Grenfell Tower Inquiry

Day 186

October 6, 2021

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(10.00 am)

SIR MARTIN MOORE-BICK: Good morning, everyone. Welcome to today's hearing. Today we're going to hear further evidence from a member of the London Fire Brigade.

Yes, Mr Kinnier, who is your witness?

MR KINNIER: Sir, with your permission, may I call David Brown.

SIR MARTIN MOORE-BICK: Thank you.

MR DAVID BROWN (affirmed)

SIR MARTIN MOORE-BICK: Thank you very much. Now, please sit down, make yourself comfortable.

(Pause)

All right?

THE WITNESS: Yes, thank you.

SIR MARTIN MOORE-BICK: Thank you very much.

Yes, Mr Kinnier.

Questions from COUNSEL TO THE INQUIRY

MR KINNIER: Thank you, sir.

Good morning. Would you please confirm your name for the record?

A. David Brown.

Q. Thank you.

Mr Brown, thank you very much for attending to give evidence today.

Before we start, just three pieces of advice I should give you at the outset.

First of all, if any of my questions are unclear or too long, please say so; the fault is mine and I will shorten or clarify them.

Secondly, if you could keep your voice up, that's so the transcriber can capture everything you say and accurately.

Thirdly, if at any stage you require a break, please say so, that's not a problem. We will be having a break at about 11.15 in any event and then breaking for lunch.

Now, you have provided two statements to this Inquiry; is that right?

A. That's correct.

Q. The first one is dated 29 January 2019, and we can find that at {LFB00032166}. Is that your first statement?

A. It is.

Q. If we go to page 25, is that your signature?

A. It is.

Q. Thank you.

The second statement is dated 16 December 2019 and that can be found at {LFB00084020}. Is that it?

A. That's correct.

Q. Again, if we can turn to page 25 in this statement, is that your signature?

A. It is.

Q. Thank you.

Have you had the opportunity to read both those statements recently?

A. I have.

Q. Can you confirm that the contents of each are true?

A. They are.

Q. And are you happy to have those statements taken as your evidence to this Inquiry?

A. Yes, I am.

Q. Thank you.

I can take it that you have read and familiarised yourself with the exhibits to both of those statements?

A. Yes, I have.

Q. Thank you.

Now, the first part of your evidence today, I'd like to discuss the roles and responsibilities you held most recently in your time at the London Fire Brigade.

First of all, am I right in understanding that you joined the LFB as a firefighter in 1985?

A. That's correct.

Q. And that, over the next 20 years or so, you held a number of positions, progressing up the ranks, until in July 2006 you started in the temporary role of assistant commissioner?

A. That's correct.

Q. And initially for service delivery but later in operational response; is that right?

A. That's correct.

Q. In June 2008, you were promoted to the permanent post of assistant commissioner for service delivery north east and north west areas and mobilising; is that right?

A. That's correct.

Q. Now, if we can go to your first witness statement, {LFB00032166/3}, paragraph 6, you say here this:

"My primary responsibilities in the role of AC Service Delivery (North East & North West Areas & Mobilising) were to take a strategic overview of the planning, direction and delivery of LFB's operational service to Londoners in the North East and North West Areas and the mobilising service to the whole of London. In that role I reported to the Deputy Commissioner, which was Roy Bishop until October 2009 and then Rita Dexter until 31 March 2015."

Now, in that particular role, were you responsible for managing all of the LFB's fire stations in the north east and north west areas?

A. Yes, so London was split into four areas, north east, north west, south east, south west, so basically the north of London broadly defined by the River Thames.

Q. Thank you.
Did that role include responsibility for overseeing the planning, direction and delivery of section 7(2)(d) visits specifically?
A. It did, yes.
Q. And the management of operational risk information in the north east and north west areas of London?
A. In terms of collection and application, yes.
Q. For those who may not be familiar with those terms, first of all, section 7(2)(d) relates to the LFB's duty to obtain information for the purposes of extinguishing fires and protecting life and property in the event of a fire in the area, and visits to premises were the means by which the LFB primarily gathered that information.
A. That's correct.
Q. In relation to the phrase "management of operational risk", that describes the LFB's procedures and systems to collect, manage and use the information at operational incidents; is that a fair summary?
A. And in training, yes.
Q. Thank you.
Did your role as AC service delivery and mobilising have a counterpart, namely AC service delivery for the south east and south west areas?

A. Yes, it did, and in the four years I was doing that role, there was four separate colleagues that undertook that role at various times.
Q. Was Andy Barrett one of those individuals?
A. He was, yes.
Q. Was Andy Barrett responsible for managing the LFB's stations south of the river?
A. Yes.
Q. Although separately responsible for your individual areas, would you and AC Barrett collaborate on London-wide service delivery?
A. Yes, we had offices next door to each other and we met daily.
Q. Would that collaboration extend to matters relating to section 7(2)(d) visits and the management of operational risk information?
A. Yes.
Q. In October 2010, is it right that you were given the additional role of third officer?
A. That's correct.
Q. Now, if we can go back to your first witness statement, which is on the screen, and paragraph 8, which is on page 4 {LFB00032166/4}, here you describe what being the third officer involved, and you say this:
"My primary responsibility in the role of Third

Officer was to provide Brigade wide operational cover. The Commissioner, the Director of Operational Resilience and Training, and the Third Officer provided Brigade wide operational cover between them for major or serious incidents, 24 hours a day, seven days a week."
If we can go back to paragraph 5 at page 3 of this statement {LFB00032166/3}, you say in the final five or six lines of that paragraph, this:
"In June 2012 the role of AC Service Delivery (North East & North West Areas) & Mobilising was disbanded and a single role was formed to consolidate responsibility for all four Areas of North and South London, Mobilising and Community Safety. Following that restructure, the Department was renamed Operations, Prevention and Response and I was the AC allocated to that Department."
Did that role change mean that you became responsible for managing all of the LFB's fire stations across London from June 2012 onwards?
A. Yes, effectively the two AC roles were combined into a single role.
Q. Did it follow, therefore, that the role included responsibility for overseeing planning, direction and delivery of section 7(2)(d) visits for the whole of London?

A. Yes.
Q. Now, in April 2015 you started in the new position of director of operations, into which your existing role and responsibilities as AC were subsumed; is that a fair summary?
A. Sorry, can you just repeat that again?
Q. Yes, of course.
In April 2015, you started in the new position of director of operations, into which your existing responsibilities were subsumed; is that a fair summary?
A. Yes. Because it was a role that involved the amalgamation of two assistant commissioner roles, it was accepted from the beginning that it was an extensive role and closer to that of a director, and when Rita Dexter left in 2015, that role was elevated to that of director of operations.
Q. Was Ms Dexter's departure the prompting for that particular restructuring?
A. Yes.
Q. If we can go back to your first statement at paragraph 9 on page 4 {LFB00032166/4}, you say this, just flowing on from the answer you've given, actually:
"My primary responsibilities in the role of Director of Operations were to take a strategic overview of the planning, direction and delivery of LFB's operational

service, the mobilising service, and the corporate regulatory and community safety service to the whole of London ... In that role I reported to the Commissioner, which was Ron Dobson until 31 December 2016 and then Dany Cotton until my retirement on 31 March 2017. Four Heads of Department reported to me: Head of Fire Stations, Dominic Ellis; Head of Fire Safety, Neil Orbell, until March 2016, then Dan Daly; Head of Central Operations, Adrian Fenton and Head of Control and Mobilising, Tom George."

Now, in broad terms, then, the new director of operations role included your previous responsibilities as AC of operations, preventions and response, as well as the additional responsibility for corporate regulatory and community safety service; is that a fair summary?

A. Regulatory fire safety, yes. I already had responsibility for community safety. So community safety and regulatory fire safety were amalgamated into a single department and we just called it fire safety.

Q. And presumably, given the answers you've given, you remained responsible for managing all of the LFB's fire stations across London?

A. Yes, although the addition here was there was an assistant commissioner put into that role specifically

to manage fire stations, and then I was in the director position overseeing that.

Q. So ultimately responsible?

A. Ultimately, yes, but in effect took one step back as a director.

Q. Thank you.

Were your responsibilities as third officer also subsumed into your role as director of operations?

A. Yes. If I can just explain briefly, the third officer role was purely an operational role. It wasn't a managerial way in any way, shape or form. It was prompted by the fact that there needed to be three most senior officers at a strategic level, and when Roy Bishop left and Rita Dexter became deputy commissioner, there were only two, so it was a commissioner and the other director, so they needed a third person to manage the operational rota, and after an interview process I was successful in that, so I took on the operational responsibility. But it never made any change to the managerial role in any way, shape or form.

Q. But you continued in that position as third officer until your retirement in March 2017?

A. Yes. When I became director, there was therefore naturally three positions at that level that were

operational, so there was no need for a third officer as such.

Q. Thank you.

Now, your first statement in particular identifies specific actions relating to 7(2)(d) visits and operational pre-planning for which you were responsible. Now, as we go through your evidence, we'll discuss those in more detail, but I think it would probably be helpful to identify those responsibilities now so as to provide context for later questions.

If we can stay in your first statement and go to paragraph 14, which is at the bottom of page 5 {LFB00032166/5}. Now, you say there, and over the page, that you were jointly responsible for Lakanal House board action 21; is that right?

A. Yes.

Q. Now, the Lakanal House board actions were actions identified by the Brigade after the Lakanal House fire but before the inquests; is that right?

A. Yeah, they were 34 pre-inquest actions that we identified ourselves as a board.

Q. Just for context, the Lakanal House fire was in 2009 and the inquests were held in 2013; is that right?

A. That's correct.

Q. As we can see, if we turn to page 7 of your statement

{LFB00032166/7}, we see there in the last row of the table on page 7 a description of action 21, and it related, as can be seen, to the level of pre-planning at residential high-rise buildings, and specifically the move to include line drawings showing individual flats that crews would prepare as part of 7(2)(d) visits. Is that a fair summary?

A. Yes.

Q. Now, if we can go to page 9 of your first witness statement {LFB00032166/9}, and paragraph 22. Now, there we see another table which shows the action points that were overseen by LFEPA's Lakanal House working group, of which you were either the lead or joint lead; is that right?

A. Yes, these were actions that we formulated ourselves in order to meet the coroner's recommendations.

Q. We'll come on to that in due course, but just for anyone who isn't familiar with the phrase, LFEPA was the London Fire and Emergency Planning Authority.

A. Yes.

Q. Now, as you intimated there, sorry, before I interrupted you, these were post-inquest actions; is that right?

A. That's correct.

Q. They're intended to discharge the recommendations made by the coroner following the inquests.

A. Yes.
Q. And they include, if we see in the third row, action 2b, which was the creation of an inspection regime targeted at high-priority buildings; is that right?
A. Yes.
Q. The third workstream for which you were responsible was post-inquest actions, and if we see in the fifth row of this table action 2d, which was to set corporate targets for 7(2)(d) activities; is that right?
A. Yes.
Q. Thank you.

Now, if we can go to page 22 in this statement {LFB00032166/22}, paragraph 72, you say there, in relation to action 2b, this:

"I was the lead for the introduction of LFB Policy 800: Management of Operational Risk Information. The policy sets out the way in which risk was assessed and inspections prioritised."

Now, if we can just go briefly to that policy, which can be found at {LFB00083849}. If we could amplify the top third, we can see that the policy 800 deals with management of operational risk information. It was first issued in July 2012 and reviewed as current in August 2015.

When did you start work as the lead in relation to

policy 800?
A. So policy 800 -- or first of all, just to add some clarity, it continued -- it's an old instruction number on there, so it was a continuation, an updating of what was an existing policy, and we did this as a result of Lakanal House. I think originally it belonged to one of the operational policy departments, but then after Lakanal House, it become apparent really that it was my staff within fire stations that were ostensibly working towards this, so I then took ownership of the policy around about late 2012, early 2013.
Q. So after its original issue?
A. Yes.
Q. Now, I hope I'm not oversimplifying matters in this regard, but were you effectively the Brigade's senior point man in relation to 7(2)(d) visits and the management of operational risk information?
A. In terms of 7(2)(d) visits, yes, although there were a variety of other senior officers that were a key part of that. In terms of operational risk information, then collection and application, but the systems that were used to support that were very much within information management, which was in strategy and performance, because they owned the database and they looked after, administered and quality assured the database.

Q. Bearing in mind your responsibilities at this time, bearing in mind that it was your firefighters who were having to implement this, would you accept that you were perhaps the best placed or most senior placed person within the LFB in terms of knowledge, experience and position to influence and implement the Brigade's operational risk management strategy?
A. Certainly it's the case that if there were questions about the operational risk strategy, then yes, I would be the person that someone would primarily come to.
Q. Put differently, would the buck land with you?
A. Again, in terms of collection and application, yes.
Q. Now, can we turn on to the question of section 7(2)(d) visits, and if we can go back to your first statement at {LFB00032166/15}, and paragraphs 41 and 42.

Now, there, under the heading "Pre-Planning for Residential High Rise Fires", you say this:

"41. Section 7(2)(d) of the Fire and Rescue Services Act 2004 places an obligation on LFB to obtain, store, and disseminate information for the purpose of firefighting and protecting life and property. The way in which the LFB discharged this duty was by conducting visits to property ('7(2)(d) visits') and storing the information collected on their operational risk database (ORD).

"42. There was an incentive for firefighters to complete 7(2)(d) visits and record accurate information as ultimately it would enhance their safe working practices."

Now, apart from complying with the statutory obligation itself, in your view, or indeed the corporate view of the LFB, was there any other purpose served by 7(2)(d) visits?
A. Familiarisation. Familiarisation with buildings, familiarisation with station grounds, and then there was the ripple effect, because the more familiar station-based staff, ie firefighters, would become with the station's ground, the better they would get to know the community.

So the Inquiry I'm sure is aware of the fact that we were massively moving into a prevention-based role. We'd always carried out prevention work, but certainly we was massively upping our game, insomuch as trying to reach out to the community, reach out to hard to reach people in the community and try to prevent them having fires.

Just one quick anecdote, we'd go to public meetings and we'd say to the public, you know, "What do you want from the fire service?", and they would say to us, "We want a fire engine there as soon as we call it when

there's a fire", and we'd say, "Well, no, that's not really what you want; what you want is not to have a fire engine there at all, so we want to work with you to prevent there being a fire". So we was working really hard to try to prevent fires, which was one of the reasons, when I became director of operations, that we amalgamated community fire safety, which is about prevention, and regulatory fire safety, which is about protection, into one role.

Q. Thank you.

Now, if we can turn to policy 800, and particularly appendix 1 of policy 633.

Now, first of all, can we go to the revised version of policy 800, which can be found at {LFB00083849}. As you see, this was the one we looked at earlier. This was the version published in August 2015. It has the title, "Management of operational risk information" at the top.

Now, policy 800 governs the LFB's approach to the collection and dissemination of operational risk information, information which is obtained via 7(2)(d) visits. Is that a fair summary?

A. Yes, obtained by 7(2)(d) visits, but it does also mention there are other ways of obtaining the information as well, so -- although 7(2)(d) visits was

a key component to obtaining that information.

Q. I think section 7(2)(d) visits, you accepted earlier on, were the principal or primary means by which that information was collected; is that a fair summary?

A. Initially, yes, but then ongoing revisits, then we would try to use other strategies as well to make life more efficient in terms of firefighters' time.

Q. We will come on to other means of collating information in due course, but for obvious reasons I want to concentrate on 7(2)(d) today.

A. Sure.

Q. Now, I think I'm right in saying that this version of 800 is the version that was in force at the time you retired in March 2017.

A. Yes, I believe it was. It was a three-year cycle, so if this was reviewed as current in August 2015, then one imagines the next review would have been in August 2018, by which time I was retired.

Q. And so would have been the policy in force at the time of the Grenfell fire?

A. I believe so.

Q. Now, would you agree that policy 633, which concerned high-rise firefighting, and in particular appendix 1, were also relevant to information collected as part of section 7(2)(d) visits?

A. Yes.

Q. Now, can we go to policy 633, which we considered in detail at Phase 1, it can be found at {LFB00001256}.

Again, this is the version as at June 2015, so presumably you accept it's the one that was in force at the time of the Grenfell fire and when you retired?

A. Yes, I believe so.

Q. And this would be subject to the same three-year cycle as policy 800; would that be right?

A. Yes.

Q. Having looked at 633, if we briefly go back to 800, which is at {LFB00083849/2}.

Now, you will see at the very bottom of the page -- I suspect this is well familiar to you -- in section 3, it sets out five stages of really design for the identification and assessment of risk. If we just briefly go through those as providing context for the next questions.

First of all, stage 1 is the identification of premises that might potentially give rise to hazards and risks.

Stage 2 is the initial site analysis, and the guidance asks: "Does the site require a visit?"

Stage 3 is:

"Information gathering; a detailed examination of

the site where risks identified on the premises risk assessment (PRA) sheet can be verified."

If we go over the page {LFB00083849/3}:

"Stage 4 Risk assessments. Using the information to decide whether the site requires a scheduled station visit; the frequency of the visits; the level of information recorded; whether site specific training is required and level of information on the tactical plan."

And finally stage 5:

"Completing the Operational Risk Database ... recording the information. The ORD is linked to the station diary and will be completed/updated for each scheduled station diary visit."

Now, having looked at that five-stage process, is it right that, in carrying out the risk assessment at stage 4, policy 800 requires crews to complete a premises risk assessment, or PRA, using the tick-sheet at appendix 1 of this policy?

A. Yes. So that premises risk assessment probably would have been completed at stage 3, but stage 4 is consolidating and considering the information in terms of determining frequency of future visits.

Q. Thank you.

If we could turn to appendix 1, which is on page 13 {LFB00083849/13}, this is the tick-sheet, and, where

relevant, each box would have to be considered and marked as appropriate by the visiting crew?
A. That's correct.
Q. Now, is it also right, having regard to the five-stage process, that crews would then calculate the risk score of the premises using the premises risk assessment template, which is on the screen here, and apply that score to the risk matrix?
A. Yes.
Q. Now, let's look at the risk matrix itself, and go back to page 8 {LFB00083849/8}, paragraph 10.1. Is that the matrix?
A. It is, yes.
Q. And in broad terms, the matrix determines whether and how frequently premises should be subject to further scheduled section 7(2)(d) visits; is that right?
A. It is, yes, and we used it to maintain consistency across the Brigade.
Q. Now, just so that we understand the significance of a premises being identified as requiring section 7(2)(d) visits, is it right to say that essentially its significance is two-fold: first of all, the fact of the visit; and, secondly, once premises are identified, and if its risk score is high or sufficiently high, the premises and relevant details are then recorded on the

operational risk database?
A. That's correct. There was also something called a premises information plate, which I guess we may come on to later, that sat alongside this. But that was almost exclusively for high-rise.
Q. Thank you.
Now, is it also right that frequency of visits were determined by the premises risk score?
A. Yes, and in professional judgement of the station manager.
Q. So there were two stages?
A. Two stages, yes, yeah.
Q. We can work this through, but if we can look at the risk matrix itself, and if we could look at the yellow row, which is medium to low risk, we can see that if a premises scored between 250 and 499, that would require a visit at least every three years. Moving a column further to the right, it says "If deemed appropriate by [station manager]".
Now, would that mean that the station manager could make visits more or less frequently, depending upon his assessment of the risk presented by a particular high-rise building?
A. Dependent on his or her assessment, yes, they could, but the expectation wouldn't be that they would make it less

frequent, it would be more frequent.
MR KINNIER: Thank you.
SIR MARTIN MOORE-BICK: Can we just check that we haven't misunderstood this.
When I looked at this for the first time on the screen, I assumed that the box which says "If deemed appropriate by [station manager]" actually relates to the heading on the top, "Onsite exercise required".
A. Yes.
SIR MARTIN MOORE-BICK: So visit frequency would always, I suppose, be at the discretion of the station manager, but it would be at least once in every three years?
A. Absolutely. If the station manager, in his or her professional judgement, felt that, whilst the matrix had suggested this, this should be a reason why that frequency should be more often, then that's when we would expect them to intervene and change the operational risk database to reflect that.
SIR MARTIN MOORE-BICK: Yes. But whether an on-site exercise is required at all would be, as the box suggests, up to the view of the station manager?
A. Yes. Although if I can just add one thing. I've seen different versions of this within that document. So this matrix appears twice; I think it appears once within the body of the document, the policy, but it's

also in the appendices as well, and it would be useful to see the one in the appendices, because I'm not quite sure whether the visit frequency is different, because in all others I've seen it suggests one year and one to two years, not every five years or three years.
MR KINNIER: If we go to page 17 {LFB00083849/17}, it seems to be the same.
A. Okay. I've seen other versions where the low was one or two years, and it was asterisked, and it was for the station managers to determine whether it was one or two years. So I think subsequent iterations and earlier iterations, it was demonstrating a more frequent visit schedule.
Q. Certainly in this version of 800, which was current at the time of the fire, both the matrices, both the one at page 8 and 17, are identical.
A. Okay.
Q. You can take that from me.
Now, if we can go back page 8 {LFB00083849/8}, and if we can look at the green row, and it sort of sets out the approach to premises attracting a score of 150 plus.
Again, would those premises be added to the ORD and subject to regular visits?
A. Yes.
Q. And in relation to premises whose score was under 150,

paragraph 8.2, which can be found at page 7 of the policy {LFB00083849/7}, provides thus:

"Any new premises that scores between 0 and 149 will not be included on the operational risk database. Any existing premises scoring between 0 and 149 should be deleted from the outside duties master schedule."

So is the practical effect of that provision this: if a premises' risk score falls below 150, the premises will, first, be deleted from the ORD, and, secondly, they will not be subject to future scheduled visits?

A. That is the intention, and just to put some context behind this, the operational risk database had taken over from a previous application called the central risk register, and this was before we had more advanced systems that we have now, and even at the time. So the central risk register, in transferring over, needed to be cleansed, so I guess that's what it's referring to when it says it should be deleted from the schedule, because in case there was some on there that never really should have been on there. But now we had a much more advanced and technologically supported way of determining what should go on the register.

In saying all of that, if -- and staff understood this, station managers and above understood, that if a premises did come out to between 0 and 149, but the

professional judgement was such that that just is an affront to common sense, then that could be included necessarily on the operational risk database.

Q. Was that overriding discretion vested in station managers something that was well understood by those station managers?

A. I would say so, yes, and certainly by borough commanders.

Q. Can you identify when and in what format station managers were told that they ought not to follow the risk matrix robotically, that it was always going to be subject to their discretion?

A. Yes. So I used to host borough commander meetings religiously every quarter, and it was something that had been done even prior to my commencement in service delivery in 2006, and that was a fantastic way of keeping touch with what was going on within boroughs.

Q. How did you make sure that the borough commanders were telling their station managers not to follow a robotic approach to the risk matrix, but to ensure it was subject to their professional judgement as to the risk presented by a particular building?

A. Well, firstly, it wasn't just about not following a robotic approach to the risk matrix, it was about having sound judgement and integrity to be able to stand

up and say things are wrong or are right whenever they felt that to be the case. So it was far broader than just the matrix. But the way I would determine it is because, in addition to meeting borough commanders on a quarterly basis en masse, then I had a scheduled programme of meeting the area deputy assistant commissioners on a monthly basis, on a one-to-one, and that would include me visiting them out in their areas with the relevant borough commander. So, for example, in the north west area, I'd meet the north west area deputy assistant commissioner maybe one month at Wembley and see the borough commander for Wembley there at the same time, and another month I might meet them at Heston and talk to them there. So I would be able to personally satisfy myself that people understood.

And the dialogue that we used to have with borough commanders and station managers was very much in terms of staff would stand up and say things that they didn't agree with.

Q. Thank you.

If we can go to page 14 in this policy {LFB00083849/14}, and the very bottom of that page, we see there that the very last box says this: "High Rise premises e.g. over 6 floors or 18 [metres]" would attract a score of 75 points.

That provision aside, is the process for determining which properties would be recorded on the ORD applied equally to high-rise buildings as to any other building?

A. Yes.

Q. Put differently, there was no bespoke 7(2)(d) process particular to high-rise buildings?

A. No.

Q. Thank you.

So is it right that whether a high-rise building received scheduled 7(2)(d) visits depends upon the nature of the risks that a particular building presents, which in turn determines that building's risk score?

A. Yes.

Q. Now, during your time at the LFB, would you have expected that all high-rise buildings would have met the threshold of 150 points?

A. Yes. I think for a high-rise not to meet that threshold, it would need a combination of two things. One would be absolutely zero risk whatsoever, and you could go through the various iterations of this matrix and see all the various things that factored into it, such as no elements of hoarding, no one living in the high-rise that was non-ambient, no unoccupied premises. So first of all, it would need a near-perfect solution, and then also it would need, quite possibly, some

advanced fire suppression systems, because some aspects of this actually reduce the score rather than add to the score.
Q. So your practical expectation would be that all high-rise residential buildings would be recorded on the operational risk database; is that right?
A. Invariably. You know, there may well be some that do fit in that category, but I'd say looking at all of them, I would say the absolute vast majority would be on there, and if they weren't on there, there would need to be a very good reason why not.
Q. Put differently, were you ever aware of a high-rise residential building that a decision had been taken not to include it on the operational risk database?
A. There was no such building ever brought to my attention.
Q. Thank you.
Now, we touched on appendix 1 of 633. If we can go back to that. That can be found at {LFB00001256/19}. Again, this is a document that was subject to particular scrutiny at Phase 1, and it provided guidance to crews carrying out 7(2)(d) visits at high-rise premises.
We see at paragraph 1, at the top of the page, the guidance says this:
"During 7(2)(d) visits personnel should ensure they are familiar with the following and their impact on

firefighting and search and rescue operations."
Then it sets out 22 particular items.
Now, in her evidence at Phase 1, the then commissioner, Dany Cotton, was asked whether, from a practical, frontline firefighting perspective, some of the matters in appendix 1 were impractical. She agreed that that was the case, and stated that the appendix 1 list needed "rewording", and that some of the items on the list were "not realistic". She also stated that frontline firefighters don't have the technical knowledge or ability to be able to do some of those things.
Now, during your time as director of operations, also in your time as third officer, did you expect crews carrying out section 7(2)(d) visits to familiarise themselves with each of the 22 matters set out in paragraph 1 of appendix 1?
A. My expectation was that they would use this as an aide memoire, and they would look at these various component parts and, where practicable and possible and realistic, then they would take them into consideration.
Q. Just looking at paragraph 1, the words "where realistic" or "where practicable" aren't there, are they?
A. No, but I think again if I can put some context behind this --

Q. Please do.
A. -- and I understand this has been an issue in Phase 1, but the word "should" carries a lot of weight in London Fire Brigade. We had lots of discussion on terminology in terms of "should" versus "must", and where we say "should", we use that word carefully and deliberately. The reason is because we see "should" as being a word that describes where practicable, whereas "must" is there is no flexibility, you will do it. And we had lots of -- so every policy that gets promulgated to staff has to go through union consultation and sometimes negotiation. We were going through a period for quite some time, actually, where relations with staff side were not as good as we would have liked, and we had to carefully tread through various terminology, and our legal advice at the time was "must" means you will and "should" means you may, and we used to have that understanding with the Fire Brigades Union, and staff at stations, as far as I'm concerned, understood the difference between "should" and "must".
Q. I suppose your evidence is perhaps slightly more subtle than former Commissioner Cotton's. What you're saying is, depending upon the particular building, it may not be realistic or reasonably practicable to do each of the 22 items set out in appendix 1.

A. Yes, I think probably it does need rewording, because from the outside looking in, if it needs the level of explanation I've just given, then clearly it could be clearer. I accept that.
Q. Looking at it from a different perspective and based on the evidence that Commissioner Cotton gave, would you agree that frontline crews lacked the technical knowledge to look at each and every one of these matters?
A. Not each and every one. There are some issues within here that sit perfectly and exclusively in terms of frontline crews.
Q. Can we maybe look at it slightly more directly. Look at the tenth bullet point, which is:
"The likelihood and impact of any fire spread beyond the compartment of origin and the potential for multiple rescues."
Is that something that falls within the category you've just identified, ie that operational crews would be sufficiently able to identify and assess the likelihood and impact of fire spread beyond the compartment of origin?
A. Fire crews at stations, so station-based staff, didn't have the technical fire safety knowledge to be able to look in depth in terms of breaches of compartmentation

and fire safety regulations, so I think unless there was something that was absolutely obvious, so for example, an open vent above an exit door into a common stairwell, then no, I think it's beyond that, it is outside the remit and wit of a firefighter. No disrespect meant to firefighters, they just weren't employed or trained in that level of technical detail.

Q. So the key word in your evidence there is "in depth" and that, if I can summarise it this way, you would expect the reasonably competent crew to identify obvious matters such as vents, but nothing more than that that may have an effect on compartmentation?

A. Yeah. I've used vents just as an obvious example which I think any person would realise, but beyond that, that required any specific training, then, no, I wouldn't expect them to be able to do that, and that probably is a good example of where realism rears its head in terms of this list.

Q. I suppose looking at matters slightly differently, how would you have expected them to have considered the issue of likelihood and impact of fire spread on a 7(2)(d) visit?

A. Well, when they arrive, the common way of conducting a 7(2)(d) visit on a high-rise would be to do what we call walk the building. So they would get in a lift,

they would go to the top, and then they would walk down and they would check each floor, intermittently looking at common areas. Dependent on the time of day and if applicable, they would be expected to maybe even knock on a door and see if a resident would allow them access so they could just see what the construction was in terms of the way the compartment was laid out.

They would also, if possible, do it with the responsible person, so whoever had oversight of that building, and they then could give them some advice and guidance in terms of some of the questions.

Q. We will come on to the involvement of the responsible person in due course, but if you wouldn't ordinarily expect crews to be able to assess likelihood and impact of fire spread beyond compartment of origin --

A. No.

Q. -- how would London Fire Brigade go about assessing that likelihood in relation to high-rise residential buildings?

A. So high-rise residential buildings, in terms of fire safety regulation, involve a mixture, so there's the individual compartments which don't come under legislation, but then there's the common parts, ie stairwells and escape routes, that do. So in terms of looking at that particular issue, then fire safety would

have been involved with the original planning and construction advice, et cetera, and then in terms of regular audits, or even if there had been an incident there, a fire, so been a post-fire audit. So fire safety regulation would have an involvement with a building in the same -- under the Regulatory Reform Order in the same way as firefighters at stations would have an involvement with it under 7(2)(d).

Q. So let's just look at that. There are two means, on the basis of that evidence, by which likelihood of spread is examined. First of all, at the time of the original design. Presumably you're indicating there the involvement of fire safety in the building control process, is that what you're thinking of there?

A. Yes.

Q. So if, for example, that building control process doesn't happen or fire safety is not involved, that route does not allow the LFB to assess the likelihood of impact of spread, does it?

A. If that hasn't happened originally then that is the case. However, in saying that, one would expect, if station-based staff are out and about on the station's ground doing a whole variety of jobs that they're doing, a new construction clearly wouldn't bypass them. They would involve themselves in terms of carrying out

a 7(2)(d), that would be placed on the operational risk database, and fire safety had access to the operational risk database, so eventually it would become within organisational knowledge, although it would be a clear omission on behalf of the construction engineers and the responsible person why they never informed the Fire Brigade in the first place.

Q. But it assumes a proactiveness on the part of a visiting crew, doesn't it, if they're to pick up that there may well be changes that require more detailed fire safety involvement?

A. Oh, sorry, I was picking it up on the basis that a building had been constructed originally and never been alerted to the fire service, not so much about a building that's already in existence and they were inspecting it and talking about some sort of constructional change.

Q. Now, the second means you identified was a fire safety audit related to the RRO. Now, forgive me, it's not entirely clear when and by whom you saw that particular role being fulfilled.

A. Fire safety audits would be carried out by fire safety inspecting officers, and they would inspect buildings as part of a programmed proactive campaign, or it might be a reactive visit because of something that's happened.

So that could have been a fire there, so we'd carry out a post−fire audit; or it could be that they'd been alerted by the local authority that there has been some kind of construction going on at that building, so they inspect it to see if it still complies; or it might be a complaint from a member of the public, who might see things happening and say, "I'm not happy about this, I live in this building, I'm concerned"; or it could be a borough commander in liaison with the local authority, it's come to their attention, and he or she would alert fire safety.

Q. Thank you.

Now, if we can go back to the bullet point list {LFB0001256/19}, and if we can look at the 12th bullet point, which reads:

"Floor layouts and any building construction features which may promote rapid or abnormal fire spread, such as sandwich panels, timber−framed construction, atria or voids."

Again, would that be the type of matter which you wouldn't expect a visiting crew ordinarily to pick up on?

A. Yes, this will be something that's at the extreme ends of the expectation of the knowledge of a firefighter.

Q. And your assumption, therefore, would be that those

issues would be picked up by one or both of the alternative means that we have just been discussing?

A. Yes.

Q. Now, where the text uses words such as "such as sandwich panels", am I right in understanding that that was not intended to be an exhaustive list of construction features; they should just be on the lookout for particular features that may well have an impact on fire spread, evacuation and the rest of it?

A. Yeah, that was an example to focus the mind.

Q. Would you expect a crew to be alive to the risk presented by cladding systems, albeit in very high−level terms?

A. Crews were aware and probably have experienced fires in high−rise where cladding has become involved, so it's within their operational knowledge, skills and experience. In terms of whether they expect cladding to be an issue that would be a predominant part of a fire and, indeed, flammable to the degree where it could envelope a building, then no.

Q. Just staying with that question of cladding, could we go briefly to GRA 3.2, which can be found at {LFB00001255/18}.

If we go to the second line of the fourth bullet point from the bottom of the first list, that bullet

point starts with the words "Building construction features", and it provides this:

"Building construction features, such as the presence and location of maisonette−style construction, sandwich panels, timber framing, cladding systems, surface mounted trunking, ducting and voids, in addition to features which present a specific hazard, such as asbestos."

Now, can you help us at all as to why cladding systems, which are expressly referred to in GRA 3.2, were not specifically referred to in the 12th bullet point of appendix 1 of 633?

A. Sorry, can I just see the paragraph that sits above these bullet points, please?

Q. Of course.

(Pause)

A. And can I read the bullet point again, please?

Q. Of course, yes.

(Pause)

A. Well, so GRA, Generic Risk Assessment 3.2, about high−rise, would have been national guidance, and that would have been the responsibility of, I think, operational procedures to write the policy notes that took this into account.

In terms of why cladding systems aren't specifically

mentioned in there, I think that's probably a question that's better aimed at those who wrote the policy notes. However, bearing in mind what we've just said in terms of the phrase "such as", I think we did also have this issue in the Brigade about not overloading staff with information and just point them in the direction of things to consider.

But I think in terms of any deeper than that, I think those managing policy would probably be better able to answer why cladding isn't specifically in there.

Q. Thank you for that, but bearing in mind your experience and your seniority, did you have a view yourself as to whether cladding systems or external façades should be considered by crews as part of the 7(2)(d) visit programme?

A. It was never on my radar that when the crews went to undertake a 7(2)(d), either initially or as part of an ongoing visit, when they stood outside a building they should look at the cladding on it and make a determination as to whether it formed part of a risk assessment, no.

Q. Even after Lakanal, that was your view, was it?

A. Well, Lakanal obviously had its unique issues attached to it, and certainly the panels below windows added to the fire somewhat. Organisationally, I don't think we

saw Lakanal as a cladding fire, in the way that you might determine Grenfell as a cladding fire, and there was other fires, obviously, Shepherds Court, where there was cladding, and fires where spandrel panels had caught alight. So we were alive to the fact that they can add to the fire, but not necessarily seeing them as issues to put them in their own category as a cladding fire.

Q. If you didn't see Lakanal as a cladding fire —— you I mean corporately as the LFB —— what did you see Lakanal as being?

A. I'm not sure I could describe it in terms of a particular pigeonhole—type explanation, but certainly Lakanal —— or the fire at Lakanal had some unusual aspects to it, one of the main ones being that the fire travelled downwards. So I wouldn't really determine it in particular ways.

I'm not saying cladding's not involved in Lakanal, clearly it was, but I think to call it a cladding fire is —— would be misrepresenting what Lakanal was.

Q. Bearing in mind that answer, can we just go to a letter that former Commissioner Dobson wrote to Sir Ken Knight when Sir Ken was the chief fire adviser, and that letter can be found at {LFB00104291}.

Now, that letter is dated 14 December 2009 and, in broad terms, it raised concerns about the use of

combustible cladding panels at Lakanal, and which Commissioner Dobson indicated the LFB were concerned might well be present on other high—rise properties.

Now, first of all, is that letter familiar to you? Have you seen it before?

A. I have seen it before, yes. I wasn't involved, I don't believe, in the construction of it, but yes, I'm aware of it.

Q. Is the practical effect that notwithstanding that Commissioner Dobson was moved to write to Sir Ken to highlight the problem of cladding, particularly in the context of high—rise buildings, nonetheless it wasn't something, to use your phrase, that crossed your radar as something that had to be emphasised to 7(2)(d) crew visits?

A. Sorry, could you rephrase that question, please?

Q. Commissioner Dobson has seen fit to write to Sir Ken Knight, in his capacity as chief fire adviser, to highlight the problems posed by cladding, particularly on high—rise buildings.

A. Mm—hm.

Q. Now, given that, is it still your position that the risks posed by cladding on high—rise residential buildings was not on "the radar" in terms of giving advice to crews attending to visit high—rise buildings

for the purposes of section 7(2)(d)?

A. Okay, there's a couple of answers to that.

So I think it's, you know, quite right for the commissioner to inform Sir Ken Knight of the issues around cladding involved in Lakanal, because, as I've said, there clearly were issues. It's the definition of the fire in terms of how we describe it, I think, is more what I would question.

Crews were aware of the issue of cladding as a result of Lakanal. The Lakanal House presentation and the training that we did to crews, and the specific training over and above that that we did with borough commanders, clearly exposed that issue. I think the issue for crews in terms of being on their radar, it's their ability to be able to determine whether, looking at a building on a 7(2)(d) visit, it involves cladding that may be an issue, because it goes outside of the remit of their ability and training to be able to do that.

Q. Can we look at the substance of this letter, and can we start with the first paragraph, where Mr Dobson stated this:

"I am writing to inform you that as part of our investigation into the fire at Lakanal House ... we have had tests carried out on the exterior wall panels of the

building and that those tests have given rise to concerns which may well be relevant to other high rise premises. Although our investigations are continuing and the matter has still to come before the Coroner, I feel that it is in the public interest to draw the issue to your attention so that the matter can be discussed within the Department and any necessary advice can be given to owners and landlords of high rise buildings."

Then if we can go to the third and fourth paragraphs on that page, Mr Dobson sets out the functional requirements of Approved Document B4, before he goes on to say, over the page {LFB00104291/2} in the third, fourth and fifth paragraphs, this:

"Based on the tests conducted by the Building Research Establishment, it appears that there are external wall panels at Lakanal House, that do not have the necessary reaction to fire properties required for the location in which they have been used.

"We have also become aware that this type of panel has been supplied by more than one company.

"In the circumstances, we believe it may be appropriate for a warning to be given to housing providers that it would be advisable to check the specification for external wall panels in their high

rise housing stock and check that what has been installed meets the correct specification (i.e. that fire safety requirements of the Building Regulations were taken into account); and to include this in fire risk assessments for relevant properties."

Now, did you, either at the time this letter was sent or later, consider whether operational crews should be directed expressly to look out for the presence of cladding or façade panels on high-rise buildings as part of their section 7(2)(d) visits?

A. No, because there were various other issues in train to deal with this. So the borough commanders were well aware of the issues, having seen the presentations, the detailed presentations by David Crowder. Then there was toolkits being sent out by fire safety and the deputy commissioner in terms of local authorities to use. So we were pitching it at a strategic level, so that the appropriate people could be aware of this.

Going back to for firefighters to check, it's -- it wasn't -- and it wasn't an expectation that they should get involved in that level of detail on an external wall of a high-rise.

Q. It could have been, though, pitched at a practical level, couldn't it, simply by including the words "cladding systems" at the 12th bullet point at

appendix 1 of 633 so they were at least alive to the need to look out for cladding systems which may have an effect on fire spread in the event of a fire?

A. But even if we had have done that, then there would have been questions in terms of: well, exactly what are we looking for? How are we supposed to determine whether one piece of cladding is any different to another? How do we know if there are voids? What do we know about the construction of it? Et cetera.

But apart from that, firefighters, I would suggest -- well, I know -- were well aware of the issues of cladding in terms of firefighting, and it would have been in their knowledge and experience that if a fire escapes a compartment externally then, you know, there have been some occasions where cladding has become involved. So they were aware of it, but there's a difference between aware of the potential and their knowing how to look at something and determine whether it has the potential to become involved in a fire over and above any other type of cladding.

Q. Now, did anyone else at the LFB seek to discuss with you the need to direct operational crews to have regard to cladding systems as part of the 7(2)(d) visit programme?

A. Not that I can recall.

Q. After the Lakanal House Inquests, which had established

that the panels were not of the requisite standard and had contributed to the speed of the fire, did anyone raise with you again the need to direct crews explicitly to the need to look at cladding systems?

A. Not that I can recall, no.

Q. Did the Shepherds Court fire in August 2016 prompt any consideration whether crews ought to be expressly directed to look at cladding as part of the 7(2)(d) process?

A. Not that I can remember, no.

Q. No.

You touched earlier on in evidence on the involvement of the responsible person on fire safety visits. Now, the Phase 1 report concluded that crews who carried out 7(2)(d) visits at Grenfell should have obtained information about the building's cladding system from the TMO directly. Would LFB crews normally have made enquiries of the responsible person before or after conducting 7(2)(d) visits?

A. When crews conduct a 7(2)(d) visit, when they make the arrangement, just out of sheer courtesy, if nothing else, there's an expectation that they would contact the responsible person to let them know that they are coming, and that responsible person ideally would join them on the visit and answer any questions and show them

any particular issues that they need to be able to complete the premises risk assessment.

Q. So the answer is yes?

A. Yes.

Q. Was there any system for monitoring the quality of 7(2)(d) visits and the information they were collecting, ie were they collecting the information that they needed to in order to discharge the duty?

A. Yes. So a crew would, having completed the premises risk assessment, then come back, and they would get on to the operational risk database and they would put the information in there. If there was any hazard information, they'd fill that section in, and if there was any tactical plan to be considered, then they'd fill that in as well. Once they'd done that, then it sits in what's known as a work queue, and the station manager needs to quality assure that and make sure the station manager is content and satisfied that the visit has gained the necessary information. If they're not, then the station manager would send it back to the crew to do what needed to be done. Once the station manager had quality assured that, it then got sent up to information management, the people who owned the operational risk database. And this is why I made the distinction between collection and application, because

there is another big part of it in terms of owning the database, which was information management, and they would quality assure the information as well and make sure they were content with it.
Q. If I can stop you there, how does the station manager go about discharging the quality assurance function? Say, for example, we found at Grenfell that there were several errors ——
A. Yes.
Q. —— in relation to the information that was recorded, as basic as not correctly recording the right number of floors, for example.
A. Yes.
Q. How can the station manager assure himself that basic information is correct, other than going out there and inspecting the building himself? How do you see him discharging that function?
A. Well, that's a good point, and the station manager, as I did when I was a station manager, would be expected to actually go and sample some of the visits that are being carried out. And the station manager managing the four watches would get a feel for the level of expertise and professionalism on the watches, and it may well be that he or she needs to make visits accordingly.
Q. What policy direction —— let's confine ourselves to

policy, first of all. Were station managers directed to carry out this sampling exercise you've referred to?
A. Well, we introduced, or I introduced, something called service standards. So one of the challenges that I faced and the London Fire Brigade faced is that it's a vast organisation. The size of some of the four areas in London are bigger than most other fire brigades in the country, so, you know, we could argue that we were managing four separate fire brigades. Some boroughs were bigger than some fire services in the country. So we needed standardisation and consistency. The matrix is one of those ways of achieving that, but service standards was another way.
Q. Can I cut through this: was there a specific provision in the service standards or any other policy that directed station managers to conduct a sampling exercise to verify the accuracy of information collected by crews as part of a 7(2)(d) visit?
A. As far as I'm concerned, service standard 8, which was about contingency planning, advised station managers to sample the accuracy of visits, as well as quality assuring from a desktop. And it was also something that I would make sure again at these borough commander meetings —— and I can't —— and I'll probably over—mention these during the next few days, but they

were absolutely vital to the information flow between the strategy of the organisation and the application at local level, and I would make it clear there as well.
Q. Was the sampling exercise defined by the risk presented by particular properties, so the station manager's quality assurance programme would concentrate on high—risk buildings?
A. The quality assurance in terms of desktop was for all buildings, every single building that goes on the ORD.
Q. But would the sampling exercise be prioritised and focus on accuracy of information relating to high—risk buildings?
A. Not necessarily.
Q. No. Again, it would be subject to the individual discretion of a station manager; would that be right?
A. Yes.
Q. Can we look briefly at the LFB's Lakanal assurance review, which can be found at {LFB00004801}. This document summarises the required actions identified by the LFB following the Lakanal fire, and it also includes the recommendations made by the coroner.
If we can go to page 28 {LFB00004801/28}, it deals with section 7(2)(d) visits at high—rise premises and actions taken specifically in response to the coroner's recommendations.

If we can see the second full paragraph on the left—hand side, which says this:
"A review of the Operational Risk Database shows that on average approximately 40 visits to residential high rise premises, that were not yet recorded on the Operational Risk Database, were completed each month under the requirements of section 7(2)(d) of the Fire and Rescue Services Act resulting in the production of an electronic—Premises Information Plate for those premises (Note: data between April 2014 and October 2017). Using the same data set (i.e as of October 2017) it was identified that approximately 1,700 residential high rise premises had a premises risk assessment recorded against a total of approximately 6,900 residential high rise premises in London."
I'm mindful that those numbers —— 1,700 and 6,900 —— relate to October 2017, ie after you retired, but are we safe or reasonable in assuming that the figures would have been broadly the same during your time at the LFB, ie in terms of total number of high—rise properties in London and those that had had PRAs conducted?
A. Well, the only thing I would say about that was I remember in September 2013 a presentation which may well —— we may well discuss at some point, and in there we highlighted there was 1,300 high—rises on the

operational risk database, and that was in September 2013. So four years later, more or less, only an extra 400 I find surprising, and mathematically incorrect. If 40 visits per month were being undertaken, then one of those figures is wrong somewhere.

Q. Well, some of the data set postdates your retirement ——

A. Yes.

Q. —— so I think we have to bear that in mind, but if we can take these figures at face value, they show or seem to show that 1,700 high—rise premises were on the ORD ——

A. Yeah.

Q. —— and subject to scheduled section 7(2)(d) visits, it would follow?

A. Yeah. I guess what I'm trying to say is I would have expected there to have been more than 1,700, but taking that at face value, yeah.

Q. It's unfair on you because you're not in a position to verify the data, we have to take this as face value.

So we've got there 1,700 which would be on the ORD and therefore subject to scheduled 7(2)(d) visits; is that right?

A. Yes.

Q. And looking at the figures we've got here, that would mean that 5,200 high—rise premises were not on the ORD

and so therefore not subject to scheduled 7(2)(d) visits?

A. Based on these figures, yes.

Q. Now, would it have been a source of concern to you —— let's assume these figures were whilst you were still in post —— that more than 5,000 high—rise properties were not on the ORD and were therefore not subject to scheduled 7(2)(d) visits?

A. Absolutely, and it was a certain of mine when I was in post, and it was one of my many things that we were trying to improve. So there was clear instruction given to station—based staff and borough commanders and processes and procedures put in place that we could increase that number.

My utopia was that every single high—rise premises in London would have been visited and been risk assessed. Whether it stayed on the operational risk database after that visit was another issue, but we needed to have carried out that visit and the premises information plate been created and installed.

Q. Bearing in mind that answer, was the position, therefore, there was a similar disparity during your time as director of operations between the number of high—rise buildings that were recorded on the ORD and subject to 7(2)(d) and those which were not?

A. It's true that there wasn't every single high—rise on the ORD, but it's also true that we were working really hard to rectify that, and we was aware of the issue.

Q. I'm sorry to interrupt you, Mr Brown, but it's not just that not every one was recorded; the fact here is we have a disparity where 1,700 were, more than 5,000 were not. Now, my question is: was that same proportion of disparity the case when you were director of operations, a similar order?

A. There was a large number of high—rise that weren't on there. Without wanting to split hairs, I also want to alert the Inquiry to the fact that we had a real challenge, and it might seem strange, but in finding out exactly how many high—rises there were in London, and we did an awful lot of work in trying to actually determine that, talking to the local authorities, housing providers, and we could never get a complete straight answer. So we was never entirely sure how far we were way from achieving our objective.

But, yes, there was a significant amount that weren't on there, but we were aware of that and trying to rectify that.

MR KINNIER: Mr Brown, we will come on to that subject in due course.

Sir, it's 11.15. Given where we're at in the

examination, that's a convenient time, subject to your permission.

SIR MARTIN MOORE—BICK: Yes, all right. Well, then, that sounds as though it's a good point at which to have a break.

Well, Mr Brown, as you were told earlier, we have a break part—way through the morning. We will take that break now. We will resume, please, at 11.30.

I have to ask you on this and every other occasion on which you leave the room, please don't talk to anyone about your evidence or anything relating to it while you're out. All right?

THE WITNESS: Okay, thank you.

SIR MARTIN MOORE—BICK: Thank you very much indeed. Would you go with the usher, then, please.

(Pause)

Thank you. 11.30, then, please.

MR KINNIER: Thank you.

(11.16 am)

(A short break)

(11.30 am)

SIR MARTIN MOORE—BICK: Right, Mr Brown, ready to carry on?

THE WITNESS: Thank you, yes.

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

Yes, Mr Kinnier.

MR KINNIER: Thank you, sir.

Mr Brown, can we turn now to your email to LFB stations sent on 20 April 2009. It was sent on your behalf, and you deal with this email in page 15 of your first witness statement, {LFB00032166/15}. We see at paragraph 43 you cite this email as being an example, and following on from your earlier evidence, of the importance the LFB placed on pre-planning for residential high-rise fires.

Now, if we go to the email itself, which can be found at {LFB00032161}, we see at the bottom of page 1 the email says at its head:

"This message is from AC Brown (Service Delivery & Mobilising) and is for all Station based Station Managers and Borough Commanders."

It deals with section 7(2)(d) visits at the top of page 2 {LFB00032161/2}, and it says this:

"A database of high rise premises (see attached) has been compiled that falls within the criteria set out by AC Webb (Ops Planning) in April 2007 [so roughly two years before], which defined a High Rise as a domestic residential premises which is fitted with a) firefighting lift and b) dry or wet rising main. As part of the ongoing familiarisation training for station based staff, station managers are to ensure that watch

and crew managers diarise, book and visit the high rise premises on their station's ground during 2009/10. This process should begin with immediate effect and then be undertaken annually thereafter. Borough Commanders should liaise with their DAC to discuss prioritisation of these visits."

First of all, do you remember that email?

A. I do, yes.

Q. Now, at first blush, your instruction appears to be a direction to visit all high-rise premises on a station's ground annually. Is that a fair reading of what you intended?

A. Can I just read it again?

Q. Of course.

(Pause)

A. So there was a database that Jon Webb, ops planning, had prepared, and we wanted staff to look at that. So whether I mean by that all the high-rise that was on that list prepared by Jon Webb or whether I mean going above and beyond that in terms of all high-rise, I'm not quite sure. But ultimately, yes, I would have expected all high-rise to be visited and, yes, at that point it would have been annually.

Q. Looking at really what you say in that paragraph at the top of page 2, you say:

"... station managers are to ensure that watch and crew managers diarise ... the high rise premises on their station's ground ..."

Now, that suggests all high-rises on a particular station's ground; would you accept that?

A. Sorry, where is that exactly?

Q. Top paragraph.

A. Yeah.

Q. Third line.

A. Ah, yes. Yeah, absolutely. But, as I say, whether it referred initially to high-rise that was on Jon Webb's email and on their station's ground or not, I can't quite recall. But I would accept that ultimately, yes, we expected that all high-rises on their station's ground would be diarised and visited annually.

Q. Can you help us, what was the reasoned basis for the annual requirement for crews to visit all high-rise premises on the station ground?

A. I think probably at that time we wasn't quite sighted on the number of high-rises that were available, and we felt that that would be an appropriate and not an unreasonable expectation. That was back in 2009. I think once the enormity of the task become more apparent, then we took more of a risk-based approach as we saw with the premises risk assessment.

Q. Before you sent the email in April 2009, did you consider or take advice about whether it was reasonably practicable for all high-rise buildings on a station's ground to be visited annually?

A. I don't believe so.

Q. So really the underlying intent was a scoping exercise to identify high-rises and then take it from there; is that a fair summary?

A. That isn't a way I would have considered describing it, but yes, that's not an unreasonable way to describe it.

Q. When you sent this email, was there a plan to monitor how the aim of annual inspections was to be achieved?

A. Well, yes, but that plan would have been what I would describe as normal business. So we were forever monitoring, performance managing, overseeing progress in terms of making sure that what we wanted to happen was happening, and then fitting in other objectives as well.

Q. Can we look at the database that was referred to in your email. That can be found at {LFB00104535}. This document will need to be downloaded, so there may well be a bit of a delay.

(Pause)

There we go, thank you.

Do you remember providing or reviewing this document before it was attached to the email that was sent in

your name?
A. Well, I don't remember doing it, and, to be honest, I don't think I did. This was prepared by ops planning and I've taken this on face value that it was properly checked, and I've attached it there as guidance to station-based staff in terms of -- in case they weren't aware of some of the premises.
Q. Can you help us as to where the list of properties came from?
A. I'm afraid I can't. I've thought about that in readiness for this Inquiry, and it was prepared in very early tenure of mine by a colleague in ops planning, and I don't know where they got that information from, I'm afraid.
Q. So you don't know what criteria they applied in determining --
A. Well, I can only imagine it was the criteria that I put in that email, in terms of dry riser, et cetera. But other than that, I don't know.
Q. But that's an assumption?
A. It is an assumption, yes.
Q. Can you remember, how was the database to be managed if this was the database?
A. Well, it was on the central risk register, which was the forerunner of the operational risk database. So the

idea, for want of a better term, was to cleanse the central risk register, and the premises on here would find their way onto the central risk register or the operational risk database, whatever was in process at the time.
Q. So who would be ultimately responsible for managing this database?
A. This actual database I'm looking at now?
Q. Yes.
A. Well, once it got on to the operational risk database, it would be information management.
Q. Thank you.
Now, can we look at the draft amendments to the high-rise policy 633 that were circulated in 2010, and for that purpose can we go to an email sent by Peter Cowup, which can be found at {LFB00082695}.
As you can see from the top of this, Mr Cowup emailed James Knighton in relation to a draft version of 633. You were not included on the email chain, Mr Brown, I should make clear. His email is set out there, and I would like to start at the fourth paragraph, where Mr Cowup said this:
"Although I believe the current draft represents a significant step forward, there remain a number of key issues and points that I believe require further work

and consideration. These include ..."
If we go to the second bullet point:
"The feasibility of station personnel visiting all high premises on their stations ground, as this is a very significant task, especially for central London stations. I fully understand why we would state that in Policy, but it may be worth giving this statement further consideration - I have left it in for now!"
Now, that second bullet point appears to be a reference to paragraph 3.1 of the draft policy 633 which was attached to this email, and we can see that draft at {LFB00039485/4}. What that says in the second sentence is this:
"Station personnel should be familiar with all high rise buildings on their ground."
Now, Mr Cowup appears to have interpreted policy as requiring stations to visit all high-rise premises. Was that how paragraph 3.1 was being interpreted generally across the LFB at the time, or is it a policy aspiration?
A. I think it's both, really, but personally I was always of the view, and I made it absolutely clear, I cannot see from a moral or professional perspective that we could exclude any high-rise. So if any building needs inspecting, then we should inspect it. Whether it led

to further ongoing inspections is another issue, but for me, my position was that, over a period of time, every single high-rise should be visited.
Q. Were you aware at the time that Mr Cowup had reservations about the practicability of visiting all high-rise buildings on a particular station's patch?
A. I wasn't, no.
Q. Had anyone else raised that concern with you at the time, or indeed afterwards?
A. I don't recall anyone raising the issue with me prior to. In terms of afterwards, there was extensive pressure that I applied to my own staff to achieve this objective, and, yes, I then did get feedback, from a range of sources, how challenging this was. And I accepted, and I accept now, it is challenging, but for me that's not a reason not to do it.
Q. Were you asked to contribute to this particular review of 633?
A. Personally, no, but it would have been standard practice that heads of service would have been involved. If I had have received an email on it, I invariably would have passed it on to people that worked for me, most probably central service delivery as they were called at the time, and they would have commented on it on my behalf.

Q. You don't remember expressing your own views personally about the practicability of annual visits?
A. Not at this time, no.
Q. Now, in 2015 ——
A. Sorry, if I can just clarify there. So the annual visits issue, no. The concept of all high—rise being visited per se is —— they're two separate things.
Q. You've made that clear.
A. Yeah.
Q. Thank you.

Now, in 2015, policy 633 was again updated and the new version published on 1 June 2015, and that can be found at {LFB00001256}.

If we can go to page 7 {LFB00001256/7} and section 4, you can take it from me that paragraph 3.1 of the previous draft which required station personnel to be familiar with all high—rise buildings on their ground had gone.

Now, were you consulted about that particular change?

A. Not that I can recall.
Q. No. Again, can you remember whether you were involved or consulted as part of the revision process for this particular iteration of 633, and by you I mean you personally?

A. Other than the well laid out practice that I've just explained in terms of heads of service consultation, I don't specifically remember.
Q. Are you able to assist the panel as to whether omitting what previously had been paragraph 3.1 was a deliberate change in policy to downgrade the regularity of visits?
A. I'd be speculating if I was to say yes or no to that.
Q. I'm not asking you to speculate, but mindful of your previous evidence, you said that members of your staff had forcibly emphasised to you the practical difficulties confronting annual visits to high—rise buildings; is that a fair summary?
A. It wasn't only members of my staff, it would have been in discussions with staff side as well, because I introduced certain practices that would enable staff to be able to achieve the objective of visiting all high—rise, which wasn't necessarily popular with staff side.
Q. Could we now turn on to Operational News, and it's edition 20, which was an article published in November 2011. We can find this particular edition of Operational News at {LFB00047224}. We can see there, on the front page, it contains an article entitled "High rise firefighting", the first few paragraphs of which are the text immediately below the photograph

under the heading "High rise firefighting", and it addresses the issue of pre—planning.

Now, the operations directorate co—ordination board, I think you were a member, were you; is that right?

A. That's correct.
Q. They were responsible for articles published in Operational News; is that right?
A. That's right, yes.
Q. Who within ODCB was responsible for the content of articles published?
A. It depended on who was the subject matter expert. So dependent on that particular subject, we would look at the section within the department that concentrated on that area, and they would have been the author, original author, of each aspect. So this particular article probably would have come from somewhere within ops policy or ops assurance.
Q. Can we take it from that that you weren't involved at all in the drafting of this article?
A. No.
Q. Would you have been consulted about the contents of the article?
A. Once the article was written, it would then be circulated to various people, which may or may not have included me, dependent on when it was. Certainly when

I was a director of operations, so after April 2015, it would have done, prior to that possibly not.
Q. Is it right that the content of articles is a matter that would have been discussed at ODCB, and so they were the ones who agreed content, and so you would have been aware, at least from ODCB meetings, that this article was being published?
A. Well, at ODCB meetings we would have determined the need for an article and an associated training package, but then after that point, when the article was written, it wouldn't then come back to ODCB for approval. It would be the fact that it was being written, and the parameters in which it needed to be written. Communications team had a big part to play in terms of presentation, and fitting in within a certain size of the document, but it didn't come back in a loop for final approval to ODCB before we published.
Q. But you were aware in broad terms of the topic that was going to be ——
A. Oh, absolutely, yes.
Q. Now, if we can look at the article itself. Stay on this page and look at the middle column underneath the photo, where it says this:

"Any visit to a high rise building should be used as an opportunity to pre—plan; this will include the

location of the LFB premises information box (if fitted) as well as the accuracy and completeness of information provided including evacuation plans. Any high rise buildings which pose a particular risk should be subject to 7(2)d visits."

Looking at that last line, "Any high rise buildings which pose a particular risk should be subject to 7(2)d visits", that appears to be a departure from the terms of your April 2009 email which required all high-rise buildings to be inspected.

Was there a conscious departure, therefore, in the Operational News issue 20, away from the inspection of all high-rise buildings that you'd encouraged or directed in your April 2009 email?

A. Can you just remind me, please, of the date of this Ops News article?

Q. Yes, it's November 2011.

A. Okay.

I think there's a subtle difference here. I don't think it is a departure. I think the 2009 email was about making sure that every premises had been visited to determine whether it needed to be included on future 7(2)(d) visits. What this is saying is any high-rise buildings which -- and I would add: having been initially inspected -- pose a particular risk should be

subject to future 7(2)(d) visits.

So the concept was and remains, as far as I'm concerned, that no building can never be not inspected because that initial inspection determines future inspections.

Q. And so this should not be read as a reflection of the concerns that Peter Cowup had raised about --

A. No, absolutely not.

Q. -- the practicability of section 7(2)(d) visits?

A. Yeah. So we need to know what is out there, and once we know what is out there, we can then decide in terms of risk assessment whether it requires ongoing visits.

Q. Are you able to help us as to what was meant by the phrase "posed a particular risk"?

A. I would suggest that's just a broad terminology to reflect that there's a whole range of different risks that you might experience in any building or in a high-rise.

Q. Again, there would be an element of discretion exercised by the station manager based on his knowledge of the features of a particular high-rise building?

A. Up until the point that we introduced the premises risk assessment, which made it far more prescriptive and consistent.

Q. Thank you.

Now, can I turn to a separate and distinct topic, which is the introduction of policy 800 in 2012.

Now, as we've seen previously, it was first issued in July 2012, and its stated purpose was to assist station personnel with the risk assessment process for sites in their area.

Now, I think as we touched on earlier, you were the lead senior officer in relation to the introduction of 800, though particularly in relation to action 2b.

Now, one thing I'd like to look at is that particular action for which you were responsible, which was to create an inspection regime targeted at the high-priority buildings.

Now, were you the lead for the first introduction of policy 800 or only for the later version? It seems to be, I think, the later version, given what you have said earlier on.

A. Yes, that's right, yes.

Q. Who was your predecessor as the lead on formulation of the policy?

A. I think it was operational assurance -- sorry, operational resilience, that's right, I think it was operational resilience, and at that time -- I know Tim Cutbill was the assistant commissioner for operational resilience at some point. I'm not sure

whether he was at that time. I can't recall exactly who that person would have been.

Q. In summary, what were the responsibilities of the lead in relation to 800?

A. Well, the lead really would have been making sure that the policy was fit for purpose and that it was reviewed periodically as and when it was scheduled to be reviewed. In terms of the specifics within it, the lead would have delegated that to members of their staff.

Q. So you weren't involved in the substantive drafting process?

A. No.

Q. Thank you.

As we've seen, policy 633 included a list of items which crews should consider when carrying out section 7(2)(d) visits at high-rise properties. Why was that list not included in policy 800 so as to give comprehensive advice as to what section 7(2)(d) visits should be directed to?

A. I don't know for sure, but in saying that, there was a view within the organisation that we wanted to keep policies, I'd say, to a minimum. We had too many policies at one point, I think, and we wanted to rationalise our policies. We wanted to make sure that our policies didn't overburden staff with too much

information, and that they just did what they needed to do. So I can only imagine that there was -- to avoid duplicating lists, just a mere reference from one policy to another was sufficient.

Q. Following on from that, though, there is no reference in the 2012 iteration of policy 800 to the guidance in appendix 1 of policy 633. How were crews therefore to know whether to cross-refer to appendix 1 of 633 in the absence of any specific reference?

A. Well, if there wasn't a reference then that's clearly an omission, and that's something that hopefully has been remedied now. All I would say is that policy note 800 and policy note 633 to do with information-gathering and high-rise firefighting were such a component part of a firefighter's role that they would be aware of both. But in saying that it is -- if it is the case that there isn't any reference at all, then that's certainly something that was -- that shouldn't have been the case.

Q. Would you accept -- and I'm putting this to you simplistically -- that because there was an absence of a cross-reference in the policy, there was at least a risk of crews missing or not being directed to securing relevant information as part of section 7(2)(d) visits?

A. I can see why you would say that, but all I would say is high-rise firefighting was -- has always been high on the agenda of firefighters, so I cannot imagine that they wouldn't be aware of what they needed to do under policy note 633.

Q. Would it be fair to say that the risk of information not being caught was not identified at the time that 800 was issued in July 2012?

A. Yes, that's not an unreasonable way to describe it.

Q. Can I now turn to a separate and distinct topic which concerned the incident at Salamanca Place in July 2011.

Now, Salamanca Place was a high-rise building in Lambeth, wasn't it, or is?

A. Yes.

Q. If we can look at the senior accident investigation report in relation to that incident, which is at {LFB00102299}.

Now, we are proceeding on the basis that, although this is watermarked "Draft", it is in fact the final version, and that basis, so people know what it is, is paragraph 55, footnote 4 of Mr Cowup's third statement, which can be found at {LFB00119849/28}.

First question, Mr Brown, is: do you remember the Salamanca Place incident?

A. I don't remember it well, but yes, I do recall it.

Q. In summary, a crew attended a fire incident on 15 July 2011. During the incident, four firefighters became trapped in a lift, exposed to heat and smoke, before being rescued by colleagues. Are those the pertinent details?

A. Yes.

Q. In summary, this report was the culmination of the SAI process, which involved the investigation of safety events; is that right?

A. Yes.

Q. SAI stands for senior accident investigation.

A. Yes.

Q. And its purpose is to examine by senior and specially trained LFB personnel to identify any underlying systemic failures that might have led to a safety event occurring during an incident.

A. Yes, and to aid organisational learning to prevent it reoccurring.

Q. Thank you.

Now, is it correct that such an investigation concludes, or should at least conclude, with an action plan which sets out the measures that the Brigade intends to take to address any deficiencies identified?

A. That would be normal practice, yes.

Q. During your time at the LFB, SAI action plans were

monitored by the operational directorate's co-ordination board; is that correct?

A. Yes, and we had a rolling log of various actions under SAIs and we would add new ones to it to make sure nothing was lost.

Q. Now, the SAI report for Salamanca Place is on the screen. If we could turn to page 7 {LFB00102299/7}, there you see, roughly the top third of the page, the heading "Pre-planning", and what it says from the end of the second line is this:

"The building was not on the Brigade's central database for high rise buildings and a Fire and Rescue Services Act 2004 section 7(2)(d) visit had not been carried out by the watch involved."

Now, the report then goes on to set out relevant pre-planning policy provisions, including 633 and 521, and if we turn over the page to page 8 {LFB00102299/8}, we can see the text in italics is your email of April 2009 to station staff about the database of high-rise premises and the need to carry out annual visits to high-rise buildings on a particular station's ground.

If we can go to the middle of page 9 {LFB00102299/9}, so over the page, we can see there the heading "Pre-planning analysis", and that states this --

and if we could expand it in such a way that notes GR3 and GR4 can be seen by Mr Brown and the panel, thank you:

"There is evidence that the crew at Lambeth were aware of the premises and that there may be access difficulties. The opportunity was not taken for a 7(2)(d) visit to be arranged.

"There was a failure to carry out a 7(2)(d) visit.

"High rise database:

"It is unclear how the high rise database is maintained or updated for new high rise buildings.

"There is no clear mechanism for fire stations to be informed of new high rise buildings which require section 7(2)(d) visits."

Now, I have assumed that the reference there to high-rise database is to the database that was set out in the Excel spreadsheet that was attached to your April 2009 email. Is that a safe assumption to make?

A. Either that or they're referring to the electronic database, either the central risk register or the operational risk database.

Q. Thank you.

Now, we can see the comments on the side, "GR". Is GR Gary Reason?

A. I would imagine so.

Q. And what he says in GR4 is this:

"It would be helpful to have a footnote explaining how stations access this database (if they can?)."

Now, that comment requesting clarification as to whether stations are able to use the database is unlikely to refer to the ORD, isn't it, given that the ORD was capable of regular and easy access?

A. Yes, I think by this time, I think the ORD probably had formally taken over from the central risk register, so yes, it would seem reasonable that it's referring to that at that moment, yes, yeah.

Q. Sorry, just to clarify your answer, what I was suggesting to you was that the database that is the subject of the text here is unlikely to be the ORD, is what I put to you. I just want to make sure you agree with that proposition.

A. Oh, I see. I'm not sure we can say that, to be honest. I mean, first of all, there is -- to my knowledge, there was no such thing as a high-rise database as such, they're referring to a database that contains high-rise, and the ORD -- and Gary was well aware of the existence of the ORD at that time.

Q. And it's for that reason, Mr Brown, I suggest to you it's not the ORD he's referring to, and the other factor that he appears to have in mind, or the author of this

report appears to have in mind, is the Excel spreadsheet that was attached to your April 2009 email, because that's what has been quoted extensively on the preceding page.

A. I'm not sure we can draw the conclusion -- so if we're looking at comment GR4, ie "It would be helpful to have a footnote explaining how stations access this database", I don't think we can necessarily draw the conclusion that Gary's not referring to the ORD. It may well be he's just trying to have an explanation that just makes it helpful for the reader.

Q. Okay.

Now, if we can just look at these comments in more detail, the first one, GR3, said this:

"... as the building is adjacent to the fire station did it not occur to any of the watches that it should be subject to a 7(2)d visit? Irrespective of whether it appeared on the database."

Now, that comment suggests that the crews were not expected to use the database as a comprehensive list of premises they were required to visit. Would you agree with that? That assumes, of course, that the database is the Excel spreadsheet which was attached to your 2009 email.

A. I think the crews or certainly managers, station

managers, borough commanders -- and I'm sorry to repeat the comment again, but I think it's worthy of just -- of clarifying how much -- how important an issue it was for us -- were aware that all buildings need to be -- have an initial inspection to determine their future inspection regime. So whether it's on the database or not, I wouldn't expect crews or managers to be led exclusively by the database, because people should have known that not everything was on that database.

Q. And there may be cause for concern about the quality assurance process taking place if the crews had not identified a high-rise building immediately adjacent to the fire station.

A. Well, the quality assurance process that we've spoken about was assuring the quality of the information that's gone on the operational risk database once it's been inspected. The proposition here is about buildings that have never even received that initial inspection in terms of even carrying out that quality assurance. So that boils down basically to station managers and borough commanders making sure that all buildings have had that initial inspection, which is a slightly different nuance to quality assurance.

Q. Now, the report on Salamanca Place led to the creation of an action plan entitled "SAI 282 Salamanca Place".

That can be found at {LFB0095042}. That plan was dated 22 August 2012, so more than a year after the incident.

I would like to focus on two particular actions. The first one is action 2, which can be seen in the second row in the table, and it provided thus:

"Carry out a review of the existing high rise database to determine whether it is viable and beneficial to develop and maintain this data set.

"The term 'beneficial' relates to station staff being able to access this type of information to highlight new high rise premises and inform 7(2)(d) visits."

Now, that action was allocated to the head of information management; is that right?

A. Yes.

Q. And the third officer, which was at that time you?

A. Yes.

Q. And the head of information management at this time was David Wyatt; is that right?

A. Yes, and still is, I believe.

Q. Now, does that help you identify what the database was that these people were referring to? Do you think it was the Excel spreadsheet attached to your email or was it the ORD?

A. I think it must be the ORD, because head of information

management was managing the contents of the ORD.

Q. Was the review carried out?

A. To my knowledge, yes.

Q. By whom?

A. I don't know for sure, but certainly I would have made sure -- it would have been -- it would almost certainly have been David Wyatt, and then maybe some people that worked for me. But I can't recall any further details, I'm afraid.

Q. Can you remember when it was carried out?

A. I don't remember particularly when, but all I can say is on all of these, whenever dates were given to carry out actions, I was very ... I gave a lot of scrutiny, shall we say, to making sure actions were carried out when they were supposed to be carried out. So if there was a completion date on it, I'd be confident that it would have been done within that time, but I can't remember any further than that, I'm afraid.

Q. There is no completion date identified there. So, in the circumstances, what steps would you have taken to ensure the review was actually carried out?

A. Well, it was an ongoing transfer. So the wider picture is the CRR, the central risk register, was being carried over on to the operational risk database. The list of high-rise premises that Jon Webb had collated was

another area that was feeding into the operational risk database. So it was a process, an ongoing process, that was going on to make sure (a) everything was finding its way onto the new portal, if you like, you know, the complete database, ie the ORD, and that we continued in making sure new premises, regardless of whether it had been on the list or not before, found its way on there.

Q. Can you remember the substance of the conclusion of the review? Don't speculate if you can't.

A. No, I can't remember specifically.

Q. Okay.

Now, can we go on to an email chain that was pertinent to this action, and it can be found at {LFB00095342}. It's an email chain initiated by David Wyatt on 22 August 2012.

If we can turn to the bottom of page 2 {LFB00095342/2}, we see an email that Mr Wyatt sent at 9.11 on 22 August, in respect of SAI 282, so that's Salamanca Place, draft action plan, and he said this:

"So, the action in this plan for me (with Dave Brown) is ... the database is, of course, ORD ... I am assuming ... but will clarify ..."

Now, if we go back to page 2, we get an email from Anna Lockwood, and if we could go up the page so we can see that email. That was sent at 9.50, and she said

this:

"I have had a conversation with Andy O'Loughlin about this a few months ago. He was under the impression that PDA Section maintained a database of all high rise residential flats. I informed him that this was not the case. Some entries have been made in ORD but not all. We can extract all the properties from the mobilising system, but this does take some time."

If we go to page 1 {LFB00095342/1} and Clive Eustice's email, which is at the top of the page, he says this:

"I don't think it is ORD but do think it is a very confused message in the first place.

"The 'High Rise Database' they refer to is, I am sure, the list sent round to [stations] some months (years) ago and I have no idea who owned this but can pretty much guarantee it was never updated and is therefore of no/very limited value.

"This was the 'knee jerk' list where the message said visit every high rise and consider 7(2)(d) but what Dave meant was add one of the blocks in an estate if there are unusual or very difficult circumstances to be found there ..... he couldn't say this in an email of course and we ([information management]) therefore had to make sure people understood it at [information

management] Days."

Now, that email chain appears to say that the SAI action plan was referring to the high-rise database attached to your April 2009 email.

Now, having had your memory refreshed by contemporary correspondence, would you accept that?

A. Well, based on -- so Andy O'Loughlin, from what I can recall, had a lot to do with senior accident investigations, so if that was Andy's understanding then, yes, he may well have been referring to that list. But I would clarify that and say the fact that that list was finding its way onto the operational risk database. So whilst it might seem -- I don't want to appear to be dancing on a pinhead with this one, but the information that was in that list was going into the operational risk database. The operational risk database was going to be the all-consuming, one-stop place where all the information should be. I think what this does highlight is, yes, there clearly was confusion, and part of our remit was to eradicate that confusion so everyone understood where they needed to go to for what information.

Q. So the basic position is that three-plus years after you sent your email of April 2009, there was still confusion about the basics of what high-rise properties were on

the books, as it were, and what the risks were arising from those high-rise properties?

A. No, I wouldn't agree that there was confusion about what high-rises were on the books. There may have been some residual misunderstanding that pre-determines(sic) the section carried some kind of exclusive list of high-rise, rather than just the all-consuming list on the operational risk database, but I don't think it demonstrates there was confusion about what was on the list and what wasn't, it was all about organisational knowledge.

Q. So there was confusion, looking back at your earlier answer, as to where to find that information, though?

A. Well, according to this email chain, yes. But I wouldn't -- I don't believe there was such confusion, to be honest, because the central --

Q. I'm sorry to stop you there, Mr Brown, because I think if there is any confusion now, it's about the evidence you're just giving.

If we can scroll back, I had understood you to indicate that you're accepting that there was confusion as to where the information regarding high-rise buildings was located. Is that your evidence or isn't it?

A. Sorry, can you repeat that?

Q. Yes. I'd understood you to indicate that you're

accepting that there was confusion, as evidenced by this email chain, as to where information regarding high-rise buildings was located. Do you accept that?

A. In terms of whether it was located on an Excel spreadsheet or on the operational risk database, yes.

Q. And that's the clear thrust of what Mr Eustice is saying in this email, isn't it?

A. Well, he certainly says in the opening sentence, "I don't think it is the ORD but ... it is a ... confused message", yes, it does say that.

Q. Now, when in his email he refers to a message that said visit every high-rise and consider every 7(2)(d), that appears to be a reference back to your email of April 2009. Would you accept that?

A. Yes.

Q. Now, Mr Eustice described that list as a "knee-jerk" list. First of all, do you accept that proposition?

A. No.

Q. Can you remember what event might have triggered the knee jerk to which Mr Eustice is referring?

A. Well, that's why I wouldn't agree with it, because I don't think there was such an event. I think the rationale behind the 2009 email was the fact that we'd become more organisationally aware. There was an Ops News that had gone out not long before talking

about high-rise. There was another Ops News coming out about a month later, after that particular email. There was the operational risk database being formulated. There was mobile data terminals about to come online, which displayed the information to crews at an incident from the operational risk database. So there was a number of things going on, and then there was the ongoing -- and I can't underline this enough -- there was the ongoing -- at the forefront of our minds about the importance of high-rise, for various reasons. So --

Q. Sorry to interrupt, was it a knee jerk to the impulse behind your email of April 2009?

A. No, I wouldn't accept there was -- it was impulsive or it was a knee-jerk reaction.

Q. I'm not suggesting it was impulsive. What I'm suggesting is that the trigger for the knee-jerk list was your underlying motivation for sending the April 2009 email.

A. The fact that a list existed certainly underpinned the email, but it wasn't the motive for doing it. There was a range of other organisational things going on.

Q. Okay.

Mr Eustice says in that email, and we can see there:

"... the message said visit every high rise ... but what Dave meant was ..."

And he sets out there what he understood you to be saying.

Now, is Mr Eustice correctly summarising your true concern in that email?

A. No.

Q. From where could he have got that impression, do you think?

A. I don't know. I think that's something that only Clive would know himself. But it was common knowledge that there were certain housing estates where there might -- and I can think of one in particular in east London where there are 12 high-rise blocks and they're all absolutely identical to each other.

Q. What were IM days?

A. Oh, IM days were something that Clive Eustice and his team would run, and we would invite borough commanders and station managers up to headquarters, and then Clive and his team would go through with them all the various technological support systems -- ORD for one, for example, station diary, outside master duties list -- that station managers and borough commanders can use to make their role a lot easier and more efficient.

Q. What guidance was given to the information management department to allow audience members at these IM days to know what constituted unusual or very difficult

circumstances?

A. I don't believe these days would have covered that kind of area, because that wouldn't have been the remit of what an IM day was. An IM day was to know how to use the information management systems that were in place.

Q. Now, can we look at the fourth and fifth paragraphs of Mr Eustice's email. He starts with this:

"It has been a constant battle, with some SMs [presumably station managers] insisting they have been told to add all 200 odd high rises they have as visits in the SD OSD Master List ..."

Station diary? Outside schedule diary, is that OSD?

A. I think it's outside duty master list, I'm not sure what the S is for.

Q. "... which adds them to ORD of course ...) It is now back again, but has exactly the same issue ..... people cannot add all high rise blocks on their ground to MDT via ORD as they would have no time to visit them all and it would be of very little value anyway... The ones that are dodgy - upside down maisonettes, DR [dry riser] outlets only on alternate floors etc should already be on!

"If we had a complete list we could add as an overlay of course ..... but this is valueless apart from ticking a box unless the data held specific things .....

saying there is a large/high building here on MDT is pretty pointless when they are outside it and can see that etc!"

Now, where Mr Eustice says there has been a constant battle, were you aware of a constant battle, or at very least concerns raised by station managers as to the practicability of adding all high-rise buildings?

A. I wasn't aware of issues from station managers at that time. I think as I said earlier, once we put our systems in place to make sure that every high-rise and every building was visited, then we did get some push-back, feedback, in terms of at least, you know: how are we going to achieve that?

I have a vague recollection of Clive being concerned in the issues that he's raising, but then he was coming at it, understandably, from the point of view of managing the database, and then the quality assurance issues that go on there, and I understand his position, but my position was, and for what it's worth still is, that every single building should be visited, because just because -- and I use that example of this housing estate in east London, there are 12 high-rises that are identical; the people that live in them aren't identical and the risks therefore are not identical, and you could have a hoarder in one of those 12 and you could have

a different risk in another, so you need to visit every single one. And once you've done that -- if, having done that, you can then determine that they remain identical, then maybe we can move to the position that Clive is talking about, but up until that time, my position was firefighter safety, it was extinguishing fires, gathering information, and you can't make assumptions on that regard.

Q. You said you were vaguely aware of the concerns that prompted Mr Eustice's email. Were you concerned as a result of those matters which were exercising him that crews might be taking inconsistent approaches to which high-rise buildings to visit, et cetera?

A. Yes. Clive, understandably, a professional officer, likes things done properly and was very protective of this new database, operational risk database, and he wanted it to be a clean and efficient and effective database, which is what I wanted too. And I had a lot to do with Clive, and so therefore in the margins of normal meetings, yes, I would be aware of Clive's views on this.

Q. As we discussed earlier on, we are sort of three-plus years on from your April 2009 email and the position may not have materially improved.

Did Mr Eustice communicate his concerns to you more

directly at this time and, if so, what action did you take to try and expedite the improvement of how you held knowledge in relation to high-rise buildings?

A. From what I can recall, Clive's concern was that we were putting too much information on the ORD, whereas my concern is that I wanted to make sure everything was inspected and the appropriate information went on the ORD. But I think where we both agreed is that the premises risk assessment would be that appropriate system to satisfy both of our concerns.

Q. Now, let's focus on that, and looking at the practicability of it.

Mr Eustice said people cannot add all high-rise blocks in their ground to an MDT as they would have no time to visit them all and it would be of very little value anyway.

Would you agree with the first element of that proposition, that crews did not have time to visit all high-rise blocks in their station's ground?

A. Well, first, it depends on the station's ground. Some stations' grounds have significantly more high-rise than others, and if you was to look exclusively at the crews on some stations' ground -- let's take, for example, in Tower Hamlets, there is a predominance of high-rise. If you was to say to the crews in Tower Hamlets, "It's your

job to visit all those high-rises and your job alone", then, yes, it would be a very challenging task, but that wasn't the approach that we took.

Q. I suppose the more pertinent criticism is the second one here, that he said it would be of little value anyway. I think it would benefit the panel to have your views on that particular criticism he made.

Do you accept that that exercise would have been of very little value?

A. No, I don't, because I think what Clive is referring to is on the assumption that nothing changes and that all high-rises within that particular area or estate are the same. But we can't make that assumption. It would be dangerous to make that assumption.

Q. Is there a problem that, thinking about matters practically, if you do require crews to visit all high-rise buildings -- and I'm mindful of your sensible caveat that it depends how many there are, et cetera -- there is an element whereby they go round them in order to tick that particular box, but actually the purpose of the section 7(2)(d) would be undermined because they're not doing the job properly, examining all the matters they need to examine, in order to collect all the information the law requires them to gather?

A. I can see why someone might say that. I would counter

that with saying that this contradicts their professionalism, and what I always used to say to crews at stations at every opportunity is: you're carrying out this inspection, this 7(2)(d) inspection, because one day you might be called to go in there and risk your life and fight a fire, so it's for your own benefit and your family's benefit to make sure you've got all the appropriate information. So I don't think any sensible professional firefighter would overlook that, because they know that tomorrow they could be in there fighting a fire, and they might miss something that could save their life.

Q. Put slightly differently, were you given any substantive evidence that suggested or indicated that the value of section 7(2)(d) visits of high-rise residential premises was being debased or was materially insufficient as a result of them having to inspect all high-rise buildings on their ground?

A. I wasn't made aware of any specific issue that would underpin that statement. I guess I could look at the number of high-rise buildings that were becoming involved in the operational risk database, and recorded, and they weren't being loaded on as quickly as I would like, so that caused me some concern, but I was satisfied with the various quality assurance processes

that we had in place to make sure that the quality of the information was correct, notwithstanding the comments you've made earlier about that on Grenfell.

Q. So at the risk of oversimplification, there were no red or amber signals flashing to you that the quality of information obtained through section 7(2)(d) visits was materially deficient?

A. No, and if I can just add, as well as the quality assurance process we had in place, once we had the service standards in place, we created a group of officers called service standard support officers that didn't have managerial involvement, and they were sent round to do programmed audits of stations, to look at the various service standards, and the one that involved contingencies planning, which 7(2)(d)s would sit under, would involve an annual audit at each and every station looking at each and every watch in terms of their quality assurance.

So we were putting these systems in place to make sure, as far as we reasonably could, that the processes were being adhered to.

Q. Turning back to Mr Eustice's email, he has a pungent turn of phrase and he refers there to high-rise buildings that are "dodgy":

"... upside down maisonettes, [dry riser] outlets

only on alternative floors etc should already be on!"

Was it your understanding that those types of properties or those properties giving rise to particular issues had already been recorded on the ORD?

A. Well, I would like to think so, but I don't think we could say, which is why I was so adamant that every high-rise should be inspected so we could be sure. Nothing could have given me the assurance that -- what Clive is saying here, that they should already be on. He says it exclamation mark, so I guess, yeah, should already be on, but I wouldn't be satisfied they were, hence why I wanted everything inspected.

Q. Yes, the sentence seems pregnant with doubt, looking at it.

A. Well, it could be read that way, or it could be I guess read as an air of frustration from Clive that they should all be on, so why are you doing this. But regardless of Clive's or anyone's view, I felt morally and professionally responsible to make sure that everything should be inspected to make sure a decision is made about whether it should or shouldn't be subject to future inspections.

Q. Looking from the lay perspective, concentrating on "dodgy" buildings, does that give rise to the danger that undue focus on those would ignore other high-risk

presentations in other high-rise buildings, such as cladding, for example?

A. Oh, I mean, Clive has got a unique turn of phrase, that's for sure. But his bluntness was appreciated. I think what he's referring to in terms of upside-down maisonettes is the challenges that you experience if you're not expecting them, in terms of the dangers that a firefighter going downstairs into a fire and the heat rising up the stairs can be immense.

Q. Can we go back to the Salamanca Place incident report. That can be found at {LFB00106615/2}. This is the action plan monitoring report, and we see page 2, bottom row of the document, is the latest position in relation to action 2, which is the action we have been discussing.

What it says in the far right-hand column is this:

"28/9/12: No database to be maintained. Ops news article to raise awareness for crews regarding the importance of carrying out and recording 7(2)d visits in the correct format.

"20/11/12 & 4/12/12: As above detailed in action 1.

"14/1/13: It is agreed that there will not be a database maintained."

Now, looking at that final entry, did you agree not to maintain a database?

A. This must be referring to the issue about a specific high-rise database, not that there won't be a database with high-rise on. And it's really important that we don't think that there wasn't a database with high-rise on, because there absolutely was, and that was the operational risk database.

Q. Thank you. My question was: did you agree not to maintain a database?

A. I can't remember specifically whether I did or didn't agree, but looking back on it now, providing it was recorded on the ORD, I wouldn't have had an objection to there not being a specific high-rise database.

Q. Can you remember who else was involved in making the agreement referred to here?

A. It would have been David Wyatt.

Q. Would he have acted unilaterally or in consultation with you?

A. No, he wouldn't have acted unilaterally.

Q. Can you remember now what reasons informed the agreement?

A. I can't remember for sure, but I am aware of the drive towards simplifying everything, so one database, one-stop shop, and that I think would have been the motivation behind it.

Q. Now, in that regard, can we turn to a witness statement

of a former colleague of yours, Rita Dexter, and particularly her first witness statement. In that document she touched upon the difficulties of defining and identifying high-rise premises in London which we have been discussing this morning.

If we could go to {LFB00032363/8}, at the very bottom of the page, it's paragraph 27, and she says this -- and apologies for reading it out, it's probably helpful for people listening:

"I was present at the second meeting [of the Lakanal House working group] on 28 August 2013. Assistant Commissioner Steve Turek, who reported to me, gave a presentation on the RRO [the Regulatory Reform (Fire Safety) Order]. His presentation included a contribution from information management colleagues (who also reported to me) about the problems of defining and identifying high rise premises, given the absence of adequate and appropriate data. At the time, this was seen by officers as an important issue because uncertainty about the number, height, location and purpose of high rise buildings was an impediment to fire safety inspection, familiarisation (7(2)(d) visits) and community fire safety work. It was an issue that we continued to work on over the following years."

Now, from what you have been saying this morning, it

appears that you share, at least in broad terms, Rita Dexter's concerns there about defining and identifying high-rise buildings?
A. Yes.
Q. Would you agree that at the time -- so we're talking here about 2012 -- there was no clear and definitive list of high-rise building locations for the reasons you've given?
A. We wasn't satisfied that we knew about every single high-rise, that's for sure.
Q. Would you agree that the absence of clear data at its most basic as to how many high-rise buildings there were in London was an impediment to effective discharge of section 7(2)(d)?
A. It was a challenge that we were dealing with, yes.
Q. Well, "challenge" is one of those words that's become tarnished with overuse; "impediment", I suggest to you, is the more accurate word to use. Would you accept that?
A. So without using the word "impediment" or "challenge", I would describe it as the fact that we understood our duty and we did not know for sure of the amount of premises that existed within that definition and where they were, and we were making every effort to find them and therefore discharge our duty.

Q. Now, she concludes in the final sentence of paragraph 27:
"It was an issue that we continued to work on over the following years."
Now, from 2012 onwards, what particular workstreams that you're aware of were concerned with identifying and defining high-rise buildings?
A. So in terms of identifying high-rise buildings, there was work going on with the borough commanders. So just to put some context behind that for the panel, the borough commanders worked very closely within their boroughs with local authority chief executives, borough commanders of the police, et cetera, tripartite arrangements, so there was a close working relationship, and it would be that the chief executive of the local authority would see the borough commander as the be all and end all when it comes to the Fire Brigade, and that was deliberately why that structure was set up. So that was a crucial link into housing providers, et cetera. So a lot through borough commanders.
Then there was obviously writing to chief executive level that Rita Dexter was doing a lot of, in terms of reaching out through London Councils and trying to find out from housing providers. Working with housing providers, independent housing providers, as well,

trying to find out the various lists that existed of high-rise premises.
But then there was also: what is a high-rise? And that might seem a crazy thing to say, but it really was difficult in trying to determine what is a high-rise, because people had different ideas, and we ended up, as you saw in the premises risk assessment, working on an 18-metre rule at six floors, but that was because of when a dry riser no longer worked and we used a wet riser, so that's where water is already in the building on the roof and it comes down rather than it being pumped up. So we used that for our own definition, but you would find different definitions from different parts of London as to what was a high-rise.
So we were wrestling with both of those issues in terms of trying to define a definitive list.
Q. Before you retired, looking at the last element of your answer there, were you able to agree and promulgate a unified definition of a high-rise building that applied across London?
A. We was for the purposes of our own staff and inspections. Whether every single housing provider would agree with our definition, I can't say.
Q. In relation to an earlier answer, you said, "We'd find different definitions from different parts of London as

to what was a high-rise"; are you referring there to different definitions being applied by the area commands within LFB or are you talking there about different definitions applied by people such as housing providers?
A. Housing providers.
Q. So not a confusion within the LFB?
A. No, in the LFB we adopted the wet riser/dry riser definition and that was understood within LFB.
Q. Thank you.
Can we now turn to action 1 arising out of the Salamanca Place, and if we go to the SAI report, {LFB00095042}. If we could look at action number 1, the required action is this:
"Raising awareness through Operational News of the importance of station based staff identifying complex* and high rise premises that should be inspected under the Fire & Rescue Services Act section 7(2)(d) visits."
The word "complex" had an asterisk next to it, and the asterisk says this:
"For the purpose of this SAI action the term 'complex' relates to premises that have an unusual design/layout that would cause difficulties to crews when responding to incidents."
Now, that action was allocated to the assistant commissioner OA, which is operational assurance,

I think?
A. Yes.
Q. And at that time it was Dany Cotton; is that right?
A. I believe so, yes.
Q. And third officer, that would be you?
A. Yes.
Q. Thank you.
Now, if we can go back to the SAI action plan monitoring report from February 2013 which we looked at a few moments ago, {LFB00106615/1}. If we could look at the fifth column on the first page, ie at the extreme right, I'll let you just refresh your memory of that and let you read it briefly.
(Pause)
A. Yes.
Q. Now, the thrust of the substance of that column is that awareness was raised through the publication of articles in Operational News issue 24 in March 2013 and in the November 2012 SHOUT! newsletter. Is that a fair summary of the actions taken?
A. Yes.
Q. Thank you.
A. And associated training packages.
Q. Yes.
Now, in relation to Operational News 24, can we go

to that, and that can be found at {LFB00050215}.
Now, this, rather than the article itself, is an email chain in relation to a draft of that particular edition, and if we can go to page 3 in this email chain {LFB00050215/3}, and it's really the top, we see an email from Graham Ellis timed at 9.19 on 12 January 2013, and he forwarded the latest draft to Dany Cotton and Gary Reason.
Helpfully, Mr Ellis has set out further in the chain the draft text of Operational News to which he is referring, and we see that at the bottom of page 1 {LFB00050215/1}. We see there it starts "Description of 7(2)(d) visits".
If we go over the page {LFB00050215/2}, it's the third paragraph I'd like to look at. It says this:
"Fire Station personnel will often be best placed to identify significant developments or changes to property which may have an impact on safe operations. Policy 800 – Information gathering/contingency plans, explains the risk assessment process which should be used to establish whether a premises requires visiting and describes the method of recording on the Operational Risk Database (ORD). It is important that crews always refer to the risk assessment process when carrying out initial and re–visits, as changes to the building or the

risk matrix within policy 800 can [affect] whether the premises is added to or removed from the ORD.
"Whenever a high rise residential building is assessed to be entered on the ORD a suitable line drawing of the layout should be included. It is also important that personnel plan for the possibility that any fixed installations are unavailable ..."
As we have referred to earlier, the reference to the risk matrix in policy 800 is the formalised process by which a property is scored and, on the basis of that, visits determined and their regularity.
A. Yes.
Q. The property score then determines frequency of visits; is that fair?
A. Yes.
Q. In the case of properties that are scored as being very low on the matrix, they don't need to be included on the ORD at all.
A. 149 and below, yes.
Q. Yes.
Now, if we can go, mindful of that context, to Dany Cotton's email, which is in the bottom half of page 2, so the one we're looking at at the moment, she says:
"Hi folks,

"I still have some concern with the matrix [in] Policy 800 and what happens if the [watch manager] deems that a premises does not present a complex or unusual risk? I have discussed this a number of times with Dave Brown as he and Dave Lindridge tried it out on Lakanal House and came up with different answers. I am just concerned that we may end up with conflicting messages! Maybe you could have a quick chat at DMB."
What does DMB stand for?
A. Directorate management board.
Q. Thank you:
"I know that the Commissioner wants the message to be reinforced in Ops News but I would hate for us to confuse the opportunity to make sure that crews are increasing their operational knowledge."
Now, Dany Cotton then says in a later email in the same thread, if we go up to the middle of page 1 {LFB00050215/1}, an email at 8.42, this:
"My main concern is that DB [Dave Brown] and DL [Dave Lindridge] applied the same matrix LH [which I'm assuming to be Lakanal House] and came out with a different response and DB [you] said that he was confident that all [watch managers] would opt to do the work and make the buildings [fit] the more complex/challenging criteria and include drawings rather

than take the easy option ..."

Just to conclude the email chain, can we go to the top of page 1 and the email from Graham Ellis. Row of dots, and he says this:

"... and it would be fair to assume that the situation will not improve when there are far fewer crews to go out and do the work in the first place. I still think that there needs to be a more systems based approach, where crews are provided with a list of premises that they should visit. The building information plates will also play a key role, as crews will be travelling further to attend incidents off their local patch.

"We are looking at Camden and Lambeth to trial the plates. I am keen that I/we don't get dumped with making it all work though. We have provided the idea and wise council, but I think RFS ..."

A. Regular fire safety.

Q. And ORM?

A. I have never heard that one before.

Q. Presumably operations response and mobilising?

A. Yeah, maybe, or operational risk management. I'm not sure, but ...

Q. "... need to take ownership to move it forward.

"The Matrix and policy owners really do need to get

this sorted out though."

There is a lot in that email chain, Mr Brown. Can we take it step by step.

A. Sure.

Q. First of all, did you and Dave Lindridge apply the risk matrix to Lakanal House?

A. I don't remember doing that, but it would have —— it wouldn't have been an unreasonable thing to do.

Q. Are we safe to assume that the matrix referred to is the risk matrix we've considered in policy 800?

A. Yes.

Q. Why did you and Mr Lindridge apply the risk matrix to Lakanal House?

A. If we did do it, it would have been as a scoping exercise, as a test to see whether the likes of Lakanal House, had the premises risk assessment been in place at the time, would it or would it not have passed the test and been put onto the operational risk database. And the reason Dave Lindridge is because Dave Lindridge carried out the review of the Lakanal House action plan.

Q. When was that work done, can you remember?

A. What, the tester, if you like, for Lakanal House?

Q. Yes.

A. Again, I want to caveat it, because I don't specifically

remember doing it, but if it did happen, and I've no reason to assume that this is wrong ——

Q. I was about to say, there's no reason here to assume that Dany Cotton is wrong, is there?

A. No, no, no, no, no.

Q. So we can proceed on the assumption you and Lindridge did do it?

A. Yeah. If it did happen, it would have been probably around the time that Dave Lindridge was doing his review, so it would have been late 2012, early 2013.

Q. Can you remember, did you and Dave Lindridge come up with different answers?

A. Well, I don't recall that. I would say, though, that if you look at the premises risk assessment, it is a guide, so it isn't beyond reasonableness to think that you could come up with different answers, and I'll give you an example to demonstrate that.

So one of the criteria is a building with 500 or more people residing there. Now, if one person looks at it and thinks, well, actually there is less than 500, another person thinks there is more, and there isn't a responsible person there to be able to clarify for sure, then straightaway whatever points are allocated to that decision might be on one person's risk estimate or another. So it would be foolish of me to try to say

that actually every single premises risk assessment would come out identical.

What I would be very, very confident of saying, however, though, is even if there were these nuances, as I have explained, I am still absolutely satisfied that each risk assessment would land within the zone. So for example, 500 to 750 points. One might get 550 and one might get 600, but they would both be in the right place.

Q. So on the basis of that answer, you didn't necessarily share the full extent of Dany Cotton's concerns about different answers being produced by different people applying the matrix?

A. No, I think what was behind Dany's concern —— and a genuine concern —— is that if there was different answers, that would be leading it to such a low score that it's above or below 150. That's what Dany's concern was. And I didn't share that concern because whilst I accept there is the potential for two different scores, they would come the right side of 150.

Q. Did you consider that any training measures were required to ensure sufficient consistency in application of the matrix so that the score did end up on the right side of 150, if I can put it that way?

A. Well, there were Ops News articles on MDTs and

operational risk database, and there were associated training packages. And then we of course verified this, because apart from the systems we've spoken about already, every training exercise that was carried out on high-rise or any building, for example, part of that training exercise would be to look at what was on the operational risk database. Every performance review of command and every performance review of operations would consider the initial information-gathering which was therefore on the operational risk database. Every fatal fire review we did would look at information-gathering. So there was a whole range of what I would call reactive measures in place that we looked at as and when incidents arise and we asked ourselves that question: was there sufficient information on that operational risk database?

Q. Looking at Dany Cotton's email, her concern appears to be prompted by the Brown/Lindridge exercise. Were you aware at the time of any broader concerns that there was an inconsistency in application of the risk matrix so that properties weren't being accurately or appropriately scored?

A. No, I wasn't aware of any concern in that regard, and whilst I can understand people -- you know, their professionalism asking that question, I don't think it

was a real concern, because I truly didn't believe that this would become an issue, particularly at such a low level of scoring.

Q. Thank you.

Now, if we can just go back to it, so you have it on the screen, so you remember what I'm talking about, Graham Ellis' email at the top of page 1 {LFB00050215/1}. There we go.

Now, he expressed a preference for a more systems-based approach, where crews are provided with a list of premises that they should visit.

Now, had Mr Ellis been raising and explaining with you what he meant by "a more systems based approach"?

A. I can't recall Graham raising this. I can imagine what he means. I think he goes on to explain this in this email, in terms of -- or later email that you've shown me just now, in terms of just being given a list. Oh, yeah, he does say that --

Q. Exactly, it's the extract I've just quoted to you, the provision of a list.

A. So I think that's what he is referring to.

Q. Not much more of a substantive system beyond provision of a list then?

A. No, and for the record, I would completely disagree with a list because, firstly, where is that list going to

come from?

Q. I was about to ask you, it's going to be the station manager, isn't it, presumably, or the watch manager?

A. Yeah, and then where are they going to get that information from? And this is all about ownership. This is about making crews own their station grounds and become part of the community and familiarise themselves with it, and there is a whole range of other reasons why we would want them to get out and about on their station's ground and do this. It's not just about information-gathering, it's about being seen in the community, being part of the community, for people to come and ask advice. It's about being able to recognise people that are in trouble and need our help and refer them to serious outstanding risk, home fire safety risk assessments, all designed to work in partnership with the local authority and the police to drive down fire and crime and to make -- you know, achieve our overall objective of making London a safer city.

So it's far, far broader than just being out there, and if staff were just given a list to do that, then we miss a fantastic opportunity to do so much more good work.

Q. Was that discussion a discussion that you had with

Mr Ellis at this time, so start of 2013? You have given a pungent analysis of the disadvantages of what he was suggesting. Was that a discussion that was had at the time?

A. I don't recall Graham Ellis ever actually raising this issue with me in those terms, but had he have done so, then I would have given the same answer I've just given then.

Q. Can you remember Dany Cotton or anyone else raising it with you, because obviously at this stage she was AC operational assurance, so it fell directly within her remit?

A. I do recall that Dany was concerned about the issue that we've just discussed, ie that things might not make themselves on to the operational risk database, and that was a genuine and professional concern. But in terms of just giving a list as Graham suggests, I don't recall Dany ever mentioning that to me.

MR KINNIER: Thank you.

Sir, we're slightly early, but we've come to the end of the questions in relation to this topic and the next topic will take longer than five minutes.

SIR MARTIN MOORE-BICK: So it would be sensible to stop a little early at this point?

MR KINNIER: It would, sir.

SIR MARTIN MOORE-BICK: Yes, very well.
Well, we would normally stop about 1 o'clock, Mr Brown, but for the reasons that Mr Kinnier has just explained, it's probably better to stop now.
So we will break now. We will resume, please, at 2 o'clock, and again, please don't talk to anyone about your evidence while you're out of the room. All right?
THE WITNESS: Okay, thank you very much.
SIR MARTIN MOORE-BICK: Thank you very much, would you go with the usher, then, please.
(Pause)
Thank you. 2 o'clock, then, please.
MR KINNIER: Thank you, sir.
SIR MARTIN MOORE-BICK: Thank you.
(12.57 pm)
(The short adjournment)
(2.00 pm)
SIR MARTIN MOORE-BICK: All right, Mr Brown, ready to carry on?
THE WITNESS: Yes, thank you.
SIR MARTIN MOORE-BICK: Good, thank you very much.
Yes, Mr Kinnier.
MR KINNIER: Thank you, sir.
Before the lunchtime break we were talking about Operational News 24 and you referred to the training

packages that were initiated by that. Can we now turn to those particular training packages.
A. Yes.
Q. Now, if we can go back to the final published version of Operational News 24, it included the reference to a training package on 7(2)(d) visits, if we go to {LFB00118959/4}. If we can look at the second to last red box on the page, which states in relation to 7(2)(d) this:
"Training pack available to watch officers through Training Support icon – Knowledge Centre – Ops News 24 – Watch training packages."
Was there mandatory training that all watches would have been expected to carry out?
A. Yes.
Q. Now, the Inquiry has identified TCAP 0055, entitled, "7(2)(d) Ops News 24", and that can be found at {BAB00000035}. If we look at the first page of this TCAP, we can see that its title refers to section 7(2)(d) and Ops News 24.
For the avoidance of doubt, was this the TCAP that was specifically created for the creation of the training package following on from Operational News 24?
A. I believe so, although I just would add that I would never normally see the TCAP. But, yes, I'm satisfied

this is the correct one.
Q. If we can turn to page 8 within this document {BAB00000035/8}, we can see in the second box that AC Cotton, as she then was, is listed as the commissioning officer, and DAC Mick Ellis is the client.
Is it right that DAC Mick Ellis reported to you?
A. He did. He managed central service delivery and reported directly to me.
Q. Is he another Ellis at the LFB? He is neither Dominic nor Graham.
A. That's correct, there was an overabundance of Ellises and he was one of them, yeah, Michael Ellis.
Q. If we look in the following section on page 8 entitled "Background/Context", 2.4, it states in the second paragraph in that box this:
"The ODCB (Operational Directorates Coordination Board) stated that it requires a CBT package regarding 7(2)(d) visits, following their meeting of 3.9.12. This requirement is driven by concerns raised by the Salamanca Place investigation over when and how 7(2)(d) visits are undertaken. The concerns centre around what risk based approach is taken to identifying buildings, including high rise, and how it is recorded on the ORD ..."
First of all, CBT stands for computer-based

training, I think?
A. Yes.
Q. Thank you.
Does that summary there accord with your recollection of the concerns which motivated ODCB at the time?
A. I'm just going to re-read it.
Q. Please do.
(Pause)
A. Yes.
Q. Thank you.
Babcock, the Brigade's external training provider, has provided a slideshow for this training programme, and if we can turn to {BAB00000056}, there we see it's entitled "7(2)(d) Visits".
Do you remember having cause to read these slides before they were trained out to personnel?
A. I didn't, no, and it wouldn't be normal practice for me to do that, no.
Q. Put colloquially, would it have been below your pay grade to review these matters?
A. I would never use that terminology, but yes.
Q. Could we turn to page 2 {BAB00000056/2}, and the bottom slide in particular. Now, these set out the learning objectives.

If we turn to page 6 {BAB00000056/6}, the bottom slide there is entitled, "What to look for on a 7(2)(d) Visit?"

Now, would you agree with me there is no reference there to the 22 items identified in the appendix 1 to 633? Or express reference, I should say.

A. Yeah, there is no express reference. I'd have to go through each of those icons and think carefully about how they cross-reference with those 22, but notwithstanding that, those items aren't expressly listed, no.

Q. Thank you.

If we could turn over the page and just go through from pages 7 {BAB00000056/7} onwards. What we see here are a number of examples on how to calculate risk scores and what action to take based on identified risks.

Now, we've gone through these, and you can go through them yourself if you would like to, but the essential point is that the training nowhere provides any guidance on how crews should actually go about identifying risks when carrying out the visit.

Now, looking at this page, would you accept that as a criticism, for example, of this slide?

(Pause)

A. Okay, can I just qualify my answer on this?

Q. Well, if you give your answer first and then the qualification might be easiest.

A. Okay. No, there isn't any specific reference on here in terms of how you go about interpreting that risk. The qualification I'd like to give to that is I think the premises risk assessment is very much a linear based approach. So, for example, you either think there are 500 or more (inaudible) premises or you don't. You either think there's sleeping for 100 or there isn't. So I think what this does is it gives the opportunity for crews to practice that linear premises risk assessment.

So in terms of do I think it is satisfactory, then I think it works in terms of crews being able to apply this and then discuss their rationale after.

Q. But in terms of telling them and training them as to how to go about, in practical terms, a 7(2)(d), would you accept it's not quite achieving that aim?

A. I accept your earlier proposition that it doesn't give guidance on how to complete the risk assessment, but, as I say, I think that is straightforward and linear, and this gives you the opportunity to practice it. So I wouldn't agree that it doesn't meet the objective of the 7(2)(d) training package in that regard.

Q. Right.

Let's now look at {BAB00000058}. Now, as the front slide suggests, these are trainer notes for the training, which give guidance on how to deliver the training.

Can you remember, was this training delivered by staff at station level?

A. I can't remember.

Q. Would that be the usual level at which this type of training is pitched?

A. If it was a CBT training, there's a fair chance that this would be delivered by the watch officer in charge of that particular watch at the station.

Q. Would the watch officers themselves have received training on how to conduct 7(2)(d) visits?

A. Not over and above what they would have experienced as a firefighter.

Q. Do you consider that to be a gap in the system, in the sense there is a missed opportunity to ensure consistency of approach to 7(2)(d) visits by ensuring all watch officers are trained in the same way as to how to conduct them?

A. I don't think it's a missed opportunity in terms of should we supply training over and above for watch officers as opposed to firefighters, because I think the process doesn't distinguish between who it is that's

carrying out the risk assessment. I think it matters not whether it's a firefighter or a watch officer. At the end of the day, the inspection is the inspection. So I don't see any specific issue there.

I think where an opportunity was overlooked in the past is the question about what training did we give staff to do 7(2)(d)s prior to this training package, and I think up to that point it was only initial training when joining the organisation and on-the-job training, learning as you did the inspection.

So I think probably this hopefully rectified what had maybe been missed in the past, but I wouldn't -- I don't believe there needs to be any different training for watch officer as opposed to a firefighter on this particular issue.

Q. Just following on from the more procedural mechanics of the training programme, Mr Brown, see how far you can help us on this. Can we go to {BAB00000035/23}. If we look at the final box on that page under the heading "Final sign off", there appears to be no final sign-off.

Do you know whether the training -- and this TCAP concerns the 7(2)(d) training programme we've just been considering -- was in fact provided, notwithstanding the absence here, or the apparent absence, of any final sign-off?

A. I believe the training was provided, yes.
Q. What's the basis of that belief?
A. Because -- well, a number of things. So, firstly, we've issued the publication. Secondly, we've issued the training package. But crucially, what I always would have done is seek to performance management the completion of that training.
So information management were able to supply me with reports in terms of how each watch were progressing, and we would red, amber and green it in terms of have they started it, have they not started it, have they completed it, and then I would report the outcomes of that to ODCB to close that loop, as it were, to demonstrate that, yes, the training was required, yes, it's been provided and yes, it's been completed.
Q. Just in relation to training on how to carry out section 7(2)(d) visits -- sorry to sort of belabour the point -- Dany Cotton, when she gave evidence to the Inquiry at Phase 1, said that no training was provided to firefighters on how to go about conducting a visit. Is that consistent with your understanding of the position?
A. It's consistent with my understanding in terms of up until this point, but thereafter, then no, that's not the case.

Q. So your position is that this training programme remedied any previous deficiencies?
A. Yes.
Q. Can I now turn to a draft email from you to stations regarding the recording of high-rise premises on the ORD.
To start this line of questioning, can we go to {LFB00113599/2}. Now, what we can see here, and if we go to the bottom half of page 2, is an email chain from November 2012, so after the publication of policy 800 in July 2012, and around about the time I think you thought or werent entirely sure that your involvement in policy 800 started.
What we have down here is an email from David Lindridge to Richard Binder.
First of all, who was Richard Binder?
A. Richard Binder was a group manager who worked in central service delivery and would have worked for Mick Ellis.
Q. Looking at this, we have the first line:
"This message is from Assistant Commissioner (Operations, Prevention & Response) Dave Brown and is for all station based Managers."
The email was headed, "Recording of Residential High Rise on the Operational Risk Database". I hope you don't mind, I'll read it out, so apologies to people

having to listen to me:
"This message is being sent to remind station-based managers to review the risks on their stations ground, with a particular focus on the recording of residential high rise. The quality of information held in the Operational Risk Database (ORD) is instrumental in reducing the risk our crews and the members of the public are exposed to through the use of the Mobile Data Terminals (MDTs).
"The publication of PN800 'Information Gathering/Contingency Plans', earlier this year gives guidance on identifying and gathering operationally important Site Risk Information (SRI) and other supporting information and recording it on the Operational Risk Database (ORD). This risk based approach allows watch and station managers to prioritise the premises on their station's ground and familiarise their crews accordingly."
Now, the following section is emboldened and italicised in the text of the draft:
"It might be useful to describe here which High Rise premises are expected to be recorded. All? Only those presenting additional risk? Only those above 149 on the scale described in PN800? The latter will exclude most.
"When visiting residential high rise premises, watch

managers are encouraged to record details that would be of assistance to crews attending an incident with no prior knowledge of the building. This email is to remind visiting managers of the facility to add images to the ORD, which is ideal for delivering an initial understanding of the premises very quickly. The current use of this facility is not widely used and does not always deliver sufficient detail."
Now, my first question is simple: was that message drafted at your behest?
A. I can't recall whether I asked Dave Lindridge or whether Dave Lindridge suggested it, but what I can recall is we both agreed it was a good idea.
Q. And if we can stop there, what was your reason for having the message sent?
A. Because of the number. If we go back a slide, if I may.
Q. Of course, do you want to go back to page 2 {LFB00113599/2}?
A. Yes, please. It might be even earlier than this. I've seen this email, and I know what precedes it, so I might have -- I might be thinking of what I've read in preparation for the Inquiry, but there was an email exchange with Dave Lindridge that highlighted the fact that there was in the region of, I think, 250/260 premises on the ORD -- high-rise premises on the ORD.

Now, that was unacceptable and this, I believe, was to re-engage, if indeed that's the right word, to push through what I wanted in terms of more premises being put on the operational risk database. I believe that was the emphasis of this.

Q. Looking at the emboldened, italicised words there set out in the penultimate paragraph on that page, that tends to suggest that even within your team, in November 2012, there was still confusion or uncertainty about which high-rise premises were actually to be recorded on the ORD. Would you accept that?

A. Well, Dave Lindridge wasn't in my team, but notwithstanding that, I think -- no, I wouldn't accept that. I think what he's doing is just giving me as the sender the option as to which I would want to include.

Q. But which of itself, looking at the words actually used, there is an absence of certainty as to what level of detail is to be included; would you accept that?

A. No, no, I wouldn't accept that there's a confusion over it. I think it's really just him giving the option, quite possibly because his final point, "Only those above 149 on the scale described in PN800?" and his comment that "The latter will exclude most", which (a) I don't agree with, but maybe he just wants to remind me that if we did follow this policy, in his view it would

exclude most, and is that what I really wanted.

Q. Well, it'll be for the panel in due course to make of that email what they make.

A. Sure.

Q. But what was your response to this question? What level of detail did you require to be recorded?

A. Well, I ... unless I'm about to see an email that contradicts what I'm about to say, I would have gone for the final option, so only those above 149 on the scale described in PN800, because (a) that's what we'd set out and (b) even if they were under 149, they still would have had a premises information plate attached to them. So there still would have been information about them available to arriving crews if there was an incident there around things such as how many stairways, where they were, where the fire lift was, how many lengths of hose, water supplies, number of floors in the building. So it still would have been a useful exercise in terms of crews having on-arrival information.

Q. I think it flows from what you have just said -- well, I think you have said explicitly that you accept Mr Lindridge's view that taking the latter approach, ie including those above 150, would exclude most high-rise buildings.

A. Well, no, I don't accept that is true. I accept that

that might be what he believed, but I don't accept that that's a statement of fact.

Q. Now, did you raise that point with him at the time, do you remember?

A. I don't remember, no.

Q. Now, if we can go further up in this email chain to the bottom half of page 1 {LFB00113599/12}, here we go, it's an email from Mr Binder himself to you, and it says as follows:

"Guv,

"Regarding the issues of recording high rise info on the ORD/MDT (pre-planning at residential high rise fires to include single line diagrams showing number and location of individual flats).

"I have spoken with Dave Wyatt and the consensus is that since that action was required, there has been for good reasons a more intelligent and risk based approach in recording operational risks to firefighters on their stations ground. This culminated in the information gathering note (PN800), and the matrix used is specific in what should be added.

"David Lindridge has undertook a quick trawl of the brigade and approx 250 high rise premises are recorded on the ORD, of which 61 have some limited information recorded be it a plan or a picture, with 6 having

greater details including a simple plan drawing.

"As it stands now this will not fulfil the action in increasing the level of preplanning required."

Now, the high-rise database that you sent to station staff in April 2009 contained over 1,800 entries. Are you able to help us as to why there are now comparatively so few, ie 250 high-rise premises on the ORD three years later?

A. I don't -- I can't help with certainty. I would --

Q. If you don't know, say you don't know.

A. No, I was just going to use a professional opinion as to why it might be the case, but no, I don't know for certain, no.

Q. If we can go back to Mr Binder's email, which in its fifth paragraph says this:

"The comms message below from DL [David Lindridge] details how this may be achieved.

"The problem is that personnel might with good reason decide that a high rise might not now be worthy of inclusion (due to the score following use of the matrix), which could then allow the premise to be removed from the OR, which we would have to accept as part of this process, however this review will allow those that do attract inclusion will then have the single line drawings added to the premises information,

as is the intention of the comms message.

"By approaching it this way a review is carried out of all listed high rise premises, and where applicable, where currently there are no single line drawings they are then added increasing our numbers, accepting that some premises will ultimately be removed.

"It might be worth putting a review/deadline date in if this needs to look a lot healthier by January? and sent it to Area DACs and BCs [borough commanders] to ensure this is actioned?"

Now, this email there refers explicitly to the problem that "personnel might with good reason decide that a high rise might not now be worthy of inclusion", because of the matrix.

When would you expect a high-rise building to receive a very low score on the matrix meaning that it would not be included on the ORD at all? Is this the paradigm model that you were talking about earlier that had impressive fire suppression systems and the rest of it?

A. Yes.

Q. Now, the Inquiry has not been able to find any evidence that the draft email that we started with was in fact sent. Are you able to help us as to whether it was in fact sent?

A. As far as I'm aware, it was sent, yes. And the reason I say that it because I remember being disappointed with those figures, and wanted to action it and make sure that we got on with increasing the numbers on the operational risk database.

Q. Can you remember now what, if any, guidance was given with the final version of this email to essentially advise station managers on which high-rise buildings were required to be recorded on the ORD?

A. It would have been to follow the guidance given in policy note 800 and therefore --

Q. Sorry, if I can stop you there. You have said in a number of answers today, "It would have been". My question was more direct: was guidance given with the final version of the email that was sent out? Are you able to remember whether that was done?

A. I can't categorically state, but I can't imagine a situation where I wouldn't have sent it out, and if I did and when I did it would have involved policy note 800.

Q. But your recollection is sure that it would have been?

A. Yes.

Q. Now, can I turn to a separate but related topic, which is the LFB's response to PORIS guidance.

Now, the PORIS guidance was published in 2012; is

that correct?

A. Yes.

Q. Can you help the panel and anyone watching who may not be familiar, what is/was the PORIS guidance?

A. It's the provision of operational risk information system, and it was a document that was provided by the ... effectively central government, really, in response to a health and safety risk assessment that had been carried out on the UK fire service nationally. So this gave guidance that fire and rescue services should follow in terms of the kind of information that they should be collecting and how they should collect it.

Q. Thank you.

Now, can we start this line of questioning going to a report produced for the corporate management board on 27 February 2013. That can be found at {LFB00091785}. As you can see, it's entitled "Operational risk information: LFB response to national operational guidance".

The report's summary on the front page says this:

"DCLG [Department of Communities and Local Government, as was] issued operational guidance on 'operational risk information' in April 2012. This paper considers the content of that guidance and the extent to which LFB is compliant with the guidance."

Now, as you've adverted to, the national guidance introduced a model approach which was called the provision of operational risk information system, and if we can look in broad terms at the substance of that model. If we could turn to {HOM00045364/48}.

Now, Mr Brown, the five stages of the PORIS model are described between pages 48 and 49 here. What I'd like to do is just discuss these very briefly in headline terms so that the panel is familiar with them.

The first one we have at page 48 is stage I, which describes itself as the initial site risk analysis process. In broad terms, am I right in thinking that this is a review of the existing information about a premises in order to determine whether a visit is required at all?

(Pause)

A. Sorry, the reason I'm just pausing is certainly it covers what you've said, I'm just trying to determine in my own mind whether it goes beyond just that initial decision.

Q. We're just talking in broad terms here, headline points about the stage. I just want to identify them because --

A. Okay.

Q. -- there are complexities to it, but just to give people

some ——
A. It certainly covers what you've said, yes.
Q. Thank you.
If we could turn to page 50 {HOM00045364/50}, and here we have stage II, the data—gathering process.
Again, broad terms summary, Mr Brown, see whether you agree with it: this is the site visit in those cases where one has been deemed necessary.
A. Yes.
Q. Thank you.
Turn over the page to page 51 {HOM00045364/51}, we find stage III, which is the detailed site risk analysis process. This involves, in broad terms again, assessment of the data that is collected during the visit at stage II. In broad terms, is that right?
A. Yes.
Q. Then the model, or certainly the model at this stage, provides various templates as appendices that are there to assist the assessment process itself.
A. Yes.
Q. Thank you.
From the lay perspective, Mr Brown —— please shout if this is an undue simplification —— this looks like the most important stage of the five—stage process; is that an accurate or sensible summary?

A. It's a sensible summary, yes, yeah.
Q. Could we now turn on to page 54 {HOM00045364/54}. Here we have stage IV, which is the risk management process. I'm putting this really simply, and hopefully not at the expense of accuracy, but this is what you do with the risk information and the assessment of risk once it's been collected; is that fair?
A. Yes.
Q. Finally, can we turn to page 58 {HOM00045364/58}, which is the fifth and final stage, which is the incident information distribution process. Again, in broad terms, this relates to how risk information should be distributed to incident commanders for use at incidents; is that fair?
A. Yes.
Q. Thank you.
Could we turn briefly over the page to page 59 {HOM00045364/59}, and paragraph 10.44. I'll just let you familiarise yourself with that.
(Pause)
A. Okay, thank you.
Q. In general terms, that suggests that there may be different layers of information that are required at different stages of the incident; is that a fair overview?

A. Yes, and also that information applying to the arrival of resources at various stages of the incident as well.
Q. Thank you.
Now, if we can put PORIS itself to one side and go back to the LFB report of February 2013, which can be found at {LFB00091785/5}.
Now, just to help you, you may not have seen this document for some time, but the report is structured in tabular form, setting out the substantive points made by key paragraphs of the national guidance in the middle column, and the LFB's position is in the column on the far right—hand side.
Now, if we could skip to page 20 {LFB00091785/20}, paragraph 33, we see here the conclusion. Again, apologies for reading this out, but it's probably easier. Paragraph 33 says this:
"LFB arrangements in place for the gathering of risk information appear to be robust and largely in compliance with the national operational guidance issued in April 2012. It is not considered necessary or practical to make significant adjustments to current arrangements. A few issues are highlighted for some further action and recommendations are made."
Before we turn to those recommendations themselves, what process did the LFB follow in arriving at the

conclusion that its existing arrangements for the management of operational risk did not require significant amendment?
A. So this was a report completed by information management, so David Wyatt would have been instrumental in this. My understanding is what was presented at the corporate management board was, as we saw in the previous page, a list of the areas of provisional —— provision of operational risk information, and in comparisons with the various parts of our process and policy note 800. So it would have been a desk—based research, but would have involved discussion with those who apply the policy in terms of just, you know, gathering the information and triangulating understanding of the way the process works.
Q. You say, "My understanding is what was presented at the corporate management board"; were you a member of the corporate management board?
A. I was there for this paper. I was ultimately a member of the corporate management board. I can't recall exactly when I became a member, but I certainly would have been here for this paper.
Q. Were discussions held with station—based staff to assess the practice of those on the ground?
A. My understanding of this is yes, it was.

Q. For the purposes of this paper, was an audit of the ORD carried out?
A. I don't know on that one.
Sorry, when you say an audit of the ORD, what do you mean exactly?
Q. A more forensically targeted review to see whether the information recorded on the ORD, for example in respect of high-rises, was accurate or not.
A. Oh, I see. I don't know, but I can't imagine what that would have added to this paper, because this was about the process.
Q. If we could go to page 3 in this paper {LFB00091785/3}, and the box at the top of that page.
Now, the report notes that you were consulted and gave comments on an earlier version, together with a number of your colleagues.
Can you help us now: can you remember the extent of your contribution to the drafting of this report?
A. I can't remember. It would have been on process, but I can't remember exactly what comments I would have made.
I can say, though, however, Richard Binder, as we've just discussed, was a key part of this in terms of central service delivery, and John Elwell was a borough commander who was the lead for our service

standard on contingency planning. So he was -- would have had some useful and valuable comments in regards this. So I'd have been comforted by the fact that John and Richard both commented on this paper.
Q. We will be coming on to Mr Elwell in due course, as you can imagine, but did you agree with the overall conclusion that significant amendment was not required to the LFB's processes?
A. Yeah, I agreed, it was broadly compliant. There were one or two issues, but it was broadly compliant.
Q. Now, the report's recommendations are set out at pages 1 and 2 of this report, and if we can go to page 2 {LFB00091785/2}, there's just a limited number of recommendations I'd briefly like to discuss with you now.
The first one is recommendation (g), and that provided:
"Agree that an operational assurance audit/review take place to identify the consistency with which stations identify sites/buildings that might present an operational risk or hazard, and compliance with Policy 800 (and the risk matrix). The audit/review to take place after new section 7(2)(d) training has been put in place and is delivered."
If we go to page 14 {LFB00091785/14}, and the bottom

row on that page, what that says there is this:
"One of the challenges is how to process a very large number of sites in order to identify those where the availability of accurate, relevant and timely information may be of value at any reasonably foreseeable incident. Many buildings or risks may not require detailed site specific information in order to expect a safe and successful outcome to operational interventions."
Now, if we look rightwards, we see the LFB's response, which was as follows:
"The current process, as outlined in LFB policy 800, is regarded as adequate to identify the key buildings that are likely to present operational risks. The onus is on stations to identify risks on the station ground and to schedule regular visits (if required). The risk matrix in policy 800 provides a way of determining if a site/building should appear on the ORD and the frequency of revisits.
"Operational News in February 2013 will also include a specific article on recording information relating to complex buildings that are likely to cause difficulties to operational staff in the event of an emergency."
Now, the key question here is: do you agree with the conclusion that the LFB's process was "adequate to

identify the key buildings that are likely to present operational risks", given the problems you'd experienced over the preceding years achieving that aim?
A. I think the process was adequate, but undoubtedly there were issues in terms of achieving the outcome we were looking for.
Q. In the sense you hadn't yet achieved the outcome?
A. Yes.
Q. Could we go to page 15 {LFB00091785/15}, please, and again the bottom row. Here it deals with paragraph 8.28 of the PORIS guidance, and it summarises that thus:
"Periodic audit is a useful means to enable a deeper and more critical appraisal of the operational risk information systems ... and whether the system has been properly implemented and maintained and is effective in meeting organisational policies."
Looking at the far right column, the LFB responded as follows:
"There are inconsistencies in the approach taken by stations about what is included on the ORD and the quality of data capture and usage is variable. Policy 800 (and the risk matrix within it) is designed to improve this over time. It will be useful for the Head of Operational Assurance to review/audit how stations identify sites/buildings that might present

a risk or hazard, and the consistency of approach against Policy 800. Such an audit/review should take place once the new training ... is in place and has been delivered."

On what basis did the report conclude that there are inconsistencies in the approach taken by stations about what is included on the ORD and the quality of data capture and usage is variable?

A. That would have been based on the general understanding that, prior to the premises risk assessment, there were premises on the central risk database, which became the operational risk database, which, when considering risk in its purest form, really shouldn't have been there, and there were other premises that clearly should have been there. And that's obvious by the basis of how many premises were on the database.

Q. Now, given the report's finding that there were inconsistencies in approach, and the recommendations for review to investigate further, mindful of that further investigation, how could the LFB or how did the LFB conclude, before that review had in fact been carried out, that its processes were nonetheless adequate?

A. Because the process -- as it says here, policy -- so in the third line on the far right column, "Policy 800 (and the risk matrix within it) is designed to improve this

over time". So because of that, and we were satisfied that we had a system in place to increase the numbers of inspections, and we had a consistent and standardised system to make sure that the appropriate premises were recorded on the ORD, we felt that the process was accurate and fit for purpose.

Q. Bearing that in mind, can we go back to page 15 {LFB00091785/15}, looking at the column on the far right-hand side, and roughly two-thirds of the way down that last box, this form of words, which I've quoted but I'll take you to again:

"Such an audit/review should take place once the new training ... is in place and has been delivered."

Is the training that's being referred to here the TCAP 0055 that we were discussing earlier on?

A. Yes.

Q. Why was it recommended that the audit review take place after the new section 7(2)(d) training had been put in place and delivered?

A. Because this was probably the first time that we'd formally trained staff in 7(2)(d)s, or certainly for some considerable time, then to allow that to bed in and allow staff to understand that training, and to enhance what they're already doing. So I don't want to run away with the idea that staff didn't know how to do

a 7(2)(d), they did, but this was formal training. So to allow that to bed in, and then along with policy note 800 and the PRA, that will be an appropriate time then to carry out this Brigade-wide audit.

Q. Can I put the point more directly: hadn't you put the cart before the horse here? Ought you to have carried out the review/audit first to identify what deficiencies the training needed to address?

A. We could, we could have done that, but I think we accepted -- following the Lakanal House action plan, we accepted that there were gaps in the provision of information and training we were giving to our crews. So I think we accepted that we needed to start afresh with training. So I don't think we really wanted to get involved in finding out what the gaps are, we were just doing a belt and braces approach to 7(2)(d)s, albeit in the knowledge that there was a lot of organisational knowledge at stations in terms of how to do a 7(2)(d), but also thinking of new entrants as well, so ...

Q. What happens if the audit/review had identified yet further gaps or deficiencies in training that would have to be remedied?

A. Well, that's when the dynamic intelligent operational training kicks in, because we would find that out and we'd continue looking to approve our training. So if we

did find that there were further gaps, we would have amended the training course and re-issued it.

Q. But if you are to take a belt and braces approach, isn't it best done on the basis of a thorough review before any remedial training is rolled out to personnel?

A. Except for the fact that we accepted, after the Lakanal House coroner's inquiry and the pre-inquest actions that we'd put in place, that it was, on reflection, an omission that this hadn't been done earlier. So we felt there was no need to carry out a review because we was going to start from square one, if you like, in terms of 7(2)(d) training. So the only thing we risked was training some people in things that they knew exactly what to do already, but that would be a better approach, in our view, than it would be to potentially miss something.

Q. I think we have probably exhausted that topic.

Can we look at a separate document now, {LFB00041365}. Now, this is an email exchange you would not have seen because it postdates by nine months your retirement. It is an email exchange from December 2017 between Dany Cotton and Adrian Bevan, and you will see that Adrian Bevan says this in the second email on that page:

"Sorry to bother, as part of my review of Lakanal

actions I have come across this and I have no recollection of it myself.

"Do you remember it?"

Mr Bevan's email then sets out what appears to be an extract of the action plan relating to X-OR17, which replicates the text of recommendation (g) set out in the 2013 report which we've just been looking at, ie the audit/review to identify consistency of station identification of sites.

Now, in the middle column, your name is crossed out, replaced with that of Dany Cotton, and the far right column says this:

"Work by Head of Operational Assurance to validate the work at stations to identify and record operational risks will need to await the embedding and outcome of work by the Third Officer to increase the number of visits (and premises on the ORD) which is outlined in item ORI 4 above. The lead for this action should be [Head of Operational Assurance]."

If we could look at the email at the head of this chain from Dany Cotton, she says:

"Hiya.

"No, I don't think I've ever seen this before and Dave Brown would definitely not have allowed us to do this!!"

Now, the language of that email chain is clear. It suggests that the recommended audit was never carried out. Now, is that right?

A. There's a couple of issues here --

Q. Well, if we can start off with an answer to the question: is it right that the audit/review was not carried out?

A. I don't believe the audit/review by operational assurance was ever carried out.

Q. Your answer suggests it was carried out by someone else.

A. Yes.

Q. Who?

A. So the service standards that I introduced in 2014 had a specific service standard for contingency planning, and we had structured approaches to be able to audit what was going on with regards 7(2)(d)s and operational contingency planning in general. So my service standard support officers would certainly have carried out audits in this regard on an annual basis from 2014 onwards.

Q. Were those service standards designed or were they used -- I should take it down in stages: were they designed to discharge the recommendation (g), ie to carry out the audit/review?

A. No.

Q. Do you believe or do you know whether the audit/review

was in fact carried out under the umbrella of the service standard audit that you've referred to?

A. In my opinion, that would have addressed this particular issue, yes.

Q. I'm sorry to press you, I'm not interested and we don't want to hear your opinion. Was the audit/review carried out as a fact or not? Was the audit/review carried out envisaged by recommendation (g) under the umbrella of the service standard audit procedures that you've just referred to?

A. I never offered that up as an outcome for that particular action, no.

Q. So when you sought to qualify your answer earlier on by saying the review/audit was not carried out by ops or assurance, is it right, therefore, to take it from the evidence you've given that you don't know whether your department carried out an audit or review following recommendation (g)?

A. Oh, no, sorry, I've misrepresented myself then. So I know that my service standard support officers did regularly audit on an annual basis a range of issues and this would have been one of them. What I'm not suggesting is I then went forward and said, "Hey, that particular action in this action plan, we can tick that one off now because I've dealt with it", I never said

that, I never did that. That was for operational assurance to do, and this comment in the far right column in terms of being suspended awaiting outcome of further work by me in terms of increasing the number of premises on there, is accurate. But at some point it would have been for the head of operational assurance to say, "It's now my turn to pick this up and get on with this audit", and the reason we're both on there is because we both owned that action: me to get the training done, me to build up the numbers on the database, and then the head of ops assurance to take over and use her staff to do the audit for which her staff were auditors.

Q. That's a very long answer. Can I just take us back to what recommendation (g) was, because I think there is a danger here of generality obscuring the particular.

A. Okay.

Q. If we go back to {LFB00091785/2} and amplify recommendation (g). It was a specific recommendation, Mr Brown:

"... operational assurance audit/review take place to identify the consistency with which stations identify sites/buildings that might present an operational risk or hazard ..."

So the focus was on the consistency or otherwise of

the approach adopted by stations to operational risk or hazard.

Was there a particular audit or review that answered that specific recommendation carried out by your department?

A. As part of normal business, as part of these service standards, then yes. But that particular recommendation refers to joint work between head of operations, prevention and response and OA, and on that respect, no, that wasn't carried out.

Q. Thank you.

Can we go back to the Cotton/Bevan email correspondence {LFB00041365}. Dany Cotton's email at the top:

"... Dave Brown would definitely not have allowed us to do this!!"

Can you help as to why she had formed the view that you would not have allowed us, ie the LFB or operational assurance, to do this?

A. Well, first of all, that's a really disappointing comment to read, and I worked closely with operational assurance, who did lots of audits in terms of senior accident investigations and performance reviews of command at fire stations, without anything other than full co-operation from me, so I've got no idea why Dany

would have suggested such a thing.

Q. Indeed, there is nothing in the February 2013 report on PORIS that suggests that you disagreed with or weren't willing to implement recommendation (g).

A. No, and even if I had for some bizarre reason wanted to stand in the way of this, which I didn't, this is a corporate action, and there was no way that I'm going to stand in way of a corporate action agreed at CMB for which I was present.

Q. Thank you.

Can we now turn to a separate topic, which is the Lakanal Rule 43 actions.

Now, if we can go back to your first statement, first of all, {LFB00032166/7}, and start with paragraph 16.

Now, here you set out at the bottom of the page, in paragraph 16, the following:

"16. In 2013, Inquests were held into the death of the six people who died as a result of the fire at Lakanal House. On 28 March 2013, Her Honour Francis Kirkham CBE, Assistant Deputy Coroner, sent a letter to the Commissioner setting out her five recommendations for action by the LFB ('rule 43 recommendations').

"17. In my capacity as the LFB's Head of Operations, Prevention and Response, I was allocated the

role of Lead Officer for recommendation two, which concerned 'Visits made pursuant to s7(2)(d) of the Fire and Rescue Services Act 2004' and recommendation four, regarding 'Brigade Control'. I also had an involvement in recommendation one in relation to 'Public Awareness' and recommendation three, involving 'Incident Commanders'."

Now, in your evidence at Module 5, Mr Brown, I would like to concentrate on recommendation 2, so section 7(2)(d) visits.

A. Okay.

Q. The then commissioner, Ron Dobson, wrote to the coroner on 23 May, setting out the LFB's response to her recommendations. We can find that at {LFB00042089/4}. In the second paragraph, we see there the response in relation to recommendation 2 on which you led. Really it's the second paragraph at the top of that page. It says this:

"It is recommended that the Brigade review procedures for sharing information gained as a result of section 7(2)(d), familiarisation and home fire safety visits with crews both within the station in question and at other local stations."

In response, the commissioner wrote at the third paragraph, under the heading "Response", this:

"The Brigade's policies concerning the 'gathering of operational knowledge' are under regular review and many have been modified to reflect the lessons learned in the Lakanal House fire."

He then continues, under the heading "Proposed Action", with this:

"To further enhance current systems, the Brigade will:

"▪ Undertake a review of the existing policy relating to information gathering and contingency plans. This review will aim to optimise all of the Brigade's pre-planning activities to ensure the effective sharing of information gained as a result of section 7(2)(d) familiarisation and Home Fire Safety Visits. It will aim to maximise the use and availability of this information when operational personnel respond to emergencies;

"▪ Create an inspection regime that targets high priority residential and non residential buildings with a view to increasing the number of premises records which are available to the Brigade's operational staff on the Operational Risk database;

"▪ Develop guidance to assist staff to create consistent tactical plans focused on improving speed of firefighting and life saving interventions;

"▪ Develop a new policy guidance to address known outstanding risks identified through the Brigade's Home Fire Safety Visits and other engagement activities;

"▪ Establish a corporate mechanism by which targets for the Brigade's 7(2)(d) activities are set."

Now, that, as we understand it, formed the basis for the actions that are referred to as actions 2a, 2b, 2c and 2d in the Lakanal assurance review, a document to which you have clearly had regard in reaching your statement; is that correct?

A. That's true, yes.

MR KINNIER: Now, I would like to take a moment to identify each of the actions as described in the Lakanal assurance review, and if I could ask the trial director to bring up the ——

SIR MARTIN MOORE—BICK: Before we do that, Mr Kinnier, can you just help me with this, because I want to understand where we're going.

The recommendation doesn't address concerns about the system for obtaining information; it's concerned with sharing information gained as a result of section 7(2)(d) and so on visits.

Is there anything in this that actually deals with sharing of information?

MR KINNIER: When you say "this", you mean the response

or ——

SIR MARTIN MOORE—BICK: The response, yes.

MR KINNIER: Not especially, no. Well, no.

SIR MARTIN MOORE—BICK: This doesn't actually address the recommendation at all?

MR KINNIER: No.

SIR MARTIN MOORE—BICK: All right, thank you.

MR KINNIER: That's a point which will be covered with Mr Dobson.

SIR MARTIN MOORE—BICK: All right. Thank you very much.

MR KINNIER: If we could go to the assurance review itself, which is {LFB00004801}. If we could put page 4 of the commissioner's letter, so {LFB00042089/4}, side by side, thank you.

Now, the coroner's recommendation 2 is set out on page 25 of the assurance review {LFB00004801/25}. It's in the left column, bold blue text, and action 2a is then identified on the same page in the right—hand column.

(Pause)

Thank you.

As we see, 2a is there identified. Do you have it, Mr Brown?

A. Yes.

Q. It says:

"Review existing policy related to information gathering and contingency plans."

That responds to the first bullet point in the commissioner's letter to the coroner; would you agree?

A. Yes.

Q. Apologies to the trial director for this, but if we can go to page 27 in the assurance review {LFB00004801/27}, looking at the left—hand column, the bold red text identifies action 2b which is to, "Create an inspection regime targeted at high priority buildings". Would you agree that 2b corresponds to the second bullet point in the commissioner's response letter?

A. Yes.

Q. Action 2c is also on page 27 of the assurance review, and you will see that is entitled:

"Develop new policy/guidance to address known outstanding risks identified through home fire safety visits."

That corresponds to the fourth bullet point in the commissioner's response.

A. Yes.

Q. Thank you.

Finally, action 2d is also on page 27, and that is entitled "Set corporate targets for 7(2)(d) activities". Would you agree that that corresponds to the fifth

bullet point in the commissioner's response letter?

A. Yes.

Q. Thank you.

Just to add administrative complexity, action 2 in its four component parts were also known as action 18a to d in the context of the LFB's internal Lakanal House action plan. Do you remember that level of detail?

A. Yes, yeah, and it wasn't particularly helpful. That was an action plan being incorporated with another action plan and being renumbered, but yes.

Q. Just so people know what we're talking about, if we can put —— with apologies again to the trial director —— both of those documents down and put another one up, which is {LFB00029307}.

Now, this is the LFB's Rule 43 monitoring report. We can see its date in the top right corner, November 2013, and for people who are watching proceedings, these documents were produced regularly following the Lakanal House Inquests for the purpose of monitoring the LFB's progress in implementing the actions identified to satisfy the coroner's recommendations. Is that a fair and accurate summary, Mr Brown?

A. Yes.

Q. Now, we can see from the top of the first page that this

was a consolidated action plan arising from actions arising at Lakanal, as well as those arising from another inquest, which was Shirley Towers in Hampshire; is that right?
A. Yes, Shirley Towers happened not long after Lakanal and we was minded to look at the issues out of that and see whether there was any that applied to our own organisation, so we combined them together.
Q. Thank you.
If we can turn to page 17 {LFB00029307/17}, here we find the entries for action 18 parts a to b. If we could look very briefly at the text in the third column, ie the middle one, I think, under the heading "LFB action":
"a) Review existing policy related to information gathering ...
"b) Create an inspection regime targeting high priority buildings.
"c) Develop new policy ... to address outstanding risks ... through home fire safety visits."
If we could turn over the page {LFB00029307/18}:
"d) Set corporate targets for 7(2)(d) activities."
Just to bring everything full circle, these are what you and the Lakanal assurance review refer to as action 2, parts a to d; is that right?

A. Yes.
Q. Thank you.
We can also see here, in the fourth column under the heading "Lead", that you were allocated as the sole lead officer for each component part of action 18, is that right, apart from action 18a?
A. Yes, where I was a joint lead, yes.
Q. You were a joint lead with AC fire safety and regulation, who was Steve Turek at the time.
A. Yes.
Q. Thank you.
Apologies for that somewhat pedantic, painful trawl through the bureaucracy.
Can we go back to page 4 of the commissioner's letter to the coroner, which is at {LFB00042089/4}.
Can you help us, how was the coroner's recommendation that the Brigade "review procedures for sharing information gained as a result of section 7(2)(d) visits" converted into the five actions proposed by the commissioner in this letter?
A. So as a senior management group we discussed each of the recommendations from the coroner and discussed ways that we could achieve them. So we broke them down into component parts that we felt added to the completion of each of the recommendations, and these were the issues

that we agreed as a group that would address the coroner's recommendation.
Q. What was the extent of your involvement as joint lead in respect of a and sole lead in respect of the other three actions that were required?
A. Well, the joint lead on a was because we used premises information plates. We incorporated that into this particular action 2a, and the premises information plates were plates that were allocated to the -- to high-rise residential buildings, and on that regard we needed input from regulatory fire safety, which is where the joint lead come in with regulatory fire safety.
Q. It was probably that my question was unclear. What was the extent of your involvement? What did you do? What were you doing --
A. Oh, I see.
Q. -- to lead the work or jointly lead the work to implement these recommendations?
A. So it varies. Overall what I would have done is allocated members of staff to deal with each of these and then they would have reported back to me. I had more to do with some than others, but overall, yes, I would be allocating members of staff to complete each of these leads and then report back by a dedicated time.
Q. Did anyone during the course of this work ask the

question that the Chairman asked, which was: the recommendation is focused on sharing; what are these recommendations doing to meet the concerns the coroner obviously had in respect of sharing of information?
A. No, they didn't.
Q. Can you help us as to why?
A. I think that 2a, the first one, undertake a review of the existing policy -- so by using that policy and by collecting the information and rolling out mobile data terminals, so we were -- operational staff were collecting the information, feeding it into the operational risk database, the appropriate information, and that information would then be regurgitated to operational crews, ie shared, as and when they arrived at incidents.
Q. So although it's not articulated anywhere, the assumption was that the MDT was the mechanism by which improvements would be made to the sharing of information; is that a fair summary?
A. Yes, and I think to varying degrees each of the five makes sure that we've got the appropriate information to be shared and enhances that sharing. So I totally understand the Chair's question in that regard. Looking at it now, I can see that it isn't clear. But we were satisfied that it was dealing with sharing the

information within the organisation to the appropriate people at the right time.
Q. Now, looking at the extent to which the actions implemented the response to the recommendation, the third bullet point set out in the commissioner's response, ie "Develop guidance to assist staff to create consistent tactical plans focused on improving speed of firefighting and life saving interventions", that isn't covered in any of the four actions that purported to implement these actions; do you accept that?
A. I feel that that third bullet point is effectively a subset of the first bullet point. But in terms of individually highlighting it and reporting against it, yes, I would accept that that's missing.
Q. Why does action 2a or 18a not specifically address the third bullet point?
A. I suggest it's because of an over-familiarisation with what policy note 800 was all about. So obviously it was about hazard information and it was about tactical plans, which is that third bullet point, so I think it was just an unhelpful assumption on our part that the third bullet point is part of the first bullet point. But in terms of reporting, then clearly that's not clear.
Q. Now, let's look at action 2a/18a, which is the review of

existing policy related to information-gathering and contingency plans. We know it deals with those matters.
Can we now turn to your first witness statement, which is at {LFB00032166/22}, and paragraph 71. Here you say this:
"This action was shared with the AC Fire Safety Regulation, Steve Turek. My involvement in this action was limited to providing operational insight into the feasibility and practicalities of obtaining useful information. I was also involved in the initiative to introduce ePIPs."
Now, in his statement -- and it's probably useful to go to it so you can see it, it can be found at {LFB00032128/11}, at paragraph 34 -- AC Turek said this:
"Action 2a - The Third Officer [so that's you] had primary responsibility for the execution of this action, again I provided support of a technical nature, namely to advise on our responsibilities under fire safety legislation."
Now, you can't both be right.
Having gone through the relevant documents, having seen Mr Turek's recollection, are you wrong or is he wrong?
A. Can you just remind me, please, of exactly what I said in --

Q. Yes, we can go back to your witness statement, which is at {LFB00032166/22}, paragraph 71.
A. I don't think either of us are wrong. I think it's just in the terminology we've used. I think my phrase "limited to providing" I guess suggests it was a minor role. I didn't mean it in that regard. If we was to do a percentage split between the two of us, I guess I would have had a greater percentage responsibility.
Q. So Mr Turek was right in the sense that you had primary responsibility?
A. Well, primary suggests one is more important than another, and I don't think that, but I would accept that I took a larger share of responsibility, yes.
Q. In fairness, he said primary responsibility for the execution of this action.
A. Yes, because it very much would have been my staff that were involved in collecting information. It would have been the technical know-how of Steve Turek that would have been key to this.
Q. Now we've got that cleared up, can we look at a later version of the Lakanal and Shirley Towers Rule 43 action plan, and that can be found at {LFB00031066}. This is dated March 2016. There we see the date in the top right corner.
If we could turn to page 22 {LFB00031066/22}, which

deals with action 18a, also known as action 2a, we can see 18 is at the bottom. Just reading across from the left to the right, the first entry in the "Action Update" column on the far right-hand side says this:
"04/07/2013: A review of PN800 has been completed and it has been recommended to include 7(2)(d) guidance in PN800 rather than create a new and separate policy."
Who carried out the review of policy 800?
A. That would have been my department. I think it was Group Manager Andrew Bell, I think, who would have led on it.
Q. Is he now AC Andy Bell?
A. Yes.
Q. What is the section 7(2)(d) guidance referred to here?
A. There was discussion over -- because of the prominence of 7(2)(d) there was discussion over whether there should be a separate standalone policy on 7(2)(d). But on the basis that we were also organisationally keen to keep things as straightforward as possible, and not increase the number of policies, rather amalgamate, we decided that policy note 800 was an appropriate place to use 7(2)(d) guidance, so we would incorporate it there.
Q. Why there rather than say, for example, appendix 1 of 633 as well?

A. That's a good question. I think the reason is because policy note 633 is all about high−rise firefighting, so whilst it's clearly essential that we've got the appropriate information in terms of on−arrival tactics, policy note 800 is a better fit because this is all about information−gathering before the incident, so we felt that's where it better sat.
MR KINNIER: Thank you.
Sir, it's just after 3.15. This is a convenient place.
SIR MARTIN MOORE−BICK: Well, then, we'd better have a break now, hadn't we?
MR KINNIER: Thank you, sir.
SIR MARTIN MOORE−BICK: Mr Brown, I think it's a good time for us to have the afternoon break. We'll stop now. We'll resume at 3.30, please. And as usual, please don't talk to anyone about your evidence while you're out of the room.
THE WITNESS: Thank you, sir.
SIR MARTIN MOORE−BICK: All right? Thank you very much, would you go with the usher, please.
(Pause)
Thank you, Mr Kinnier. 3.30, then.
MR KINNIER: Thank you, sir.
SIR MARTIN MOORE−BICK: Thank you.

(3.16 pm)
(A short break)
(3.32 pm)
SIR MARTIN MOORE−BICK: Right, Mr Brown, ready to carry on?
THE WITNESS: Yes, thank you.
SIR MARTIN MOORE−BICK: Yes, Mr Kinnier.
MR KINNIER: Thank you, sir.
Can we go back to the March 2016 action plan, which can be found at {LFB00031066/22}. Now, that's the page that we were discussing just before the afternoon break.
If I could ask us to turn over the page to page 23 {LFB00031066/23}, and looking at that far right column, Mr Brown, what we see there in broad terms is an iterative process of amendment and consultations relating to PN800.
If we turn over the page to 24 {LFB00031066/24}, that process ended on 25 August 2015, when the process ended.
Now, can you help us as to why it took over two years for the iterative process of amendment and consultation to take place and before the policy was finally published on 25 August 2015?
A. Can we go back, please ——
Q. Where would you like to go back to, page 22 or 23?
A. Sorry, just so I can quickly remind myself of some of

the iterations in this action update.
Q. If we go to 23 {LFB00031066/23}, that's probably the easiest.
A. Thank you.
(Pause)
Okay, well, two things. I'm slightly surprised to see that, because I thought there had been an issuing of the policy in 2013, which is why I just wanted to read that. But clearly that doesn't support what I thought was the case.
So in terms of the second issue, as to why it took so long, this was a key policy and we had a long and arduous path to go through in terms of consultation. There was two staff side arenas, industrial relations and health and safety, and it was a process that we needed to go all the way through one process, industrial relations, and then start all over again at health and safety.
We tried in the past with staff side to have a one−stop shop, where we had one set of discussions and consultations, but we weren't successful. Unfortunately this was in the backdrop of difficult industrial relations with staff side and things tended to take a long time.
So not wishing to apportion blame, but clearly this

got caught up in long discussions with staff side, both from an industrial relations perspective and a health and safety perspective.
SIR MARTIN MOORE−BICK: Can you just tell us, Mr Brown, what is BJCHSW?
A. That's the Brigade joint committee for health and safety.
SIR MARTIN MOORE−BICK: Because it seems to have got stuck there between June or July and November, or maybe a bit even beyond.
A. Yes, yes, it was —— health and safety, of the two, would be the more difficult in terms of satisfying staff side. And there was —— it was also, you know, a difference in opinion whether these documents were what we call consultative, ie we asked staff side's opinion and we do our best to achieve it but we can do it anyway, or negotiation, where we cannot move forward without their agreement. And because issues were so difficult, we would invariably opt for the negotiation type, because what we didn't want to do was cause any more challenges with staff side than already existed. So what that meant was sometimes things were being requested by staff side which were difficult to achieve and we spent time trying to weed our way through it.
I was involved in the industrial relations

consultations. It would have been a different set of people, I think Dany Cotton at some point, in BJCHSW, the health and safety side of it.

MR KINNIER: Just taking a step back from this, as the Chairman observed, about nine months out of this process seems to be consumed by discussions with the BJCHSW out of a period roughly of two years. Is that the norm, where a policy change bites on or touches health and safety, that the process of amendment consultation would take something in the order of two years?

A. No.

Q. Or nine months —— no. Was that exceptional, that it would take this long?

A. Yes.

Q. Can you remember now what the particular concerns were that had been raised in the forum of the BJCHSW that had consumed so much time?

A. No, I can't, I'm afraid. I would have had nothing whatsoever to do with the health and safety consultations. Mine would have been purely the industrial relation consultations.

Q. Even in terms of office discussions, can you remember whether the concerns raised staff side concerned the subject matter or the substance of the policy, or was it

sort of other issues that caused the delay?

A. I'm sorry, I'd be speculating if I was to try to guess, I'm sorry.

Q. Do you recall if, as part of the review and consultation process, there was any discussion of any of the concerns in relation to 7(2)(d) visits that we've been discussing today, for example inconsistent approach of crews to identifying buildings in need of visits?

A. That certainly was an issue that was discussed, and staff side, to their credit, always would have been seeking appropriate training for their members, ie our firefighters, in terms of achieving a new policy.

Q. Do you remember whether there was much substantive discussion, if any, about concerns about the quality of entries on the ORD and their inconsistency?

A. That would have —— that was an issue that we raised, management side, in terms of why we wanted such a policy and a risk assessment process. But to my memory, staff side hadn't raised that issue, that was one of our issues.

Q. Looked at more generally, did anyone raise that particular concern?

A. Outside the management team?

Q. Yes.

A. Not that I can recall, no.

Q. Can you remember whether there was much discussion, whether in the management team or staff side, on the question whether operational crews properly understood what was required of them when carrying out section 7(2)(d) visits?

A. There wasn't, when we was consulting on this policy, from the management side. We were satisfied that the training would address that issue. I don't recall staff side raising any issues in that regard.

Q. Okay.

Mr Brown, can we now turn on to action 2b or 18b, which was creation of an inspection regime targeted at high—priority buildings.

Can we start, first of all, with what your understanding was of what this action required.

First of all, what did you understand high—priority buildings to encompass?

A. "High—priority buildings" was a phrase that got into discussions, I'm not quite sure where it came from, but we could translate it across really to high—risk buildings.

Q. This phrase emerged; did people understand what it meant? Was everyone talking to the same definition?

A. I don't think it was a phrase that was corporately used, but certainly in the exchanges on this particular action

it found its way into the correspondence between us, and I think it caused, at least for a period of time, some unnecessary confusion.

Q. But eventually did those involved in the review understand that it was a synonym for high—risk buildings?

A. Yes.

Q. Who brought clarity to the confusion? Did you knock heads together, or ...?

A. No, I think it just ... I think in correspondence it just became clear what was meant and the high—priority phrase just disappeared.

Q. How did you understand that the proposed inspection regime would relate to the existing regime for carrying out 7(2)(d) visits under policy 800?

A. So the existing regime was about staff (a) finding buildings that currently had never been assessed, and (b) once they had been assessed, following the risk matrix in terms of frequency. So it was the bit about getting buildings —— if I can call it —— let's call them unknown buildings, so getting unknown buildings onto the operational risk database. So the inspection regime was about giving some guidance as to where to focus your efforts to get those unknown buildings onto the operational risk database, because without that

guidance, there was the danger that buildings of a lower risk, shall we say, might be being visited, and of a higher risk are just sitting there waiting to be visited. So it was to try and give some structure around that inertia of getting more premises onto the ORD.

Q. I suppose the one thing that's telling about that answer is that it begs the question: how do you define high risk? To what extent did the discussions seek to identify that concept first as a means of providing context for the new proposed regime?

A. So this was a -- 2b or 18b was a task that I asked Tom George, who was a deputy assistant commissioner, to undertake for me, and Tom then sought the assistance of one of his borough commanders within his area, John Elwell, who also happened to be the lead for the service standard that dealt with this kind of thing, so that was a wise choice, and it was between the three of us. I think there was some initial clarification required, but we resolved that.

Q. So when, thinking back -- we can go to it if you want -- Mr Dobson responded to the coroner that the creation of this new inspection regime was specifically "with a view to increasing the number of premises records which are available to the Brigade's operational staff on the

ORD", that appears to have been your understanding also about the aim of the exercise?

A. Yeah, it was to get more on there, but also make sure it was the right ones in the right order.

Q. And it was not confined to high-rise buildings; it was buildings generally, from what I make from your evidence.

A. Yes, yeah, there was a banding process and high-rise was one of the priority bands.

Q. Now, just flowing on from the evidence you gave in respect to Tom George, can we go to his statement, which can be found at {LFB00032823/17}, paragraph 69. We see there at paragraph 69, Mr George said this:

"In November 2013, the Third Officer instructed me to carry out some work on a particular action from the Lakanal House Action Plan, namely to create an inspection regime targeted at high priority buildings. One of my [borough commanders] ([borough commander] for Kingston) was already the lead officer for Service Standard 7 – Operational Contingency Planning. With the Third Officer's agreement, I therefore asked the [borough commander] for Kingston to consider the action and put forward a proposal on what could be achieved."

Now, just to get some understanding of the hierarchy, Tom George at this stage was a deputy

assistant commissioner who reported to you; is that right?

A. That's correct.

Q. The borough commander from Kingston, that's John Elwell; is that right?

A. That's correct.

Q. Can you help us, Mr Elwell's role as the lead officer for service standard 7, what did that role entail?

A. So service standards was something that was in the Brigade some considerable time ago and for whatever reason it fell by the wayside, and it was something that I always thought was a shame and it should be reintroduced because it helped standardise issues across the Brigade. So I sought to re-introduce those after I managed to consolidate the north and the south of London together.

I then set up -- I think there was ten service standards, and then we sought to provide a lead for each one of those service standards in terms of creating those service standards all over again, coming up with common standards that every borough across the Brigade could use, performance indicators that cross-referenced with them, and advice and guidance, really. So, you know, a new borough commander could look at these and he or she could be following the same process as

a very experienced borough commander. So I had the same thing going on.

This one, service standard 7, operational contingency planning, covered, amongst other things, 7(2)(d)s, so John Elwell's role was to arrange the standards and the performance indicators, et cetera, to bring that up to fruition, that the whole Brigade could use.

Q. I think there are now 11 service standards.

A. Oh, okay.

Q. I don't know whether there were in your time. But would it be fair to say that the weight of those standards is concerned with measuring performance in a manner akin to KPIs?

A. That's part of the role, but it's also to give guidance on what should be done and how it should be done, which together leads into a performance indicator.

Q. Can you help us as to what about the particular role of lead officer for service standard 7, operational contingency planning, made Mr Elwell appropriate for leading the work on action 2b?

A. Well, because the whole issue of 7(2)(d)s is about information-gathering, so effectively creating contingency plans for operations, ie incidents. So it fell squarely within service standard 7, the whole issue

of information−gathering, 7(2)(d)s.
Q. Can we now turn to an email chain which can be found at {LFB00042252}. Now, this is an email chain from November 2013 between DAC Tom George and John Elwell.
If we can go to the bottom of page 2 {LFB00042252/2}, which is an email from Tom George to John Elwell, it says this:
"John,
"As you're the Service Standards lead officer for Operational Contingency Planning, Dave Brown has given out a piece of work that I'd like you to think about and put some suggestions to me please.
"The Coroner's Rule 43 letter (monitoring report) following Shirley Towers and Lakanal House includes an action − Action 18 − The Brigade review procedures for sharing information gained as a result of section 7(2)d visits with crews both within the station in question and other local stations. As a result of this, PN800 is being reviewed (action 18a) as you know. Also attached to this action is to create an inspection regime targeted at high priority buildings (action 18b) and it is this that Dave and I would like you to review please.
"There are currently only 7000 ORD entries and the Third Officer feels there should be more, he wants us to 'beef up' our inspection programme − can you please have

a think on this and put a proposal to me on what would be more appropriate than what is done currently and how this could be achieved. Dave has asked for a response ASAP so could I ask for your thoughts within 2 weeks if possible. Many thanks, much appreciated."
Now, Tom George has taken your name in vain there, or he has certainly taken your name; is he doing justice to your intentions when he says you wanted to "beef up" the inspection programme?
A. I don't recall making that comment, but ...
Q. Does it convey the tenor of your aspirations for the work?
A. I would have said −− I may well have said that, but it was far more than just beef up the inspection programme. I had regular meetings with the deputy assistant commissioners and probably spoke with them almost daily as well, by telephone or otherwise, certainly had numerous email conversations with them, and so I've made it clear to Tom that I want an inspection programme that (a) leads to more ORD entries and (b) gets the right ones on there. If that is interpreted as beef up −− I think that oversimplifies it, but that's not an unreasonable way to describe part of it.
Q. It seems on the basis of that that he has fairly summarised your intentions in terms of getting more −−

A. Yes.
Q. −− premises' details on the ORD.
A. Yes, but also making sure that we get the right ones on there as well, at least to start off with.
Q. Can you help us, the reference to 7,000 properties in that quote, was that a reference to high−rise properties specifically or just properties generally?
A. No, that was the total number of buildings that were on the operational risk database. So the operational risk database is really any −− could be any non−commercial building or, indeed, as in high−rise for example, it could be residential buildings. So there is a whole range of different buildings that could effectively be on the ORD.
Q. Tom George sent this email. Can we now look at John Elwell's response, which starts at the bottom of page 1 of the chain {LFB00042252/1}. He asks first of all for a copy of the monitoring report, and then goes on to ask this at the bottom of the page:
"Could you also confirm the use/definition of the term 'high priority buildings' in action 18b, as currently this does not accord with any terminology in PN800. Based on the Premises Risk Assessments (Appendix 2) premises are rated as 'high risk' − is this the same concept or does the action plan refer or allude

to a different grading model?"
Now, Mr George replied at the top of page 1 in the second paragraph, and he answers candidly:
"I have no other detail other than this, have a look and if I still need to seek guidance on 'high priority buildings' I will do but I'd read this as those that present the greatest risk to firefighters."
Now, did Mr George discuss the definition of high−priority buildings with you as part of the iterative process of clarification that you referred to earlier on?
A. Certainly Tom did come back to me. I can't recall the conversations, but what I do know is that we eventually got to the agreed position that we're talking about high−risk as defined by the action plan.
Q. Here, high−risk is more specific: it's that which presents the greatest risk to firefighters; was that your understanding of what the term meant at the time?
A. I wouldn't describe it in that way necessarily. We were obviously always massively concerned about the risk to our staff at emergency incidents, and one could argue that those sites that are the highest risk to the public also are of great risk to firefighters, but I wouldn't simplify it in those terms.
Q. So did Mr George say to you, "Guv, have I got the right

definition"?
A. I can't recall exact details of our conversation, but I do know we got to the position in the end where it was about high-risk as per the action plan.
Q. Ie greatest risk to both firefighters and residents of those buildings?
A. Absolutely.
Q. Can we now turn to a briefing paper which is the initial paper that Mr Elwell produced, which can be found at {LFB00032825}.
At page 1 of the paper, which is entitled "Action 18b – London Fire Brigade consolidated action plan following Coroners recommendations", the third paragraph under the heading "Background" sets out a number of issues which Mr Elwell identified as "implicit within the concern on numbers of ORD entries".
If we could just go through these, simply because of the importance of the document:
"a) Is the existing guidance (PN800) fit for purpose to achieve the desired outcomes?
"b) What other Brigade data could be deployed to identify relevant premises for inclusion on the ORD.
"c) Are the 7000 we have all relevant and in compliance with the guidance in PN800?
"d) Which premises are 'missing' from the ORD given

the guidance in PN800?
"e) What is the capacity of a station/watch in terms of the number of ORD entries that can be effectively entered and revisited with the existing guidance. A pertinent point, given the disparity of the numbers, risk and types of premises on different stations ground.
"f) Is the quality of existing ORD entries providing data to underpin safe systems of work?
"g) Are our staff competent to carry out the 72d visits and enter meaningful data and professional tactical plans?
"h) What are the existing Performance Evaluation Tools to monitor performance?
"i) What Service Standard is in place to Quality Assure the relevant extant policies?
"As these issues start to be effectively defined, addressed and monitored I would suggest that an improvement in the quality and quantity of ORD entries will be observed.
"Note: The term 'high priority buildings' used in Action 18b does not accord with the definitions in the extant Policy Note 800 or draft Policy Note 800, this term is therefore taken to mean 'High Risk' in line with the terminology currently in use in both versions of PN800."

Now, taking a step back, that's a summary rich in detail and complexity. Mr Elwell was proposing a fundamental review of the basic adequacy of the Brigade's existing operational risk management systems; would you agree with that description?
A. Yes.
Q. Can we now look at another email chain, which can be found at {LFB00041360}. I'm afraid this is a long chain.
Could we go to page 10 {LFB00041360/10}, and the bottom of that page. We can see there that on 13 December 2013, Mr Elwell lodged his report both with you and Tom George.
Do you recall receiving Mr Elwell's report?
A. Yes.
Q. Now, Mr George followed up with the following email to you the next day, and that can be found at the bottom of page 9 {LFB00041360/9}. Mr Elwell is not copied in to this email. Again, apologies for reading it out:
"Dave,
"Following the action given to me at PMB – regarding action 18 from the Rule 43 letter following the Shirley Towers and Lakanal House incidents, specifically to create an inspection83 regime targeted at high priority buildings, I asked John Elwell (lead officer for SS7) to

look into this and provide me with some suggestions which I was going to review, collate with other observations, and report back to you at or before the next PMB. John has been extremely thorough and produced a 16 page report (attached, and already forwarded to you from John). This report is actually only 5 pages long and is well worth a read, the following pages are associated appendices. John has made some recommendations which I've listed below (although they really need to be read in context).
"You asked me to think about how we could improve on our 7.2(d) inspection programme, particularly for high risk premises. I believe John's report does exactly that and each recommendation should therefore be carefully considered in my opinion. Please let me know how you wish for this to be taken forward or I'll leave it to you to raise at PMB (unfortunately I'm not there on Wednesday as I'm on leave, Rick is covering)."
Mr George then listed the recommendations from the report in the latter half of his email:
"Recommendation 1 – That the on-going review of PN800 provides explicit detail of the types of risk that should be present, the layout of the note should be user friendly and be a one stop shop for all guidance pertaining to the ORD system, including the gap analysis

undertaken during the Service Standard process.

"Recommendation 2 — If an immediate focus is required on the completion of the ORD to enhance the quantity of entries then face to face meetings should take place between the appropriate managers DAC/BC, BC/SM, SM/WM to reinforce the provisions of PN800 and the expectations required. This can be undertaken as part of the performance management review cycle or if required in a more urgent manner as a bespoke meeting specifically for this purpose.

"Recommendation 3 — When the revised PN800 is promulgated, the publication is carried out simultaneously with a series of face to face workshops with Station and Borough Commanders. These workshops should provide a detailed explanation and expectations of the content of PN800. The current practice of entering new Policy notes onto the station circulation folder or announcing the Policy by email will not be sufficient to effectively explain the expectations required.

"Recommendation 4 — A feasibility study is undertaken into the use of existing Brigade data ...

"Recommendation 5 — A review is undertaken of the disparity of risks across different station grounds and a methodology developed to determine the optimum number

of ORD entries for stations with high numbers of applicable premises.

"Recommendation 6 — Further training is provided to all personnel with a role in the ORD process to ensure they have the skills to meet the competencies required.

"Recommendation 7 — Consideration is given to redefining the KPIs in Service Standard 7 ... to include measurement of the quantity and quality of ORD entries ...

"Recommendation 8 — The Service Standard Board finalises the arrangements in a timely manner, for the publication of the agreed Service Standards, associated systems and policies. With particular reference to Service Standard 7, the timely publication will provide a further performance assurance process to improve ORD entries both in quantity and quality."

Now, that's a very long run—up to one final email before I actually ask a question.

If we go to the top of page 9, you responded on 16 December 2013, so just two days later:

"Tom,

"This is interesting and helpful, and I am sure we can use some of John's recommendations; however it doesn't feel to me that any of the recommendations actually deals with the requirement to 'create an

inspection regime targeted at high priority buildings.' ... or am I missing something?"

That's a very long run—up to one very short question: was your view that Mr Elwell's report did not fulfil the brief of creating an inspection regime targeting high—priority buildings?

A. That's correct, yes.

Q. Do you accept that Mr Elwell's report raised some significant broader concerns, though, about the adequacy of the LFB's current arrangements?

A. Yes. However, I do need to qualify that, because some of the recommendations that he raised had been dealt with already, were being dealt with, or were within John's sphere of influence to deal with by virtue of the fact that he was contributing to the policy note 800 and he was also lead service standard 7, and there were one or two that were very aspirational, and in an ideal world, yes, great, but the reality just didn't work.

Q. Let's look at some of the black and white of some of these recommendations.

Could we go to {LFB00032825/2}. Looking at recommendations 2 and 3, which are in the top half of this page, both those recommendations emphasised the importance of face—to—face meetings and workshops between crews and their managers; do you accept that?

(Pause)

A. Recommendation 2 and 3 ask for that kind of interaction, yes.

Q. Yes. Recommendation 2, I don't think there is any serious doubt, but you accept and you agree and endorse the aim to enhance the quality and quantity of the entries on the ORD; is that fair?

A. Yes.

Q. Would you agree that in order to achieve the improvements in both quality and quantity, what was required was more face—to—face time between operational staff and their managers to explain what was required of them for the purpose of the process; do you accept that?

A. I accept it, but then I also expect that was normal business.

Q. Given it was the subject of recommendation, isn't that a warning or at least a suggestion to you that it wasn't routinely part of normal business across the LFB's operations?

A. No, because I know that it was the case. I mean, so John, for example, is —— was a borough commander, so —— and I knew John, for example, had regular meetings with the DAC and I knew John had regular meetings with his station manager. So this to me seemed to be stating —— it's the correct thing to do, but it was already

happening. This is normal business.
Q. Isn't that the problem? Haven't you inadvertently put your finger on the problem, though? You've got a borough commander who is the lead on service standard 7. He is making a recommendation to you that there should be more or face-to-face meetings. That tends to suggest it isn't happening because he felt the need to make the recommendation. Why isn't that a reasonable supposition based on what he is setting out here?
A. I can only use -- so my knowledge of the Brigade, having -- so by this time, this is 2013, so I had been in post now for seven years nearly, and my experience in them seven years is that actually there was an abundance of meetings, and I could use my knowledge in terms of I was aware of what was going on all over London in every single borough, and I knew that DACs met with their borough commanders and borough commanders met with their station managers. I knew that for a fact. So --
Q. Sorry to interrupt. Let's look at the level below. You have keenly emphasised those discussions. What about the most pertinent discussions between crews and their managers?
A. Again, from my experience, this is something that was happening. I mean, what I would want to emphasise is

recommendation 2 is a sound recommendation. It's absolutely right there should be discussion between crews and managers and watch managers and station managers, et cetera, et cetera, it was absolutely right, but it's something that is already happening.
So my understanding of why that recommendation is being put in there is because it's the right thing to do. It shouldn't necessarily be drawing to the conclusion it's not happening. There's other recommendations in here as well that are the right thing to do but also were already happening.
Q. Can we look at recommendation 3 in relation to things that are already happening and look at the last three lines, which says:
"The current practice of entering new Policy notes onto the station circulation folder or announcing the Policy by email will not be sufficient to effectively explain the expectations required."
Now, were those means of communication consistent with your experience? Were new policies usually introduced simply by insertion in a folder or circulation by email without accompanying workshops or training?
A. That was the case sometimes, yes.

Q. Sometimes. That formula of words there suggests it was generally the case.
A. It depends on what the policy was, what the prior knowledge ... so the issue that we would always consider, and we did this in training packages as well, is: what is the gap? What is the need in terms of what staff need to know? And then we would think to ourselves: how do we address that need? Do we address that need through a training package or through face-to-face meetings or by an email announcement or just by a policy being sent out for staff to read through?
There was a desire for staff to always have some kind of training package or extended explanation, but that isn't always practical or necessary.
Q. Can we go back and look at recommendation 5, which can be found at page 3 {LFB00032825/3}, in the second paragraph on that page.
Now, the report recommended there, at 5:
"A review is undertaken of the disparity of risk across different station grounds and a methodology developed to determine the optimum number of ORD entries for stations with high numbers of applicable premises."
Now, that's an issue you refer to in paragraph 40 of your second statement. It would probably be useful if

we go to it, {LFB00084020/15}. If we can look at paragraph 40 at the bottom of the page, you say there:
"There are 33 boroughs across London. There is significant variation between the built environment in each London borough. Some boroughs will have a large amount of commercial buildings whereas others with have a high percentage of residential buildings, and some will have both, all of which require an awareness of by fire station staff. Accordingly, it was impractical to set fixed targets for the number of s7(2)(d) visits that staff at each fire station should complete in high rise residential buildings ... as it would place an inequitable workload on some fire station staff that was not placed on others, especially when taking into account the range of other commitments such as training and community safety."
Again, apologies for the long run-up to a short question: did a review of disparity of risks that was recommended by Mr Elwell take place?
A. A review, no, but a recognition that that was an accurate summary of an issue to be resolved, and I put in place a method to resolve it.
Q. Why was the review not carried out?
A. Because I think we were both in agreement that there was a disparity, so the review would only have confirmed

what we already knew and agreed about.
Q. So the recognition was on your part, that you referred to?
A. Oh, yes, absolutely, it was something that I was fully aware of anyway, and John quite rightly also underlined the point.
Q. And what method did you put in place to resolve it?
A. So there's a lot been mentioned about crews on their own station's ground, and there is where the inequity lies. So we had a method called strategic resource, and what that effectively did was it allowed us to take a fire general off the run, ie make it unavailable for a shift, and in that time the crew on that fire engine could go anywhere they liked in London to do training or community safety activities, and so strategic resource had been developed so that we could take a large number of fire engines off the run on particular shifts.
So then what I did was, knowing which boroughs had a higher prevalence of high-rise buildings and other buildings that needed to go on the operational risk database, we put systems in place where we would flood, for want of a better expression, certain areas with a number of appliances, number of fire engines, and say to them, "You need to go out, and in line with what the station manager of that station has given you, go and

inspect these buildings and get them on the operational risk database".
So that would assist -- so, for example, the City has one fire engine in it, the City of London, but yet has got, as one would imagine, an incredible amount of high-rise, they could never do it on their own, so we would send other appliances in, and I would always use the analogy -- because it wasn't popular, people didn't like the idea of this, and I would use the analogy that if there was a large fire in the City, you would have no problem coming from Havering in the east to help out with that fire in the middle, so equally you should have no problem coming in the middle and helping out with doing some inspections that needed to go on beforehand. And I used that same philosophy with home fire safety visits, and things where it required a large number of personnel in an area where we wouldn't normally have a large number of personnel.
So that was my approach to dealing with John's recommendation, although, to be fair, that was something that was in my mind to do anyway, John just quite rightly underlined the need for it.
Q. Recommendation number 5 is in two parts. The first part is a review of disparity of risks. The second part is development of a methodology to determine the optimum

number of ORD entries for stations.
Now, as I understand the evidence you've just given, the method you put in place did not involve developing a methodology to determine the optimum number of ORD entries; is that right?
A. In terms of -- if what you mean by that is how many exist on that station's ground, so when we know it's complete, no, it didn't, because we were still struggling at that time to determine how many there actually were.
Q. Was a methodology ever developed?
A. No.
Q. Why not?
A. Because we just didn't know how many there were there. So the idea was that we would just -- we knew what areas they would be in, in terms of if you look at London as three rings, there's the inner ring and then the second ring is where most of them will be. The inner ring is mostly commercial, the second ring mostly residential, the outer ring, you know, the more suburbs, far less of either. So we knew where to place our resources, but we just didn't know at that time -- whether the Brigade knows now, I'm not sure -- exactly when that pot will be exhausted.
But we also felt that we were so far away from

exhausting the pot that there was little point in putting too much effort into it, because we weren't near the finishing line on that one, we just needed to -- it was an affront to our common sense. We knew there was so many missing and we needed to get them on there.
Q. Thank you.
Could we go back to Mr Elwell's report and look at recommendation 6, which can be found at {LFB00032825/3}, where he said or recommended this:
"Further training is provided to all personnel with a role in the ORD process to ensure they have the skills to meet the competencies required."
The paragraph at the bottom of page 3 immediately above this recommendation says this:
"During of the development of the Service Standard [presumably 7] and at recent incidents a number of existing ORD entries have been examined. A number of sub-standard examples were found, this could indicate a poor understanding of the rationale and a lack of competency based on the above list in recording relevant risk and tactical planning information at all levels of the process - [watch manager/station manager/ borough commander/deputy assistant commissioner]."
Was that reference to substandard ORD entries any cause of concern for you, first of all?

A. Oh, absolutely. Yes, of course.
Q. Were you already aware of the problem of substandard entries?
A. Yes, which is -- I don't want to overplay it in terms of substandard entries, but in my view one substandard entry is one too many. We can have no flexibility on this. So, yes, I was aware that there were examples, but then that was part of the reason why we were doing what we were doing with policy note 800 and also with the training that had probably only just been rolled out some seven months before John made this recommendation.
Q. You don't want to overplay the problem about substandard entries in respect of the ORD. We already know the substandard nature of the entry in regulation to Grenfell --
A. Yes.
Q. -- that's the subject of findings.
Can we look at the ORD entry for Grenfell, which is at {LFB00003116}. It's something we have touched on earlier but it's probably useful to go back on to, to remind people.
The ORD entry was considered in Phase 1 and a number of deficiencies were identified. I will take you through them. First of all, there were no plans of the tower on the ORD, despite the fact that Nicholas Davis,

the station manager, noted that plans are required, and we see that on the entry for 10 May, which is in the fifth row in the main table on page 1.
Secondly, the only photograph of the tower was a small aerial image which gave no information about the building or access to that building, and that can be seen at page 7 {LFB00003116/7}.
Thirdly, the incorrect number of floors was recorded, 20 is stated on page 3 {LFB00003116/3}, under "Hazards", and under the heading "Tactical Plan" on page 4 {LFB00003116/4}, the subheading "Operational Contingency Plan" contained simply a blank box dated 30 October 2009.
Are you familiar with the ORD entry for Grenfell Tower?
A. No. I've become aware of it, clearly, since the Inquiry, but prior to that, no.
Q. Were you aware of the extent of the findings in relation to the deficiencies of that ORD that were made by the Chairman in the Phase 1 report?
A. Yes.
Q. Was the standard of ORD entry as exemplified by Grenfell typical of the quality of ORD entries generally, in your experience?
A. No.

Q. Did you agree with Mr Elwell that the problem with substandard entries could indicate a poor understanding of the rationale and a lack of competency on the part of personnel who made those entries?
A. Not a poor understanding, I think staff did understand, but I think what it does indicate is that there's -- somewhere along the line, there's clearly a gap in the process, and this entry on Grenfell is clearly poor and wrong, and when I found out about this, yes, it was something that I reflected on and thought: how could this happen?
Q. Did you reflect upon it to the extent of actually taking action, for example requiring further training to remedy the potential problems identified by Mr Elwell, poor understanding of the rationale and a lack of competency?
A. Well, when I saw this entry, obviously I'd left the Brigade, but at the time, in terms of John's recommendation back in 2013, more training, yeah, it was a valid point, but my position on that was we had only just rolled out the training some six or seven months prior to that, so the need for further training -- I took the position that what we needed to do is what we do with all training: we roll it out and then we monitor performance in terms of entries into the operational management performance database, and if we find evidence

that it's not working, and also in fatal fire reviews and in training exercises and in performance reviews of commands, if there is evidence coming through that despite that training it's still not working, then, yes, we would revisit it. But with the greatest respect to John or any other borough commander that makes that recommendation, we need to follow due process in terms of determining whether the training has worked or not.
MR KINNIER: Sir, it's 4.20.
SIR MARTIN MOORE-BICK: Yes.
MR KINNIER: The next matters I wish to turn to I won't get done in ten minutes. I'm mindful it's been a long day also for Mr Brown and it may be useful to start at a logical starting point first thing tomorrow morning.
SIR MARTIN MOORE-BICK: Well, I don't suppose Mr Brown will object to an early afternoon.
How are you getting on with his examination?
MR KINNIER: Timewise?
SIR MARTIN MOORE-BICK: Yes, just as a general indication. Can he hope to be free tomorrow?
MR KINNIER: Yes.
SIR MARTIN MOORE-BICK: Can he put his hopes high?
MR KINNIER: I would never wish to overestimate anyone's hopes in terms of time management here, but I'm confident that Mr Brown's examination will be complete

tomorrow.
SIR MARTIN MOORE-BICK: Yes. Well, that's very helpful, because I think he would like to know that.
Well, Mr Brown, it is slightly earlier than usual but I think we will stop at that point for the day. I will have to ask you to come back to continue tomorrow, but I think you were expecting that, but it sounds as though you can hope to finish tomorrow.
THE WITNESS: Thank you, sir.
SIR MARTIN MOORE-BICK: So thank you very much indeed. We will resume at 10 o'clock tomorrow, please, and as before, please don't talk to anyone about your evidence or anything relating to it while you're away. All right?
THE WITNESS: Thank you very much.
SIR MARTIN MOORE-BICK: Thank you very much indeed. Yes, if you could go with the usher, please.
(Pause)
Thank you very much, Mr Kinnier. Well, 10 o'clock tomorrow, then.
MR KINNIER: Thank you, sir.
SIR MARTIN MOORE-BICK: Thank you.
(4.21 pm)
(The hearing adjourned until 10 am on Thursday, 7 October 2021)

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