates** [1]

Evacuation Strategy for the Building. This envisaged a plan to be considered between the KTMO and LFB. Further and importantly it raised the issue of disabled and vulnerable residents.[2]

(ii) **Building Regulations Section 1 of B1, Means of Escape from Flats 2.3** [3]

4. We represent a number of disabled residents/bereaved relatives of residents whose ability to leave the building was impaired by disability, age (children and older people), and/or by their position as carers for the disabled, children, elderly relatives . See **Table No. 5 G11.**

(i) The Inquiry has heard and seen evidence that the TMO Emergency manual was some 15 years out of date; containing minimal and inaccurate evidence about the vulnerable and disabled residents in the Tower.

(ii) Children, older people, disabled residents and those with dependent relatives with impaired mobility were afforded no additional protection or consideration of their special needs in the event of any emergency and specifically not a fire. The duty to protect life was owed to all residents of the Tower by the public authorities

---

[1] LFB00000066_005 **Evacuation Strategy for the Building.** *"For the residents of this building there is a "stay put" evacuation strategy, this means the residents can remain within their own dwelling during a fire incident in this building unless the fire is in their dwelling or that their dwelling is otherwise affected by the fire. In which case they should immediately evacuate their dwelling and call the Fire and Rescue Service.* ***The Fire Service or TMO employees will arrange for a general evacuation of the whole building, at any time if this is appropriate to do so****. Alternatively, the residents can leave their dwelling at any time if they wish to do so"*

[2] **LFB00000066_004: Fire Risk Assessment for Grenfell Tower for the TMO by Carl Stokes 20.06.16** Suggested Review date July 2017, with a new FRA in July 2019.

Box 13. Disabled People The yes box is ticked with regard to the question: Is it considered that the building is provided reasonable arrangements for means of escape for disabled people? In the comments box it is noted that *"at the time of the risk assessment there is no evidence of any resident within the premises who suffers from sensory impairment that would prevent them from hearing a shouted warning of fire"*.

The KTMO will be gathering evidence from residents and any disabilities that they may have and whether there is the need for Personal Emergency Evacuation Plan (PEEPs). There is also a reliance on the firefighting lifts to be used to evacuate disabled persons.

[3] The provisions for means of escape for flats are based on the assumption that: (i) the fire is generally in a flat; (ii) there is no reliance on external rescue (e.g. by a portable ladder); (iii) measures in Section 8 (B3) provide a high degree of compartmentation and therefore a low probability of fire spread beyond the flat of origin, so that simultaneous evacuation of the building is unlikely to be necessary; and (iv) although fires may occur in the common parts of the building, the materials and construction used there should prevent the fabric from being involved beyond the immediate vicinity (although in some cases communal facilities exist which require additional measures to be taken). beyond the immediate vicinity (although in some cases communal facilities exist which require additional measures to be taken).

See also BS 9991:2011 Fire Safety in the design, management and use of residential buildings- Code of Practice, Section 0.2 Flats and Maisonettes, General Principles.

concerned. In relation to the above classes of residents, an additional duty was owed to adapt the measures in place to ensure they were effective. RBKC/KCTMO and the LFB failed in these duties.

5. The evidence from firefighters was that they did not knock on doors of flats where no FSG had been given or specifically tasked to attend. We would also submit that consideration needs to be given as to how any evacuation planning takes account of those residents who do not make 999 calls or are unaware because they are asleep or oblivious to an encroaching fire, particularly at night, e.g Gloria Trevisan on the 23rd floor, she did not make any emergency calls.

6. **FINDINGS SOUGHT:**

(i) That there was a systemic failure in training of Firefighters in evacuation procedure.

(ii) No consideration was given to the special needs and requirements of physical or mentally disabled or impaired residents, or those suffering from learning difficulties and disabilities. These residents required Personal Emergency Evacuation Plans. RBKC/KTMO failed to provide these or make any provisions for these residents.

(iii) A number of residents were carers (either registered or known to social services) for vulnerable family members. There were no evacuation provisions which gave due consideration to the specific and added requirements that they may need.

(iv) There were no provisions for residents with children, elderly parents or other dependent relatives who may face added difficulties evacuating the Tower especially those on higher floors.

DECISION No. 5 THE LFB CONTROL ROOM

LFB Policy Fire Survival Guidance Calls 790 LFB00001257
Emergency Call Management 539 LFB00000737 [1]

1. It is submitted that there were serious and disastrous decisions made within the

[1] Emergency Call Management policy 539 lists the following skills required of a call room officer
listen (not to make assumptions)
talk (maintain a dialogue)
record (key the relevant details accurately in the appropriate place on the mobilising system)
think – what information is/is not being given and what information is required
make decisions – is this call appropriate from the brigade to attend and if so what attendance is required

Control Room in terms of the handlers responses and advice to callers, FSG management and situational awareness. Additionally, their record keeping and priotising of calls, their communications with CU7, the lack of training on and understanding of the LFB's own policies and their misdirection on advice e.g. the stay put policy.

2. The G3 group of lawyers will be dealing with the issue of FSG management and communications in details, including the Peter Johnson model of FSG management; so our submissions on this issue are limited to a few key specific points.

(i) We submit that a culture of complacency had developed in the LFB control room. Many of the control room operators had been in post for 20, 30 years plus. Their training was out of date and inconsistent. They were unprepared for calls at such a volume, with even seasoned controllers such as Christine Howson, 31 years in post, having only ever taken FSG calls in single figures previously.

(ii) One aspect of the CRO evidence that particularly alarmed the BSRs we represent was the seeming reluctance on the part of many of the CROs to believe or take at face value the information that callers were providing. All too often a caller's entreaty that they were finding it difficult to breath, were being affected by heat or smoke, or that they could see flames inside their flats were greeted with incredulity, at times bordering on ennui, and the stock reply that the fire was on the 4th floor and firefighters would get to them in due course. These types of responses from professionals charged with the vital task of being the first port of call to residents in distress and sometimes life threatening peril, were wholly irresponsible, reprehensible and unacceptable. The residents of Grenfell Tower deserved better.

(iii) Use of the television, heli teli and other media. Jo Smith, specifically stated that the television was not used as it would distress officers. This evidence was contradicted by other staff. We submit that use of media such as televisions as a tool is clearly something that would be of use to controllers.

(iv) As Calli Beckham, the Surrey controller, noted the visuals from the news feed greatly assisted her understanding of the fire.[2] Much flows from Ms Beckham's short sentence, as

[2] **MET00010868_0004** *"We have the Sky News Channel switched on in our control room and use it as a tool to assist us and build a picture of an incident.* ***I could see that the tower was engulfed in flames and was escalating quickly . My immediate thoughts were that it was going to be really difficult to attempt a rescue, especially on the 22nd floor in relation to the calls we were dealing with****."*

she, sitting in Surrey was to appreciate with greater sophistication and clarity than her counterparts in London a) the scale of the fire, b) make a visual assessment that it would be difficult to get to residents on the higher floors, and c) as a corollary consider in her own mind whether rescues would be possible which logically would lead to a consideration of the stay put advice as against self-evacuation.

3. A comparison between the set up and operation of the Stratford control room and Surrey is highly illustrative of the problems with the LFB control room.

(i) Rob Brown was the commander at the Surrey Control Room and took calls from members of the Disson family. He described the role of the Surrey Controllers.[3]

(ii) Information sharing between the LFB and Surrey (and Kent) was poor.[4]

(iii) We submit that Mr Brown provided a clearer and importantly caller led understanding of what fire survival guidance should entail and the LFB would do well to learn from this.[5] Further, Surrey used media such as the television in the way that one would have expected the LFB controllers to.[6]

4. **FINDINGS SOUGHT:**

(i) There was a complete lack of adequate training of LFB Control Operators.

---

[3] **MET00010868_0002:** *"The essence of call handling is to acquire 3 pieces of information; the address , the incident type and the phone number . Once we have all 3 we can start building on the specifics for the crews that are required. Ultimately we need to get as much information as possible to aid the crews in their attendance. We also try and ascertain where exactly the fire is within a property so the crews have a good overall picture before they attend."*

[4] **MET00010784_0003,** Calli Beckham (nee Anderson) reports that she *"was actually quite surprised that we had not been made aware by London of the scale and that we may receive overflow calls…. To be honest we were caught completely off guard."*

[5] **MET00010868_0002:** *" Fire Survival Guidance becomes applicable and we need to give the best possible advice available in order to keep them safe until crews arrive. The advice often includes opening windows , blocking doors and finding ways of alerting people who are on the ground that they are trapped inside. It is very much led by what the caller says as they are the eyes and ears of the situation and the advice can very much be dependent on what they say. We are led by information given by/obtained from the caller."*

[6] **MET00010784_0003**: Calli Anderson (Beckham) states: *"At the time I did not know the scale of the incident and assumed that the call had come through to us in error as that sometimes happens. I passed the details to Rob who the phoned London. When he got off the phone to me he said that they were taking a lot of calls.*
I checked BBC News and Twitter and then saw the scale they were talking about - 200 firefighters. It was horrifying. ***I had never seen anything quite like it and was actually quite surprised that we had not been made aware by London of the scale and that we may receive overflow calls****. We assumed that because we had not heard from London then they must have been dealing with it adequately . To be honest we were caught completely off guard. We had not been informed how London was dealing with it."*

(ii) The control operators failed to follow their own policy most disastrously in their mis-interpretation of the stay put advice. They repeatedly failed to advise callers to leave who were affected by heat, smoke or fire.

(iii) There was no training for dealing with callers where English is not their first language nor is there training for calls in a panic.

(iv) There was no training to deal with calls from children or other vulnerable adults.

(v) There was a delay in changing stay put advice.

(vi) The absence of the use of the televisions to monitor the news, and the heli teli compromised the situational awareness of those in the control room.

(vii) There was a failure to provide monitoring of calls and advice to junior officers.

5. Going Forward we submit that the following is required:

(i) Complete overhaul of the FSG system. Peter Johnson model.

(ii) Complete overhaul of the training programme for Control Room operators.

(iii) The use of the control room, televisions and other media. Merton and Lambeth and how rooms were used there.

(iv) Monitoring of calls by senior officers.

(v) Use of big screens to show who is on a call and where.

(vi) Review of the buddy system and co-operation between Fire and Rescue Services.

DECISION No. 6 BRIDGEHEAD MANAGEMENT

ToR:- the chain of events before the decision was made that there was no further saveable life in the building;

Table No. 6: Bridgehead Issues

1. **Bridgehead Briefings**

The briefings at the BH were of vital importance as this was the last point before a firefighter went into the unknown and it was the information they were armed with to effect rescues. Where the information was incomplete or just plain wrong, the consequences could be dire. We have heard evidence from a number of firefighters who describe their briefings as just plain bad.

2. We submit that there was basic information that should have and could have been

provided to BA crews at the BH briefings:

-Floor number and flat number, Names (if available) and number of occupants. Ages, any mobility issues, any other disabilities or vulnerabilities. The state of the property at the time of FSG calls: i.e., affected by smoke, heat, actual fire. What advice and been given to the occupants. Conditions on the stairs and lobbies. Plan of the tower and layout of the flats and floors. Details of dry risers.

3. Craig Eden CM at Willesden provides a particularly trenchant and blunt evaluation of the briefings: *"what the fuck sort of briefing was that"* [1]**.** Tom Welch.[2]

(i) See also: No information given about the FSG that the FF was supposed to respond to: Christopher Secrett.[3] No search coordinator: Thomas Goodall [4]. Lack of a strategic planning regarding BA/ EDBA deployment at the Bridgehead: Raoul Codd [5] and Kate Foster [6] and Richard Lawson.[7]

C. COMPLETE BUILDING FAILURE

1. In the first few weeks of evidence FFs were voicing their concerns about the building.

---

[1] Witness statement of Craig Eden: **MET00008019_0007:** *"The bridgehead seemed chaotic with lots of people inside, 3 or 4 BA boards on the left and there was lots of things going on - talking and radio messages but everyone seemed to know what they were doing…. Watch Manager O'KEEFE, who I think is stationed at Kensington, gave us our brief.* ***He said that a BA team was required to go to the 20th floor and tell the bridgehead what we could see and find. I asked him to repeat the brief, as it was not the standard brief you would normally receive for a high-rise building. Normally I would expect to receive more information, such as where the fire was, what room, how many people are trapped, how many flats there are on the floor etc. It is normally quite specific. I did turn around to Tom and said "what the fuck sort of briefing is that?" but I accepted what was said, instead of challenging it, due to the situation and circumstances, but it felt like we were being sent up to the 20th floor to complete a reccy.*** *I think someone had been sent up to the 20th floor before us, but still knew very little about Grenfell Tower itself."*

[2] Witness statement Tom Welch: **MET000080606_0005** *"We was briefed by a watch manager with an Irish accent. I do not know his name.* ***The briefing was to go to the 20th floor and see what we could find. I found this briefing to be unusual and slightly vague. A normal briefing at an incident would contain details of a specific task****. My adrenaline was pumping at this point as I knew this was a big fire, I wanted to get in as quickly as possible and assist in bringing the incident to an end. During the briefing I asked if we were using the fire lift or the stairs. I was told to use the stairs."*

[3] CM Chris Secrett oral evidence 04.07. 18*. His experience in BH was that as a BA wearer, he stood staring at the wall looking at the FSG information to determine where he should be deployed; he was under no direction. Information regarding the 12-year-old FSG ultimately came from FF Badillo, not through BH.*

[4] He admitted being aware that a search co-coordinator should have been appointed but he is unaware if a search co-ordinator was actually appointed on the night of the incident: "***Due to the sheer volume of information that was coming in, you know it doesn't surprise me that it didn't happen".***

[5] Despite being the first EDBA crew on the incident ground, after attending CU, they were tasked to gather equipment rather than attend BH to be committed. He stated that his crew could and should have been committed earlier than 03:05 hours.

[6] Despite being SDBA, she was tasked to attend the 18th floor. She felt this was a long way to go with SDBA. To tackle this issue, her crew did not initially put their masks on to conserve the air in their sets. Whilst on the 18th floor inside a flat occupied by 1 adult female and 3 child, they also took their masks off to save air.

[7] Shared Kate Foster's concerns.

(i) Christopher Dorgu: **The lack of key fire safety measures implemented during 2016 renovation of GT** [1]

2. **Building Regulations 2000**

(i) - **Regulation 38** requires that where building work is undertaken involving the erection or extension of a relevant building, fire safety information should be given to the responsible person at the completion of the project, or when the building is first occupied.

(ii) - **Section B5 of Approved Document B** to the Building Regulations provides detailed guidance on the passive and active systems that should be provided in new or materially altered buildings to assist firefighters.

3. **Ventilation System**

(i) Both firefighters and residents have given evidence as to the faulty ventilation system. See **Table FF evidence in relation to ventilation.**

(ii) Andy Walton's visit in 2016 makes it plain that the ventilation system he was shown in the demonstration bore little resemblance to that which was installed in Grenfell Tower, e.g no integrated alarm system.

(iii) - Dr Barbara Lane has concluded that the design of the lobby smoke control system was "*substantially non-compliant*" with the performance requirements of the relevant British Standard, and consequently, it did not meet the guidance within ADB 2013. She says that despite extensive documentation being available to her, she has been unable to determine how the design was intended to meet the requirements of the Statutory Guidance and therefore comply with the functional requirements of the Building Regulations.

- Dr. Lane has also concluded that on the basis of the information she was provided with, she says that she is unable to confirm that the lobby smoke control system was fully

[1] He stated that during his 7(2)(d) familiarisation visit at GT during July 2016, he describes the building's exterior as looking as if money had been spent on it. Despite this, he noted that he thought the building should have had sprinklers and fire alarms fitted. Consequently, there would be no one on site with detailed or any knowledge of: the internal layout of Tower, flat numbers, a list of names of residents, ages or any special needs of residents.

commissioned to BS EN 12101-6:2005. [2]

- She noted the oral evidence of Mr Farhad Neda [3]

4. **Doors/ Windows:** All BSRs gave compelling evidence about the deficiencies in the building as a result of the refurbishment, including the drafts from the windows and repeated failure of the self -closing mechanisms of the "new" flat front doors.

D. EVIDENCE OF THE BSRs

Table No. 7: Transcript Extracts from the BSRs

1. We have always maintained that the BSRs should be front and centre of this Inquiry. There have just been some very powerful exhortations from recent witnesses amongst others:

- Sid Ali Atmani ,Nick Burton, Marcio Gomes and Hanan Wahabi.

(i) They all wanted no more waiting, no more wasted or missed opportunities. Above all GT must not happen again and need not do so. Lessons must be learnt and changes made sooner rather than later. They are far from alone in these aspirations.

(ii) It is not difficult therefore, to distill the main BSR demands...a combustibles ban, a reappraisal of the stay put policy, a recognition of residents representations, and governance accountability. Putting it shortly we are obliged on the families behalf, and the public at large, to pursue these demands and prevent this Inquiry from becoming an exercise in the long grass.

(iii) They lived in that Tower, they lived through the refurbishment. They foretold the failings of the building and the lack of compliance with building regulations. They are themselves experts.

---

[2] The commissioning documentation which was provided to the inquiry omitted a large number of the performance requirements of BS EN 12101-6:2005; and that the commissioning of the system also omitted a substantial proportion of the provisions made within the Smoke Control Association (SCA) Guidance on Smoke Control to Common Escape routes in apartment Buildings (Flats and Maisonettes) Rev 2: October 2015.

[3] (Transcript 18th October, p27) about smoke leaking into the lobby of Level 23 via the smoke shaft vents, on the north and south side. Dr Lane considers this to be a critical piece of evidence going forward, as it could indicate a significant failure of the smoke control system to prevent contamination of compartments away from the fire compartment (in breach of Section 11.8.2.10 of BS EN 12101-6). She also considers that this evidence may indicate that there was a failure to comply with the compartmentation rules for protected shafts in Section 8 of ADB 2013.

2. The evidence given by BSRs often visceral, harrowing and palpably painful, but without exception that evidence was given in the dignified and eloquence that the Chair no doubt become accustomed to hearing from the outset at the Pen Portrait hearings to the BSR evidence in October and November. We are particularly mindful that the Chair should place the BSR evidence front and centre of this Inquiry.

3. A particularly poignant personal plea to the Chair came right at the end of Hanan's evidence. She set out in careful and reasoned terms the key to this Inquiry. There has to be change so that those who died did not do so in vain. Exceptionally the Chair responded directly to Hanan describing her observations as 'powerful, perceptive and generous', and added, moved by her words, a commitment to lessons and change.

4. Counsel to the Inquiry Mr. Millet QC, paid a striking tribute to the courage of the BSR witnesses at the end of this part of the evidence, and characterised BSR evidence as ' a source for hope '.

E. RECURRING THEMES IN PHASE I EVIDENCE

"If history repeats itself, and the unexpected always happens, how incapable must man be of learning from experience" George Bernard Shaw

1. Lakanal and Beyond

At the conclusion of the Inquests into the Lakanal fire in 2013, the Coroner made a number of recommendations to the London Fire Brigade, Southwark Council and the Department for Communities and Local Government in her prevention of future deaths report/ Regulation 28 report.[1]

(i) It is abundantly clear that very few lessons have been remembered never mind learnt. Whilst Grenfell Tower represented one the largest loss of life through fire since WWII, in the past 40 years there have been a litany of fires in high rise towers in the UK and the rest of the world, each providing an insight and understanding that should have been brought to bear on the next generation of architects, builders, contractors, local authorities and fire and rescue services. Each time there is a disaster in this country, there is the ritual

[1] **LFB0000275_0001**. One of the recommendation was that the LFB considered how to improve dissemination of fire safety information to achieve effective communication of residents in high rise residential buildings.

wringing of hands, words of condolescenes, politicians vying for sound bites and declarations that this never happens again, whilst the industries involved vow that lessons will be learnt and a new dawn in regulations, trainings, equipment, etc will rise. Sadly history teaches us that even before the grieving period for the dead has ended, governments, public bodies, private companies etc all too quickly fall back into their old practices and ways.

(ii) Thomas Goodall sums up the post Lakanal learning by some in the LFB: Organisationally "***post Lakanal we were aware of unusual fire spread, we were aware of a fire being able – that was new – a new risk that came out of the Lakanal incident***" – but for an entire external envelope to be alight, "***I had never done any training, I had never delivered any training in preparation for an incident***" to the extent of GT.

(iii) Andy Roe, rightly complained at the 0730 TC meeting that the absence of plans would be seen as a serious failing especially in the light of Lakanal.[2]

(iv) The challenge for this Inquiry is to buck the trend. The evidence in phase 1 has highlighted that the Lakanal recommendations have only been partially recognised and implemented by the LFB and certainly not in a consistent or systematic manner.

2. **<u>Deficiency of Firefighter Training and Knowledge</u>**

With particular reference to High Rise Blocks, this was one of the most glaringly obvious recurring themes of the evidence. It is alarming that despite the plethora of literature, policies, guidance, circulars much of it is either not read, not retained or not disseminated.

3. The outsourcing of training to Babcock has seen the replacement of traditional training of fire fighters with theoretical exercises and Computer Based Training (CBTs). In addition, Babcock also hold the contract for servicing the LFB equipment.

(i) See Mike Dowden's training.[1] This was echoed by other FFs including Raymond Keene[2] and FF Michael Mulholland[3].

---

[2] Thatcher Body Cam

[1] 25.6.18 [page lines 3– 25] 3 Who delivers the initial watch manager training? A. The London Fire Brigade deliver that. That has changed… for my promotion, it was the Fire Brigade…. facilitating totally its own training. Since then we have outsourced that to Babcock. Now Babcock deal with raft training; so that's officer training, firefighter training, refresher training. We used to go to the Fire Service College, but now that Babcock provide our training, we do that at sites internally in the London Fire Brigade. That was facilitated generally for incident command refresher courses, that's at Harrow fire station… they've got a training centre there, and that's done by a simulation…. you'll go into a room and you'll be given different scenarios on a computer based training package.

(ii) FF Daniel Brown gave trenchant evidence of the failure to desk top training packages to deliver adequate training of the lesson learned from Lakanal.[4] This was confirmed by DAC Adrian Fenton.

(iii) See also Glynn Williams on previous training on responding to fire spread from secondary gas emissions.[5]

4. We submit that this is clear evidence from those directly effected of the failure of Babcock's training across all levels of seniority within the LFB. We further submit that by placing the training in the hands of the private sector has led to a "race to the bottom" and impacted on quality assurance with the clear casualty being safety of the public. Their position of training providers and owners of IT and equipment requires an urgent review.

5. Lone voices such as Peter Johnson have sought to challenge the prevailing directions of the LFB leadership and stem the tide on de-regulations and privatisation. Whether Commission Cotton's lack of knowledge of Peter Johnson's initiatives was real or illustrative the closing LFB managerial ranks neither is acceptable. The refrain "broken equipment" must have been known by all, including Babcock. [6]

FINDING SOUGHT:

(i) Babcock International as training providers for the LFB have failed in the mandate and left an ill-informed workforce, deficient in key areas of knowledge, training and implementation of policy. This impacts upon their operational and strategic roles as FFs.

(ii) This also impacts upon public safety and confidence in the Fire and Rescue service in the Capital.

---

[2] 18.7.18 [page 6 10- 16] There are training packages from Babcock. It used to be through the Brigade, but since Babcock has taken over, it's their training packages..

[3] 01.8.18 [page 11]

[4] 28.6.18 [page 176 1-4; 177 1-5].Were you aware from your experience about Lakanal House? A. No. I mean, we did a basic -- again, a basic desktop package, that's theory, and -- no, not really. The training on it wasn't great, no, in my opinion... It's just very hard because, literally, most of the training that we receive is just text written on a bit of paper, it's just written out, printed out. It's given to the watch manager, "There you go, deliver that".

[5] 30.7.18 [page 7 lines 15 – 22]: how to respond to a fire that is spreading internally because of secondary gas emission. So this was very practical. This was at the Fire Service College. This was real fire training using combustible products, and it's where we historically carried out our real fire training. We don't have that facility anymore, so it's not training that takes place now.

[6] Peter Johnson's evidence 4.9.18 – 5.9.18; Norman Harrison's evidence 19.9.18

(iii) The leadership and management of the LFB, failed to listen or engage with the advice and proposals put forward by Peter Johnson in respect of FSG management, IT and training. This was a serious and material failing that impacted upon their response to the fire that night.

(iv) In doing so, they not only compromise public safety and lives but those of the rank and file FFs.

6. Impact of deregulation and budget cuts on the capabilities of the Fire Fighters

The correlation between the reduction of resources and the ability of the LFB adequately respond to fires is self-evident.

(i) The LFB's response to Grenfell tower was invariably affected by deregulation, outsourcing, budget cuts and a growing culture of the neglect of essential services. The devastating effect on fire safety calls for an urgent halt to deregulation of the LFB and input of resources into the service.

(ii) The Command Unit,[7] was largely ineffective as most of the equipment did not work. The consequential effect LFB's response to the fire, coordination of responses of the emergency services the deployment of resources on the ground is axiomatic.

(iii) Deregulation has overseen the reduction in number of fire fighters and the capacity of the LFB. See evidence of Dan Brown[8] which adds to the call for urgent review of the resources being allocated to this critical service.

7. Effective implementation of the existing LFB/Fire Safety policies

There are serious concerns with regard to the level and rigour of training and subsequent compliance with existing fire brigade policies and national legislation. Crucially, the nature and extent of the section 7(2)(d) familiarisation visits both to Grenfell Tower specifically by the local crews, and the wider training and practice in these visits amongst LFB crews, falls short in terms of detail, specificity and compliance with the relevant legislation and guidance. The resultant information that is gathered at such visits is minimal as reflected by

[7] Tony Peckham 26.7.18 page 89 line 18

[8] Dan Brown 28.6.18 [page 182 lines 8 – 15] Part of working on the front line within a fire station is there's a real struggle for resources. I think we're nearly 300 firefighters short right now. It's really hard to maintain pumps on the run, particularly in summer. So many are coming off the run during the summer. It's really hard to maintain a level of fire cover. It's a real struggle. It's hard, I won't lie.

the very basic information recorded on the MDTs . Section 7 (2) (d) **Fire and Rescue Services Act 2004** Attached. Non-compliance and poor implementation places not only the public at risk but firefighters too. The LB policies and legislative framework supporting section 7(2) (d) is also clear and ambiguous **Policy 633, GRA.3A.**

8. A properly conducted section 7(2)(d) at Grenfell Tower would have produced invaluable information for the firefighters on the night such as access issues, layout, realisation of the single narrow staircase, that there was no concierge or alarm system and informed their firefighting strategies. However, even that would and could not have provided the firefighters with the crucial information concerning the nature and composition of the cladding, the design and installation and other aspects of the fabric of the building which caused and accelerated the speed of the fire spread. Information in the hands of the contractors, RBKC and KCTMO.

9. Christopher Dorgu spoke of the changes in the LFB roles regarding **enforcement of fire regulations .**[1]

10. **FINDINGS SOUGHT:** (i) There has been a systemic failing on the part of the LFB and Babcock to ensure consistent and effective dissemination and implementation of existing LFB policies amongst the wider firefighting population.

(ii) The section 7 (2)(d) familiarisation visits have fallen into disrepute.

(iii) It must be an essential part of a firefighters role to undertake effective and detailed section 7 (2)(d) visits in accordance with the legislation and guidance.

(iv) Appropriate time must be given to individual firefighers to conduct such visits.

(v) The responsible persons for high rise buildings within a fire station area must cooperate with the LFB to facilitate these visits.

MICHAEL MANSFIELD QC, MARCIA WILLIS STEWART QC (HON), ALLISON MUNROE JUSTIN BATES, PHILIP DAYLE, JOSH TERRY

6TH DECEMBER 2018

[1] Dorgu Witness statement: **We are no longer qualified to actually check things on a minute bases so we don't – were not obliged to check things - they don't teach us how to check things so it's more a curiosity inspection [with regards to 7(2)(d) visit]".** No longer in the scope of the role of a FF; 20 years ago we conducted more in depth inspections.