

WITNESS STATEMENT

Criminal Procedure Rules, r27.2; Criminal Justice Act 1967, s.9; Magistrates' Courts Act 1980, s.5b

Statement of: ALIE, DANIEL

Age if under 18: Over 18 (if over 18 insert 'over 18')

Occupation: FIRE OFFICER

This statement (consisting of 24 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false, or do not believe to be true.

Signature: D ALIE

Date: 15/03/2018

Tick if witness evidence is visually recorded ☐ (supply witness details on rear)

This is my account of the fire at Grenfell Tower in the early hours of Wednesday 14th June 2017.

I will mention a number of people all of whom are in the London Fire Brigade (LFB);

Assistant Commissioner (A/C) Andy ROE.

Deputy Assistant Commissioner (DAC) Andrew O'LOUGHLIN.

Temporary DAC Rick ODGEN

Group Manager (G/M) Pat GOLDBOURNE.

G/M John GRAHAM.

G/M Tim FROST.

G/M Neil CHISHOLM.

G/M DISSANAYAKE.

Station Manager (S/M) Sam KASMANY

S/M Steve CHESSUM.

S/M David REID.

I will mention Grenfell Tower and the internal layout of it up to, and including, around the 10th floor.

I joined the London Fire Brigade (LFB) on 3rd March 2002 when I underwent an 18-week basic fire fighter training course at Southwark.

From there, in June 2002 I was posted to Holloway fire station and during my time there, I sat the leading fire fighter promotion exams and was then signed off from phase 2 which is a form of probation. I was now a substantive fire fighter.

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In 2004, I was posted to Edmonton fire station and 3 months later was transferred to Enfield on promotion to Crew Manager. I was in development for about 6 months there as a Crew Manager and in 2005/6 I was selected to be on a fast track promotion process.

I transferred to Head Quarters as a Watch Manager to the Strategic Risk Team as part of the targeted development programme.

In 2006/7 I moved to Finchley where I completed my development as a Watch Manager.

From there I shadowed DAC Ian HUGHES for 5 months and in 2008 became part of the Incident Command Team as a Temporary Station Manager at HQ. At the same time, I also had responsibility for managing Edmonton and Wembley Command Units, developing 7 CU watch managers.

Whilst at HQ, as a station manager, I was assigned the role of test manager for the brigade's new command support system.

The system was to be installed on the 9 command support units that had recently been introduced. I'll explain what happened when I was there later in the statement.

In 2010 I went to Hornsey and later became a Substantive Station Manager and in 2012 moved to Finchley where I was part of the health and safety functional working team, managing health and safety at 9 stations.

During my time at Hornsey I qualified as a press officer and later gained my qualifications as a bulk media specialist. I can find and move water, and I can deploy fire fighting foam. I am one of the brigade's fire fighting media specialists.

From around 2008 until around 2013, I was often posted as Office Of The Day to the brigade resource management centre at Stratford, probably around 3 times a month. During these days, I was on a 24 hour call and any issues that came into the brigade would come to me. I would triage them and either deal with them or send them to the appropriate person.

It is a responsible job and gives you a broad insight into the workings of the LFB.

In 2013, I moved as Station Manager to Kentish Town and whilst there I gained a senior accident investigator tag. That means that I was trained to investigate safety events to determine cause and underlying causes of accidents in a senior role.

In October/November 2013 I moved to Southgate as a Station Manager and at the same time was appointed to be the community fire safety liaison officer for Enfield and Barnet. This involved creating partnerships and enhancing working practices with local authorities, police, other statutory bodies as well

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as housing, care organisations and the general public. At the time I was the only officer within the brigade to hold such a post.

In January 2015, I spent some time as a Station Manager at both Hendon and Mill Hill fire stations as they were short of Station Managers.

In September 2015 I went back to Southgate as its station manager whilst maintaining the fire safety officer role.

I have since been promoted to Temporary Group Manager in Health And Safety team at Brigade HQ where I am now posted.

In terms of training, all fire fighters and officers have Continuous Professional Development (CPD). As a bulk media specialist I continually have regular training days with the Bulk media cadre to maintain my skills.

I have attended the fire service college for these CPDs and also as a senior investigator I attend, a CPD day every 4/6 weeks. During these days, we look at new procedures and strategies and recent events.

Every year I attend a Tactical Incident Command Course at one of the training centres where I am assessed to ensure my command skills are up to date. I've actually been on three of these in the last year. These courses assess my command and control skills and I've never had a problem passing these courses. This is demonstrated by the Brigade deploying me at operational incidents, without supervision, from November 2017 to date as an operational Group Manager.

The day before Grenfell, I completed the first day of one of these courses, but the second day was when the incident happened so I didn't complete the course on that day. I did the 2nd day on 19th December 2017 which I passed.

In addition, when I went through the Group Manager promotion process in January 2017, I was assessed as being suitable to perform at that level. Sadly for me, there were not sufficient spaces for me to be promoted substantively and so I am currently going through another process.

I complete additional mandatory training. Everyone from fire fighter up to Commissioner has a record of training with is stored electronically.

The day before Grenfell, so Tuesday 13th June, I was on a 2-day course at Harrow during the day. I've mentioned this course earlier, it was the Tactical Incident Command Course.

I was due to go to the second day of the course on the day of Grenfell. On Wednesday 14th June, I woke up at around 4.30am. I went downstairs, turned the TV on and saw the fire on the news. We've all seen

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the footage on the TV, most of the building was alight. At first thought it was a massive tower block fire in an overseas country. It didn't occur to me that anything like that could happen in the UK.

I then realised that it was in West London and simply couldn't believe that something like that could happen here. I woke my wife and we watched the news for a bit.

I knew that I was likely to be required and so at around 5.00am contacted our control and told them that I was available. I knew that even if I wasn't sent to Grenfell, there would be a lot of personnel there and they would be short of officers elsewhere.

They said that they would get back to me. I continued watching the news and started to get ready. I left home sometime after 7.00am and began to drive to Harrow.

Because of the incident, I knew that I was unlikely to be on the course but I began to drive there anyway. Shortly after I left home, just before I got onto the M25 at junction 25, my brigade pager went off. It was now around 7.30am.

It told me that there was a 40-pump fire at Grenfell Tower. It gave me the address of the RVP and I was ordered to attend. I booked in with control and called my wife telling her that I was going there.

I had a brigade vehicle, equipped with two tones and sirens and an airwave radio, the traffic on which was busy. I had the call sign of A36S. I also had LBC on so that I could gauge what was happening.

I booked on with control and because I don't know the area, put the address in my Sat Nav and made my way. I travelled down the A10 and then onto the North Circular Road on two tones and blue lights.

I remember hearing on LBC of a man leaning from one of the lower floor windows of the tower waving a cloth in order to be seen. The airwave radio mentioned this man with the police asking the brigade to get him. I remember hearing the brigade acknowledging the request, saying that they were trying to rescue him.

It took around 25 minutes for me to get to the area of the tower and I found the RVP. There are 8 mobile Command Units (CU) within the LFB and I knew that one of them would be the main control vehicle and I needed to find it to tell them of my arrival and to be tasked.

Back in 2008, I was brigade test manager for the command support system, so I know command units and their functions.

A command unit is an 8 tonne chassis lorry with all you need on board to control an incident. It has phones, white boards, advanced computer and communication systems, Internet and all you need to command a major incident.

I parked on a main road, I can't remember exactly where, and got rigged in my fire clothing.

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As I walked towards the CU I saw tired, drawn and drained fire fighters walking back past me. They had clearly been operational and looked so drained. I knew that this was going to be a busy period.

I remember one of them saying with a blank expression "50 ON THE STAIRS". I took it that he meant that he had seen 50 deceased casualties. He had a blank expression on his face and walked off.

I had now met up with S/M Steve CHESSUM but we couldn't find the Command CU. I could see the tower so we followed other fire fighters who we assumed were heading towards the CU.

I remember a man, a member of the public, coming out of a house to my left and speaking to me saying that he knew what had happened to the tower and it was because of a cannabis factory inside.

There were other fire fighters around so I asked one of them to gather the man's details and what he was saying. I don't know what happened to that information. I'll describe the man at the end of this statement.

It was a bright sunny day and after a 10-minute walk, I found the CU. There were around 10 other officers waiting outside.

From the CU I could see the tower. There was grey/black smoke and flames coming from it. I know that the darker the smoke, the more the building is actually on fire so I knew from its colour that some of the tower was alight. The upper floors of the building were well compromised with two thirds of it being alight. There was a jet of water being thrown onto the outside of the building from the right as I looked at it.

From the CU I took a photo of the tower on my phone. (SJH/2)

I stayed with the other officers for a short while, talking about the incident. During the conversation, I heard that a person had jumped from the tower, hitting both a canopy and a Crew Manager.

A/C Andy ROE, the Incident Commander, then came out from the CU.

It was clear that they were busy, he said that earlier there was around 60 machines at the scene and we were asked to wait until they were ready to task us. We completely understood the delay as we have been in CUs and know how busy they are during major incidents like this one.

I had earlier handed in my Nominal Role Board (NRB) to the CU at the RVP when I arrived.

Every appliance and officer has an NRB which is a small piece of tin. It has a space on it where you can record the names of the crews that are on a particular appliance, or the officers' name, all sign, skills, vehicle registration and telephone number.

That NRB is handed in to the CU so that they know exactly what staff they have on the fire ground.

When crews leave the scene, they must collect their NRB so that the CU knows that they have left.

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About 5 minutes later, DAC Andrew O'LOUGHLIN came out and asked for volunteers to go inside the building to the Bridgehead and the Lobby.

A Bridgehead is used mainly in high-rise incidents and is there to provide a command and control platform, generally 2 floors below the fire floor.

It is part of the National Incident Command System to sectorise fires to provide a means of addressing fires in a safe manner.

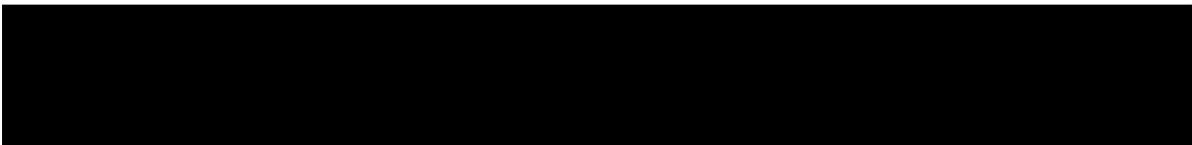
It will be managed by a minimum of a Crew Manager.

On the Bridgehead we will have keys, breaking in gear, a Thermal Imaging Camera (TIC), a first aid kit, hose and an Entry Control board (ECB) which will be operated by an Entry Control Officer (ECO). There will be other essential equipment which is stated in the high rise policy.

An ECB provides a monitoring system for breathing apparatus (BA). It is electronic and enables us to monitor BA wearer's use of air and inform us of time of whistle, how much air they have left, to determine how hard they are working and when they should leave the risk area.

The electronic ECBs came to us around 3 years ago and prior to that entry control was managed on a manual board. The boards are a big improvement to the method that we had previously.

S/M Sam KASMANY, from Soho fire station, and I volunteered to go to the Bridgehead and S/M CHESSUM was deployed to the lobby area. We walked towards the tower. No one was looking at each other, it was clear to me that the building was in danger of completely coming down and we were walking towards it.



I wrote my name with a China graph on my helmet. The reason for that is that in New York during 9/11, when the buildings collapsed, it killed a number of fire fighters. When they were subsequently clearing the scene, some of the fire fighters couldn't easily be identified. I remembered that and so wrote my name.

It just demonstrates my feelings and fears as I walked towards the tower.

As I got to the tower there was either an Ariel Ladder platform (ALP) or a Turn Table Ladder (TT), which was parked and couldn't deploy as it was blocked in with vehicles, hose and debris, which had fallen from the building.

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Opposite the main entrance to the building was a fixed undercover area with a concrete walkway above.

This provided safety from the debris but in order to so, there was a 15 feet uncovered area which you needed to get across whilst being exposed to the debris.

Under the covered area were police in riot gear and they were escorting fire fighters in and out using riot shields above our heads. This provided a degree of protection from the falling debris.

S/M KASMANY and I were safely escorted in by the police and we reported to G/M Pat GOLDBOURNE in the ground floor lobby area. The visibility within this area was fine and the air was breathable, but the floor was covered with fast moving water.

He was the officer in command of the ground floor area and was controlling Breathing Apparatus (BA) wearers into the building.

He asked S/M KASMANY and myself to go to the 4th floor where the Bridgehead was situated and report to G/M GRAHAM.

I made my way up the staircase and was struck with the amount of water streaming down the stairs, It was like a waterfall, pouring down and at least ankle deep.

I remember seeing that fire fighters had written the number of each floor on the wall. There were loads of hoses on the stairs, it was dark with very little lighting. The first part of the staircase was modern but that changed into an older style staircase as we went up.

S/M KASMANY and myself made our way up and by the time we got to the 4th floor Bridgehead, we were absolutely soaked wet through. I remember that Sam took a load of photos as we walked up the stairs.

Because of my bulk media training I just felt that it was too much water coming down the stairs. I thought that we must have been putting a lot of water on the building or a hose had broken or something. There just seemed to be too much water.

Once on the Bridgehead, I was met by G/M John GRAHAM who was in charge of it. Also there was G/M Tim FROST.

There were loads of fire fighters there and the area was really busy. They had set up in the lobby area and had started a grid system written on the door of an electrical cupboard. There were two fire fighters writing information onto the grid.

That system was there in order to record what flats and floors had been searched, which ones were clear and which ones were outstanding.

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G/M GRAHAM tasked me to be recorder, to record where fire fighters had been and searched, where the casualties were located and to manage where we had been in the incident. That information would be fed back to G/M GRAHAM and the CU.

G/M GRAHAM used S/M KASMANY to help deploy the fire fighters up into the building.

On the Bridgehead was some lighting, at least one ECB an ECO and a comms officer.

I've been shown a picture of the grid on the electrical cupboard. (SJH/5)

When you look at the picture, there is a straight lined grid on the left with floor and flat numbers and some hand written information on the right.

The straight lined grid has floor numbers going upwards and flat numbers which should correspond correctly to what floors they are on.

On the right is a separate table which includes the call sign of the crews, what type of BA they were wearing, the time that they went in and what floor they were briefed to go up to.

The times start at 9.44am and finish at 11.03am.

When I got there, some was already written but some of the writing is mine, some belongs to others.

Where it says "7 SEARCH - NONE - DOG", that's my writing.

It would make sense that I got to the Bridgehead a short while after 9.44am.

Most of the writing on both sides of the picture is not mine. So crews were being deployed throughout the first hour and a quarter or so that I was there but I then realised that something was wrong.

If you look at the left hand side of the picture, there is a dark circular shaped marking on the wall. That is a plate, which was on the wall of the building and shows what flat numbers are on the 4th floor.

I noticed that our grid showed that flats 23, 24, 25, 26, 27 and 28 were on the 4th floor.

When I looked at the plate, and when you took at the photo, I saw that in fact, flats 11,12,13,14,15 and 16 are on that floor.

Our grid was clearly incorrect.

I realised that I needed to take control of this and start again. So when you look at the photo, you will see on both sides, a number of crosses marked in yellow. That was me. I did them to indicate that the information was incorrect. I also wrote "IGNORE SM" which is written above the chart.

I asked for a Forward Information Board (FIB) to be brought up. An FIB is a large plastic white board that we use to write information on. It's about 2 X 2.5 feet in size. They were introduced to the LFB after a fire in Lakanal House in 2009. These boards were not being used at the time. Earlier on it must have been very chaotic.

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Once I had one, I started transfer some of the information from the wall chart onto it and also captured new information onto it.

Looking at the times on the picture, that must have been after 11.03am as that is when the grid stops. However it was much too busy on the bridgehead. There was so much going on, there were so many people, that I needed somewhere more calm to carry out the task.

So looked for and found a flat on the floor that I could use as a base. I thought that if I set myself up slightly away from the main area, I could capture the information much better. I don't know the number of the flat that I used but I've been shown a diagram of the layout of the floors. I've marked on it where the flat was. (SJH/6)

I'm 100% sure that I have marked the correct flat, which is opposite the lifts and behind the staircase. I'm now aware that the fire started in flat 16 on that floor. I wasn't aware of that throughout my time in the building. I'm certain that I didn't use that flat. I think 16 was next to the one that I used, as you look from the lifts, diagonally in front to the left of them.

I put my head into into every flat on the 4th floor so must have done so for 16. But I can't remember actually being in it and don't recall anything different to any of the others.

I remember fire safety officers being at flat 16 checking the compartmentation of it and removing some of the panelling around the door.

Inside the flat that I was using was a kitchen, with a sink full of overflowing water, a coffee table and a settee. There was also a wall in the living room, which was ideal for writing my information on.

Although I had started using an FIB, the information that I was getting was sketchy. By putting the information up on the wall, it enabled crews to visually see the floors and flat numbers. The FIB could be moved and I didn't want that, I wanted a fixed place that I could use.

So I used the wall in the living room as a base and each time a crew came down from above, G/M GRAHAM made sure that they would come into the flat and I would debrief them.

On a piece of paper, I had drawn a floor plan of the layout of the floors, similar to SJH/6, and had given it to the ECO so that crews had an idea of what to expect when they went to the floors. I'm fairly sure that I also drew a sketch of the floor layout on an FIB.

The debrief included the flat number, the conditions, whether there was fire, whether they saw anyone, location of casualties, places that they couldn't get to because of the conditions and any difficulties or hazards that they had encountered.

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I wrote what they had or hadn't managed to do on the wall with a China graph and from there I relayed that information back to G/M GRAHAM.

He in turn passed the information to the CU so that everyone knew where we were.

Before I left the building, I took a photo of the writing on the wall. (SJH/4).

When you look at the photo, you can see the timings.

So for example, 6th floor, the crew F41 I told me at 13.58 that it was all clear.

I didn't have any information about the 7th floor.

On the 8th floor, the crew A352 told me at 14.05 that there was a dog and a deceased casualty on the floor.

I remember the crews told me it looked like the remains of a male and a dog on a bed inside a flat. That stuck with me as either they were asleep when it happened or the man decided that that was the safest place to be.

On the 9th floor, the crew F471 told me at 14.00 that pockets of fire remain and 1 deceased casualty was found in the lobby. I think that casualty was the renowned artist lady who has since been in the media. I'll explain why I think that later in the statement.

I remember at some stage a police officer coming to us and asking to go up to retrieve her. G/M GRAHAM told him that he couldn't as it wasn't safe for him to do so.

On 9th floor again, the crew A351 told me at 14.10 that there were 2 deceased casualties.

So different crews were reporting back but I wasn't sure if they had found the same casualties. The heat up there was making things so difficult.

On the 10th floor, the crew F451 came back at 14.15 but couldn't give me any information.

On the 11th floor, a crew told me at 14.17 that there were no casualties. I haven't written down the crew but I think it was F451.

For my entire time in the building, based upon what I had been told by the fire fighters that I debriefed, I can vouch for floors up to the 11th.

It wasn't easy, it was difficult. We were working in an extremely pressurised confined space environment, we were deploying large numbers of fire fighters and we had water and heat challenges.

Add to that what people were seeing and the constant threat of collapse to the building it gave us an unprecedented situation. But I did this for hours.

I remember that there were runners coming up from the CU asking for updates. They would return to the CU with our updates.

We were making slow progress and the CU wanted to know why. The answer lay in hoses.

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Before I had arrived, it was clear that crews had laid a lot of hose throughout the building and particularly on the staircase. There were layers of hose lines entwined and fire fighters were telling me that those hoses had become tangled and were blocking the route up and down the building. This was preventing them from moving hose forward to search the building and extinguish the fires.

The hose was fed from the dry riser but had become a tangled mess and the water pressure was low because of this. I am unaware of what water set up was in place externally. Procedures prevent crews from entering a fire compartment without a water supply. So it was important to untangle the hoses to enable water to be supplied.

Just because of the conditions, things had become really challenging. It was a real issue and one that needed to be addressed.

So being a bulk media specialist, I told G/M GRAHAM what the fire fighters had been telling me and I told him that we needed to start again with the hoses. We couldn't untangle them and needed to remove them and run new lines of hose from the dry riser.

G/M GRAHAM told me that he would not run new lines of hose. I told him that I am a bulk media specialist but he would not tell me why he wouldn't run new lines of hose.

He had been there before I arrived and had been on the bridgehead for a very long time. He was shouting at fire fighters and I even saw him hit G/M Tim FROST over the head with a plastic bottle whilst Tim was briefing two fire fighters.

I felt that he had lost control of himself and of the Bridgehead which was far too busy. He had been under too much pressure and had been there for too long.

He is a good capable officer. But he had been there for too long a time and I believe the immense pressure that he was under had started to have a negative effect on his decision making and interaction with other bridgehead staff.

By refusing to address the issue of the tangled hoses when presented to him, this delayed sufficient amounts of water being available to fire fighters and stopped them progressing through the building in a timely manner.

I spoke to Tim FROST and spoke to him about G/M GRAHAM's behaviour, I said that he needed to speak to him to calm him down. Tim said that G/M GRAHAM can't speak to people as he was but I didn't see him challenge or speak to him about it.

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About 5 minutes later I decided to take him to one side and politely and respectfully speak to G/M GRAHAM and I asked him, one officer to another, to calm down. I told him that his behaviour was affecting the crews. He said that it was a pressurised situation and dismissed my concerns.

DAC Rick OGDEN arrived at the Bridgehead and I told him about the hose issue and that G/M GRAHAM had refused to move them.

I told him that we needed to move the hoses and put them into flats out of the way and replace them with fresh ones from the dry riser.

I also told him that I thought G/M GRAHAM was compromised and told him how he had been behaving. I saw him speak to G/M GRAHAM but nothing was done at that stage.

DAC OGDEN left for a bit.

So I was in my flat when there came a point, sometime before 2.00pm, where I realised that I'd not received any fire fighters to debrief for some time.

I left the flat onto the bridgehead and found myself completely alone. It took me some time to realise that the bridgehead had been moved from the 4th to 6th floor.

No one had told me. A couple of times I heard loud bangs and thought that the building may be coming down with me and others inside it. When I was left alone when the bridgehead moved, I was at the height of my feelings of fear.

You never leave anyone. Not on a bridgehead and my initial thoughts were that there had been an order to evacuate as the building was going to come down, that everyone had gone and left me there alone to die.

It's something that I still literally have nightmares about.

I went out onto the stairs and paused to decide whether or not to leave or go looking for my colleagues. I called on the radio and received no reply. I then heard a noise above and decided to go and look for them and not leave in case they were there. That was a hard decision.

I was having a mixture of emotions. I was scared, I didn't want to leave my colleagues but I just didn't know where they were.

I found the bridgehead on the 6th floor.

I spoke to G/M GRAHAM and ask him why I'd been left alone. He laughed it off. I was still in a state of shock as for the whole morning I'd been in fear of building collapse. To have him laugh it off made me even more concerned about his welfare and behaviour.

On the 6th floor I began to set up a similar base to the one I had on the 4th floor. I used the exact same flat, directly above the one I had been using but my time there was short lived.

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Shortly into the 6th floor an experienced looking Crew Manager noticed that there was a fire underneath us on the 5th floor. It not unusual for an extinguished fire to rekindle but we can't be above the fire.

I told G/M GRAHAM who didn't react so I personally ordered everyone off of the 6th floor down to the 4th. Officers and fire fighters immediately complied. I was the last one off of the 6th floor, ensuring that everyone came off of the floor.

I went back into my room and continued doing what I was doing before.

DAC OGDEN then returned asking G/M GRAHAM about progress. Progress was slow and so DAC OGDEN ordered that the hoses be moved and new lines run.

It must have taken around 3 hours from me initially telling G/M GRAHAM about the hoses until they were finally moved.

New hoses were then laid, causing less of an obstruction for crews and an adequate water supply. From there we progressed up the block much quicker.

The bridgehead was then again moved upwards to the floor. The Bridgehead moves weren't my decision although I guess they were made in order that the fire fighters were nearer to where they had to get to and could therefore preserve more of their air.

So I was now on the 6th floor bridgehead for the second time and saw that it was equally as busy as the one on the 4th had been. There were EDBA and SDBA crews everywhere. It was just too busy so I identified two flats and, with a wet cloth on the soot on the wall, marked "EDBA" on the front of one and "SDBA" on the front of the other.

I used the two flats to hold crews in a holding area until being deployed. That way the bridgehead became more manageable. I've marked a separate diagram of the 6th floor where I based those crews. (SJH/7)

We had some issues with water as the higher we went up, the lower the water pressure became.

I spent most of my time in the flat on the 4th floor but was relieved by S/M David REID from the tower whilst on the 6th floor for the second time at around 3.30pm. I completed a handover.

So having been relieved, I decided that I needed to take a look upstairs to get an appreciation of what the crews had been going into and what they still faced. By now, G/M Neil Chisholm had relieved G/M GRAHAM and I asked him if I could go upstairs. He said I could so I went up.

Some of the fire doors from the staircase to the lobbies were closed, some were being kept open by hoses.

I climbed the stairs and stopped at each of the floors. During my climb, I looked inside some of the flats.

Some weren't badly damaged and were in tact, some were completely destroyed. They were now open plan with all of the partitioning walls completely gone. There was nothing left.

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I remember seeing a few times, open gas pipes, which had flames coming from them, It was apparent that the appliances which they supplied were not attached, the gas supply was on and had caught alight. I could see flames coming from quite a few of the pipes.

Although dangerous, it was better for them to be flaming rather than naked gas being pumped into the rooms until the main supply could be cut off.

There were also burst water pipes, which were pouring out water. I guess this contributed to the amount of water coming down the stairs.

I came to the 9th floor. In the lobby area, lying against a wall, was a deceased lady. She was covered with a blue brigade salvage sheet but I could see her ankle so could see that she was a black lady. She was a very large lady.

I marked a separate diagram of the 9th floor as to where the lady was situated. (SJH/8). I think this is the lady that I mentioned earlier that I recorded on my wall on the 9th floor.

Near to her was something else. I don't know what that was, but it could have been another body. It was covered but I'm not sure for certain that it was a body.

I went up one more floor, to the 10th.

Once on the 10th floor, I realised that it wasn't safe for me to be there. There it was too hot and there was too much smoke so I came down and left the building.

Before I left the building, I went to the 4th floor, into the room that I was using. I was uncomfortable with leaving my writing on the wall. I didn't know who would subsequently see the wall, it could have been residents, families of deceased people, I didn't want the wrong people to see it. I felt that it would be insensitive.

So I took a photo of the wall and then wiped off what was on it. (SJH/4).

Throughout my time on the Bridgeheads, I saw a range of equipment and they were headed by Group Managers. I remember seeing a repeater, which is used to boost radio signals.

That was because radio communications were challenged throughout the building. Contact with the command unit couldn't be made properly. For that reason the CU was sending runners from the CU up to the bridgeheads to obtain progress updates.

I was surprised at the time that there wasn't an Operational Review Team (ORT) officer present on the Bridgehead throughout.

With the pressure and complexities that we were under and the slow progress that we were making, I would have expected one to be there to support the bridgehead management team.

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The ORT are experienced, trained officers who are experts around procedures, policy and tactics. They are duty bound to assume command where it is identified that the Incident Commander is either unable, unwilling or the nature of the incident is beyond their experience to make the correct decisions to protect life, property or deliver the objectives of the IC.

I left the building with S/M KASMANY having been escorted out by the police with shields.

It was a relief to be out. I hadn't wanted to be in that building at any stage. Constantly in the back of my mind was the issue as to whether the building was going to collapse at any moment.

At some stage whilst in the building, I remember seeing G/M DISSANAYAKE, who runs our senior accident investigator cadre. He was with someone that I assumed to be a structural engineer.

I left the building and saw loads and loads of fire fighters knackered, smashed and blankly staring ahead sitting against walls and on the grass.

I was soaked through from all of the water and found an area near to a pub where there was some food kindly donated by the public.

I saw gasmen digging holes near to a pub and spoke to them. They said that they were trying to get to the gas pipe which was supplying the building turned off but couldn't find which was the correct pipe. For this reason, they couldn't turn the gas off which was feeding the fires inside.

The gas engineer pointed to a separate site where they were digging to demonstrate that they were trying to find the correct pipe.

I remember speaking to a member of the public, an English guy, who said that he had been there at the beginning of the fire and had seen a baby being thrown out of a window.

I've since seen him on TV but I don't know if that's true or not. I've not heard any of the crews mention it. He asked me how long I had been there and I told him about 8 hours. He told me what he had seen of the fire, how quickly the fire had caught and that the building had recently be refurbished.

Sam and I got some food, sat on a wall and ate. I can't remember even having had breakfast so I hadn't eaten since the previous night when I had dinner. I was so tired, I was smashed, I could hardly even chew the food.

I could see that the smoke from the tower was now more of a lighter colour, which told me that most of the fire had been extinguished.

I took another photo of the tower (SJH/3).

I went back to the lobby area on the ground floor and saw S/M CHESSUM, had a brief conversation with him and then went back out to my car to change out of the soaking wet clothes that I was in.

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So I was now relieved and so went back to the CU to collect my NRB.

Whilst there I saw G/M Steve DOODNEY and then heard that there was either a tactical or emergency withdrawal that had been ordered. I cant remember which one it was but I think the call was made by the structural engineer.

When such an order is made, everyone is made to leave the building and then report back to the C/U and the person in command of each machine must collect their NRB and confirm that their entire crew are accounted for.

Even though I'd been released, I took the NRBs, there were loads of them, and placed them on a nearby step so that they were neatly laid out and could be easily collected. So I helped G/M DOODNEY with the withdrawal role call until he had to leave for a task.

I carried on with the role call, I was then joined by G/M DISSANAYAKE and we signed everyone back in. Everyone was accounted for.

It took some time to do so but once everyone was accounted for, I informed the Incident Commander.

I left the scene at around 7.00pm and drove home.

At the beginning of this statement I mentioned my role as test manager for the new command support system.

I wasn't there during the early stages of the fire, but if the command systems failed in any way, my time as test manager back then is, in my view, relevant.

Whilst at headquarters between November 2008 and most of 2009, I was assigned the role of test manager for the brigade's new command support system.

The system was to be fitted on the 9 support command units (CUs) that had recently been introduced.

The electronic command support system was to provide an incident command platform for operational officers at incidents.

It's functionality was to be tested to ensure that the software that was being provided by a company called Vector Command was compatible with the hardware, the computers, and the command units which were owned by a company called Asset Co.

My job was to ensure that the software, hardware and the brigade's IT infrastructure and control, that is PROCAD the brigades mobilising system, were all compatible.

Using a series of previously provided test scripts, my role was to ensure that the system and infrastructure around it was compatible and met the resilience standards of the brigade and the CSS specifications catalogue that had been agreed between the brigade and Vector Command.

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The test scripts were held on a spread sheet containing the different functions of the system. They were designed to test every single button and action of the system.

The Command Support System (CSS) used a 3G method of communication, similar to what you have on your smartphone. So a command unit will use 3G to communicate with other Command Support Units and the brigades' communication and incident monitoring systems.

We tested on a number of different scenarios, not live ones, but including 8 pump fires, 4 pumps, special service and we ramped it up to different levels of incidents. We used 8 operational scenarios, many of which were used twice. All of this was to test whether it could cope with different types of incidents.

A key area of testing was to establish whether satellite Command units could see the changes being made by the main control unit.

During this time, I conducted a number of user acceptance tests.

Faults were categorised.

A critical fault meant a fault which prevented using the deliverable i.e. the system.

A major fault meant a fault which was neither a critical, material or cosmetic but one which caused the system not to operate in accordance with its specification and resulted in limited use of the system.

A material fault was one which meant it was neither a critical, major nor cosmetic fault including without limitation a fault which caused the system not to operate in accordance with its specification but which did not prevent the customer using the system.

A cosmetic fault meant a fault which did not prevent the system operating in accordance with its technical specification but there was no impact on its functionality, performance or service.

In the first test that I performed in December 2008, User Acceptance Test (UAT) 3, there were 2 critical faults, 1 major fault and three material faults.

Performance test PT0001 - Verifying that a CU successfully receives data about an incident without any time delay.

Critical fault.

A repeated error on the live map which should have displayed the location of the incident was displaying it at the test default location.

So the system was showing an incorrect location of the incident.

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Inconsistent performance as delays were experienced by all CUs when receiving the initial incident information.

These delays were more notable on the coordinating CU/Command CU resulting in the delayed receipt of data by the satellite CUs.

Performance test PT0004 — Organisational chart accurately represents the command structure and the allocation of resources on the incident ground.

Critical fault.

When tested this resulted in duplication and triplication of en route and in attendance resources.

The error most noticeable when, but not restricted to, the action of allocating command and satellite CUs

Performance test PT0003 — Incident site information stays updated for all resource changes.

Major fault.

The complete loss of the live map data by the command CU following a simulated power loss.

Performance test PT0002 — Mapping of the incident ground during the course of an incident with minimum time delay.

Material fault.

Time delays were experienced when the 3G connection light indicator showing red as expected but also delays taking place when indicator light was green, indicating good 3G connection.

Performance test PT0005 — Illustrate communications from messages through BizTalk to received messages on the CUs.

This involved the conference messaging capability allowing written messages to be sent between brigade control, designated senior officers and CUs.

Material Fault.

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Identified faults involved duplication of messages following allocation or change of incident command unit. Also failures to deliver any conference messages.

Performance test PT0009 — Illustrate a users ability to view and incident remotely in a read only capacity.

Material fault.

Data transfer time delays were experienced during the designation of the command CU.

These faults were just on the 1st test. Subsequent ones that I ran produced similar results.

I kept on highlighting the fact that the tests were being failed. Vector were present during all of the tests and they went away to make the necessary repairs.

At that stage, the brigade brought in an external consultant who I worked with to make the test scripts more robust.

Once that had been done, we tested again. And it failed. We tested again and it failed.

DAC Kevin HUGHES was in overall charge of the project and G/M Neil ORBELL was in charge of delivering the project and together started to put pressure on me to simply pass the system and to say that it worked.

Vector Command told me that they had other buyers waiting for the system. If the LFB, the largest brigade in the country, passed it then they would be able to sell it to other brigades.

It was down to me as the test manager to say that it worked. I refused to do so because it didn't.

When I returned, they had brought in a Command Unit Watch Manager who told me that things were progressing. I checked the test scripts and noticed that they had amended them and deleted the tests where the critical faults were happening. I am very clear on this.

They had clearly done this in order that the system would pass.

I remember in particular that one of the areas of concern was the allocating of resources which, in the tests, was freezing and then losing information. The test for this area had been removed.

When I came back and realised what had happened, I told them that I wasn't having any of it and wanted out of the team. I made it perfectly clear to HUGHES and ORBELL that I wasn't having any part of it. I went sick.

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A few weeks later, A/C John WEBB came to see me at my home and asked me to come back. I repeated that the system was faulty, it didn't work and it would hurt people in the future.

I told him that the system freezes and loses information and the consequence of that is that you would have to revert to the old way of doing things by using laminated sheets of paper which you would write on.

I had a subsequent meeting with the former head of equalities, Pat OAKLEY and A/C WEBB where I repeated my concerns.

At the end of 2009 the system was rolled out across the brigade. In January 2010, I returned to work and was appointed S/M at Hornsey.

In the 9 years since, the CCS has consistently performed badly. It got to a stage where they created a fault resolution log where control unit staff can send in the faults that they have experienced with the system.

To my knowledge 100S of such faults have been reported.

Every fault that I reported and feared would happen has occurred during the last few years. I told them that the system was not fit for purpose and over the years it has proved not to be.

Around February/March 2016, I even went to see the then Commissioner of LFB, Ron DOBSON, around a number of things but all relating to the CSS, how it had failed and how I had stood my ground. I even gave him a copy of the first test record. To my knowledge, he did nothing with it and didn't speak to me about my concerns again. He has since retired.

Since Grenfell, [REDACTED] Along with G/M GRAHAM and the rest of the bridgehead management team, we were in the tower for far too long. It that happened because of CSS failure, it only adds to my stress.

I know that the training course that I should have been on went ahead on the day of Grenfell. That is 9 senior officers who were in a classroom who could have been at Grenfell and helped rotate us, preventing us from being in there the excessive periods that we were.

When I was at HQ in November 2018, after Grenfell, I noticed a small team who are working on upgrading the CSS system to 4G. I believe that this is only happening because of the difficulties experienced at Grenfell.

By the time I arrived at the tower, any Fire Survival Guidance (FSG) calls had ceased. So I had no dealings with any FSG calls. However, FSGs are controlled by a satellite CU and so if during the incident there was a CU failure, then FSG performance would have been affected given the large number of calls that control were dealing with.

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The fire should not have behaved as it did. High rises are designed so that a fire in a flat should be contained within the compartment, ie the flat.

The fire is contained within the flat so that the brigade has time to arrive and put it out before it spreads.

However, issues may arise when work is done to the building that changes and compromises the design.

Compromise can be caused by a changing of doors, windows or poor maintenance.

If the windows or materials around them do not meet fire safety specification, then the compartmentation can be compromised.

If things change from the original building design, then compromise can occur. Normally we fight fires from the inside.

Different buildings will have different policies around staying put in the event of a fire. If it is assessed that a building should keep a fire in a compartment, then a stay put policy could be put in place. Residents should be safe in other flats for a period of time until the brigade arrive and put the fire out.

We've been dealing with fires using this method for decades. Issues arise where work is done which impacts on the compartmentation of the building.

However, all brigade staff, whether it be commissioner right through to fire fighters, use a tool called the decision making model when dealing with incidents.

It's something that we use every day and is used when decisions need to be made.

The user in the case of Grenfell, the officer in charge, will assess the risks to people, the hazards and the resources available.

From there, they will set objectives and then plan how those objectives are going to be delivered.

They will communicate them to staff and then control the operation by creating a Command structure.

They will then review the situation and then go back to the beginning and start again.

So the process is an ever changing one, depending on what the review tells you.

I wasn't there when decisions were made around the stay put policy at Grenfell. But I have watched footage of the early stages of the fire.

There was a stage early in the development of the fire when it was clear that there was no way the brigade had the resources to put it out.

In addition, a dynamic risk assessment has to be made which the incident commander has to use to determine who was at risk, what is needed to be done, to decide upon how to do it, to change monitor and review what was being done in order to meet those objectives.

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The key to this is that you need to declare a tactical mode which is sent to control by way of a message throughout the incident.

The fire was lost. In my view, the decision making model and a dynamic risk assessment should have been employed. It would have been clear that the stay put should have been lifted and people told to leave the building.

Fire fighters who attended the incident were dealing with an unprecedented event. They are the absolute salt of the earth. They risked their own lives in a way which we have come to expect.

It was harrowing for police and LAS crews, My line manager had members of the public handing him mobile phones with their trapped loved ones on the other end of the line.

There are some fire fighters who are scarred through this incident and will carry this for a long time.

It's clear that something has gone wrong. I'm hoping that the investigation identifies people responsible and action is taken. People have every right to go to their bed at night and wake up safely.

We shouldn't have had to deal with Grenfell, it shouldn't have happened.

In August 2016 there was a fire in Hammersmith which behaved similar to Grenfell although not on the same scale. As a result, in April 2017 A/C Dan DALY wrote a letter, (SJH/1), to all London boroughs informing them of the risks associated with cladding asking them to risk assess buildings under their control including windows and façade schemes. The cladding was unsuitable to be on high rise buildings. I only became aware of the letter at the beginning of June 2017 in my role as community fire safety officer.

I know that the borough that I was working with, Enfield, did some work around it.

However through Hammersmith, the brigade knew of the dangers. What they should have done was to inspect Grenfell under policy number 800 and inform the local Station Manager. He or she will create and review a tactical plan and send it to the Predetermine Attendance Section (PDA).

The PDA manage the Operational Risk Database (ORD). The ORD approve the tactical plan as to how to deal with a fire at that site.

We fight fires from the inside which I understand we did at Grenfell.

However because of the risk that we knew about from Hammersmith, there should have been a fire fighting plan for Grenfell. That plan should have included placing a spotter outside to look for external spread and also a crew above the fire with a hose able to put water on the outside from above. We call these improvised drenchers where we can put water on the outside of any external fire spread.

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It should also have instructed crews to consider the early evacuation of the building because of the risk that crews would not be able to contain the spread of the fire.

The information from the ORD is placed on each LFB fire engine via its MDT. So the first crews attending the incident would have been told that there was potential external spread of fire and what the fire fighting plan was including using improvised drenchers and consideration of evacuation.

If LFB had followed this process, there would have had been a suitable tactical plan placed on the MDT and the loss of life at Grenfell would never have happened. We told the councils but we never told our own staff.

The picture of the grid on the electrical cupboard is produced by PC Suzanne HARRIS as exhibit SJH/5.

The diagram of the 4th floor is produced by PC Suzanne HARRIS as Exhibit SJH/6.

The diagram of the 6th floor is produced by PC Suzanne HARRIS as Exhibit SJH/7.

The diagram of the 9th floor is produced by PC Suzanne HARRIS as Exhibit SJH/8.

The 1st photo that I took from the C/U is produced by PC Suzanne HARRIS as exhibit SJH/2.

The 2nd photo that I took as left the tower is produced by PC Suzanne HARRIS as exhibit SJH/3.

The photo that I took of the 4th floor flat wall is produced by PC Suzanne HARRIS as exhibit SJH/4.

The letter, authored by A/C DALY, is produced by PC Suzanne HARRIS as exhibit SJH/1.

I produce policy number 800 as exhibit DDA/1

Today I looked at each of the exhibits produced by the officer and countersigned each of the exhibit labels which are stuck to the documents.

The member of the public who I first met and mentioned the drugs factory was male, white, in his 30s and looked like a drug user.

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Statement of: ALIE, DANIEL

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