



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.

1

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?

2

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?

3

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.

4

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

5

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

6

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

7

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

8

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

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

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

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

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

9

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

3 Q. So ultimately responsible?

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

6 Q. Thank you.

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

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

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

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

10

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

3 Q. Thank you.

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

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

16 A. Yes.

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

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

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

24 A. That's correct.

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

11

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

8 A. Yes.

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

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

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

20 A. Yes.

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

23 A. That's correct.

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

12

1 A. Yes.  
 2 Q. And they include, if we see in the third row, action 2b,  
 3 which was the creation of an inspection regime targeted  
 4 at high-priority buildings; is that right?  
 5 A. Yes.  
 6 Q. The third workstream for which you were responsible was  
 7 post-inquest actions, and if we see in the fifth row of  
 8 this table action 2d, which was to set corporate targets  
 9 for 7(2)(d) activities; is that right?  
 10 A. Yes.  
 11 Q. Thank you.  
 12 Now, if we can go to page 22 in this statement  
 13 {LFB00032166/22}, paragraph 72, you say there, in  
 14 relation to action 2b, this:  
 15 "I was the lead for the introduction of LFB  
 16 Policy 800: Management of Operational Risk Information.  
 17 The policy sets out the way in which risk was assessed  
 18 and inspections prioritised."  
 19 Now, if we can just go briefly to that policy, which  
 20 can be found at {LFB00083849}. If we could amplify the  
 21 top third, we can see that the policy 800 deals with  
 22 management of operational risk information. It was  
 23 first issued in July 2012 and reviewed as current in  
 24 August 2015.  
 25 When did you start work as the lead in relation to

13

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

14

1 Q. Bearing in mind your responsibilities at this time,  
 2 bearing in mind that it was your firefighters who were  
 3 having to implement this, would you accept that you were  
 4 perhaps the best placed or most senior placed person  
 5 within the LFB in terms of knowledge, experience and  
 6 position to influence and implement the Brigade's  
 7 operational risk management strategy?  
 8 A. Certainly it's the case that if there were questions  
 9 about the operational risk strategy, then yes, I would  
 10 be the person that someone would primarily come to.  
 11 Q. Put differently, would the buck land with you?  
 12 A. Again, in terms of collection and application, yes.  
 13 Q. Now, can we turn on to the question of section 7(2)(d)  
 14 visits, and if we can go back to your first statement at  
 15 {LFB00032166/15}, and paragraphs 41 and 42.  
 16 Now, there, under the heading "Pre-Planning for  
 17 Residential High Rise Fires", you say this:  
 18 "41. Section 7(2)(d) of the Fire and Rescue  
 19 Services Act 2004 places an obligation on LFB to obtain,  
 20 store, and disseminate information for the purpose of  
 21 firefighting and protecting life and property. The way  
 22 in which the LFB discharged this duty was by conducting  
 23 visits to property ('7(2)(d) visits') and storing the  
 24 information collected on their operational risk database  
 25 (ORD).

15

1 "42. There was an incentive for firefighters to  
 2 complete 7(2)(d) visits and record accurate information  
 3 as ultimately it would enhance their safe working  
 4 practices."  
 5 Now, apart from complying with the statutory  
 6 obligation itself, in your view, or indeed the corporate  
 7 view of the LFB, was there any other purpose served by  
 8 7(2)(d) visits?  
 9 A. Familiarisation. Familiarisation with buildings,  
 10 familiarisation with station grounds, and then there was  
 11 the ripple effect, because the more familiar  
 12 station-based staff, ie firefighters, would become with  
 13 the station's ground, the better they would get to know  
 14 the community.  
 15 So the Inquiry I'm sure is aware of the fact that we  
 16 were massively moving into a prevention-based role.  
 17 We'd always carried out prevention work, but certainly  
 18 we were massively upping our game, inasmuch as trying to  
 19 reach out to the community, reach out to hard to reach  
 20 people in the community and try to prevent them having  
 21 fires.  
 22 Just one quick anecdote, we'd go to public meetings  
 23 and we'd say to the public, you know, "What do you want  
 24 from the fire service?", and they would say to us, "We  
 25 want a fire engine there as soon as we call it when

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

10 Q. Thank you.

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

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

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

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

17

1 a key component to obtaining that information.

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

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

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

11 A. Sure.

12 Q. Now, I think I'm right in saying that this version of  
13 800 is the version that was in force at the time you  
14 retired in March 2017.

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

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

21 A. I believe so.

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

18

1 A. Yes.

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

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

7 A. Yes, I believe so.

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

10 A. Yes.

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

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

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

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

24 Stage 3 is:

25 "Information gathering; a detailed examination of

19

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

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

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

9 And finally stage 5:

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

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

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

23 Q. Thank you.

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

20

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

21

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

22

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

23

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

24

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

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

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

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

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

25

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

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

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

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

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

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

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

26

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

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

20 Q. Thank you.

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

27

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

4 A. Yes.

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

7 A. No.

8 Q. Thank you.

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

13 A. Yes.

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

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

28



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

29

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

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1 Q. Please do.  
 2 A. — and I understand this has been an issue in Phase 1,  
 3 but the word "should" carries a lot of weight in London  
 4 Fire Brigade. We had lots of discussion on terminology  
 5 in terms of "should" versus "must", and where we say  
 6 "should", we use that word carefully and deliberately.  
 7 The reason is because we see "should" as being a word  
 8 that describes where practicable, whereas "must" is  
 9 there is no flexibility, you will do it. And we had  
 10 lots of — so every policy that gets promulgated to  
 11 staff has to go through union consultation and sometimes  
 12 negotiation. We were going through a period for quite  
 13 some time, actually, where relations with staff side  
 14 were not as good as we would have liked, and we had to  
 15 carefully tread through various terminology, and our  
 16 legal advice at the time was "must" means you will and  
 17 "should" means you may, and we used to have that  
 18 understanding with the Fire Brigades Union, and staff at  
 19 stations, as far as I'm concerned, understood the  
 20 difference between "should" and "must".  
 21 Q. I suppose your evidence is perhaps slightly more subtle  
 22 than former Commissioner Cotton's. What you're saying  
 23 is, depending upon the particular building, it may not  
 24 be realistic or reasonably practicable to do each of the  
 25 22 items set out in appendix 1.

31

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

32

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

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

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

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

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

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

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

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

16 A. No.

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

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

34

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

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

15 A. Yes.

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

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

35

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

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

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

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

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

36

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

12 Q. Thank you.

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

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

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

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

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

37

1 issues would be picked up by one or both of the  
2 alternative means that we have just been discussing?  
3 A. Yes.  
4 Q. Now, where the text uses words such as "such as sandwich  
5 panels", am I right in understanding that that was not  
6 intended to be an exhaustive list of construction  
7 features; they should just be on the lookout for  
8 particular features that may well have an impact on  
9 fire spread, evacuation and the rest of it?

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

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

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

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

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

38

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

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

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

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

15 Q. Of course.

16 (Pause)

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

18 Q. Of course, yes.

19 (Pause)

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

25 In terms of why cladding systems aren't specifically

39

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

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

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

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

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

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

40

1 saw Lakanal as a cladding fire, in the way that you  
 2 might determine Grenfell as a cladding fire, and there  
 3 was other fires, obviously, Shepherds Court, where there  
 4 was cladding, and fires where spandrel panels had caught  
 5 alight. So we were alive to the fact that they can add  
 6 to the fire, but not necessarily seeing them as issues  
 7 to put them in their own category as a cladding fire.  
 8 Q. If you didn't see Lakanal as a cladding fire — you  
 9 I mean corporately as the LFB — what did you see  
 10 Lakanal as being?  
 11 A. I'm not sure I could describe it in terms of  
 12 a particular pigeonhole-type explanation, but certainly  
 13 Lakanal — or the fire at Lakanal had some unusual  
 14 aspects to it, one of the main ones being that the fire  
 15 travelled downwards. So I wouldn't really determine it  
 16 in particular ways.  
 17 I'm not saying cladding's not involved in Lakanal,  
 18 clearly it was, but I think to call it a cladding fire  
 19 is — would be misrepresenting what Lakanal was.  
 20 Q. Bearing in mind that answer, can we just go to a letter  
 21 that former Commissioner Dobson wrote to Sir Ken Knight  
 22 when Sir Ken was the chief fire adviser, and that letter  
 23 can be found at {LFB00104291}.  
 24 Now, that letter is dated 14 December 2009 and, in  
 25 broad terms, it raised concerns about the use of

41

1 combustible cladding panels at Lakanal, and which  
 2 Commissioner Dobson indicated the LFB were concerned  
 3 might well be present on other high-rise properties.  
 4 Now, first of all, is that letter familiar to you?  
 5 Have you seen it before?  
 6 A. I have seen it before, yes. I wasn't involved, I don't  
 7 believe, in the construction of it, but yes, I'm aware  
 8 of it.  
 9 Q. Is the practical effect that notwithstanding that  
 10 Commissioner Dobson was moved to write to Sir Ken to  
 11 highlight the problem of cladding, particularly in the  
 12 context of high-rise buildings, nonetheless it wasn't  
 13 something, to use your phrase, that crossed your radar  
 14 as something that had to be emphasised to 7(2)(d) crew  
 15 visits?  
 16 A. Sorry, could you rephrase that question, please?  
 17 Q. Commissioner Dobson has seen fit to write to  
 18 Sir Ken Knight, in his capacity as chief fire adviser,  
 19 to highlight the problems posed by cladding,  
 20 particularly on high-rise buildings.  
 21 A. Mm—hm.  
 22 Q. Now, given that, is it still your position that the  
 23 risks posed by cladding on high-rise residential  
 24 buildings was not on "the radar" in terms of giving  
 25 advice to crews attending to visit high-rise buildings

42

1 for the purposes of section 7(2)(d)?  
 2 A. Okay, there's a couple of answers to that.  
 3 So I think it's, you know, quite right for  
 4 the commissioner to inform Sir Ken Knight of the issues  
 5 around cladding involved in Lakanal, because, as I've  
 6 said, there clearly were issues. It's the definition of  
 7 the fire in terms of how we describe it, I think, is  
 8 more what I would question.  
 9 Crews were aware of the issue of cladding as  
 10 a result of Lakanal. The Lakanal House presentation and  
 11 the training that we did to crews, and the specific  
 12 training over and above that that we did with borough  
 13 commanders, clearly exposed that issue. I think the  
 14 issue for crews in terms of being on their radar, it's  
 15 their ability to be able to determine whether, looking  
 16 at a building on a 7(2)(d) visit, it involves cladding  
 17 that may be an issue, because it goes outside of the  
 18 remit of their ability and training to be able to do  
 19 that.  
 20 Q. Can we look at the substance of this letter, and can we  
 21 start with the first paragraph, where Mr Dobson stated  
 22 this:  
 23 "I am writing to inform you that as part of our  
 24 investigation into the fire at Lakanal House ... we have  
 25 had tests carried out on the exterior wall panels of the

43

1 building and that those tests have given rise to  
 2 concerns which may well be relevant to other high rise  
 3 premises. Although our investigations are continuing  
 4 and the matter has still to come before the Coroner,  
 5 I feel that it is in the public interest to draw the  
 6 issue to your attention so that the matter can be  
 7 discussed within the Department and any necessary advice  
 8 can be given to owners and landlords of high rise  
 9 buildings."  
 10 Then if we can go to the third and fourth paragraphs  
 11 on that page, Mr Dobson sets out the functional  
 12 requirements of Approved Document B4, before he goes on  
 13 to say, over the page {LFB00104291/2} in the third,  
 14 fourth and fifth paragraphs, this:  
 15 "Based on the tests conducted by the Building  
 16 Research Establishment, it appears that there are  
 17 external wall panels at Lakanal House, that do not have  
 18 the necessary reaction to fire properties required for  
 19 the location in which they have been used.  
 20 "We have also become aware that this type of panel  
 21 has been supplied by more than one company.  
 22 "In the circumstances, we believe it may be  
 23 appropriate for a warning to be given to housing  
 24 providers that it would be advisable to check the  
 25 specification for external wall panels in their high

44

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

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

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

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

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

45

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

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

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

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

24 A. Not that I can recall.

25 Q. After the Lakanal House Inquests, which had established

46

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

5 A. Not that I can recall, no.

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

10 A. Not that I can remember, no.

11 Q. No.

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

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

47

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

3 Q. So the answer is yes?

4 A. Yes.

5 Q. Was there any system for monitoring the quality of  
6 7(2)(d) visits and the information they were collecting,  
7 ie were they collecting the information that they needed  
8 to in order to discharge the duty?

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

48

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

49

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

50

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

51

1 If we can see the second full paragraph on the  
 2 left-hand side, which says this:  
 3 "A review of the Operational Risk Database shows  
 4 that on average approximately 40 visits to residential  
 5 high rise premises, that were not yet recorded on the  
 6 Operational Risk Database, were completed each month  
 7 under the requirements of section 7(2)(d) of the Fire  
 8 and Rescue Services Act resulting in the production of  
 9 an electronic — Premises Information Plate for those  
 10 premises (Note: data between April 2014 and  
 11 October 2017). Using the same data set (i.e as of  
 12 October 2017) it was identified that approximately 1,700  
 13 residential high rise premises had a premises risk  
 14 assessment recorded against a total of approximately  
 15 6,900 residential high rise premises in London."  
 16 I'm mindful that those numbers — 1,700 and 6,900 —  
 17 relate to October 2017, ie after you retired, but are we  
 18 safe or reasonable in assuming that the figures would  
 19 have been broadly the same during your time at the LFB,  
 20 ie in terms of total number of high-rise properties in  
 21 London and those that had had PRAs conducted?  
 22 A. Well, the only thing I would say about that was  
 23 I remember in September 2013 a presentation which may  
 24 well — we may well discuss at some point, and in there  
 25 we highlighted there was 1,300 high-rises on the

52

1 operational risk database, and that was in  
 2 September 2013. So four years later, more or less, only  
 3 an extra 400 I find surprising, and mathematically  
 4 incorrect. If 40 visits per month were being  
 5 undertaken, then one of those figures is wrong  
 6 somewhere.  
 7 Q. Well, some of the data set postdates your retirement —  
 8 A. Yes.  
 9 Q. — so I think we have to bear that in mind, but if we  
 10 can take these figures at face value, they show or seem  
 11 to show that 1,700 high-rise premises were on the ORD —  
 12 A. Yeah.  
 13 Q. — and subject to scheduled section 7(2)(d) visits, it  
 14 would follow?  
 15 A. Yeah. I guess what I'm trying to say is I would have  
 16 expected there to have been more than 1,700, but taking  
 17 that at face value, yeah.  
 18 Q. It's unfair on you because you're not in a position to  
 19 verify the data, we have to take this as face value.  
 20 So we've got there 1,700 which would be on the ORD  
 21 and therefore subject to scheduled 7(2)(d) visits; is  
 22 that right?  
 23 A. Yes.  
 24 Q. And looking at the figures we've got here, that would  
 25 mean that 5,200 high-rise premises were not on the ORD

53

1 and so therefore not subject to scheduled 7(2)(d)  
 2 visits?  
 3 A. Based on these figures, yes.  
 4 Q. Now, would it have been a source of concern to you —  
 5 let's assume these figures were whilst you were still in  
 6 post — that more than 5,000 high-rise properties were  
 7 not on the ORD and were therefore not subject to  
 8 scheduled 7(2)(d) visits?  
 9 A. Absolutely, and it was a certain of mine when I was in  
 10 post, and it was one of my many things that we were  
 11 trying to improve. So there was clear instruction given  
 12 to station-based staff and borough commanders and  
 13 processes and procedures put in place that we could  
 14 increase that number.  
 15 My utopia was that every single high-rise premises  
 16 in London would have been visited and been risk  
 17 assessed. Whether it stayed on the operational risk  
 18 database after that visit was another issue, but we  
 19 needed to have carried out that visit and the premises  
 20 information plate been created and installed.  
 21 Q. Bearing in mind that answer, was the position,  
 22 therefore, there was a similar disparity during your  
 23 time as director of operations between the number of  
 24 high-rise buildings that were recorded on the ORD and  
 25 subject to 7(2)(d) and those which were not?

54

1 A. It's true that there wasn't every single high-rise on  
 2 the ORD, but it's also true that we were working really  
 3 hard to rectify that, and we was aware of the issue.  
 4 Q. I'm sorry to interrupt you, Mr Brown, but it's not just  
 5 that not every one was recorded; the fact here is we  
 6 have a disparity where 1,700 were, more than 5,000 were  
 7 not. Now, my question is: was that same proportion of  
 8 disparity the case when you were director of operations,  
 9 a similar order?  
 10 A. There was a large number of high-rise that weren't on  
 11 there. Without wanting to split hairs, I also want to  
 12 alert the Inquiry to the fact that we had a real  
 13 challenge, and it might seem strange, but in finding out  
 14 exactly how many high-rises there were in London, and we  
 15 did an awful lot of work in trying to actually determine  
 16 that, talking to the local authorities, housing  
 17 providers, and we could never get a complete straight  
 18 answer. So we was never entirely sure how far we were  
 19 way from achieving our objective.  
 20 But, yes, there was a significant amount that  
 21 weren't on there, but we were aware of that and trying  
 22 to rectify that.  
 23 MR KINNIER: Mr Brown, we will come on to that subject in  
 24 due course.  
 25 Sir, it's 11.15. Given where we're at in the

55

1 examination, that's a convenient time, subject to your  
 2 permission.  
 3 SIR MARTIN MOORE-BICK: Yes, all right. Well, then, that  
 4 sounds as though it's a good point at which to have  
 5 a break.  
 6 Well, Mr Brown, as you were told earlier, we have  
 7 a break part-way through the morning. We will take that  
 8 break now. We will resume, please, at 11.30.  
 9 I have to ask you on this and every other occasion  
 10 on which you leave the room, please don't talk to anyone  
 11 about your evidence or anything relating to it while  
 12 you're out. All right?  
 13 THE WITNESS: Okay, thank you.  
 14 SIR MARTIN MOORE-BICK: Thank you very much indeed. Would  
 15 you go with the usher, then, please.  
 16 (Pause)  
 17 Thank you. 11.30, then, please.  
 18 MR KINNIER: Thank you.  
 19 (11.16 am)  
 20 (A short break)  
 21 (11.30 am)  
 22 SIR MARTIN MOORE-BICK: Right, Mr Brown, ready to carry on?  
 23 THE WITNESS: Thank you, yes.  
 24 SIR MARTIN MOORE-BICK: Good, thank you very much.  
 25 Yes, Mr Kinnier.

56

1 MR KINNIER: Thank you, sir.  
 2 Mr Brown, can we turn now to your email to LFB  
 3 stations sent on 20 April 2009. It was sent on your  
 4 behalf, and you deal with this email in page 15 of your  
 5 first witness statement, {LFB00032166/15}. We see at  
 6 paragraph 43 you cite this email as being an example,  
 7 and following on from your earlier evidence, of the  
 8 importance the LFB placed on pre-planning for  
 9 residential high-rise fires.  
 10 Now, if we go to the email itself, which can be  
 11 found at {LFB00032161}, we see at the bottom of page 1  
 12 the email says at its head:  
 13 "This message is from AC Brown (Service Delivery &  
 14 Mobilising) and is for all Station based  
 15 Station Managers and Borough Commanders."  
 16 It deals with section 7(2)(d) visits at the top of  
 17 page 2 {LFB00032161/2}, and it says this:  
 18 "A database of high rise premises (see attached) has  
 19 been compiled that falls within the criteria set out by  
 20 AC Webb (Ops Planning) in April 2007 [so roughly  
 21 two years before], which defined a High Rise as  
 22 a domestic residential premises which is fitted with a)  
 23 firefighting lift and b) dry or wet rising main. As  
 24 part of the ongoing familiarisation training for station  
 25 based staff, station managers are to ensure that watch

57

1 and crew managers diarise, book and visit the high rise  
 2 premises on their station's ground during 2009/10. This  
 3 process should begin with immediate effect and then be  
 4 undertaken annually thereafter. Borough Commanders  
 5 should liaise with their DAC to discuss prioritisation  
 6 of these visits."  
 7 First of all, do you remember that email?  
 8 A. I do, yes.  
 9 Q. Now, at first blush, your instruction appears to be  
 10 a direction to visit all high-rise premises on  
 11 a station's ground annually. Is that a fair reading of  
 12 what you intended?  
 13 A. Can I just read it again?  
 14 Q. Of course.  
 15 (Pause)  
 16 A. So there was a database that Jon Webb, ops planning, had  
 17 prepared, and we wanted staff to look at that. So  
 18 whether I mean by that all the high-rise that was on  
 19 that list prepared by Jon Webb or whether I mean going  
 20 above and beyond that in terms of all high-rise, I'm not  
 21 quite sure. But ultimately, yes, I would have expected  
 22 all high-rise to be visited and, yes, at that point it  
 23 would have been annually.  
 24 Q. Looking at really what you say in that paragraph at the  
 25 top of page 2, you say:

58

1 "... station managers are to ensure that watch and  
 2 crew managers diarise ... the high rise premises on  
 3 their station's ground ..."  
 4 Now, that suggests all high-rises on a particular  
 5 station's ground; would you accept that?  
 6 A. Sorry, where is that exactly?  
 7 Q. Top paragraph.  
 8 A. Yeah.  
 9 Q. Third line.  
 10 A. Ah, yes. Yeah, absolutely. But, as I say, whether it  
 11 referred initially to high-rise that was on Jon Webb's  
 12 email and on their station's ground or not, I can't  
 13 quite recall. But I would accept that ultimately, yes,  
 14 we expected that all high-rises on their station's  
 15 ground would be diarised and visited annually.  
 16 Q. Can you help us, what was the reasoned basis for the  
 17 annual requirement for crews to visit all high-rise  
 18 premises on the station ground?  
 19 A. I think probably at that time we wasn't quite sighted on  
 20 the number of high-rises that were available, and we  
 21 felt that that would be an appropriate and not  
 22 an unreasonable expectation. That was back in 2009.  
 23 I think once the enormity of the task become more  
 24 apparent, then we took more of a risk-based approach as  
 25 we saw with the premises risk assessment.

59

1 Q. Before you sent the email in April 2009, did you  
 2 consider or take advice about whether it was reasonably  
 3 practicable for all high-rise buildings on a station's  
 4 ground to be visited annually?  
 5 A. I don't believe so.  
 6 Q. So really the underlying intent was a scoping exercise  
 7 to identify high-rises and then take it from there; is  
 8 that a fair summary?  
 9 A. That isn't a way I would have considered describing it,  
 10 but yes, that's not an unreasonable way to describe it.  
 11 Q. When you sent this email, was there a plan to monitor  
 12 how the aim of annual inspections was to be achieved?  
 13 A. Well, yes, but that plan would have been what I would  
 14 describe as normal business. So we were forever  
 15 monitoring, performance managing, overseeing progress in  
 16 terms of making sure that what we wanted to happen was  
 17 happening, and then fitting in other objectives as well.  
 18 Q. Can we look at the database that was referred to in your  
 19 email. That can be found at {LFB00104535}. This  
 20 document will need to be downloaded, so there may well  
 21 be a bit of a delay.  
 22 (Pause)  
 23 There we go, thank you.  
 24 Do you remember providing or reviewing this document  
 25 before it was attached to the email that was sent in

60



1 your name?

2 A. Well, I don't remember doing it, and, to be honest,

3 I don't think I did. This was prepared by ops planning

4 and I've taken this on face value that it was properly

5 checked, and I've attached it there as guidance to

6 station-based staff in terms of — in case they weren't

7 aware of some of the premises.

8 Q. Can you help us as to where the list of properties came

9 from?

10 A. I'm afraid I can't. I've thought about that in

11 readiness for this Inquiry, and it was prepared in very

12 early tenure of mine by a colleague in ops planning, and

13 I don't know where they got that information from, I'm

14 afraid.

15 Q. So you don't know what criteria they applied in

16 determining —

17 A. Well, I can only imagine it was the criteria that I put

18 in that email, in terms of dry riser, et cetera. But

19 other than that, I don't know.

20 Q. But that's an assumption?

21 A. It is an assumption, yes.

22 Q. Can you remember, how was the database to be managed if

23 this was the database?

24 A. Well, it was on the central risk register, which was the

25 forerunner of the operational risk database. So the

61

1 idea, for want of a better term, was to cleanse the

2 central risk register, and the premises on here would

3 find their way onto the central risk register or the

4 operational risk database, whatever was in process at

5 the time.

6 Q. So who would be ultimately responsible for managing this

7 database?

8 A. This actual database I'm looking at now?

9 Q. Yes.

10 A. Well, once it got on to the operational risk database,

11 it would be information management.

12 Q. Thank you.

13 Now, can we look at the draft amendments to the

14 high-rise policy 633 that were circulated in 2010, and

15 for that purpose can we go to an email sent by

16 Peter Cowup, which can be found at {LFB00082695}.

17 As you can see from the top of this, Mr Cowup

18 emailed James Knighton in relation to a draft version of

19 633. You were not included on the email chain,

20 Mr Brown, I should make clear. His email is set out

21 there, and I would like to start at the fourth

22 paragraph, where Mr Cowup said this:

23 "Although I believe the current draft represents

24 a significant step forward, there remain a number of key

25 issues and points that I believe require further work

62

1 and consideration. These include ..."

2 If we go to the second bullet point:

3 "The feasibility of station personnel visiting all

4 high premises on their stations ground, as this is

5 a very significant task, especially for central London

6 stations. I fully understand why we would state that in

7 Policy, but it may be worth giving this statement

8 further consideration — I have left it in for now!"

9 Now, that second bullet point appears to be

10 a reference to paragraph 3.1 of the draft policy 633

11 which was attached to this email, and we can see that

12 draft at {LFB00039485/4}. What that says in the second

13 sentence is this:

14 "Station personnel should be familiar with all high

15 rise buildings on their ground."

16 Now, Mr Cowup appears to have interpreted policy as

17 requiring stations to visit all high-rise premises. Was

18 that how paragraph 3.1 was being interpreted generally

19 across the LFB at the time, or is it a policy

20 aspiration?

21 A. I think it's both, really, but personally I was always

22 of the view, and I made it absolutely clear, I cannot

23 see from a moral or professional perspective that we

24 could exclude any high-rise. So if any building needs

25 inspecting, then we should inspect it. Whether it led

63

1 to further ongoing inspections is another issue, but for

2 me, my position was that, over a period of time, every

3 single high-rise should be visited.

4 Q. Were you aware at the time that Mr Cowup had

5 reservations about the practicability of visiting all

6 high-rise buildings on a particular station's patch?

7 A. I wasn't, no.

8 Q. Had anyone else raised that concern with you at the

9 time, or indeed afterwards?

10 A. I don't recall anyone raising the issue with me prior

11 to. In terms of afterwards, there was extensive

12 pressure that I applied to my own staff to achieve this

13 objective, and, yes, I then did get feedback, from

14 a range of sources, how challenging this was. And

15 I accepted, and I accept now, it is challenging, but for

16 me that's not a reason not to do it.

17 Q. Were you asked to contribute to this particular review

18 of 633?

19 A. Personally, no, but it would have been standard practice

20 that heads of service would have been involved. If

21 I had have received an email on it, I invariably would

22 have passed it on to people that worked for me, most

23 probably central service delivery as they were called at

24 the time, and they would have commented on it on my

25 behalf.

64

1 Q. You don't remember expressing your own views personally  
2 about the practicability of annual visits?  
3 A. Not at this time, no.  
4 Q. Now, in 2015 —  
5 A. Sorry, if I can just clarify there. So the annual  
6 visits issue, no. The concept of all high-rise being  
7 visited per se is — they're two separate things.  
8 Q. You've made that clear.  
9 A. Yeah.  
10 Q. Thank you.  
11 Now, in 2015, policy 633 was again updated and the  
12 new version published on 1 June 2015, and that can be  
13 found at {LFB00001256}.  
14 If we can go to page 7 {LFB00001256/7} and  
15 section 4, you can take it from me that paragraph 3.1 of  
16 the previous draft which required station personnel to  
17 be familiar with all high-rise buildings on their ground  
18 had gone.  
19 Now, were you consulted about that particular  
20 change?  
21 A. Not that I can recall.  
22 Q. No. Again, can you remember whether you were involved  
23 or consulted as part of the revision process for this  
24 particular iteration of 633, and by you I mean you  
25 personally?

65

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

66

1 under the heading "High rise firefighting", and it  
2 addresses the issue of pre-planning.  
3 Now, the operations directorate co-ordination board,  
4 I think you were a member, were you; is that right?  
5 A. That's correct.  
6 Q. They were responsible for articles published in  
7 Operational News; is that right?  
8 A. That's right, yes.  
9 Q. Who within ODCB was responsible for the content of  
10 articles published?  
11 A. It depended on who was the subject matter expert. So  
12 dependent on that particular subject, we would look at  
13 the section within the department that concentrated on  
14 that area, and they would have been the author, original  
15 author, of each aspect. So this particular article  
16 probably would have come from somewhere within ops  
17 policy or ops assurance.  
18 Q. Can we take it from that that you weren't involved at  
19 all in the drafting of this article?  
20 A. No.  
21 Q. Would you have been consulted about the contents of the  
22 article?  
23 A. Once the article was written, it would then be  
24 circulated to various people, which may or may not have  
25 included me, dependent on when it was. Certainly when

67

1 I was a director of operations, so after April 2015, it  
2 would have done, prior to that possibly not.  
3 Q. Is it right that the content of articles is a matter  
4 that would have been discussed at ODCB, and so they were  
5 the ones who agreed content, and so you would have been  
6 aware, at least from ODCB meetings, that this article  
7 was being published?  
8 A. Well, at ODCB meetings we would have determined the need  
9 for an article and an associated training package, but  
10 then after that point, when the article was written, it  
11 wouldn't then come back to ODCB for approval. It would  
12 be the fact that it was being written, and the  
13 parameters in which it needed to be written.  
14 Communications team had a big part to play in terms of  
15 presentation, and fitting in within a certain size of  
16 the document, but it didn't come back in a loop for  
17 final approval to ODCB before we published.  
18 Q. But you were aware in broad terms of the topic that was  
19 going to be —  
20 A. Oh, absolutely, yes.  
21 Q. Now, if we can look at the article itself. Stay on this  
22 page and look at the middle column underneath the photo,  
23 where it says this:  
24 "Any visit to a high rise building should be used as  
25 an opportunity to pre-plan; this will include the

68

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

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

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

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

17 Q. Yes, it's November 2011.

18 A. Okay.

19 I think there's a subtle difference here. I don't  
20 think it is a departure. I think the 2009 email was  
21 about making sure that every premises had been visited  
22 to determine whether it needed to be included on future  
23 7(2)(d) visits. What this is saying is any high-rise  
24 buildings which — and I would add: having been  
25 initially inspected — pose a particular risk should be

69

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

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

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

8 A. No, absolutely not.

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

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

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

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

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

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

25 Q. Thank you.

70

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

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

7 Now, I think as we touched on earlier, you were the  
8 lead senior officer in relation to the introduction of  
9 800, though particularly in relation to action 2b.

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

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

18 A. Yes, that's right, yes.

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

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

71

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

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

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

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

12 A. No.

13 Q. Thank you.

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

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

72

1 information, and that they just did what they needed to  
 2 do. So I can only imagine that there was — to avoid  
 3 duplicating lists, just a mere reference from one policy  
 4 to another was sufficient.  
 5 Q. Following on from that, though, there is no reference in  
 6 the 2012 iteration of policy 800 to the guidance in  
 7 appendix 1 of policy 633. How were crews therefore to  
 8 know whether to cross—refer to appendix 1 of 633 in the  
 9 absence of any specific reference?  
 10 A. Well, if there wasn't a reference then that's clearly  
 11 an omission, and that's something that hopefully has  
 12 been remedied now. All I would say is that policy  
 13 note 800 and policy note 633 to do with  
 14 information—gathering and high—rise firefighting were  
 15 such a component part of a firefighter's role that they  
 16 would be aware of both. But in saying that it is — if  
 17 it is the case that there isn't any reference at all,  
 18 then that's certainly something that was — that  
 19 shouldn't have been the case.  
 20 Q. Would you accept — and I'm putting this to you  
 21 simplistically — that because there was an absence of  
 22 a cross—reference in the policy, there was at least  
 23 a risk of crews missing or not being directed to  
 24 securing relevant information as part of section 7(2)(d)  
 25 visits?

73

1 A. I can see why you would say that, but all I would say is  
 2 high—rise firefighting was — has always been high on  
 3 the agenda of firefighters, so I cannot imagine that  
 4 they wouldn't be aware of what they needed to do under  
 5 policy note 633.  
 6 Q. Would it be fair to say that the risk of information not  
 7 being caught was not identified at the time that 800 was  
 8 issued in July 2012?  
 9 A. Yes, that's not an unreasonable way to describe it.  
 10 Q. Can I now turn to a separate and distinct topic which  
 11 concerned the incident at Salamanca Place in July 2011.  
 12 Now, Salamanca Place was a high—rise building in  
 13 Lambeth, wasn't it, or is?  
 14 A. Yes.  
 15 Q. If we can look at the senior accident investigation  
 16 report in relation to that incident, which is at  
 17 {LFB00102299}.  
 18 Now, we are proceeding on the basis that, although  
 19 this is watermarked "Draft", it is in fact the final  
 20 version, and that basis, so people know what it is, is  
 21 paragraph 55, footnote 4 of Mr Cowup's third statement,  
 22 which can be found at {LFB00119849/28}.  
 23 First question, Mr Brown, is: do you remember the  
 24 Salamanca Place incident?  
 25 A. I don't remember it well, but yes, I do recall it.

74

1 Q. In summary, a crew attended a fire incident on  
 2 15 July 2011. During the incident, four firefighters  
 3 became trapped in a lift, exposed to heat and smoke,  
 4 before being rescued by colleagues. Are those the  
 5 pertinent details?  
 6 A. Yes.  
 7 Q. In summary, this report was the culmination of the SAI  
 8 process, which involved the investigation of safety  
 9 events; is that right?  
 10 A. Yes.  
 11 Q. SAI stands for senior accident investigation.  
 12 A. Yes.  
 13 Q. And its purpose is to examine by senior and specially  
 14 trained LFB personnel to identify any underlying  
 15 systemic failures that might have led to a safety event  
 16 occurring during an incident.  
 17 A. Yes, and to aid organisational learning to prevent it  
 18 reoccurring.  
 19 Q. Thank you.  
 20 Now, is it correct that such an investigation  
 21 concludes, or should at least conclude, with an action  
 22 plan which sets out the measures that the Brigade  
 23 intends to take to address any deficiencies identified?  
 24 A. That would be normal practice, yes.  
 25 Q. During your time at the LFB, SAI action plans were

75

1 monitored by the operational directorate's co—ordination  
 2 board; is that correct?  
 3 A. Yes, and we had a rolling log of various actions under  
 4 SAls and we would add new ones to it to make sure  
 5 nothing was lost.  
 6 Q. Now, the SAI report for Salamanca Place is on the  
 7 screen. If we could turn to page 7 {LFB00102299/7},  
 8 there you see, roughly the top third of the page, the  
 9 heading "Pre—planning", and what it says from the end of  
 10 the second line is this:  
 11 "The building was not on the Brigade's central  
 12 database for high rise buildings and a Fire and Rescue  
 13 Services Act 2004 section 7(2)(d) visit had not been  
 14 carried out by the watch involved."  
 15 Now, the report then goes on to set out relevant  
 16 pre—planning policy provisions, including 633 and 521,  
 17 and if we turn over the page to page 8 {LFB00102299/8},  
 18 we can see the text in italics is your email of  
 19 April 2009 to station staff about the database of  
 20 high—rise premises and the need to carry out annual  
 21 visits to high—rise buildings on a particular station's  
 22 ground.  
 23 If we can go to the middle of page 9  
 24 {LFB00102299/9}, so over the page, we can see there the  
 25 heading "Pre—planning analysis", and that states this —

76

1 and if we could expand it in such a way that notes GR3  
 2 and GR4 can be seen by Mr Brown and the panel,  
 3 thank you:  
 4 "There is evidence that the crew at Lambeth were  
 5 aware of the premises and that there may be access  
 6 difficulties. The opportunity was not taken for  
 7 a 7(2)(d) visit to be arranged.  
 8 "There was a failure to carry out a 7(2)(d) visit.  
 9 "High rise database:  
 10 "It is unclear how the high rise database is  
 11 maintained or updated for new high rise buildings.  
 12 "There is no clear mechanism for fire stations to be  
 13 informed of new high rise buildings which require  
 14 section 7(2)(d) visits."  
 15 Now, I have assumed that the reference there to  
 16 high-rise database is to the database that was set out  
 17 in the Excel spreadsheet that was attached to your  
 18 April 2009 email. Is that a safe assumption to make?  
 19 A. Either that or they're referring to the electronic  
 20 database, either the central risk register or the  
 21 operational risk database.  
 22 Q. Thank you.  
 23 Now, we can see the comments on the side, "GR". Is  
 24 GR Gary Reason?  
 25 A. I would imagine so.

77

1 Q. And what he says in GR4 is this:  
 2 "It would be helpful to have a footnote explaining  
 3 how stations access this database (if they can?)."   
 4 Now, that comment requesting clarification as to  
 5 whether stations are able to use the database is  
 6 unlikely to refer to the ORD, isn't it, given that the  
 7 ORD was capable of regular and easy access?  
 8 A. Yes, I think by this time, I think the ORD probably had  
 9 formally taken over from the central risk register, so  
 10 yes, it would seem reasonable that it's referring to  
 11 that at that moment, yes, yeah.  
 12 Q. Sorry, just to clarify your answer, what I was  
 13 suggesting to you was that the database that is the  
 14 subject of the text here is unlikely to be the ORD, is  
 15 what I put to you. I just want to make sure you agree  
 16 with that proposition.  
 17 A. Oh, I see. I'm not sure we can say that, to be honest.  
 18 I mean, first of all, there is — to my knowledge, there  
 19 was no such thing as a high-rise database as such,  
 20 they're referring to a database that contains high-rise,  
 21 and the ORD — and Gary was well aware of the existence  
 22 of the ORD at that time.  
 23 Q. And it's for that reason, Mr Brown, I suggest to you  
 24 it's not the ORD he's referring to, and the other factor  
 25 that he appears to have in mind, or the author of this

78

1 report appears to have in mind, is the Excel spreadsheet  
 2 that was attached to your April 2009 email, because  
 3 that's what has been quoted extensively on the preceding  
 4 page.  
 5 A. I'm not sure we can draw the conclusion — so if we're  
 6 looking at comment GR4, ie "It would be helpful to have  
 7 a footnote explaining how stations access this  
 8 database", I don't think we can necessarily draw the  
 9 conclusion that Gary's not referring to the ORD. It may  
 10 well be he's just trying to have an explanation that  
 11 just makes it helpful for the reader.  
 12 Q. Okay.  
 13 Now, if we can just look at these comments in more  
 14 detail, the first one, GR3, said this:  
 15 "... as the building is adjacent to the fire station  
 16 did it not occur to any of the watches that it should be  
 17 subject to a 7(2)d visit? Irrespective of whether it  
 18 appeared on the database."  
 19 Now, that comment suggests that the crews were not  
 20 expected to use the database as a comprehensive list of  
 21 premises they were required to visit. Would you agree  
 22 with that? That assumes, of course, that the database  
 23 is the Excel spreadsheet which was attached to your 2009  
 24 email.  
 25 A. I think the crews or certainly managers, station

79

1 managers, borough commanders — and I'm sorry to repeat  
 2 the comment again, but I think it's worthy of just — of  
 3 clarifying how much — how important an issue it was for  
 4 us — were aware that all buildings need to be — have  
 5 an initial inspection to determine their future  
 6 inspection regime. So whether it's on the database or  
 7 not, I wouldn't expect crews or managers to be led  
 8 exclusively by the database, because people should have  
 9 known that not everything was on that database.  
 10 Q. And there may be cause for concern about the quality  
 11 assurance process taking place if the crews had not  
 12 identified a high-rise building immediately adjacent to  
 13 the fire station.  
 14 A. Well, the quality assurance process that we've spoken  
 15 about was assuring the quality of the information that's  
 16 gone on the operational risk database once it's been  
 17 inspected. The proposition here is about buildings that  
 18 have never even received that initial inspection in  
 19 terms of even carrying out that quality assurance. So  
 20 that boils down basically to station managers and  
 21 borough commanders making sure that all buildings have  
 22 had that initial inspection, which is a slightly  
 23 different nuance to quality assurance.  
 24 Q. Now, the report on Salamanca Place led to the creation  
 25 of an action plan entitled "SAI 282 Salamanca Place".

80

1 That can be found at {LFB0095042}. That plan was dated  
 2 22 August 2012, so more than a year after the incident.  
 3 I would like to focus on two particular actions.  
 4 The first one is action 2, which can be seen in the  
 5 second row in the table, and it provided thus:  
 6 "Carry out a review of the existing high rise  
 7 database to determine whether it is viable and  
 8 beneficial to develop and maintain this data set.  
 9 "The term 'beneficial' relates to station staff  
 10 being able to access this type of information to  
 11 highlight new high rise premises and inform 7(2)(d)  
 12 visits."  
 13 Now, that action was allocated to the head of  
 14 information management; is that right?  
 15 A. Yes.  
 16 Q. And the third officer, which was at that time you?  
 17 A. Yes.  
 18 Q. And the head of information management at this time was  
 19 David Wyatt; is that right?  
 20 A. Yes, and still is, I believe.  
 21 Q. Now, does that help you identify what the database was  
 22 that these people were referring to? Do you think it  
 23 was the Excel spreadsheet attached to your email or was  
 24 it the ORD?  
 25 A. I think it must be the ORD, because head of information

81

1 management was managing the contents of the ORD.  
 2 Q. Was the review carried out?  
 3 A. To my knowledge, yes.  
 4 Q. By whom?  
 5 A. I don't know for sure, but certainly I would have made  
 6 sure — it would have been — it would almost certainly  
 7 have been David Wyatt, and then maybe some people that  
 8 worked for me. But I can't recall any further details,  
 9 I'm afraid.  
 10 Q. Can you remember when it was carried out?  
 11 A. I don't remember particularly when, but all I can say is  
 12 on all of these, whenever dates were given to carry out  
 13 actions, I was very ... I gave a lot of scrutiny, shall  
 14 we say, to making sure actions were carried out when  
 15 they were supposed to be carried out. So if there was  
 16 a completion date on it, I'd be confident that it would  
 17 have been done within that time, but I can't remember  
 18 any further than that, I'm afraid.  
 19 Q. There is no completion date identified there. So, in  
 20 the circumstances, what steps would you have taken to  
 21 ensure the review was actually carried out?  
 22 A. Well, it was an ongoing transfer. So the wider picture  
 23 is the CRR, the central risk register, was being carried  
 24 over on to the operational risk database. The list of  
 25 high-rise premises that Jon Webb had collated was

82

1 another area that was feeding into the operational risk  
 2 database. So it was a process, an ongoing process, that  
 3 was going on to make sure (a) everything was finding its  
 4 way onto the new portal, if you like, you know, the  
 5 complete database, ie the ORD, and that we continued in  
 6 making sure new premises, regardless of whether it had  
 7 been on the list or not before, found its way on there.  
 8 Q. Can you remember the substance of the conclusion of the  
 9 review? Don't speculate if you can't.  
 10 A. No, I can't remember specifically.  
 11 Q. Okay.  
 12 Now, can we go on to an email chain that was  
 13 pertinent to this action, and it can be found at  
 14 {LFB00095342}. It's an email chain initiated by  
 15 David Wyatt on 22 August 2012.  
 16 If we can turn to the bottom of page 2  
 17 {LFB00095342/2}, we see an email that Mr Wyatt sent at  
 18 9.11 on 22 August, in respect of SAI 282, so that's  
 19 Salamanca Place, draft action plan, and he said this:  
 20 "So, the action in this plan for me (with  
 21 Dave Brown) is ... the database is, of course, ORD ...  
 22 I am assuming ... but will clarify ..."  
 23 Now, if we go back to page 2, we get an email from  
 24 Anna Lockwood, and if we could go up the page so we can  
 25 see that email. That was sent at 9.50, and she said

83

1 this:  
 2 "I have had a conversation with Andy O'Loughlin  
 3 about this a few months ago. He was under the  
 4 impression that PDA Section maintained a database of all  
 5 high rise residential flats. I informed him that this  
 6 was not the case. Some entries have been made in ORD  
 7 but not all. We can extract all the properties from the  
 8 mobilising system, but this does take some time."  
 9 If we go to page 1 {LFB00095342/1} and  
 10 Clive Eustice's email, which is at the top of the page,  
 11 he says this:  
 12 "I don't think it is ORD but do think it is a very  
 13 confused message in the first place.  
 14 "The 'High Rise Database' they refer to is, I am  
 15 sure, the list sent round to [stations] some months  
 16 (years) ago and I have no idea who owned this but can  
 17 pretty much guarantee it was never updated and is  
 18 therefore of no/very limited value.  
 19 "This was the 'knee jerk' list where the message  
 20 said visit every high rise and consider 7(2)(d) but what  
 21 Dave meant was add one of the blocks in an estate if  
 22 there are unusual or very difficult circumstances to be  
 23 found there ..... he couldn't say this in an email of  
 24 course and we ([information management]) therefore had  
 25 to make sure people understood it at [information

84

1 management] Days."

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

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

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

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

85

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

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

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

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

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

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

24 A. Sorry, can you repeat that?

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

86

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

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

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

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

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

15 A. Yes.

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

18 A. No.

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

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

87

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

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

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

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

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

22 Q. Okay.

23 Mr Eustice says in that email, and we can see there:  
24 "... the message said visit every high rise ... but  
25 what Dave meant was ..."

88

1 And he sets out there what he understood you to be  
 2 saying.  
 3 Now, is Mr Eustice correctly summarising your true  
 4 concern in that email?  
 5 A. No.  
 6 Q. From where could he have got that impression, do you  
 7 think?  
 8 A. I don't know. I think that's something that only Clive  
 9 would know himself. But it was common knowledge that  
 10 there were certain housing estates where there might —  
 11 and I can think of one in particular in east London  
 12 where there are 12 high-rise blocks and they're all  
 13 absolutely identical to each other.  
 14 Q. What were IM days?  
 15 A. Oh, IM days were something that Clive Eustice and his  
 16 team would run, and we would invite borough commanders  
 17 and station managers up to headquarters, and then Clive  
 18 and his team would go through with them all the various  
 19 technological support systems — ORD for one,  
 20 for example, station diary, outside master duties  
 21 list — that station managers and borough commanders can  
 22 use to make their role a lot easier and more efficient.  
 23 Q. What guidance was given to the information management  
 24 department to allow audience members at these IM days to  
 25 know what constituted unusual or very difficult

89

1 circumstances?  
 2 A. I don't believe these days would have covered that kind  
 3 of area, because that wouldn't have been the remit of  
 4 what an IM day was. An IM day was to know how to use  
 5 the information management systems that were in place.  
 6 Q. Now, can we look at the fourth and fifth paragraphs of  
 7 Mr Eustice's email. He starts with this:  
 8 "It has been a constant battle, with some SMs  
 9 [presumably station managers] insisting they have been  
 10 told to add all 200 odd high rises they have as visits  
 11 in the SD OSD Master List ..."  
 12 Station diary? Outside schedule diary, is that OSD?  
 13 A. I think it's outside duty master list, I'm not sure what  
 14 the S is for.  
 15 Q. "... which adds them to ORD of course ...) It is now  
 16 back again, but has exactly the same issue .....  
 17 people cannot add all high rise blocks on their ground  
 18 to MDT via ORD as they would have no time to visit them  
 19 all and it would be of very little value anyway... The  
 20 ones that are dodgy — upside down maisonettes, DR [dry  
 21 riser] outlets only on alternate floors etc should  
 22 already be on!  
 23 "If we had a complete list we could add as an  
 24 overlay of course ..... but this is valueless apart from  
 25 ticking a box unless the data held specific things .....

90

1 saying there is a large/high building here on MDT is  
 2 pretty pointless when they are outside it and can see  
 3 that etc!"  
 4 Now, where Mr Eustice says there has been a constant  
 5 battle, were you aware of a constant battle, or at very  
 6 least concerns raised by station managers as to the  
 7 practicability of adding all high-rise buildings?  
 8 A. I wasn't aware of issues from station managers at that  
 9 time. I think as I said earlier, once we put our  
 10 systems in place to make sure that every high-rise and  
 11 every building was visited, then we did get some  
 12 push-back, feedback, in terms of at least, you know: how  
 13 are we going to achieve that?  
 14 I have a vague recollection of Clive being concerned  
 15 in the issues that he's raising, but then he was coming  
 16 at it, understandably, from the point of view of  
 17 managing the database, and then the quality assurance  
 18 issues that go on there, and I understand his position,  
 19 but my position was, and for what it's worth still is,  
 20 that every single building should be visited, because  
 21 just because — and I use that example of this housing  
 22 estate in east London, there are 12 high-rises that are  
 23 identical; the people that live in them aren't identical  
 24 and the risks therefore are not identical, and you could  
 25 have a hoarder in one of those 12 and you could have

91

1 a different risk in another, so you need to visit every  
 2 single one. And once you've done that — if, having  
 3 done that, you can then determine that they remain  
 4 identical, then maybe we can move to the position that  
 5 Clive is talking about, but up until that time, my  
 6 position was firefighter safety, it was extinguishing  
 7 fires, gathering information, and you can't make  
 8 assumptions on that regard.  
 9 Q. You said you were vaguely aware of the concerns that  
 10 prompted Mr Eustice's email. Were you concerned as  
 11 a result of those matters which were exercising him that  
 12 crews might be taking inconsistent approaches to which  
 13 high-rise buildings to visit, et cetera?  
 14 A. Yes. Clive, understandably, a professional officer,  
 15 likes things done properly and was very protective of  
 16 this new database, operational risk database, and he  
 17 wanted it to be a clean and efficient and effective  
 18 database, which is what I wanted too. And I had a lot  
 19 to do with Clive, and so therefore in the margins of  
 20 normal meetings, yes, I would be aware of Clive's views  
 21 on this.  
 22 Q. As we discussed earlier on, we are sort of three-plus  
 23 years on from your April 2009 email and the position may  
 24 not have materially improved.  
 25 Did Mr Eustice communicate his concerns to you more

92



1 directly at this time and, if so, what action did you  
 2 take to try and expedite the improvement of how you held  
 3 knowledge in relation to high-rise buildings?  
 4 A. From what I can recall, Clive's concern was that we were  
 5 putting too much information on the ORD, whereas my  
 6 concern is that I wanted to make sure everything was  
 7 inspected and the appropriate information went on the  
 8 ORD. But I think where we both agreed is that the  
 9 premises risk assessment would be that appropriate  
 10 system to satisfy both of our concerns.  
 11 Q. Now, let's focus on that, and looking at the  
 12 practicability of it.  
 13 Mr Eustice said people cannot add all high-rise  
 14 blocks in their ground to an MDT as they would have no  
 15 time to visit them all and it would be of very little  
 16 value anyway.  
 17 Would you agree with the first element of that  
 18 proposition, that crews did not have time to visit all  
 19 high-rise blocks in their station's ground?  
 20 A. Well, first, it depends on the station's ground. Some  
 21 stations' grounds have significantly more high-rise than  
 22 others, and if you was to look exclusively at the crews  
 23 on some stations' ground — let's take, for example, in  
 24 Tower Hamlets, there is a predominance of high-rise. If  
 25 you was to say to the crews in Tower Hamlets, "It's your

93

1 job to visit all those high-rises and your job alone",  
 2 then, yes, it would be a very challenging task, but that  
 3 wasn't the approach that we took.  
 4 Q. I suppose the more pertinent criticism is the second one  
 5 here, that he said it would be of little value anyway.  
 6 I think it would benefit the panel to have your views on  
 7 that particular criticism he made.  
 8 Do you accept that that exercise would have been of  
 9 very little value?  
 10 A. No, I don't, because I think what Clive is referring to  
 11 is on the assumption that nothing changes and that all  
 12 high-rises within that particular area or estate are the  
 13 same. But we can't make that assumption. It would be  
 14 dangerous to make that assumption.  
 15 Q. Is there a problem that, thinking about matters  
 16 practically, if you do require crews to visit all  
 17 high-rise buildings — and I'm mindful of your sensible  
 18 caveat that it depends how many there are, et cetera —  
 19 there is an element whereby they go round them in order  
 20 to tick that particular box, but actually the purpose of  
 21 the section 7(2)(d) would be undermined because they're  
 22 not doing the job properly, examining all the matters  
 23 they need to examine, in order to collect all the  
 24 information the law requires them to gather?  
 25 A. I can see why someone might say that. I would counter

94

1 that with saying that this contradicts their  
 2 professionalism, and what I always used to say to crews  
 3 at stations at every opportunity is: you're carrying out  
 4 this inspection, this 7(2)(d) inspection, because  
 5 one day you might be called to go in there and risk your  
 6 life and fight a fire, so it's for your own benefit and  
 7 your family's benefit to make sure you've got all the  
 8 appropriate information. So I don't think any sensible  
 9 professional firefighter would overlook that, because  
 10 they know that tomorrow they could be in there fighting  
 11 a fire, and they might miss something that could save  
 12 their life.  
 13 Q. Put slightly differently, were you given any substantive  
 14 evidence that suggested or indicated that the value of  
 15 section 7(2)(d) visits of high-rise residential premises  
 16 was being debased or was materially insufficient as  
 17 a result of them having to inspect all high-rise  
 18 buildings on their ground?  
 19 A. I wasn't made aware of any specific issue that would  
 20 underpin that statement. I guess I could look at the  
 21 number of high-rise buildings that were becoming  
 22 involved in the operational risk database, and recorded,  
 23 and they weren't being loaded on as quickly as I would  
 24 like, so that caused me some concern, but I was  
 25 satisfied with the various quality assurance processes

95

1 that we had in place to make sure that the quality of  
 2 the information was correct, notwithstanding the  
 3 comments you've made earlier about that on Grenfell.  
 4 Q. So at the risk of oversimplification, there were no red  
 5 or amber signals flashing to you that the quality of  
 6 information obtained through section 7(2)(d) visits was  
 7 materially deficient?  
 8 A. No, and if I can just add, as well as the quality  
 9 assurance process we had in place, once we had the  
 10 service standards in place, we created a group of  
 11 officers called service standard support officers that  
 12 didn't have managerial involvement, and they were sent  
 13 round to do programmed audits of stations, to look at  
 14 the various service standards, and the one that involved  
 15 contingencies planning, which 7(2)(d)s would sit under,  
 16 would involve an annual audit at each and every station  
 17 looking at each and every watch in terms of their  
 18 quality assurance.  
 19 So we were putting these systems in place to make  
 20 sure, as far as we reasonably could, that the processes  
 21 were being adhered to.  
 22 Q. Turning back to Mr Eustice's email, he has a pungent  
 23 turn of phrase and he refers there to high-rise  
 24 buildings that are "dodgy":  
 25 "... upside down maisonettes, [dry riser] outlets

96

1 only on alternative floors etc should already be on!"

2 Was it your understanding that those types of

3 properties or those properties giving rise to particular

4 issues had already been recorded on the ORD?

5 A. Well, I would like to think so, but I don't think we

6 could say, which is why I was so adamant that every

7 high-rise should be inspected so we could be sure.

8 Nothing could have given me the assurance that — what

9 Clive is saying here, that they should already be on.

10 He says it exclamation mark, so I guess, yeah, should

11 already be on, but I wouldn't be satisfied they were,

12 hence why I wanted everything inspected.

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

14 it.

15 A. Well, it could be read that way, or it could be I guess

16 read as an air of frustration from Clive that they

17 should all be on, so why are you doing this. But

18 regardless of Clive's or anyone's view, I felt morally

19 and professionally responsible to make sure that

20 everything should be inspected to make sure a decision

21 is made about whether it should or shouldn't be subject

22 to future inspections.

23 Q. Looking from the lay perspective, concentrating on

24 "dodgy" buildings, does that give rise to the danger

25 that undue focus on those would ignore other high-risk

97

1 presentations in other high-rise buildings, such as

2 cladding, for example?

3 A. Oh, I mean, Clive has got a unique turn of phrase,

4 that's for sure. But his bluntness was appreciated.

5 I think what he's referring to in terms of upside-down

6 maisonettes is the challenges that you experience if

7 you're not expecting them, in terms of the dangers that

8 a firefighter going downstairs into a fire and the heat

9 rising up the stairs can be immense.

10 Q. Can we go back to the Salamanca Place incident report.

11 That can be found at {LFB00106615/2}. This is the

12 action plan monitoring report, and we see page 2, bottom

13 row of the document, is the latest position in relation

14 to action 2, which is the action we have been

15 discussing.

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

17 "28/9/12: No database to be maintained. Ops news

18 article to raise awareness for crews regarding the

19 importance of carrying out and recording 7(2)d visits in

20 the correct format.

21 "20/11/12 & 4/12/12: As above detailed in action 1.

22 "14/1/13: It is agreed that there will not be

23 a database maintained."

24 Now, looking at that final entry, did you agree not

25 to maintain a database?

98

1 A. This must be referring to the issue about a specific

2 high-rise database, not that there won't be a database

3 with high-rise on. And it's really important that we

4 don't think that there wasn't a database with high-rise

5 on, because there absolutely was, and that was the

6 operational risk database.

7 Q. Thank you. My question was: did you agree not to

8 maintain a database?

9 A. I can't remember specifically whether I did or didn't

10 agree, but looking back on it now, providing it was

11 recorded on the ORD, I wouldn't have had an objection to

12 there not being a specific high-rise database.

13 Q. Can you remember who else was involved in making the

14 agreement referred to here?

15 A. It would have been David Wyatt.

16 Q. Would he have acted unilaterally or in consultation with

17 you?

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

19 Q. Can you remember now what reasons informed the

20 agreement?

21 A. I can't remember for sure, but I am aware of the drive

22 towards simplifying everything, so one database,

23 one-stop shop, and that I think would have been the

24 motivation behind it.

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

99

1 of a former colleague of yours, Rita Dexter, and

2 particularly her first witness statement. In that

3 document she touched upon the difficulties of defining

4 and identifying high-rise premises in London which we

5 have been discussing this morning.

6 If we could go to {LFB00032363/8}, at the very

7 bottom of the page, it's paragraph 27, and she says

8 this — and apologies for reading it out, it's probably

9 helpful for people listening:

10 "I was present at the second meeting [of the

11 Lakanal House working group] on 28 August 2013.

12 Assistant Commissioner Steve Turek, who reported to me,

13 gave a presentation on the RRO [the Regulatory Reform

14 (Fire Safety) Order]. His presentation included

15 a contribution from information management colleagues

16 (who also reported to me) about the problems of defining

17 and identifying high rise premises, given the absence of

18 adequate and appropriate data. At the time, this was

19 seen by officers as an important issue because

20 uncertainty about the number, height, location and

21 purpose of high rise buildings was an impediment to

22 fire safety inspection, familiarisation (7(2)(d) visits)

23 and community fire safety work. It was an issue that we

24 continued to work on over the following years."

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

100

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

101

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

102

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

103

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

104

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

105

1 to that, and that can be found at {LFB00050215}.  
 2 Now, this, rather than the article itself, is  
 3 an email chain in relation to a draft of that particular  
 4 edition, and if we can go to page 3 in this email chain  
 5 {LFB00050215/3}, and it's really the top, we see  
 6 an email from Graham Ellis timed at 9.19 on  
 7 12 January 2013, and he forwarded the latest draft to  
 8 Dany Cotton and Gary Reason.  
 9 Helpfully, Mr Ellis has set out further in the chain  
 10 the draft text of Operational News to which he is  
 11 referring, and we see that at the bottom of page 1  
 12 {LFB00050215/1}. We see there it starts "Description of  
 13 7(2)(d) visits".  
 14 If we go over the page {LFB00050215/2}, it's the  
 15 third paragraph I'd like to look at. It says this:  
 16 "Fire Station personnel will often be best placed to  
 17 identify significant developments or changes to property  
 18 which may have an impact on safe operations. Policy 800  
 19 – Information gathering/contingency plans, explains the  
 20 risk assessment process which should be used to  
 21 establish whether a premises requires visiting and  
 22 describes the method of recording on the Operational  
 23 Risk Database (ORD). It is important that crews always  
 24 refer to the risk assessment process when carrying out  
 25 initial and re-visits, as changes to the building or the

106

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

107

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

108

1 than take the easy option ..."

2 Just to conclude the email chain, can we go to the

3 top of page 1 and the email from Graham Ellis. Row of

4 dots, and he says this:

5 "... and it would be fair to assume that the

6 situation will not improve when there are far fewer

7 crews to go out and do the work in the first place.

8 I still think that there needs to be a more systems

9 based approach, where crews are provided with a list of

10 premises that they should visit. The building

11 information plates will also play a key role, as crews

12 will be travelling further to attend incidents off their

13 local patch.

14 "We are looking at Camden and Lambeth to trial the

15 plates. I am keen that I/we don't get dumped with making

16 it all work though. We have provided the idea and wise

17 council, but I think RFS ..."

18 A. Regular fire safety.

19 Q. And ORM?

20 A. I have never heard that one before.

21 Q. Presumably operations response and mobilising?

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

23 sure, but ...

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

25 "The Matrix and policy owners really do need to get

109

1 this sorted out though."

2 There is a lot in that email chain, Mr Brown. Can

3 we take it step by step.

4 A. Sure.

5 Q. First of all, did you and Dave Lindridge apply the risk

6 matrix to Lakanal House?

7 A. I don't remember doing that, but it would have — it

8 wouldn't have been an unreasonable thing to do.

9 Q. Are we safe to assume that the matrix referred to is the

10 risk matrix we've considered in policy 800?

11 A. Yes.

12 Q. Why did you and Mr Lindridge apply the risk matrix to

13 Lakanal House?

14 A. If we did do it, it would have been as a scoping

15 exercise, as a test to see whether the likes of

16 Lakanal House, had the premises risk assessment been in

17 place at the time, would it or would it not have passed

18 the test and been put onto the operational risk

19 database. And the reason Dave Lindridge is because

20 Dave Lindridge carried out the review of the

21 Lakanal House action plan.

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

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

24 Q. Yes.

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

110

1 remember doing it, but if it did happen, and I've no

2 reason to assume that this is wrong —

3 Q. I was about to say, there's no reason here to assume

4 that Dany Cotton is wrong, is there?

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

6 Q. So we can proceed on the assumption you and Lindridge

7 did do it?

8 A. Yeah. If it did happen, it would have been probably

9 around the time that Dave Lindridge was doing his

10 review, so it would have been late 2012, early 2013.

11 Q. Can you remember, did you and Dave Lindridge come up

12 with different answers?

13 A. Well, I don't recall that. I would say, though, that if

14 you look at the premises risk assessment, it is a guide,

15 so it isn't beyond reasonableness to think that you

16 could come up with different answers, and I'll give you

17 an example to demonstrate that.

18 So one of the criteria is a building with 500 or

19 more people residing there. Now, if one person looks at

20 it and thinks, well, actually there is less than 500,

21 another person thinks there is more, and there isn't

22 a responsible person there to be able to clarify for

23 sure, then straightaway whatever points are allocated to

24 that decision might be on one person's risk estimate or

25 another. So it would be foolish of me to try to say

111

1 that actually every single premises risk assessment

2 would come out identical.

3 What I would be very, very confident of saying,

4 however, though, is even if there were these nuances, as

5 I have explained, I am still absolutely satisfied that

6 each risk assessment would land within the zone. So

7 for example, 500 to 750 points. One might get 550 and

8 one might get 600, but they would both be in the right

9 place.

10 Q. So on the basis of that answer, you didn't necessarily

11 share the full extent of Dany Cotton's concerns about

12 different answers being produced by different people

13 applying the matrix?

14 A. No, I think what was behind Dany's concern — and

15 a genuine concern — is that if there was different

16 answers, that would be leading it to such a low score

17 that it's above or below 150. That's what Dany's

18 concern was. And I didn't share that concern because

19 whilst I accept there is the potential for two different

20 scores, they would come the right side of 150.

21 Q. Did you consider that any training measures were

22 required to ensure sufficient consistency in application

23 of the matrix so that the score did end up on the right

24 side of 150, if I can put it that way?

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

112

1 operational risk database, and there were associated  
 2 training packages. And then we of course verified this,  
 3 because apart from the systems we've spoken about  
 4 already, every training exercise that was carried out on  
 5 high-rise or any building, for example, part of that  
 6 training exercise would be to look at what was on the  
 7 operational risk database. Every performance review of  
 8 command and every performance review of operations would  
 9 consider the initial information—gathering which was  
 10 therefore on the operational risk database. Every fatal  
 11 fire review we did would look at information—gathering.  
 12 So there was a whole range of what I would call reactive  
 13 measures in place that we looked at as and when  
 14 incidents arise and we asked ourselves that question:  
 15 was there sufficient information on that operational  
 16 risk database?  
 17 Q. Looking at Dany Cotton's email, her concern appears to  
 18 be prompted by the Brown/Lindridge exercise. Were you  
 19 aware at the time of any broader concerns that there was  
 20 an inconsistency in application of the risk matrix so  
 21 that properties weren't being accurately or  
 22 appropriately scored?  
 23 A. No, I wasn't aware of any concern in that regard, and  
 24 whilst I can understand people — you know, their  
 25 professionalism asking that question, I don't think it

113

1 was a real concern, because I truly didn't believe that  
 2 this would become an issue, particularly at such a low  
 3 level of scoring.  
 4 Q. Thank you.  
 5 Now, if we can just go back to it, so you have it on  
 6 the screen, so you remember what I'm talking about,  
 7 Graham Ellis' email at the top of page 1  
 8 {LFB00050215/1}. There we go.  
 9 Now, he expressed a preference for a more  
 10 systems-based approach, where crews are provided with  
 11 a list of premises that they should visit.  
 12 Now, had Mr Ellis been raising and explaining with  
 13 you what he meant by "a more systems based approach"?  
 14 A. I can't recall Graham raising this. I can imagine what  
 15 he means. I think he goes on to explain this in this  
 16 email, in terms of — or later email that you've shown  
 17 me just now, in terms of just being given a list. Oh,  
 18 yeah, he does say that —  
 19 Q. Exactly, it's the extract I've just quoted to you, the  
 20 provision of a list.  
 21 A. So I think that's what he is referring to.  
 22 Q. Not much more of a substantive system beyond provision  
 23 of a list then?  
 24 A. No, and for the record, I would completely disagree with  
 25 a list because, firstly, where is that list going to

114

1 come from?  
 2 Q. I was about to ask you, it's going to be the  
 3 station manager, isn't it, presumably, or the  
 4 watch manager?  
 5 A. Yeah, and then where are they going to get that  
 6 information from? And this is all about ownership.  
 7 This is about making crews own their station grounds and  
 8 become part of the community and familiarise themselves  
 9 with it, and there is a whole range of other reasons why  
 10 we would want them to get out and about on their  
 11 station's ground and do this. It's not just about  
 12 information—gathering, it's about being seen in the  
 13 community, being part of the community, for people to  
 14 come and ask advice. It's about being able to recognise  
 15 people that are in trouble and need our help and refer  
 16 them to serious outstanding risk, home fire safety risk  
 17 assessments, all designed to work in partnership with  
 18 the local authority and the police to drive down fire  
 19 and crime and to make — you know, achieve our overall  
 20 objective of making London a safer city.  
 21 So it's far, far broader than just being out there,  
 22 and if staff were just given a list to do that, then we  
 23 miss a fantastic opportunity to do so much more good  
 24 work.  
 25 Q. Was that discussion a discussion that you had with

115

1 Mr Ellis at this time, so start of 2013? You have given  
 2 a pungent analysis of the disadvantages of what he was  
 3 suggesting. Was that a discussion that was had at the  
 4 time?  
 5 A. I don't recall Graham Ellis ever actually raising this  
 6 issue with me in those terms, but had he have done so,  
 7 then I would have given the same answer I've just given  
 8 then.  
 9 Q. Can you remember Dany Cotton or anyone else raising it  
 10 with you, because obviously at this stage she was AC  
 11 operational assurance, so it fell directly within her  
 12 remit?  
 13 A. I do recall that Dany was concerned about the issue that  
 14 we've just discussed, ie that things might not make  
 15 themselves on to the operational risk database, and that  
 16 was a genuine and professional concern. But in terms of  
 17 just giving a list as Graham suggests, I don't recall  
 18 Dany ever mentioning that to me.  
 19 MR KINNIER: Thank you.  
 20 Sir, we're slightly early, but we've come to the end  
 21 of the questions in relation to this topic and the next  
 22 topic will take longer than five minutes.  
 23 SIR MARTIN MOORE-BICK: So it would be sensible to stop  
 24 a little early at this point?  
 25 MR KINNIER: It would, sir.

116

1 SIR MARTIN MOORE—BICK: Yes, very well.  
 2 Well, we would normally stop about 1 o'clock,  
 3 Mr Brown, but for the reasons that Mr Kinnier has just  
 4 explained, it's probably better to stop now.  
 5 So we will break now. We will resume, please, at  
 6 2 o'clock, and again, please don't talk to anyone about  
 7 your evidence while you're out of the room. All right?  
 8 THE WITNESS: Okay, thank you very much.  
 9 SIR MARTIN MOORE—BICK: Thank you very much, would you go  
 10 with the usher, then, please.  
 11 (Pause)  
 12 Thank you. 2 o'clock, then, please.  
 13 MR KINNIER: Thank you, sir.  
 14 SIR MARTIN MOORE—BICK: Thank you.  
 15 (12.57 pm)  
 16 (The short adjournment)  
 17 (2.00 pm)  
 18 SIR MARTIN MOORE—BICK: All right, Mr Brown, ready to carry  
 19 on?  
 20 THE WITNESS: Yes, thank you.  
 21 SIR MARTIN MOORE—BICK: Good, thank you very much.  
 22 Yes, Mr Kinnier.  
 23 MR KINNIER: Thank you, sir.  
 24 Before the lunchtime break we were talking about  
 25 Operational News 24 and you referred to the training

117

1 packages that were initiated by that. Can we now turn  
 2 to those particular training packages.  
 3 A. Yes.  
 4 Q. Now, if we can go back to the final published version of  
 5 Operational News 24, it included the reference to  
 6 a training package on 7(2)(d) visits, if we go to  
 7 {LFB00118959/4}. If we can look at the second to last  
 8 red box on the page, which states in relation to 7(2)(d)  
 9 this:  
 10 "Training pack available to watch officers through  
 11 Training Support icon — Knowledge Centre — Ops News 24 —  
 12 Watch training packages."  
 13 Was there mandatory training that all watches would  
 14 have been expected to carry out?  
 15 A. Yes.  
 16 Q. Now, the Inquiry has identified TCAP 0055, entitled,  
 17 "7(2)(d) Ops News 24", and that can be found at  
 18 {BAB00000035}. If we look at the first page of this  
 19 TCAP, we can see that its title refers to  
 20 section 7(2)(d) and Ops News 24.  
 21 For the avoidance of doubt, was this the TCAP that  
 22 was specifically created for the creation of the  
 23 training package following on from Operational News 24?  
 24 A. I believe so, although I just would add that I would  
 25 never normally see the TCAP. But, yes, I'm satisfied

118

1 this is the correct one.  
 2 Q. If we can turn to page 8 within this document  
 3 {BAB00000035/8}, we can see in the second box that  
 4 AC Cotton, as she then was, is listed as the  
 5 commissioning officer, and DAC Mick Ellis is the client.  
 6 Is it right that DAC Mick Ellis reported to you?  
 7 A. He did. He managed central service delivery and  
 8 reported directly to me.  
 9 Q. Is he another Ellis at the LFB? He is neither Dominic  
 10 nor Graham.  
 11 A. That's correct, there was an overabundance of Ellises  
 12 and he was one of them, yeah, Michael Ellis.  
 13 Q. If we look in the following section on page 8 entitled  
 14 "Background/Context", 2.4, it states in the second  
 15 paragraph in that box this:  
 16 "The ODCB (Operational Directorates Coordination  
 17 Board) stated that it requires a CBT package regarding  
 18 7(2)(d) visits, following their meeting of 3.9.12. This  
 19 requirement is driven by concerns raised by the  
 20 Salamanca Place investigation over when and how 7(2)(d)  
 21 visits are undertaken. The concerns centre around what  
 22 risk based approach is taken to identifying buildings,  
 23 including high rise, and how it is recorded on the  
 24 ORD ..."  
 25 First of all, CBT stands for computer-based

119

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

120

1 If we turn to page 6 {BAB00000056/6}, the bottom  
 2 slide there is entitled, "What to look for on a 7(2)(d)  
 3 Visit?"  
 4 Now, would you agree with me there is no reference  
 5 there to the 22 items identified in the appendix 1 to  
 6 633? Or express reference, I should say.  
 7 A. Yeah, there is no express reference. I'd have to go  
 8 through each of those icons and think carefully about  
 9 how they cross—reference with those 22, but  
 10 notwithstanding that, those items aren't expressly  
 11 listed, no.  
 12 Q. Thank you.  
 13 If we could turn over the page and just go through  
 14 from pages 7 {BAB00000056/7} onwards. What we see here  
 15 are a number of examples on how to calculate risk scores  
 16 and what action to take based on identified risks.  
 17 Now, we've gone through these, and you can go  
 18 through them yourself if you would like to, but the  
 19 essential point is that the training nowhere provides  
 20 any guidance on how crews should actually go about  
 21 identifying risks when carrying out the visit.  
 22 Now, looking at this page, would you accept that as  
 23 a criticism, for example, of this slide?  
 24 (Pause)  
 25 A. Okay, can I just qualify my answer on this?

121

1 Q. Well, if you give your answer first and then the  
 2 qualification might be easiest.  
 3 A. Okay. No, there isn't any specific reference on here in  
 4 terms of how you go about interpreting that risk. The  
 5 qualification I'd like to give to that is I think the  
 6 premises risk assessment is very much a linear based  
 7 approach. So, for example, you either think there are  
 8 500 or more (inaudible) premises or you don't. You  
 9 either think there's sleeping for 100 or there isn't.  
 10 So I think what this does is it gives the opportunity  
 11 for crews to practice that linear premises risk  
 12 assessment.  
 13 So in terms of do I think it is satisfactory, then  
 14 I think it works in terms of crews being able to apply  
 15 this and then discuss their rationale after.  
 16 Q. But in terms of telling them and training them as to how  
 17 to go about, in practical terms, a 7(2)(d), would you  
 18 accept it's not quite achieving that aim?  
 19 A. I accept your earlier proposition that it doesn't give  
 20 guidance on how to complete the risk assessment, but,  
 21 as I say, I think that is straightforward and linear,  
 22 and this gives you the opportunity to practice it. So  
 23 I wouldn't agree that it doesn't meet the objective of  
 24 the 7(2)(d) training package in that regard.  
 25 Q. Right.

122

1 Let's now look at {BAB00000058}. Now, as the front  
 2 slide suggests, these are trainer notes for the  
 3 training, which give guidance on how to deliver the  
 4 training.  
 5 Can you remember, was this training delivered by  
 6 staff at station level?  
 7 A. I can't remember.  
 8 Q. Would that be the usual level at which this type of  
 9 training is pitched?  
 10 A. If it was a CBT training, there's a fair chance that  
 11 this would be delivered by the watch officer in charge  
 12 of that particular watch at the station.  
 13 Q. Would the watch officers themselves have received  
 14 training on how to conduct 7(2)(d) visits?  
 15 A. Not over and above what they would have experienced as  
 16 a firefighter.  
 17 Q. Do you consider that to be a gap in the system, in the  
 18 sense there is a missed opportunity to ensure  
 19 consistency of approach to 7(2)(d) visits by ensuring  
 20 all watch officers are trained in the same way as to how  
 21 to conduct them?  
 22 A. I don't think it's a missed opportunity in terms of  
 23 should we supply training over and above for watch  
 24 officers as opposed to firefighters, because I think the  
 25 process doesn't distinguish between who it is that's

123

1 carrying out the risk assessment. I think it matters  
 2 not whether it's a firefighter or a watch officer. At  
 3 the end of the day, the inspection is the inspection.  
 4 So I don't see any specific issue there.  
 5 I think where an opportunity was overlooked in the  
 6 past is the question about what training did we give  
 7 staff to do 7(2)(d)s prior to this training package, and  
 8 I think up to that point it was only initial training  
 9 when joining the organisation and on—the—job training,  
 10 learning as you did the inspection.  
 11 So I think probably this hopefully rectified what  
 12 had maybe been missed in the past, but I wouldn't —  
 13 I don't believe there needs to be any different training  
 14 for watch officer as opposed to a firefighter on this  
 15 particular issue.  
 16 Q. Just following on from the more procedural mechanics of  
 17 the training programme, Mr Brown, see how far you can  
 18 help us on this. Can we go to {BAB00000035/23}. If we  
 19 look at the final box on that page under the heading  
 20 "Final sign off", there appears to be no final sign-off.  
 21 Do you know whether the training — and this TCAP  
 22 concerns the 7(2)(d) training programme we've just been  
 23 considering — was in fact provided, notwithstanding the  
 24 absence here, or the apparent absence, of any final  
 25 sign-off?

124



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

125

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

126

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

127

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

128

1 Now, that was unacceptable and this, I believe, was to  
 2 re-engage, if indeed that's the right word, to push  
 3 through what I wanted in terms of more premises being  
 4 put on the operational risk database. I believe that  
 5 was the emphasis of this.  
 6 Q. Looking at the emboldened, italicised words there set  
 7 out in the penultimate paragraph on that page, that  
 8 tends to suggest that even within your team, in  
 9 November 2012, there was still confusion or uncertainty  
 10 about which high-rise premises were actually to be  
 11 recorded on the ORD. Would you accept that?  
 12 A. Well, Dave Lindridge wasn't in my team, but  
 13 notwithstanding that, I think — no, I wouldn't accept  
 14 that. I think what he's doing is just giving me as the  
 15 sender the option as to which I would want to include.  
 16 Q. But which of itself, looking at the words actually used,  
 17 there is an absence of certainty as to what level of  
 18 detail is to be included; would you accept that?  
 19 A. No, no, I wouldn't accept that there's a confusion over  
 20 it. I think it's really just him giving the option,  
 21 quite possibly because his final point, "Only those  
 22 above 149 on the scale described in PN800?" and his  
 23 comment that "The latter will exclude most", which (a)  
 24 I don't agree with, but maybe he just wants to remind me  
 25 that if we did follow this policy, in his view it would

129

1 exclude most, and is that what I really wanted.  
 2 Q. Well, it'll be for the panel in due course to make of  
 3 that email what they make.  
 4 A. Sure.  
 5 Q. But what was your response to this question? What level  
 6 of detail did you require to be recorded?  
 7 A. Well, I ... unless I'm about to see an email that  
 8 contradicts what I'm about to say, I would have gone for  
 9 the final option, so only those above 149 on the scale  
 10 described in PN800, because (a) that's what we'd set out  
 11 and (b) even if they were under 149, they still would  
 12 have had a premises information plate attached to them.  
 13 So there still would have been information about them  
 14 available to arriving crews if there was an incident  
 15 there around things such as how many stairways, where  
 16 they were, where the fire lift was, how many lengths of  
 17 hose, water supplies, number of floors in the building.  
 18 So it still would have been a useful exercise in terms  
 19 of crews having on-arrival information.  
 20 Q. I think it flows from what you have just said — well,  
 21 I think you have said explicitly that you accept  
 22 Mr Lindridge's view that taking the latter approach, ie  
 23 including those above 150, would exclude most high-rise  
 24 buildings.  
 25 A. Well, no, I don't accept that is true. I accept that

130

1 that might be what he believed, but I don't accept that  
 2 that's a statement of fact.  
 3 Q. Now, did you raise that point with him at the time, do  
 4 you remember?  
 5 A. I don't remember, no.  
 6 Q. Now, if we can go further up in this email chain to the  
 7 bottom half of page 1 {LFB00113599/12}, here we go, it's  
 8 an email from Mr Binder himself to you, and it says as  
 9 follows:  
 10 "Guv,  
 11 "Regarding the issues of recording high rise info on  
 12 the ORD/MDT (pre-planning at residential high rise fires  
 13 to include single line diagrams showing number and  
 14 location of individual flats).  
 15 "I have spoken with Dave Wyatt and the consensus is  
 16 that since that action was required, there has been for  
 17 good reasons a more intelligent and risk based approach  
 18 in recording operational risks to firefighters on their  
 19 stations ground. This culminated in the information  
 20 gathering note (PN800), and the matrix used is specific  
 21 in what should be added.  
 22 "David Lindridge has undertaken a quick trawl of the  
 23 brigade and approx 250 high rise premises are recorded  
 24 on the ORD, of which 61 have some limited information  
 25 recorded be it a plan or a picture, with 6 having

131

1 greater details including a simple plan drawing.  
 2 "As it stands now this will not fulfil the action in  
 3 increasing the level of preplanning required."  
 4 Now, the high-rise database that you sent to station  
 5 staff in April 2009 contained over 1,800 entries. Are  
 6 you able to help us as to why there are now  
 7 comparatively so few, ie 250 high-rise premises on the  
 8 ORD three years later?  
 9 A. I don't — I can't help with certainty. I would —  
 10 Q. If you don't know, say you don't know.  
 11 A. No, I was just going to use a professional opinion as to  
 12 why it might be the case, but no, I don't know for  
 13 certain, no.  
 14 Q. If we can go back to Mr Binder's email, which in its  
 15 fifth paragraph says this:  
 16 "The comms message below from DL [David Lindridge]  
 17 details how this may be achieved.  
 18 "The problem is that personnel might with good  
 19 reason decide that a high rise might not now be worthy  
 20 of inclusion (due to the score following use of the  
 21 matrix), which could then allow the premise to be  
 22 removed from the OR, which we would have to accept as  
 23 part of this process, however this review will allow  
 24 those that do attract inclusion will then have the  
 25 single line drawings added to the premises information,

132

1 as is the intention of the comms message.  
 2 "By approaching it this way a review is carried out  
 3 of all listed high rise premises, and where applicable,  
 4 where currently there are no single line drawings they  
 5 are then added increasing our numbers, accepting that  
 6 some premises will ultimately be removed.  
 7 "It might be worth putting a review/deadline date in  
 8 if this needs to look a lot healthier by January? and  
 9 sent it to Area DACs and BCs [borough commanders] to  
 10 ensure this is actioned?"  
 11 Now, this email there refers explicitly to the  
 12 problem that "personnel might with good reason decide  
 13 that a high rise might not now be worthy of inclusion",  
 14 because of the matrix.  
 15 When would you expect a high-rise building to  
 16 receive a very low score on the matrix meaning that it  
 17 would not be included on the ORD at all? Is this the  
 18 paradigm model that you were talking about earlier that  
 19 had impressive fire suppression systems and the rest of  
 20 it?  
 21 A. Yes.  
 22 Q. Now, the Inquiry has not been able to find any evidence  
 23 that the draft email that we started with was in fact  
 24 sent. Are you able to help us as to whether it was in  
 25 fact sent?

133

1 A. As far as I'm aware, it was sent, yes. And the reason  
 2 I say that it because I remember being disappointed with  
 3 those figures, and wanted to action it and make sure  
 4 that we got on with increasing the numbers on the  
 5 operational risk database.  
 6 Q. Can you remember now what, if any, guidance was given  
 7 with the final version of this email to essentially  
 8 advise station managers on which high-rise buildings  
 9 were required to be recorded on the ORD?  
 10 A. It would have been to follow the guidance given in  
 11 policy note 800 and therefore —  
 12 Q. Sorry, if I can stop you there. You have said in  
 13 a number of answers today, "It would have been". My  
 14 question was more direct: was guidance given with the  
 15 final version of the email that was sent out? Are you  
 16 able to remember whether that was done?  
 17 A. I can't categorically state, but I can't imagine  
 18 a situation where I wouldn't have sent it out, and if  
 19 I did and when I did it would have involved  
 20 policy note 800.  
 21 Q. But your recollection is sure that it would have been?  
 22 A. Yes.  
 23 Q. Now, can I turn to a separate but related topic, which  
 24 is the LFB's response to PORIS guidance.  
 25 Now, the PORIS guidance was published in 2012; is

134

1 that correct?  
 2 A. Yes.  
 3 Q. Can you help the panel and anyone watching who may not  
 4 be familiar, what is/was the PORIS guidance?  
 5 A. It's the provision of operational risk information  
 6 system, and it was a document that was provided by  
 7 the ... effectively central government, really, in  
 8 response to a health and safety risk assessment that had  
 9 been carried out on the UK fire service nationally. So  
 10 this gave guidance that fire and rescue services should  
 11 follow in terms of the kind of information that they  
 12 should be collecting and how they should collect it.  
 13 Q. Thank you.  
 14 Now, can we start this line of questioning going to  
 15 a report produced for the corporate management board on  
 16 27 February 2013. That can be found at {LFB00091785}.  
 17 As you can see, it's entitled "Operational risk  
 18 information: LFB response to national operational  
 19 guidance".  
 20 The report's summary on the front page says this:  
 21 "DCLG [Department of Communities and Local  
 22 Government, as was] issued operational guidance on  
 23 'operational risk information' in April 2012. This  
 24 paper considers the content of that guidance and the  
 25 extent to which LFB is compliant with the guidance."

135

1 Now, as you've adverted to, the national guidance  
 2 introduced a model approach which was called the  
 3 provision of operational risk information system, and if  
 4 we can look in broad terms at the substance of that  
 5 model. If we could turn to {HOM00045364/48}.  
 6 Now, Mr Brown, the five stages of the PORIS model  
 7 are described between pages 48 and 49 here. What I'd  
 8 like to do is just discuss these very briefly in  
 9 headline terms so that the panel is familiar with them.  
 10 The first one we have at page 48 is stage I, which  
 11 describes itself as the initial site risk analysis  
 12 process. In broad terms, am I right in thinking that  
 13 this is a review of the existing information about  
 14 a premises in order to determine whether a visit is  
 15 required at all?  
 16 (Pause)  
 17 A. Sorry, the reason I'm just pausing is certainly it  
 18 covers what you've said, I'm just trying to determine in  
 19 my own mind whether it goes beyond just that initial  
 20 decision.  
 21 Q. We're just talking in broad terms here, headline points  
 22 about the stage. I just want to identify them  
 23 because —  
 24 A. Okay.  
 25 Q. — there are complexities to it, but just to give people

136

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

137

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

138

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

139

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

140

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

141

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

142

1 row on that page, what that says there is this:  
2 "One of the challenges is how to process a very  
3 large number of sites in order to identify those where  
4 the availability of accurate, relevant and timely  
5 information may be of value at any reasonably  
6 foreseeable incident. Many buildings or risks may not  
7 require detailed site specific information in order to  
8 expect a safe and successful outcome to operational  
9 interventions."

10 Now, if we look rightwards, we see the LFB's  
11 response, which was as follows:

12 "The current process, as outlined in LFB policy 800,  
13 is regarded as adequate to identify the key buildings  
14 that are likely to present operational risks. The onus  
15 is on stations to identify risks on the station ground  
16 and to schedule regular visits (if required). The risk  
17 matrix in policy 800 provides a way of determining if  
18 a site/building should appear on the ORD and the  
19 frequency of revisits.

20 "Operational News in February 2013 will also include  
21 a specific article on recording information relating to  
22 complex buildings that are likely to cause difficulties  
23 to operational staff in the event of an emergency."

24 Now, the key question here is: do you agree with the  
25 conclusion that the LFB's process was "adequate to

143

1 identify the key buildings that are likely to present  
2 operational risks", given the problems you'd experienced  
3 over the preceding years achieving that aim?

4 A. I think the process was adequate, but undoubtedly there  
5 were issues in terms of achieving the outcome we were  
6 looking for.

7 Q. In the sense you hadn't yet achieved the outcome?

8 A. Yes.

9 Q. Could we go to page 15 {LFB00091785/15}, please, and  
10 again the bottom row. Here it deals with paragraph 8.28  
11 of the PORIS guidance, and it summarises that thus:

12 "Periodic audit is a useful means to enable a deeper  
13 and more critical appraisal of the operational risk  
14 information systems ... and whether the system has been  
15 properly implemented and maintained and is effective in  
16 meeting organisational policies."

17 Looking at the far right column, the LFB responded  
18 as follows:

19 "There are inconsistencies in the approach taken by  
20 stations about what is included on the ORD and the  
21 quality of data capture and usage is variable.  
22 Policy 800 (and the risk matrix within it) is designed  
23 to improve this over time. It will be useful for the  
24 Head of Operational Assurance to review/audit how  
25 stations identify sites/buildings that might present

144

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

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

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

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

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

145

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

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

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

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

16 A. Yes.

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

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

146

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

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

9 A. We could, we could have done that, but I think we  
10 accepted — following the Lakanal House action plan, we  
11 accepted that there were gaps in the provision of  
12 information and training we were giving to our crews.

13 So I think we accepted that we needed to start afresh  
14 with training. So I don't think we really wanted to get  
15 involved in finding out what the gaps are, we were just  
16 doing a belt and braces approach to 7(2)(d)s, albeit in  
17 the knowledge that there was a lot of organisational  
18 knowledge at stations in terms of how to do a 7(2)(d),  
19 but also thinking of new entrants as well, so ...

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

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

147

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

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

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

17 Q. I think we have probably exhausted that topic.

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

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

148

1 actions I have come across this and I have no  
 2 recollection of it myself.  
 3 "Do you remember it?"  
 4 Mr Bevan's email then sets out what appears to be  
 5 an extract of the action plan relating to X—OR17, which  
 6 replicates the text of recommendation (g) set out in the  
 7 2013 report which we've just been looking at, ie the  
 8 audit/review to identify consistency of station  
 9 identification of sites.  
 10 Now, in the middle column, your name is crossed out,  
 11 replaced with that of Dany Cotton, and the far right  
 12 column says this:  
 13 "Work by Head of Operational Assurance to validate  
 14 the work at stations to identify and record operational  
 15 risks will need to await the embedding and outcome of  
 16 work by the Third Officer to increase the number of  
 17 visits (and premises on the ORD) which is outlined in  
 18 item ORI 4 above. The lead for this action should be  
 19 [Head of Operational Assurance]."  
 20 If we could look at the email at the head of this  
 21 chain from Dany Cotton, she says:  
 22 "Hiya.  
 23 "No, I don't think I've ever seen this before and  
 24 Dave Brown would definitely not have allowed us to do  
 25 this!!"

149

1 Now, the language of that email chain is clear. It  
 2 suggests that the recommended audit was never carried  
 3 out. Now, is that right?  
 4 A. There's a couple of issues here —  
 5 Q. Well, if we can start off with an answer to the  
 6 question: is it right that the audit/review was not  
 7 carried out?  
 8 A. I don't believe the audit/review by operational  
 9 assurance was ever carried out.  
 10 Q. Your answer suggests it was carried out by someone else.  
 11 A. Yes.  
 12 Q. Who?  
 13 A. So the service standards that I introduced in 2014 had  
 14 a specific service standard for contingency planning,  
 15 and we had structured approaches to be able to audit  
 16 what was going on with regards 7(2)(d)s and operational  
 17 contingency planning in general. So my service standard  
 18 support officers would certainly have carried out audits  
 19 in this regard on an annual basis from 2014 onwards.  
 20 Q. Were those service standards designed or were they  
 21 used — I should take it down in stages: were they  
 22 designed to discharge the recommendation (g), ie to  
 23 carry out the audit/review?  
 24 A. No.  
 25 Q. Do you believe or do you know whether the audit/review

150

1 was in fact carried out under the umbrella of the  
 2 service standard audit that you've referred to?  
 3 A. In my opinion, that would have addressed this particular  
 4 issue, yes.  
 5 Q. I'm sorry to press you, I'm not interested and we don't  
 6 want to hear your opinion. Was the audit/review carried  
 7 out as a fact or not? Was the audit/review carried out  
 8 envisaged by recommendation (g) under the umbrella of  
 9 the service standard audit procedures that you've just  
 10 referred to?  
 11 A. I never offered that up as an outcome for that  
 12 particular action, no.  
 13 Q. So when you sought to qualify your answer earlier on by  
 14 saying the review/audit was not carried out by ops or  
 15 assurance, is it right, therefore, to take it from the  
 16 evidence you've given that you don't know whether your  
 17 department carried out an audit or review following  
 18 recommendation (g)?  
 19 A. Oh, no, sorry, I've misrepresented myself then. So  
 20 I know that my service standard support officers did  
 21 regularly audit on an annual basis a range of issues and  
 22 this would have been one of them. What I'm not  
 23 suggesting is I then went forward and said, "Hey, that  
 24 particular action in this action plan, we can tick that  
 25 one off now because I've dealt with it", I never said

151

1 that, I never did that. That was for operational  
 2 assurance to do, and this comment in the far right  
 3 column in terms of being suspended awaiting outcome of  
 4 further work by me in terms of increasing the number of  
 5 premises on there, is accurate. But at some point it  
 6 would have been for the head of operational assurance to  
 7 say, "It's now my turn to pick this up and get on with  
 8 this audit", and the reason we're both on there is  
 9 because we both owned that action: me to get the  
 10 training done, me to build up the numbers on the  
 11 database, and then the head of ops assurance to take  
 12 over and use her staff to do the audit for which her  
 13 staff were auditors.  
 14 Q. That's a very long answer. Can I just take us back to  
 15 what recommendation (g) was, because I think there is  
 16 a danger here of generality obscuring the particular.  
 17 A. Okay.  
 18 Q. If we go back to {LFB00091785/2} and amplify  
 19 recommendation (g). It was a specific recommendation,  
 20 Mr Brown:  
 21 "... operational assurance audit/review take place  
 22 to identify the consistency with which stations identify  
 23 sites/buildings that might present an operational risk  
 24 or hazard ..."  
 25 So the focus was on the consistency or otherwise of

152

1 the approach adopted by stations to operational risk or  
2 hazard.  
3 Was there a particular audit or review that answered  
4 that specific recommendation carried out by your  
5 department?  
6 A. As part of normal business, as part of these service  
7 standards, then yes. But that particular recommendation  
8 refers to joint work between head of operations,  
9 prevention and response and OA, and on that respect, no,  
10 that wasn't carried out.  
11 Q. Thank you.  
12 Can we go back to the Cotton/Bevan email  
13 correspondence {LFB00041365}. Dany Cotton's email at  
14 the top:  
15 " ... Dave Brown would definitely not have allowed us  
16 to do this!!"  
17 Can you help as to why she had formed the view that  
18 you would not have allowed us, ie the LFB or operational  
19 assurance, to do this?  
20 A. Well, first of all, that's a really disappointing  
21 comment to read, and I worked closely with operational  
22 assurance, who did lots of audits in terms of senior  
23 accident investigations and performance reviews of  
24 command at fire stations, without anything other than  
25 full co-operation from me, so I've got no idea why Dany

153

1 would have suggested such a thing.  
2 Q. Indeed, there is nothing in the February 2013 report on  
3 PORIS that suggests that you disagreed with or weren't  
4 willing to implement recommendation (g).  
5 A. No, and even if I had for some bizarre reason wanted to  
6 stand in the way of this, which I didn't, this is  
7 a corporate action, and there was no way that I'm going  
8 to stand in way of a corporate action agreed at CMB for  
9 which I was present.  
10 Q. Thank you.  
11 Can we now turn to a separate topic, which is the  
12 Lakanal Rule 43 actions.  
13 Now, if we can go back to your first statement,  
14 first of all, {LFB00032166/7}, and start with  
15 paragraph 16.  
16 Now, here you set out at the bottom of the page, in  
17 paragraph 16, the following:  
18 "16. In 2013, Inquests were held into the death of  
19 the six people who died as a result of the fire at  
20 Lakanal House. On 28 March 2013, Her Honour Francis  
21 Kirkham CBE, Assistant Deputy Coroner, sent a letter to  
22 the Commissioner setting out her five recommendations  
23 for action by the LFB ('rule 43 recommendations').  
24 "17. In my capacity as the LFB's Head of  
25 Operations, Prevention and Response, I was allocated the

154

1 role of Lead Officer for recommendation two, which  
2 concerned 'Visits made pursuant to s7(2)(d) of the Fire  
3 and Rescue Services Act 2004' and recommendation four,  
4 regarding 'Brigade Control'. I also had an involvement  
5 in recommendation one in relation to 'Public Awareness'  
6 and recommendation three, involving 'Incident  
7 Commanders'.  
8 Now, in your evidence at Module 5, Mr Brown, I would  
9 like to concentrate on recommendation 2, so  
10 section 7(2)(d) visits.  
11 A. Okay.  
12 Q. The then commissioner, Ron Dobson, wrote to the coroner  
13 on 23 May, setting out the LFB's response to her  
14 recommendations. We can find that at {LFB00042089/4}.  
15 In the second paragraph, we see there the response in  
16 relation to recommendation 2 on which you led. Really  
17 it's the second paragraph at the top of that page. It  
18 says this:  
19 "It is recommended that the Brigade review  
20 procedures for sharing information gained as a result of  
21 section 7(2)(d), familiarisation and home fire safety  
22 visits with crews both within the station in question  
23 and at other local stations."  
24 In response, the commissioner wrote at the third  
25 paragraph, under the heading "Response", this:

155

1 "The Brigade's policies concerning the 'gathering of  
2 operational knowledge' are under regular review and many  
3 have been modified to reflect the lessons learned in the  
4 Lakanal House fire."  
5 He then continues, under the heading "Proposed  
6 Action", with this:  
7 "To further enhance current systems, the Brigade  
8 will:  
9 " ■ Undertake a review of the existing policy  
10 relating to information gathering and contingency plans.  
11 This review will aim to optimise all of the Brigade's  
12 pre-planning activities to ensure the effective sharing  
13 of information gained as a result of section 7(2)(d)  
14 familiarisation and Home Fire Safety Visits. It will  
15 aim to maximise the use and availability of this  
16 information when operational personnel respond to  
17 emergencies;  
18 " ■ Create an inspection regime that targets high  
19 priority residential and non residential buildings with  
20 a view to increasing the number of premises records  
21 which are available to the Brigade's operational staff  
22 on the Operational Risk database;  
23 " ■ Develop guidance to assist staff to create  
24 consistent tactical plans focused on improving speed of  
25 firefighting and life saving interventions;

156



1 " ■ Develop a new policy guidance to address known  
 2 outstanding risks identified through the Brigade's Home  
 3 Fire Safety Visits and other engagement activities;  
 4 " ■ Establish a corporate mechanism by which targets  
 5 for the Brigade's 7(2)(d) activities are set."  
 6 Now, that, as we understand it, formed the basis for  
 7 the actions that are referred to as actions 2a, 2b, 2c  
 8 and 2d in the Lakanal assurance review, a document to  
 9 which you have clearly had regard in reaching your  
 10 statement; is that correct?  
 11 A. That's true, yes.  
 12 MR KINNIER: Now, I would like to take a moment to identify  
 13 each of the actions as described in the Lakanal  
 14 assurance review, and if I could ask the trial director  
 15 to bring up the —  
 16 SIR MARTIN MOORE—BICK: Before we do that, Mr Kinnier, can  
 17 you just help me with this, because I want to understand  
 18 where we're going.  
 19 The recommendation doesn't address concerns about  
 20 the system for obtaining information; it's concerned  
 21 with sharing information gained as a result of  
 22 section 7(2)(d) and so on visits.  
 23 Is there anything in this that actually deals with  
 24 sharing of information?  
 25 MR KINNIER: When you say "this", you mean the response

157

1 or —  
 2 SIR MARTIN MOORE—BICK: The response, yes.  
 3 MR KINNIER: Not especially, no. Well, no.  
 4 SIR MARTIN MOORE—BICK: This doesn't actually address the  
 5 recommendation at all?  
 6 MR KINNIER: No.  
 7 SIR MARTIN MOORE—BICK: All right, thank you.  
 8 MR KINNIER: That's a point which will be covered with  
 9 Mr Dobson.  
 10 SIR MARTIN MOORE—BICK: All right. Thank you very much.  
 11 MR KINNIER: If we could go to the assurance review itself,  
 12 which is {LFB00004801}. If we could put page 4 of the  
 13 commissioner's letter, so {LFB00042089/4}, side by side,  
 14 thank you.  
 15 Now, the coroner's recommendation 2 is set out on  
 16 page 25 of the assurance review {LFB00004801/25}. It's  
 17 in the left column, bold blue text, and action 2a is  
 18 then identified on the same page in the right-hand  
 19 column.  
 20 (Pause)  
 21 Thank you.  
 22 As we see, 2a is there identified. Do you have it,  
 23 Mr Brown?  
 24 A. Yes.  
 25 Q. It says:

158

1 "Review existing policy related to information  
 2 gathering and contingency plans."  
 3 That responds to the first bullet point in the  
 4 commissioner's letter to the coroner; would you agree?  
 5 A. Yes.  
 6 Q. Apologies to the trial director for this, but if we can  
 7 go to page 27 in the assurance review {LFB00004801/27},  
 8 looking at the left —hand column, the bold red text  
 9 identifies action 2b which is to, "Create an inspection  
 10 regime targeted at high priority buildings". Would you  
 11 agree that 2b corresponds to the second bullet point in  
 12 the commissioner's response letter?  
 13 A. Yes.  
 14 Q. Action 2c is also on page 27 of the assurance review,  
 15 and you will see that is entitled:  
 16 "Develop new policy/guidance to address known  
 17 outstanding risks identified through home fire safety  
 18 visits."  
 19 That corresponds to the fourth bullet point in the  
 20 commissioner's response.  
 21 A. Yes.  
 22 Q. Thank you.  
 23 Finally, action 2d is also on page 27, and that is  
 24 entitled "Set corporate targets for 7(2)(d) activities".  
 25 Would you agree that that corresponds to the fifth

159

1 bullet point in the commissioner's response letter?  
 2 A. Yes.  
 3 Q. Thank you.  
 4 Just to add administrative complexity, action 2 in  
 5 its four component parts were also known as action 18a  
 6 to d in the context of the LFB's internal Lakanal House  
 7 action plan. Do you remember that level of detail?  
 8 A. Yes, yeah, and it wasn't particularly helpful. That was  
 9 an action plan being incorporated with another action  
 10 plan and being renumbered, but yes.  
 11 Q. Just so people know what we're talking about, if we can  
 12 put — with apologies again to the trial director —  
 13 both of those documents down and put another one up,  
 14 which is {LFB00029307}.  
 15 Now, this is the LFB's Rule 43 monitoring report.  
 16 We can see its date in the top right corner,  
 17 November 2013, and for people who are watching  
 18 proceedings, these documents were produced regularly  
 19 following the Lakanal House Inquests for the purpose of  
 20 monitoring the LFB's progress in implementing the  
 21 actions identified to satisfy the coroner's  
 22 recommendations. Is that a fair and accurate summary,  
 23 Mr Brown?  
 24 A. Yes.  
 25 Q. Now, we can see from the top of the first page that this

160

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

161

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

162

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

163

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

164

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

165

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

166

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

167

1 deals with action 18a, also known as action 2a, we can  
 2 see 18 is at the bottom. Just reading across from the  
 3 left to the right, the first entry in the  
 4 "Action Update" column on the far right—hand side says  
 5 this:  
 6 "04/07/2013: A review of PN800 has been completed  
 7 and it has been recommended to include 7(2)(d) guidance  
 8 in PN800 rather than create a new and separate policy."  
 9 Who carried out the review of policy 800?  
 10 A. That would have been my department. I think it was  
 11 Group Manager Andrew Bell, I think, who would have led  
 12 on it.  
 13 Q. Is he now AC Andy Bell?  
 14 A. Yes.  
 15 Q. What is the section 7(2)(d) guidance referred to here?  
 16 A. There was discussion over — because of the prominence  
 17 of 7(2)(d) there was discussion over whether there  
 18 should be a separate standalone policy on 7(2)(d). But  
 19 on the basis that we were also organisationally keen to  
 20 keep things as straightforward as possible, and not  
 21 increase the number of policies, rather amalgamate, we  
 22 decided that policy note 800 was an appropriate place to  
 23 use 7(2)(d) guidance, so we would incorporate it there.  
 24 Q. Why there rather than say, for example, appendix 1 of  
 25 633 as well?

168

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

169

1 (3.16 pm)  
 2 (A short break)  
 3 (3.32 pm)  
 4 SIR MARTIN MOORE-BICK: Right, Mr Brown, ready to carry on?  
 5 THE WITNESS: Yes, thank you.  
 6 SIR MARTIN MOORE-BICK: Yes, Mr Kinnier.  
 7 MR KINNIER: Thank you, sir.  
 8 Can we go back to the March 2016 action plan, which  
 9 can be found at {LFB00031066/22}. Now, that's the page  
 10 that we were discussing just before the afternoon break.  
 11 If I could ask us to turn over the page to page 23  
 12 {LFB00031066/23}, and looking at that far right column,  
 13 Mr Brown, what we see there in broad terms is  
 14 an iterative process of amendment and consultations  
 15 relating to PN800.  
 16 If we turn over the page to 24 {LFB00031066/24},  
 17 that process ended on 25 August 2015, when the process  
 18 ended.  
 19 Now, can you help us as to why it took over  
 20 two years for the iterative process of amendment and  
 21 consultation to take place and before the policy was  
 22 finally published on 25 August 2015?  
 23 A. Can we go back, please —  
 24 Q. Where would you like to go back to, page 22 or 23?  
 25 A. Sorry, just so I can quickly remind myself of some of

170

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

171

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

172

1 consultations. It would have been a different set of  
2 people, I think Dany Cotton at some point, in BJCHSW,  
3 the health and safety side of it.  
4 MR KINNIER: Just taking a step back from this, as  
5 the Chairman observed, about nine months out of this  
6 process seems to be consumed by discussions with the  
7 BJCHSW out of a period roughly of two years. Is that  
8 the norm, where a policy change bites on or touches  
9 health and safety, that the process of amendment  
10 consultation would take something in the order of  
11 two years?  
12 A. No.  
13 Q. Or nine months — no. Was that exceptional, that it  
14 would take this long?  
15 A. Yes.  
16 Q. Can you remember now what the particular concerns were  
17 that had been raised in the forum of the BJCHSW that had  
18 consumed so much time?  
19 A. No, I can't, I'm afraid. I would have had nothing  
20 whatsoever to do with the health and safety  
21 consultations. Mine would have been purely the  
22 industrial relation consultations.  
23 Q. Even in terms of office discussions, can you remember  
24 whether the concerns raised staff side concerned the  
25 subject matter or the substance of the policy, or was it

173

1 sort of other issues that caused the delay?  
2 A. I'm sorry, I'd be speculating if I was to try to guess,  
3 I'm sorry.  
4 Q. Do you recall if, as part of the review and consultation  
5 process, there was any discussion of any of the concerns  
6 in relation to 7(2)(d) visits that we've been discussing  
7 today, for example inconsistent approach of crews to  
8 identifying buildings in need of visits?  
9 A. That certainly was an issue that was discussed, and  
10 staff side, to their credit, always would have been  
11 seeking appropriate training for their members, ie our  
12 firefighters, in terms of achieving a new policy.  
13 Q. Do you remember whether there was much substantive  
14 discussion, if any, about concerns about the quality of  
15 entries on the ORD and their inconsistency?  
16 A. That would have — that was an issue that we raised,  
17 management side, in terms of why we wanted such a policy  
18 and a risk assessment process. But to my memory, staff  
19 side hadn't raised that issue, that was one of our  
20 issues.  
21 Q. Looked at more generally, did anyone raise that  
22 particular concern?  
23 A. Outside the management team?  
24 Q. Yes.  
25 A. Not that I can recall, no.

174

1 Q. Can you remember whether there was much discussion,  
2 whether in the management team or staff side, on the  
3 question whether operational crews properly understood  
4 what was required of them when carrying out  
5 section 7(2)(d) visits?  
6 A. There wasn't, when we was consulting on this policy,  
7 from the management side. We were satisfied that the  
8 training would address that issue. I don't recall staff  
9 side raising any issues in that regard.  
10 Q. Okay.  
11 Mr Brown, can we now turn on to action 2b or 18b,  
12 which was creation of an inspection regime targeted at  
13 high—priority buildings.  
14 Can we start, first of all, with what your  
15 understanding was of what this action required.  
16 First of all, what did you understand high—priority  
17 buildings to encompass?  
18 A. "High—priority buildings" was a phrase that got into  
19 discussions, I'm not quite sure where it came from, but  
20 we could translate it across really to high—risk  
21 buildings.  
22 Q. This phrase emerged; did people understand what it  
23 meant? Was everyone talking to the same definition?  
24 A. I don't think it was a phrase that was corporately used,  
25 but certainly in the exchanges on this particular action

175

1 it found its way into the correspondence between us, and  
2 I think it caused, at least for a period of time, some  
3 unnecessary confusion.  
4 Q. But eventually did those involved in the review  
5 understand that it was a synonym for high—risk  
6 buildings?  
7 A. Yes.  
8 Q. Who brought clarity to the confusion? Did you knock  
9 heads together, or ...?  
10 A. No, I think it just ... I think in correspondence it  
11 just became clear what was meant and the high—priority  
12 phrase just disappeared.  
13 Q. How did you understand that the proposed inspection  
14 regime would relate to the existing regime for carrying  
15 out 7(2)(d) visits under policy 800?  
16 A. So the existing regime was about staff (a) finding  
17 buildings that currently had never been assessed, and  
18 (b) once they had been assessed, following the risk  
19 matrix in terms of frequency. So it was the bit about  
20 getting buildings — if I can call it — let's call them  
21 unknown buildings, so getting unknown buildings onto the  
22 operational risk database. So the inspection regime was  
23 about giving some guidance as to where to focus your  
24 efforts to get those unknown buildings onto the  
25 operational risk database, because without that

176

1 guidance, there was the danger that buildings of a lower  
 2 risk, shall we say, might be being visited, and of  
 3 a higher risk are just sitting there waiting to be  
 4 visited. So it was to try and give some structure  
 5 around that inertia of getting more premises onto the  
 6 ORD.  
 7 Q. I suppose the one thing that's telling about that answer  
 8 is that it begs the question: how do you define  
 9 high risk? To what extent did the discussions seek to  
 10 identify that concept first as a means of providing  
 11 context for the new proposed regime?  
 12 A. So this was a — 2b or 18b was a task that I asked  
 13 Tom George, who was a deputy assistant commissioner, to  
 14 undertake for me, and Tom then sought the assistance of  
 15 one of his borough commanders within his area,  
 16 John Elwell, who also happened to be the lead for the  
 17 service standard that dealt with this kind of thing, so  
 18 that was a wise choice, and it was between the three of  
 19 us. I think there was some initial clarification  
 20 required, but we resolved that.  
 21 Q. So when, thinking back — we can go to it if you want —  
 22 Mr Dobson responded to the coroner that the creation of  
 23 this new inspection regime was specifically "with a view  
 24 to increasing the number of premises records which are  
 25 available to the Brigade's operational staff on the

177

1 ORD", that appears to have been your understanding also  
 2 about the aim of the exercise?  
 3 A. Yeah, it was to get more on there, but also make sure it  
 4 was the right ones in the right order.  
 5 Q. And it was not confined to high-rise buildings; it was  
 6 buildings generally, from what I make from your  
 7 evidence.  
 8 A. Yes, yeah, there was a banding process and high-rise was  
 9 one of the priority bands.  
 10 Q. Now, just flowing on from the evidence you gave in  
 11 respect to Tom George, can we go to his statement, which  
 12 can be found at {LFB00032823/17}, paragraph 69. We see  
 13 there at paragraph 69, Mr George said this:  
 14 "In November 2013, the Third Officer instructed me  
 15 to carry out some work on a particular action from the  
 16 Lakanal House Action Plan, namely to create an  
 17 inspection regime targeted at high priority buildings.  
 18 One of my [borough commanders] ([borough commander] for  
 19 Kingston) was already the lead officer for Service  
 20 Standard 7 — Operational Contingency Planning. With the  
 21 Third Officer's agreement, I therefore asked the  
 22 [borough commander] for Kingston to consider the action  
 23 and put forward a proposal on what could be achieved."  
 24 Now, just to get some understanding of the  
 25 hierarchy, Tom George at this stage was a deputy

178

1 assistant commissioner who reported to you; is that  
 2 right?  
 3 A. That's correct.  
 4 Q. The borough commander from Kingston, that's John Elwell;  
 5 is that right?  
 6 A. That's correct.  
 7 Q. Can you help us, Mr Elwell's role as the lead officer  
 8 for service standard 7, what did that role entail?  
 9 A. So service standards was something that was in  
 10 the Brigade some considerable time ago and for whatever  
 11 reason it fell by the wayside, and it was something that  
 12 I always thought was a shame and it should be  
 13 reintroduced because it helped standardise issues across  
 14 the Brigade. So I sought to re-introduce those after  
 15 I managed to consolidate the north and the south of  
 16 London together.  
 17 I then set up — I think there was ten service  
 18 standards, and then we sought to provide a lead for each  
 19 one of those service standards in terms of creating  
 20 those service standards all over again, coming up with  
 21 common standards that every borough across the Brigade  
 22 could use, performance indicators that cross-referenced  
 23 with them, and advice and guidance, really. So,  
 24 you know, a new borough commander could look at these  
 25 and he or she could be following the same process as

179

1 a very experienced borough commander. So I had the same  
 2 thing going on.  
 3 This one, service standard 7, operational  
 4 contingency planning, covered, amongst other things,  
 5 7(2)(d)s, so John Elwell's role was to arrange the  
 6 standards and the performance indicators, et cetera, to  
 7 bring that up to fruition, that the whole Brigade could  
 8 use.  
 9 Q. I think there are now 11 service standards.  
 10 A. Oh, okay.  
 11 Q. I don't know whether there were in your time. But would  
 12 it be fair to say that the weight of those standards is  
 13 concerned with measuring performance in a manner akin to  
 14 KPIs?  
 15 A. That's part of the role, but it's also to give guidance  
 16 on what should be done and how it should be done, which  
 17 together leads into a performance indicator.  
 18 Q. Can you help us as to what about the particular role of  
 19 lead officer for service standard 7, operational  
 20 contingency planning, made Mr Elwell appropriate for  
 21 leading the work on action 2b?  
 22 A. Well, because the whole issue of 7(2)(d)s is about  
 23 information-gathering, so effectively creating  
 24 contingency plans for operations, ie incidents. So it  
 25 fell squarely within service standard 7, the whole issue

180

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

181

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

182

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

183

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

184

1 definition?"

2 A. I can't recall exact details of our conversation, but

3 I do know we got to the position in the end where it was

4 about high-risk as per the action plan.

5 Q. Is the greatest risk to both firefighters and residents of

6 those buildings?

7 A. Absolutely.

8 Q. Can we now turn to a briefing paper which is the initial

9 paper that Mr Elwell produced, which can be found at

10 {LFB00032825}.

11 At page 1 of the paper, which is entitled

12 "Action 18b — London Fire Brigade consolidated action

13 plan following Coroners recommendations", the third

14 paragraph under the heading "Background" sets out

15 a number of issues which Mr Elwell identified as

16 "implicit within the concern on numbers of ORD entries".

17 If we could just go through these, simply because of

18 the importance of the document:

19 "a) Is the existing guidance (PN800) fit for purpose

20 to achieve the desired outcomes?

21 "b) What other Brigade data could be deployed to

22 identify relevant premises for inclusion on the ORD.

23 "c) Are the 7000 we have all relevant and in

24 compliance with the guidance in PN800?

25 "d) Which premises are 'missing' from the ORD given

185

1 the guidance in PN800?

2 "e) What is the capacity of a station/watch in terms

3 of the number of ORD entries that can be effectively

4 entered and revisited with the existing guidance. A

5 pertinent point, given the disparity of the numbers,

6 risk and types of premises on different stations ground.

7 "f) Is the quality of existing ORD entries providing

8 data to underpin safe systems of work?

9 "g) Are our staff competent to carry out the 72d

10 visits and enter meaningful data and professional

11 tactical plans?

12 "h) What are the existing Performance Evaluation

13 Tools to monitor performance?

14 "i) What Service Standard is in place to Quality

15 Assure the relevant extant policies?

16 "As these issues start to be effectively defined,

17 addressed and monitored I would suggest that

18 an improvement in the quality and quantity of ORD

19 entries will be observed.

20 "Note: The term 'high priority buildings' used in

21 Action 18b does not accord with the definitions in the

22 extant Policy Note 800 or draft Policy Note 800, this

23 term is therefore taken to mean 'High Risk' in line with

24 the terminology currently in use in both versions of

25 PN800."

186

1 Now, taking a step back, that's a summary rich in

2 detail and complexity. Mr Elwell was proposing

3 a fundamental review of the basic adequacy of

4 the Brigade's existing operational risk management

5 systems; would you agree with that description?

6 A. Yes.

7 Q. Can we now look at another email chain, which can be

8 found at {LFB00041360}. I'm afraid this is a long

9 chain.

10 Could we go to page 10 {LFB00041360/10}, and the

11 bottom of that page. We can see there that on

12 13 December 2013, Mr Elwell lodged his report both with

13 you and Tom George.

14 Do you recall receiving Mr Elwell's report?

15 A. Yes.

16 Q. Now, Mr George followed up with the following email to

17 you the next day, and that can be found at the bottom of

18 page 9 {LFB00041360/9}. Mr Elwell is not copied in to

19 this email. Again, apologies for reading it out:

20 "Dave,

21 "Following the action given to me at PMB — regarding

22 action 18 from the Rule 43 letter following the Shirley

23 Towers and Lakanal House incidents, specifically to

24 create an inspection regime targeted at high priority

25 buildings, I asked John Elwell (lead officer for SS7) to

187

1 look into this and provide me with some suggestions

2 which I was going to review, collate with other

3 observations, and report back to you at or before the

4 next PMB. John has been extremely thorough and produced

5 a 16 page report (attached, and already forwarded to you

6 from John). This report is actually only 5 pages long

7 and is well worth a read, the following pages are

8 associated appendices. John has made some

9 recommendations which I've listed below (although they

10 really need to be read in context).

11 "You asked me to think about how we could improve on

12 our 7.2(d) inspection programme, particularly for high

13 risk premises. I believe John's report does exactly

14 that and each recommendation should therefore be

15 carefully considered in my opinion. Please let me know

16 how you wish for this to be taken forward or I'll leave

17 it to you to raise at PMB (unfortunately I'm not there

18 on Wednesday as I'm on leave, Rick is covering)."

19 Mr George then listed the recommendations from the

20 report in the latter half of his email:

21 "Recommendation 1 — That the on-going review of

22 PN800 provides explicit detail of the types of risk that

23 should be present, the layout of the note should be user

24 friendly and be a one stop shop for all guidance

25 pertaining to the ORD system, including the gap analysis

188



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

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

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

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

189

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

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

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

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

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

19 If we go to the top of page 9, you responded on  
 20 16 December 2013, so just two days later:

21 "Tom,

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

190

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

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

7 A. That's correct, yes.

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

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

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

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

191

1 (Pause)

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

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

8 A. Yes.

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

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

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

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

192

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

193

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

194

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

195

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

196

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

197

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

198

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

199

1 exhausting the pot that there was little point in  
 2 putting too much effort into it, because we weren't near  
 3 the finishing line on that one, we just needed to — it  
 4 was an affront to our common sense. We knew there was  
 5 so many missing and we needed to get them on there.  
 6 Q. Thank you.  
 7 Could we go back to Mr Elwell's report and look at  
 8 recommendation 6, which can be found at {LFB00032825/3},  
 9 where he said or recommended this:  
 10 "Further training is provided to all personnel with  
 11 a role in the ORD process to ensure they have the skills  
 12 to meet the competencies required."  
 13 The paragraph at the bottom of page 3 immediately  
 14 above this recommendation says this:  
 15 "During of the development of the Service Standard  
 16 [presumably 7] and at recent incidents a number of  
 17 existing ORD entries have been examined. A number of  
 18 sub-standard examples were found, this could indicate a  
 19 poor understanding of the rationale and a lack of  
 20 competency based on the above list in recording relevant  
 21 risk and tactical planning information at all levels of  
 22 the process — [watch manager/station manager/  
 23 borough commander/deputy assistant commissioner]."  
 24 Was that reference to substandard ORD entries any  
 25 cause of concern for you, first of all?

200

1 A. Oh, absolutely. Yes, of course.  
 2 Q. Were you already aware of the problem of substandard  
 3 entries?  
 4 A. Yes, which is — I don't want to overplay it in terms of  
 5 substandard entries, but in my view one substandard  
 6 entry is one too many. We can have no flexibility on  
 7 this. So, yes, I was aware that there were examples,  
 8 but then that was part of the reason why we were doing  
 9 what we were doing with policy note 800 and also with  
 10 the training that had probably only just been rolled out  
 11 some seven months before John made this recommendation.  
 12 Q. You don't want to overplay the problem about substandard  
 13 entries in respect of the ORD. We already know the  
 14 substandard nature of the entry in regulation to  
 15 Grenfell —  
 16 A. Yes.  
 17 Q. — that's the subject of findings.  
 18 Can we look at the ORD entry for Grenfell, which is  
 19 at {LFB00003116}. It's something we have touched on  
 20 earlier but it's probably useful to go back on to, to  
 21 remind people.  
 22 The ORD entry was considered in Phase 1 and a number  
 23 of deficiencies were identified. I will take you  
 24 through them. First of all, there were no plans of the  
 25 tower on the ORD, despite the fact that Nicholas Davis,

201

1 the station manager, noted that plans are required, and  
 2 we see that on the entry for 10 May, which is in the  
 3 fifth row in the main table on page 1.  
 4 Secondly, the only photograph of the tower was  
 5 a small aerial image which gave no information about the  
 6 building or access to that building, and that can be  
 7 seen at page 7 {LFB00003116/7}.  
 8 Thirdly, the incorrect number of floors was  
 9 recorded, 20 is stated on page 3 {LFB00003116/3}, under  
 10 "Hazards", and under the heading "Tactical Plan" on  
 11 page 4 {LFB00003116/4}, the subheading "Operational  
 12 Contingency Plan" contained simply a blank box dated  
 13 30 October 2009.  
 14 Are you familiar with the ORD entry for  
 15 Grenfell Tower?  
 16 A. No. I've become aware of it, clearly, since  
 17 the Inquiry, but prior to that, no.  
 18 Q. Were you aware of the extent of the findings in relation  
 19 to the deficiencies of that ORD that were made by  
 20 the Chairman in the Phase 1 report?  
 21 A. Yes.  
 22 Q. Was the standard of ORD entry as exemplified by Grenfell  
 23 typical of the quality of ORD entries generally, in your  
 24 experience?  
 25 A. No.

202

1 Q. Did you agree with Mr Elwell that the problem with  
 2 substandard entries could indicate a poor understanding  
 3 of the rationale and a lack of competency on the part of  
 4 personnel who made those entries?  
 5 A. Not a poor understanding, I think staff did understand,  
 6 but I think what it does indicate is that there's —  
 7 somewhere along the line, there's clearly a gap in the  
 8 process, and this entry on Grenfell is clearly poor and  
 9 wrong, and when I found out about this, yes, it was  
 10 something that I reflected on and thought: how could  
 11 this happen?  
 12 Q. Did you reflect upon it to the extent of actually taking  
 13 action, for example requiring further training to remedy  
 14 the potential problems identified by Mr Elwell, poor  
 15 understanding of the rationale and a lack of competency?  
 16 A. Well, when I saw this entry, obviously I'd left  
 17 the Brigade, but at the time, in terms of John's  
 18 recommendation back in 2013, more training, yeah, it was  
 19 a valid point, but my position on that was we had only  
 20 just rolled out the training some six or seven months  
 21 prior to that, so the need for further training —  
 22 I took the position that what we needed to do is what we  
 23 do with all training: we roll it out and then we monitor  
 24 performance in terms of entries into the operational  
 25 management performance database, and if we find evidence

203

1 that it's not working, and also in fatal fire reviews  
 2 and in training exercises and in performance reviews of  
 3 commands, if there is evidence coming through that  
 4 despite that training it's still not working, then, yes,  
 5 we would revisit it. But with the greatest respect to  
 6 John or any other borough commander that makes that  
 7 recommendation, we need to follow due process in terms  
 8 of determining whether the training has worked or not.  
 9 MR KINNIER: Sir, it's 4.20.  
 10 SIR MARTIN MOORE-BICK: Yes.  
 11 MR KINNIER: The next matters I wish to turn to I won't get  
 12 done in ten minutes. I'm mindful it's been a long day  
 13 also for Mr Brown and it may be useful to start at  
 14 a logical starting point first thing tomorrow morning.  
 15 SIR MARTIN MOORE-BICK: Well, I don't suppose Mr Brown will  
 16 object to an early afternoon.  
 17 How are you getting on with his examination?  
 18 MR KINNIER: Timewise?  
 19 SIR MARTIN MOORE-BICK: Yes, just as a general indication.  
 20 Can he hope to be free tomorrow?  
 21 MR KINNIER: Yes.  
 22 SIR MARTIN MOORE-BICK: Can he put his hopes high?  
 23 MR KINNIER: I would never wish to overestimate anyone's  
 24 hopes in terms of time management here, but I'm  
 25 confident that Mr Brown's examination will be complete

204

1 tomorrow.

2 SIR MARTIN MOORE—BICK: Yes. Well, that's very helpful,

3 because I think he would like to know that.

4 Well, Mr Brown, it is slightly earlier than usual

5 but I think we will stop at that point for the day.

6 I will have to ask you to come back to continue

7 tomorrow, but I think you were expecting that, but it

8 sounds as though you can hope to finish tomorrow.

9 THE WITNESS: Thank you, sir.

10 SIR MARTIN MOORE—BICK: So thank you very much indeed. We

11 will resume at 10 o'clock tomorrow, please, and as

12 before, please don't talk to anyone about your evidence

13 or anything relating to it while you're away.

14 All right?

15 THE WITNESS: Thank you very much.

16 SIR MARTIN MOORE—BICK: Thank you very much indeed. Yes, if

17 you could go with the usher, please.

18 (Pause)

19 Thank you very much, Mr Kinnier. Well, 10 o'clock

20 tomorrow, then.

21 MR KINNIER: Thank you, sir.

22 SIR MARTIN MOORE—BICK: Thank you.

23 (4.21 pm)

24 (The hearing adjourned until 10 am

25 on Thursday, 7 October 2021)

205

1	INDEX	
2		PAGE
3	MR DAVID BROWN (affirmed) .....	1
4		
5	Questions from COUNSEL TO THE INQUIRY .....	1
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

206

207

Opus 2  
Official Court Reporters

beforehand (1) 198:14	102:9,11,12,16,20 133:9	76:11 79:15 80:12	cart (1) 147:6	client (1) 119:5	communication (1) 194:20	47:19 125:20
begin (1) 58:3	141:25 177:15	91:1,11,20 101:7	cases (1) 137:7	clive (12) 84:10 89:8,15,17	communications (1) 68:14	confident (4) 82:16 108:23
beginning (1) 8:13	178:18,18,22 179:4,21,24	103:10,19 106:25 107:3	categorically (1) 134:17	91:14 92:5,14,19 94:10	communities (1) 135:21	112:3 204:25
begs (1) 177:8	180:1 189:14 192:21	109:10 111:18 113:5 128:3	category (3) 29:8 32:18 41:7	97:9,16 98:3	community (15) 7:13	confine (1) 49:25
behalf (3) 36:5 57:4 64:25	193:4,17,18,18 196:5	130:17 133:15 183:11	caught (3) 41:4 74:7 172:1	clives (3) 92:20 93:4 97:18	9:2,15,18,18 16:14,19,20	confined (1) 178:5
behest (1) 128:10	200:23 204:6	202:6,6	cause (6) 80:10 104:22	close (2) 102:14 125:13	17:7 100:23 115:8,13,13	confirm (3) 1:20 3:6 183:20
behind (7) 25:12 30:24 87:23	102:12 196:3,5 197:18	16:9 28:3,6,12,15 29:5	120:16 143:22 172:20	closely (2) 102:11 153:21	196:16 197:15	confirmed (1) 196:25
88:12 99:24 102:10 112:14		34:19,20 36:23	200:25	closer (1) 8:14	company (1) 44:21	conflicting (1) 108:7
being (51) 6:23 17:4 21:20	both (28) 3:3,13 24:15,15	42:12,20,24,25 44:9 45:9	caused (3) 95:24 174:1 176:2	cmb (1) 154:8	comparatively (1) 132:7	confronting (1) 66:11
31:7 36:21 41:10,14 43:14	38:1 63:21 73:16 93:8,10	47:16 51:7,9,12 54:24 60:3	caveat (2) 94:18 110:25	collaborate (1) 6:10	comparisons (1) 140:10	confuse (1) 108:14
45:15 49:20 53:4 57:6	103:15 112:8 128:13 142:4	63:15 64:6 65:17 66:12	cbe (1) 154:21	collaboration (1) 6:14	compartment (5) 32:16,22	confused (2) 84:13 87:10
63:18 65:6 68:7,12 73:23	152:8,9 155:22 160:13	69:4,6,10,13,24 71:13	cbt (3) 119:17,25 123:10	collate (1) 188:2	34:7,15 46:14	confusion (15) 85:19,20,24
74:7 75:4 81:10 82:23 88:3	166:20 172:1 181:17 185:5	76:12,21 77:11,13	central (18) 9:8 25:13,16	collated (1) 82:25	compartmentation (2) 32:25	86:3,9,12,15,18,21 87:1
91:14 95:16,23 96:21	186:24 187:12 190:16	80:4,17,21 86:22 87:3 91:7	61:24 62:2,3 63:5 64:23	collating (1) 18:8	33:12	104:6 129:9,19 176:3,8
99:12 103:11 104:2 107:16	191:23 192:10 196:8,24	92:13 93:3 94:17 95:18,21	76:11 77:20 78:9 82:23	colleague (2) 61:12 100:1	compartments (1) 34:22	conscious (1) 69:11
112:12 113:21 114:17	both (1) 148:25	96:24 97:24 98:1 100:21	86:16 119:7 126:17 135:7	colleagues (4) 6:2 75:4	competencies (2) 190:5	consensus (1) 131:15
115:12,13,14,21 122:14	bottom (25) 11:12 19:13	101:3,12 102:7,8 108:24	141:24 145:11	100:15 141:16	200:12	consider (11) 40:7 45:7 60:2
127:2 129:3 134:2 146:14	27:22 38:25 57:11 83:16	119:22 130:24 134:8	centre (2) 118:11 119:21	collect (3) 5:19 94:23 135:12	competency (3) 200:20	72:15 84:20 87:12 112:21
152:3 160:9,10 172:22	98:12 100:7 106:11 107:22	143:6,13,22 144:1 156:19	certain (6) 54:9 66:15 68:15	collected (6) 15:24 18:4,24	203:3,15	113:9 123:17 178:22 195:5
177:2 181:19 191:13 194:8	120:23 121:1 126:9 131:7	159:10 161:18 163:10	89:10 132:13 197:22	50:17 137:14 138:7	competent (2) 33:10 186:9	considerable (2) 146:22
195:11	142:25 144:10 154:16	174:8 175:13,17,18,21	certainty (2) 129:17 132:9	collecting (6) 48:6,7 135:12	compiled (1) 57:19	179:10
belabour (1) 125:17	168:2 181:5 183:16,19	176:6,17,20,21,21,24	cetera (10) 35:2 46:9 61:18	164:9,11 167:17	complaint (1) 37:6	consideration (5) 30:21 47:7
belief (1) 125:2	187:11,17 196:2 200:13	177:1 178:5,6,17 181:21	92:13 94:18 102:13,19	collection (5) 5:8 14:21	complete (11) 16:2 20:16	63:1,8 190:6
believe (21) 18:15,21 19:7	box (14) 21:1 23:6,20 27:23	183:8,12,13,21 184:6,9	180:6 194:4,4	15:12 17:20 48:25	48:2 55:17 83:5 90:23	considered (10) 19:2 21:1
42:7 44:22 60:5 62:23,25	69:1 90:25 94:20 118:8	185:6 186:20 187:25	chain (20) 62:19 83:12,14	colloquially (1) 120:20	122:20 163:23 196:11	33:20 40:14 48:14 60:9
81:20 86:15 90:2 105:4	119:3,15 124:19 141:13	191:1,6 196:6,7,12	85:2 86:14 87:2 106:3,4,9	column (20) 22:18 68:22	199:8 204:25	110:10 139:20 188:15
114:1 118:24 124:13 125:1	146:10 202:12	197:19,20 198:1	109:2 110:2 126:9 131:6	98:16 105:11,16 139:11,11	completed (7) 20:20 48:9	201:22
129:1,4 150:8,25 188:13	braces (2) 147:16 148:3	built (1) 196:4	149:21 150:1 181:2,3	144:17 145:24 146:8	52:6 125:12,15 140:4	considering (3) 20:21 124:23
believed (1) 131:1	breaches (1) 32:25	bullet (22) 2:9,10 56:5,7,8,20	183:17 187:7,9	149:10,12 152:3 158:17,19	168:6	145:12
bell (2) 168:11,13	break (12) 2:9,10 56:5,7,8,20	38:24,25 39:11,14,17	chairman (3) 164:1 173:5	159:8 161:12 162:3 168:4	completedupdated (1) 20:12	considers (1) 135:24
belonged (1) 14:6	117:5,24 169:11,15	45:25 63:2,9 159:3,11,19	202:20	170:12	completely (1) 114:24	consistency (9) 21:17 50:11
below (9) 25:8 40:24 66:25	170:2,10	165:5,11,12,16,20,22,22	chairs (1) 164:23	combination (1) 28:18	completeness (1) 69:2	112:22 123:19 142:19
107:19 112:17 120:20	breaking (1) 2:11	bureaucracy (1) 162:13	challenge (4) 55:13	combined (2) 7:20 161:8	completing (1) 20:10	145:1 149:8 152:22,25
132:16 188:9 193:20	brief (1) 191:5	business (5) 60:14 153:6	101:15,16,20	combustible (1) 42:1	completion (5) 82:16,19	consistent (7) 70:24
belt (2) 147:16 148:3	briefing (1) 185:8	192:15,18 193:1	challenges (4) 50:4 98:6	come (26) 12:17 15:10 18:8	125:7 162:24 189:3	125:21,23 146:3 156:24
beneficial (2) 81:8,9	briefly (11) 10:9 13:19	bypass (1) 35:24	143:2 172:20	23:3 25:25 34:12,22 37:10	complex (5) 104:15,18,21	165:7 194:20
benefit (3) 94:6 95:6,7	19:11,17 38:22 51:17		challenging (3) 64:14,15	44:4 48:10 55:23 67:16	108:3 143:22	consolidate (2) 7:11 179:15
bespoke (2) 28:5 189:9	105:13 136:8 138:17		94:2	68:11,16 88:4 111:11,16	complexchallenging (1)	consolidated (2) 161:1
best (4) 15:4 106:16 148:4	142:14 161:12		chance (1) 123:10	112:2,20 115:1,14 116:20	108:25	185:12
172:16	brigade (30) 1:5 3:18 7:1,3		change (7) 7:17 10:20 23:17	149:1 163:12 184:12 205:6	complexities (1) 136:25	consolidating (1) 20:21
better (10) 16:13 40:2,9	11:18 21:18 31:4 34:17		36:17 65:20 66:6 173:8	comes (2) 102:17 103:11	complexity (2) 160:4 187:2	constant (3) 90:8 91:4,5
62:1 117:4 148:15	36:7 40:5 50:5 75:22		changes (4) 36:10 94:11	comfortable (1) 1:12	compliance (3) 139:19	constituted (1) 89:25
169:5,7,11 197:22	102:17 131:23 155:4,19		106:17,25	comforted (1) 142:3	142:21 185:24	constructed (1) 36:13
between (26) 7:4 22:16	156:7 162:17 172:6		charge (1) 123:11	coming (8) 47:24 88:1 91:15	compliant (3) 135:25	construction (13) 34:6
25:3,5,25 31:20 46:17	179:10,14,21 180:7 181:15		chat (1) 108:8	142:5 179:20 198:11,13	142:9,10	35:2,24 36:5 37:4,16,19
48:25 51:1 52:10 54:23	185:12,21 189:22 193:11		check (5) 23:3 34:2 44:24	204:3	complies (1) 37:5	38:6 39:1,3,4 42:7 46:9
123:25 136:7 148:22 153:8	199:22 203:17		45:1,19	command (2) 113:8 153:24	complying (1) 16:5	constructional (1) 36:17
167:7 172:9 176:1 177:18	brigades (14) 14:15 15:6		checked (1) 61:5	commander (15) 26:13	component (6) 18:1 30:20	consultation (7) 31:11 66:2
181:4 189:5 191:25 192:11	31:18 50:7,9 76:11 120:12		chief (5) 41:22 42:18	27:9,12 37:9 50:23 102:16	73:15 160:5 162:5,24	99:16 170:21 171:13
193:22 194:2 196:4	156:1,11,21 157:2,5		102:12,15,21	141:25 178:18,22 179:4,24	comprehensive (2) 72:18	173:10 174:4
bevan (2) 148:22,23	177:25 187:4		choice (1) 177:18	180:1 192:21 193:4 204:6	79:20	consultations (5) 170:14
bevans (1) 149:4	brigadewide (1) 147:4		circle (1) 161:23	commanderdeputy (1)	computerbased (1) 119:25	171:21 173:1,21,22
beyond (10) 32:15,21	bring (3) 157:15 161:23		circulated (2) 62:14 67:24	200:23	concentrate (3) 18:10 51:6	consultative (1) 172:15
33:4,14 34:15 58:20	180:7		circulation (3) 189:17	commanders (25) 26:8,18	155:9	consulted (4) 65:19,23 67:21
111:15 114:22 136:19	broad (14) 9:11 21:14 41:25		93:13 172:17	27:4,17 43:13 45:12 54:12	concentrated (1) 67:13	141:14
172:10	68:18 70:15 101:1		cant (28) 50:24 59:12 61:10	57:15 58:4 80:1,21	concentrating (1) 97:23	consulting (1) 175:6
big (2) 49:1 68:14	136:4,12,21 137:6,13,15		72:1 82:8,17 83:9,10 88:8	89:16,21 102:9,11,13,20	concept (4) 65:6 70:2 177:10	consumed (2) 173:6,18
bigger (2) 50:7,10	138:11 170:13		92:7 94:13 99:9,21 103:23	133:9 138:13 155:7 177:15	183:25	contact (1) 47:22
binder (5) 126:15,16,17	broader (4) 27:2 113:19		114:14 123:7 128:11 132:9	178:18 189:14 193:18,18	concern (20) 54:4 64:8 80:10	contained (2) 132:5 202:12
131:8 141:22	115:21 191:9		134:17,17 140:20	claddings (35) 38:12,15,17,21	89:4 93:4,6 95:24 108:1,19	contains (2) 66:23 78:20
binders (1) 132:14	broadly (4) 4:25 52:19		39:5,9,25 40:10,13,19	39:5,9,25 40:10,13,19	112:14,15,18,18 113:17,23	contemporary (1) 85:6
bishop (2) 4:18 10:14	142:9,10		41:1,2,4,7,8,18	42:1,1,11,19,23 43:5,9,16	114:1 116:16 174:22	content (7) 48:18 49:4 67:9
bit (3) 60:21 172:9 176:19	broke (1) 162:23		45:9,25 46:2,7,12,15,20,23	80:2 129:23 152:2 153:21	185:16 200:25	68:3,5 135:24 189:16
bites (1) 173:8	brought (2) 29:15 176:8		47:4,8,16 98:2	182:10	concerned (17) 18:22 31:19	contents (3) 3:6 67:21 82:1
bizarre (1) 154:5	brown (4) 1:8,10,22,24		claddings (1) 41:17	commented (2) 64:24 142:4	37:8 42:2 50:19 70:3 74:11	content (11) 11:10,22 19:17
bjchsw (4) 172:5 173:2,7,17	55:4,23 56:6,22 57:2,13		clarification (3) 78:4 177:19	62:20 63:22 65:8 77:12	91:14 92:10 102:6 108:7	25:11 30:24 42:12 102:10
black (1) 191:19	62:20 74:23 77:2 78:23		184:10	87:6 101:6,11 150:1	116:13 155:2 157:20	107:21 160:6 177:11
blame (1) 171:25	83:21 86:17 108:5,19		clarify (6) 2:5 65:5 78:12	164:24 165:24 176:11	173:24 180:13 184:20	188:10
blank (1) 202:12	110:3 117:3,18 124:17		83:22 85:11 111:22	182:19	concerning (1) 156:1	contingencies (1) 96:15
blocks (5) 84:21 89:12 90:17	126:21 136:6 137:6,22		clarifying (1) 80:3	clear (16) 36:4,20 51:3 54:11	concerns (21) 41:25 44:2	contingency (13) 50:20
93:14,19	149:24 152:20 153:15		clarity (2) 14:3 176:8	62:20 63:22 65:8 77:12	70:7 91:6 92:9,25 93:10	142:1 150:14,17 156:10
blue (1) 158:17	155:8 158:23 160:23		clean (1) 92:17	87:6 101:6,11 150:1	101:2 112:11 113:19	159:2 166:2 178:20
bluntness (1) 98:4	169:14 170:4,13 172:4		cleans (1) 62:1	164:24 165:24 176:11	119:19,21 120:5 124:22	180:4,20,24 181:10 202:12
blush (1) 58:9	175:11 181:10 204:13,15		cleansed (1) 25:17	182:19	157:19 164:3 173:16,24	continuation (1) 14:4
board (13) 11:15,17,21 67:3	205:4 206:3		clear (16) 36:4,20 51:3 54:11	179:1 200:23	174:5,14 191:9	continue (2) 147:25 205:6
76:2 108:10 119:17 135:15	brownlindridge (1) 113:18		62:20 63:22 65:8 77:12	commissioners (9) 27:7	conclude (4) 75:21 109:2	continued (5) 10:22 14:3
140:7,17,18,20 190:10	browns (1) 204:25		87:6 101:6,11 150:1	158:13 159:4,12,20 160:1	145:5,21	83:5 100:24 102:3
body (1) 23:25	buck (1) 15:11		164:24 165:24 176:11	162:14 165:5 182:16	concluded (1) 47:14	continues (1) 156:5
boils (1) 80:20	build (1) 152:10		182:19	commissioning (1) 119:5	concludes (2) 75:21 102:1	continuing (1) 44:3
bold (2) 158:17 159:8	building (54) 22:23 26:22		cleared (1) 167:20	commitments (1) 196:15	conclusion (8) 79:5,9 83:8	contradicts (2) 95:1 130:8
book (1) 58:1	28:3,9,11 29:13,15 31:23		clearer (1) 32:4	committee (1) 172:6	139:14 140:1 142:7 143:25	contribute (1) 64:17
books (2) 86:1,4	33:25 34:10 35:6,13,16		clearly (16) 32:3 35:24 41:18	common (8) 26:2 33:3,23	194:10	contributed (1) 47:2
borough (42) 26:7,13,18	36:13,15 37:4,8,16 38:20		43:6,13 73:10 85:19	34:3,23 89:9 179:21 200:4	conduct (4) 47:20 50:16	contributing (1) 191:15
27:4,9,12,16 37:9 43:12	39:1,3 40:18 43:16 44:1,15		145:14 157:9 165:23 169:3	comms (2) 132:16 133:1</		

155:4	50:17 59:17 72:15 73:7,23	<b>date (6)</b> 69:15 82:16,19	<b>dependent (4)</b> 22:24 34:3	29:12 33:19 95:13	164:3 182:7 198:14	<b>east (12)</b> 4:6,12,15,22,23,24
<b>convenient (2)</b> 56:1 169:9	79:19,25 80:7,11 88:5	133:7 160:16 167:23	67:12,25	<b>difficult (7)</b> 84:22 89:25	201:8,9	5:7,25 7:10 89:11 91:22
<b>conversation (2)</b> 84:2 185:2	92:12 93:18,22,25 94:16	<b>dated (6)</b> 2:15,21 41:24 81:1	<b>depending (2)</b> 22:21 31:23	103:5 171:22 172:12,18,23	<b>domestic (1)</b> 57:22	198:11
<b>conversations (2)</b> 182:18	95:2 98:18 104:22 106:23	167:23 202:12	<b>depends (4)</b> 28:10 93:20	<b>difficulties (5)</b> 66:11 77:6	<b>dominic (2)</b> 9:7 119:9	<b>easy (2)</b> 78:7 109:1
184:13	108:14 109:7,9,11 114:10	<b>dates (1)</b> 82:12	94:18 195:3	100:3 104:22 143:22	<b>done (22)</b> 26:15 46:4	<b>edition (3)</b> 66:20,21 106:4
<b>converted (1)</b> 162:19	115:7 121:20 122:11,14	<b>dave (24)</b> 83:21 84:21 88:25	<b>deployed (1)</b> 185:21	<b>direct (3)</b> 46:22 47:3 134:14	48:15,21 68:2 82:17	<b>effect (7)</b> 10:4 16:11 25:7
<b>convey (1)</b> 182:11	127:7,18 128:2 130:14,19	108:5,5,19,20 110:5,19,20	<b>depth (2)</b> 32:25 33:8	<b>directed (7)</b> 45:8 47:8	92:2,3,15 110:22 116:6	33:12 42:9 46:3 58:3
<b>cooperation (1)</b> 153:25	147:12 155:22 164:14	111:9,11 126:21	<b>deputy (9)</b> 4:17 10:14	50:1,16 69:14 72:19 73:23	125:6 134:16 147:9	<b>effective (4)</b> 92:17 101:13
<b>coordination (3)</b> 67:3 76:1	174:7 175:3 181:17 191:25	128:11,12,23 129:12	27:6,11 45:15 154:21	<b>direction (7)</b> 4:14 5:3 7:23	148:4,9 152:10 163:19	144:15 156:12
119:16	193:22 194:3 197:8	131:15 149:24 153:15	177:13 178:25 182:15	8:25 40:6 49:25 58:10	180:16,16 182:2 204:12	<b>effectively (11)</b> 7:20 14:15
<b>copied (1)</b> 187:18	<b>crime (1)</b> 115:19	181:10,22 182:3 187:20	<b>describe (10)</b> 6:23 41:11	<b>directly (6)</b> 32:13 47:17 93:1	<b>dont (75)</b> 30:10 34:22 40:25	135:7 165:11 180:23
<b>copy (1)</b> 183:18	<b>criteria (5)</b> 57:19 61:15,17	<b>david (13)</b> 1:8,10,22 45:14	43:7 60:10,14 74:9 101:21	116:11 119:8 147:5	42:6 56:10 60:5	183:13 186:3,16 189:19
<b>corner (2)</b> 160:16 167:24	108:25 111:18	81:19 82:7 83:15 99:15	127:21 182:23 184:19	<b>director (20)</b> 7:2	61:2,3,13,15,19 64:10 65:1	194:18 197:11
<b>coroner (10)</b> 12:25 44:4	<b>critical (1)</b> 144:13	126:15 131:22 132:16	<b>described (6)</b> 87:16 127:24	8:3,9,14,16,23 9:11	66:3 69:19 72:20 74:25	<b>efficient (3)</b> 18:7 89:22 92:17
51:21 154:21 155:12 159:4	<b>criticism (3)</b> 94:4,7 121:23	140:5 206:3	129:22 130:10 136:7	10:1,5,8,16,24 17:6 30:13	79:8 82:5,11 83:9 84:12	<b>effort (2)</b> 101:24 200:2
162:15,22 164:3 177:22	<b>crossed (2)</b> 42:13 149:10	<b>davis (1)</b> 201:25	157:13	54:23 55:8 68:1 157:14	85:13 86:8,15 87:9,22 89:8	<b>efforts (1)</b> 176:24
<b>coroners (9)</b> 12:16 51:24	<b>crossrefer (1)</b> 73:8	<b>day (9)</b> 7:5 34:3 90:4,4 95:5	<b>describes (4)</b> 5:18 31:8	159:6 160:12	90:2 94:10 95:8 97:5 99:4	<b>eg (1)</b> 27:24
148:7 158:15 160:21	<b>crossreference (2)</b> 73:22	124:3 187:17 204:12 205:5	106:22 136:11	<b>directorate (2)</b> 67:3 108:10	107:17 109:15 110:7,25	<b>either (9)</b> 12:13 40:17 45:6
162:16 163:2 181:13	121:9	<b>days (8)</b> 7:5 50:25 85:1	<b>describing (1)</b> 60:9	<b>directorates (2)</b> 76:1 119:16	111:13 113:25 116:5,17	77:19,20 122:7,9 167:3
185:13	<b>crossreferenced (1)</b> 179:22	89:14,15,24 90:2 190:20	<b>description (3)</b> 12:2 106:12	<b>disadvantages (1)</b> 116:2	117:6 122:8 123:22	199:21
<b>corporate (14)</b> 9:1,14 13:8	<b>crowder (1)</b> 45:14	<b>db (2)</b> 108:19,22	187:5	<b>disagree (1)</b> 114:24	124:4,13 126:25 129:24	<b>electronic (1)</b> 77:19
16:6 135:15	<b>crr (1)</b> 82:23	<b>dclg (1)</b> 135:21	<b>design (2)</b> 19:15 35:12	<b>disagreed (1)</b> 154:3	130:25 131:1,5	<b>electronicpremises (1)</b> 52:9
140:7,17,18,20 154:7,8	<b>crucial (1)</b> 102:19	<b>deal (4)</b> 45:12 57:4 163:20	<b>designed (5)</b> 115:17 144:22	<b>disappeared (1)</b> 176:12	132:9,10,10,12 141:3,9	<b>element (4)</b> 70:19 93:17
157:4 159:24 161:22	<b>crucially (1)</b> 125:5	191:14	145:25 150:20,22	<b>disappointed (1)</b> 134:2	146:24 147:14 149:23	94:19 103:17
<b>corporately (2)</b> 41:9 175:24	<b>culminated (1)</b> 131:19	<b>dealing (3)</b> 101:15 164:25	<b>designlayout (1)</b> 104:22	<b>disappointing (1)</b> 153:20	150:8 151:5,16 167:3,12	<b>elements (1)</b> 28:22
<b>correct (27)</b> 2:14,23 3:21	<b>culmination (1)</b> 75:7	198:19	<b>desire (1)</b> 195:13	<b>disbanded (1)</b> 7:11	169:17 175:8,24 180:11	<b>elevated (1)</b> 8:15
4:1,4,8 5:16 6:20 11:24	<b>current (11)</b> 13:23 18:16	<b>deals (8)</b> 13:21 51:22 57:16	<b>desired (1)</b> 185:20	<b>discharge (5)</b> 12:24 48:8	182:10 192:4 201:4,12	<b>ellis (13)</b> 9:7 106:6,9 109:3
12:23 21:3 22:2 45:2 49:15	24:14 62:23 128:6 139:21	144:10 157:23 166:2 168:1	<b>deskbased (1)</b> 140:11	101:13,25 150:22	204:15 205:12	114:7,12 116:1,5
67:5 75:20 76:2 96:2 98:20	143:12 156:7 189:16	190:25	<b>desktop (2)</b> 50:22 51:8	<b>discharged (1)</b> 15:22	<b>door (3)</b> 6:12 33:3 34:5	119:5,6,9,12 126:18
119:1,11 135:1 157:10	191:10 194:16	<b>dealt (4)</b> 151:25 177:17	<b>despite (2)</b> 201:25 204:4	<b>discharging (2)</b> 49:6,17	<b>dots (1)</b> 109:4	<b>ellises (1)</b> 119:11
179:3,6 191:7 192:25	<b>currently (6)</b> 133:4 176:17	191:12,13	<b>detail (12)</b> 11:8 19:3 33:7	<b>discretion (5)</b> 23:11 26:4,12	<b>doubt (3)</b> 97:13 118:21	<b>else (6)</b> 46:21 47:22 64:8
<b>correctly (2)</b> 49:11 89:3	181:23 182:2 183:22	<b>death (1)</b> 154:18	45:21 79:14 128:8 129:18	51:15 70:19	192:5	99:13 116:9 150:10
<b>correspondence (4)</b> 85:6	186:24	<b>debased (1)</b> 95:16	130:6 160:7 184:4 187:2	<b>discuss (9)</b> 3:17 11:7 46:21	<b>down (12)</b> 1:12 34:1 80:20	<b>ellwell (16)</b> 141:24 142:5
153:13 176:1,10	<b>cut (1)</b> 50:14	<b>december (6)</b> 2:21 9:4 41:24	188:22	52:24 58:5 122:15 136:8	90:20 96:25 103:11 115:18	177:16 179:4 180:20
<b>corresponds (3)</b>	<b>cutbill (1)</b> 71:24	148:21 187:12 190:20	<b>detailed (7)</b> 19:25 36:10	142:14 184:8	126:14 146:9 150:21	181:4,7 185:9,15
159:11,19,25	<b>cycle (3)</b> 18:15 19:8 189:8	<b>decide (4)</b> 20:5 70:11 132:19	45:14 98:21 137:12 143:7	<b>discussed (9)</b> 44:7 68:4	160:13 162:23	77:18 79:2,24 81:23
<b>cotton (14)</b> 9:5 30:4 32:6		133:12	189:15	92:22 108:4 116:14 141:23	<b>downgrade (1)</b> 66:6	203:1,14
105:3 106:8 108:16 111:4	<b>D</b>	<b>decided (1)</b> 168:22	<b>details (8)</b> 21:25 75:5 82:8	162:21,22 174:9	<b>downloaded (1)</b> 60:20	<b>elwells (7)</b> 179:7 180:5
116:9 119:4 125:18 148:22	<b>d (4)</b> 160:6 161:22,25 185:25	<b>decision (4)</b> 29:13 97:20	128:1 132:1,17 183:2	128:1 38:2 98:15	<b>downstairs (1)</b> 98:8	183:16 187:14 191:4,8
149:11,21 173:2	<b>dac (5)</b> 58:5 119:5,6 181:4	111:24 136:20	185:2	100:5 146:15 170:10 174:6	<b>downwards (1)</b> 41:15	200:7
<b>cottonbevan (1)</b> 153:12	192:23	<b>dedicated (1)</b> 163:24	<b>determination (1)</b> 40:20	<b>discussion (11)</b> 31:4	<b>dr (1)</b> 90:20	<b>email (102)</b> 57:2,4,6,10,12
<b>cottons (5)</b> 31:22 107:22	<b>dacbc (1)</b> 189:5	<b>deemed (3)</b> 22:18 23:6 137:8	<b>determine (20)</b> 24:10 27:3	115:25,25 116:3 140:12	<b>draft (15)</b> 62:13,18,23	58:7 59:12 60:1,11,19,25
112:11 113:17 153:13	<b>dacs (2)</b> 133:9 193:17	<b>deems (1)</b> 108:2	41:2,15 43:15 46:6,18	168:16,17 174:5,14 175:1	63:10,12 65:16 74:19	61:18 62:15,19,20 63:11
<b>couldnt (2)</b> 45:24 84:23	<b>daily (2)</b> 6:13 182:16	<b>deeper (2)</b> 40:8 144:12	55:15 69:22 80:5 81:7 92:3	194:2	83:19 106:3,7,10 126:4	64:21 69:9,14,20 76:18
<b>council (1)</b> 109:17	<b>daly (1)</b> 9:8	<b>deficiencies (6)</b> 75:23 126:2	103:5 136:14,18 189:25	<b>discussions (10)</b> 66:14	127:20 133:23 186:22	77:18 79:2,24 81:23
<b>councils (1)</b> 102:23	<b>dan (1)</b> 9:8	147:7,21 201:23 202:19	195:22 198:25 199:4,9	140:23 171:20 172:1	<b>drafted (1)</b> 128:10	83:12,14,17,23,25
<b>counsel (2)</b> 1:18 206:5	<b>dancing (1)</b> 85:14	<b>deficient (1)</b> 96:7	<b>determined (3)</b> 22:8 68:8	173:6,23 175:19 177:9	<b>drafting (3)</b> 67:19 72:10	84:10,23 85:2,4,24 86:14
<b>counter (1)</b> 94:25	<b>danger (3)</b> 97:24 152:16	<b>define (2)</b> 103:16 177:8	107:11	193:21,22	141:18	87:2,7,11,13,23
<b>counterpart (1)</b> 5:24	177:1	<b>defined (5)</b> 4:25 51:4 57:21	<b>determines (4)</b> 21:14 28:12	<b>disparity (9)</b> 54:22 55:6,8	<b>draw (3)</b> 44:5 79:5,8	88:2,12,18,20,23 89:4 90:7
<b>country (2)</b> 50:8,10	<b>dangerous (1)</b> 94:14	184:15 186:16	70:4 107:13	186:5 189:24 195:20	<b>drawing (3)</b> 107:5 132:1	92:10,23 96:22 106:3,4,6
<b>couple (2)</b> 43:2 150:4	<b>dangers (1)</b> 98:7	<b>defining (4)</b> 100:3,16 101:2	<b>determining (6)</b> 20:22 25:22	196:18,25 198:24	194:9	107:22 108:16,18 109:2,3
<b>course (20)</b> 8:7 12:17 18:9	<b>dany (19)</b> 9:5 30:4 105:3	102:7	28:1 61:16 143:17 204:8	<b>displayed (1)</b> 88:5	<b>drawings (4)</b> 12:5 108:25	110:2 113:17 114:7,16,16
34:13 39:15,18 55:24	106:8 107:22 108:16 111:4	<b>definitely (2)</b> 149:24 153:15	<b>develop (6)</b> 81:8 156:23	<b>disrespect (1)</b> 33:5	132:25 133:4	126:4,9,14,23 128:3,20,22
58:14 79:22 83:21 84:24	112:11 113:17 116:9,13,18	<b>definition (9)</b> 43:6 101:23	157:1 159:16 161:19 165:6	<b>disseminate (1)</b> 15:20	<b>drive (2)</b> 99:21 115:18	130:3,7 131:6,8 132:14
90:15,24 113:2 128:17	125:18 148:22 149:11,21	103:12,19,23 104:8 175:23	<b>developed (4)</b> 189:25 195:22	<b>dissemination (1)</b> 17:20	<b>driven (1)</b> 119:19	133:11,23 134:7,15
130:2 142:5 148:2 163:25	153:13,25 173:2	184:8 185:1	197:16 199:11	<b>distinct (2)</b> 71:1 74:10	<b>dry (5)</b> 57:23 61:18 90:20	148:19,21,23 149:4,20
201:1	<b>danys (2)</b> 112:14,17	<b>definitions (5)</b> 103:13,25	<b>developing (1)</b> 199:3	<b>distinction (1)</b> 48:25	150:1 153:12,13 181:2,3,6	150:1 153:12,13 181:2,3,6
<b>courtesy (1)</b> 47:21	<b>data (18)</b> 52:10,11 53:7,19	104:2,4 186:21	<b>development (2)</b> 198:25	<b>distinguish (1)</b> 123:25	<b>ducting (1)</b> 39:6	182:18 183:15 187:7,16,19
<b>cover (2)</b> 7:1,4	81:8 88:4 90:25 100:18	<b>definitive (2)</b> 101:6 103:16	200:15	<b>distributed (1)</b> 138:13	<b>due (8)</b> 12:17 18:9 34:13	188:20 189:18 190:17
<b>covered (4)</b> 90:2 158:8 165:9	101:11 127:8 137:14	<b>degree (1)</b> 38:19	<b>developments (1)</b> 106:17	<b>distribution (1)</b> 138:11	55:24 130:2 132:20 142:5	194:18 23:1 195:10
180:4	144:21 145:7 164:9 185:21	<b>degrees (1)</b> 164:20	<b>dexter (5)</b> 4:19 8:15 10:14	<b>dl (2)</b> 108:19 132:16	204:7	<b>emailed (1)</b> 62:18
<b>covering (1)</b> 188:18	186:8,10 189:22	<b>delay (2)</b> 60:21 174:1	100:1 102:22	<b>dmb (2)</b> 108:8,9	<b>dumped (1)</b> 109:15	<b>embedding (1)</b> 149:15
<b>covers (2)</b> 136:18 137:2	<b>database (108)</b> 14:24,25	<b>delegated (1)</b> 72:9	<b>dexters (2)</b> 8:17 101:2	<b>dobson (10)</b> 9:4 41:21	<b>duplicating (1)</b> 73:3	<b>emboldened (2)</b> 127:19
<b>cowup (6)</b> 62:16,17,22 63:16	15:24 20:10 22:1 23:18	<b>deleted (3)</b> 25:6,9,18	<b>diagrams (1)</b> 131:13	42:2,10,17 43:21 44:11	<b>during (14)</b> 28:14 29:24	129:6
64:4 70:7	25:4,12 26:3 29:6,14	<b>deliberate (1)</b> 66:5	<b>dialogue (1)</b> 27:16	155:12 158:9 177:22	30:13 50:25 52:19 54:22	<b>emerged (1)</b> 175:22
<b>cowpys (1)</b> 74:21	36:2,3 48:11,24 49:2	<b>deliberately (2)</b> 31:6 102:18	<b>diarise (2)</b> 58:1 59:2	<b>document (16)</b> 23:23,25	58:2 75:2,16,25 137:14	<b>emergencies (1)</b> 156:17
<b>crazy (1)</b> 103:4	52:3,6 53:1 54:18 57:18	<b>deliver (2)</b> 123:3 128:8	<b>diarised (1)</b> 59:15	29:19 44:12 51:19	163:25 189:1 200:15	<b>emergency (3)</b> 12:19 143:23
<b>create (11)</b> 71:12 156:18,23	58:16 60:18 61:22,23,25	<b>delivered (6)</b> 123:5,11	<b>diary (5)</b> 20:12,13 89:20	60:20,24 68:16 98:13	<b>duties (2)</b> 25:6 89:20	184:21
159:9 161:17 165:6 168:8	62:4,7,8,10 76:12,19	142:24 145:4 146:13,19	90:12,12	100:3 119:2 135:6 139:8	<b>duty (6)</b> 5:10 15:22 48:8	<b>emphasis (1)</b> 129:5
178:16 181:20 187:24	77:9,10,16,16,20,21	<b>delivering (1)</b> 128:5	<b>didnt (21)</b> 27:18 32:23 41:8	148:18 157:8 185:18	90:13 101:22,25	<b>emphasise (1)</b> 193:25
190:25	78:3,5,13,19,20	<b>delivery (17)</b> 4:2,6,12,14	68:16 72:25 96:12 99:9	<b>documents (4)</b> 160:13,18	<b>dynamic (1)</b> 147:23	<b>emphasised (4)</b> 42:14 66:10
<b>created (3)</b> 54:20 96:10	79:8,18,20,22 80:6,8,9,16	5:3,23,24 6:11 7:9,24 8:25	112:10,18 114:1 120:18	166:21 172:14		191:23 193:21
118:22	81:7,21 82:24 83:2,5,21	26:16 57:13 64:23 119:7	146:25 154:6 164:5 167:6	<b>dodgy (3)</b> 90:20 96:24 97:24	<b>e (1)</b> 186:	



engines (2) 197:17,23	161:23	experienced (4) 38:14	feasibility (3) 63:3 166:9	17:5 38:14 41:3,4 57:9	forward (6) 62:24 109:24	83:23 91:11 109:15,25
enhance (5) 16:3 146:23	evidence (30) 1:5,25 3:9,16	123:15 144:2 180:1	189:21	92:7 131:12	151:23 172:17 178:23	112:7,8 115:5,10 147:14
156:7 189:3 192:6	11:7 30:3 31:21 32:6 33:8	expert (1) 67:11	features (7) 37:17 38:7,8	first (73) 2:3,15,16 3:16,19	188:16	152:7,9 176:24 178:3,24
enhances (1) 164:22	35:10 47:12 56:11 57:7	expertise (1) 49:22	39:2,3,7 70:21	4:9 5:10 6:21 8:20 11:4,11	forwarded (2) 106:7 188:5	183:3 198:1 200:5 204:11
enormity (1) 59:23	66:9 77:4 86:18,23 95:14	explain (5) 10:9 114:15	february (5) 105:9 135:16	12:9 13:23 14:2 15:14	found (37) 2:22 13:20 17:14	gets (2) 31:10 182:20
enough (1) 88:8	117:7 125:18 133:22	189:19 192:12 194:19	139:5 143:20 154:2	17:13 19:19 21:22 23:5	19:3 25:1 29:18 38:22	getting (5) 176:20,21 177:5
enquiries (1) 47:18	151:16 155:8 169:17	explained (3) 66:2 112:5	feedback (2) 64:13 91:12	25:9 28:24 35:11 36:7	41:23 49:7 51:18 57:11	182:25 204:17
ensure (11) 26:20 29:24	178:7,10 199:2 203:25	117:4	feeding (2) 83:1 164:11	38:25 42:4 43:21 50:1 57:5	60:19 62:16 65:13 74:22	give (15) 1:24 2:2 19:20
57:25 59:1 82:21 112:22	204:3 205:12	explaining (3) 78:2 79:7	feel (4) 44:5 49:22 165:11	58:7,9 66:24 71:3,14 74:23	81:1 83:7,13 84:23 98:11	34:10 72:17 97:24 111:16
123:18 133:10 156:12	evidenced (1) 87:1	114:12	190:24	78:18 79:14 81:4 84:13	106:1 118:17 135:16 139:6	122:1,5,19 123:3 124:6
190:4 200:11	exact (1) 185:2	explains (1) 106:19	feels (1) 181:24	87:17 93:17,20 100:2	166:13 167:22 170:9 176:1	136:25 177:4 180:15
ensuring (1) 123:19	exactly (13) 46:5 55:14 59:6	explanation (5) 32:3 41:12	fell (3) 116:11 179:11 180:25	105:11 109:7 110:5 118:18	178:12 181:2 185:9	given (38) 6:18 8:22 9:21,21
entail (1) 179:8	72:1 90:16 114:19 140:21	79:10 189:15 195:14	felt (10) 23:14 27:2 59:21	119:25 122:1 126:16,19	187:8,17 195:17 200:8,18	32:3 42:22 44:1,8,23 54:11
enter (1) 186:10	141:5,20 148:14 166:24	explicit (1) 188:22	97:18 146:5 148:10 162:24	128:9 136:10 142:16	203:9	55:25 71:16 78:6 82:12
entered (2) 107:4 186:4	188:13 199:23	explicitly (3) 47:3 130:21	169:7 193:7 199:25	146:20 147:7 153:20	four (13) 4:23 6:1,2 7:12 9:5	89:23 95:13 97:8 100:17
entering (2) 189:17 194:16	examination (4) 19:25 56:1	133:11	fenton (1) 9:9	154:13,14 159:3 160:25	49:21 50:6,9 53:2 75:2	101:8 114:17 115:22
entirely (3) 36:20 55:18	204:17,25	exposed (3) 43:13 75:3 127:8	few (6) 50:25 66:24 84:3	164:7 165:12,22 166:3	155:3 160:5 165:9	116:1,7,7 134:6,10,14
126:12	examine (2) 75:13 94:23	express (2) 121:6,7	105:10 132:7 139:22	168:3 175:14,16 177:10	fourth (7) 38:24 44:10,14	144:2 145:17 151:16
entitled (10) 66:23 80:25	examined (2) 35:11 200:17	expressed (1) 114:9	fewer (1) 109:6	183:17 198:23 200:25	62:21 90:6 159:19 162:3	181:10 185:25 186:5
118:16 119:13 120:15	examining (1) 94:22	expressing (1) 65:1	fifth (8) 13:7 44:14 90:6	201:24 204:14	framing (1) 39:5	187:21 190:6 192:16
121:2 135:17 159:15,24	example (26) 27:9	expression (1) 197:22	105:11 132:15 138:10	firstly (3) 26:23 114:25 125:3	francis (1) 154:20	197:25 199:2
185:11	33:2,13,17 35:16 38:10	expressly (4) 39:10 45:8 47:7	159:25 202:3	fit (7) 29:8 42:17 72:6	free (1) 204:20	gives (3) 122:10,22 127:11
entrants (1) 147:19	49:7,12 57:6 89:20 91:21	121:10	fight (1) 95:6	108:24 146:6 169:5 185:19	frequency (9) 20:6,22 22:7	giving (9) 42:24 63:7 86:19
entries (27) 84:6 132:5	93:23 98:2 111:17 112:7	extant (2) 186:15,22	fighting (1) 95:10	fitted (2) 57:22 69:1	23:10,16 24:3 107:13	97:3 116:17 129:14,20
161:11 174:15 181:23	113:5 121:23 122:7 141:7	extend (1) 6:14	figures (7) 52:18 53:5,10,24	fitting (2) 60:17 68:15	143:19 176:19	147:12 176:23
182:20 185:16 186:3,7,19	168:24 174:7 183:11	extended (1) 195:14	54:3,5 134:3	five (8) 7:7 19:15 24:5	frequent (3) 23:1,1 24:12	goes (7) 43:17 44:12 51:9
189:4 190:1,9,16 192:7	192:21,22 198:3 203:13	extensive (2) 8:13 64:11	fill (2) 48:13,14	116:22 136:6 154:22	frequency (2) 21:15 22:21	76:15 114:15 136:19
195:22 199:1,5 200:17,24	examples (3) 121:15 200:18	extensively (1) 79:3	final (16) 7:7 68:17 74:19	162:19 164:20	friendly (1) 188:24	183:18
201:3,5,13 202:23	201:7	extent (9) 112:11 135:25	98:24 102:1 118:4	livestage (3) 20:14 21:4	front (3) 66:23 123:1 135:20	going (30) 1:4 26:11,17
203:2,4,24	excel (5) 77:17 79:1,23	141:17 163:3,14 165:3	124:19,20,20,24 129:21	137:24	frontline (4) 30:5,10 32:7,12	131:12 37:4 45:19 49:15
entry (11) 98:24 168:3	81:23 87:4	177:9 202:18 203:12	130:9 134:7,15 138:10	fixed (2) 107:7 196:10	fruition (1) 180:7	58:19 68:19 83:3 85:15,16
201:6,14,18,22	except (1) 148:6	exterior (1) 43:25	190:17	flammable (1) 38:19	frustration (1) 97:16	88:7,21 91:13 98:8 102:9
202:2,14,22 203:8,16	exceptional (1) 173:13	external (5) 40:13 44:17,25	finalises (1) 190:11	flashing (1) 96:5	fulfil (2) 132:2 191:5	114:25 115:2,5 120:7
envelope (1) 38:20	exchange (3) 128:23	45:21 120:12	finally (4) 20:9 138:9 159:23	flats (3) 12:5 84:5 131:14	fulfilled (1) 36:21	132:11 135:14 148:11
environment (1) 196:4	148:19,21	externally (1) 46:14	170:22	flexibility (2) 31:9 201:6	full (4) 52:1 112:11 153:25	150:16 154:7 157:18 180:2
envisaged (1) 151:8	exchanges (1) 175:25	extinguishing (2) 5:11 92:6	find (17) 2:15 53:3 62:3	floor (1) 197:21	161:23	188:2 193:16
epips (1) 166:11	exclamation (1) 97:10	extra (1) 53:3	66:21 86:13 101:24 102:23	floor (2) 34:2 37:16	fully (2) 63:6 197:4	gone (6) 65:18 80:16 87:25
equally (2) 28:3 198:12	exclude (5) 63:24 127:24	extract (3) 84:7 114:19	103:1,13,24 133:22 137:12	floors (7) 27:24 49:12 90:21	function (2) 49:6,17	121:17 130:8 166:21
eradicate (1) 85:20	129:23 130:1,23	149:5	147:24 148:1 155:14	97:1 103:8 130:17 202:8	functional (1) 44:11	good (16) 1:3,20 29:11
errors (1) 49:8	exclusive (1) 86:6	extreme (2) 37:23 105:11	161:11 203:25	flow (1) 51:1	fundamental (1) 187:3	31:14 33:17 49:18 56:4,24
escape (1) 34:24	exclusively (4) 22:5 32:11	extremely (1) 188:4	finding (6) 55:13 83:3 85:12	flowing (2) 8:21 178:10	further (23) 1:4 21:15 22:18	115:23 117:21 128:13
escapes (1) 46:14	80:8 93:22		145:17 147:15 176:16	flows (1) 130:20	62:25 63:8 64:1 82:8,18	131:17 132:18 133:12
especially (3) 63:5 158:3	execution (2) 166:16 167:15		findings (2) 201:17 202:18	focus (9) 38:10 51:10 81:3	106:9 109:12 131:6 139:23	169:1,14
196:14	executive (2) 102:15,21		finger (1) 193:3	93:11 97:25 127:4 152:25	145:19,19 147:21 148:1	government (2) 135:7,22
essential (2) 121:19 169:3	executives (1) 102:12	f (1) 186:7	finish (1) 205:8	176:23 189:2	152:4 156:7 190:3,15	governs (1) 17:19
essentially (2) 21:21 134:7	exemplified (1) 202:22	faade (1) 45:9	finishing (1) 200:3	focused (3) 156:24 164:2	200:10 203:13,21	gr (2) 77:23,24
establish (2) 106:21 157:4	exercise (14) 23:8,20 50:2,16	faades (1) 40:13	fire (135) 1:5 3:18 4:21 5:13	165:7	future (7) 20:22 25:10 69:22	gr3 (2) 77:1 79:14
established (1) 46:25	51:4,10 60:6 94:8 110:15	face (8) 53:10,17,19 61:4	7:18 9:6,7,17,19,20,23	folder (3) 189:18 194:17,22	70:1,4 80:5 97:22	gr4 (3) 77:2 78:1 79:6
establishment (1) 44:16	113:4,6,18 130:18 178:2	189:4,4,13,13	10:1 11:18,22 12:19 14:9	folks (1) 107:25		gra (3) 38:22 39:10,20
estate (3) 84:21 91:22 94:12	exercised (1) 70:19	faced (2) 50:5,5	15:18 16:24,25	follow (9) 7:22 26:10,19		grade (1) 120:21
estates (1) 89:10	exercises (1) 204:2	facetoface (4) 191:24 192:11	17:1,3,4,7,8 18:20 19:6	53:14 129:25 134:10		grading (1) 184:1
estimate (1) 111:24	exercising (1) 92:11	193:6 195:10	24:15 29:1 31:4,18	135:11 139:25 204:7		graham (7) 106:6 109:3
et (10) 35:2 46:9 61:18	exhausted (2) 148:17 199:24	facility (2) 128:4,7	32:15,21,23,24 33:1,21	followed (1) 187:16		114:7,14 116:5,7 119:10
92:13 94:18 102:13,19	exhausting (1) 200:1	factor (1) 78:24	34:15,17,21,25	following (27) 7:14 12:25		great (2) 184:23 191:18
180:6 194:4,4	exhaustive (1) 38:6	factored (1) 28:21	35:4,5,13,17	26:23 29:25 51:20 57:7		greater (2) 132:1 167:8
etc (3) 90:21 91:3 97:1	exhibits (1) 3:13	failure (1) 77:8	36:2,7,10,14,18,22,22	73:5 100:24 102:4 118:23		greatest (4) 184:7,17 185:5
eustice (9) 87:6,16,20 88:23	exist (1) 199:7	failures (1) 75:15	37:1,11,18 38:9,18 40:25	119:13,18 124:16 127:19		204:5
89:3,15 91:4 92:25 93:13	existed (4) 88:19 101:23	fair (23) 5:20 8:4,10 9:15	41:1,2,6,7,8,13,14,18,22	132:20 147:10 151:17		green (2) 24:20 125:10
eustices (4) 84:10 90:7 92:10	103:1 172:21	12:7 17:22 18:4 58:11 60:8	42:18 43:7,24 44:18	154:17 160:19 176:18		grenfell (11) 18:20 19:6 41:2
96:22	existence (2) 36:15 78:21	66:12 74:6 105:19 107:14	45:3,4,15 46:3,3,13,19	179:25 181:14 185:13		47:15 49:7 96:3 201:15,18
evacuation (2) 38:9 69:3	existing (21) 8:3,9 14:5 25:5	109:5 123:10 138:7,14,24	47:2,6,13 50:5,7,9,10	187:16,21,22 188:7		202:15,22 203:8
evaluation (1) 186:12	81:6 136:13 140:1 156:9	160:22 164:19 180:12	51:20 52:7 75:1 76:12	follows (3) 131:9 143:11		ground (29) 16:13 35:23
even (15) 25:15 26:15 34:4	159:1 161:15 164:8 166:1	192:7 198:20	77:12 79:15 80:13 95:6,11	144:18		58:2,11 59:3,5,12,15,18
35:3 40:22 46:4 80:18,19	176:14,16 185:19	fairly (1) 182:24	98:8 100:14,22,23 102:17	foolish (1) 111:25		60:4 63:4,15 65:17 76:22
112:4 128:19 129:8 130:11	186:4,7,12 187:4 189:22	fairness (1) 167:14	104:17 106:16 109:18	footnote (3) 74:21 78:2 79:7		90:17 93:14,19,20,23
154:5 172:10 173:23	200:17	falls (3) 25:8 32:18 57:19	113:11 115:16,18 130:16	force (3) 18:13,19 19:5		95:18 115:11 127:3,17
event (7) 2:11 5:12 46:3	exit (1) 33:3	familiar (11) 5:9 12:18 16:11	133:19 135:9,10 153:24	forcibly (1) 66:10		131:19 140:24 143:15
75:15 87:19,22 143:23	expand (1) 77:1	19:14 29:25 42:4 63:14	154:19 155:2,21 156:4,14	forefront (1) 88:9		186:6 197:9 199:7
events (1) 75:9	expect (13) 23:17 30:14	65:17 135:4 136:9 202:14	157:3 159:17 161:20 162:8	forensically (1) 141:6		grounds (5) 16:10 93:21
eventually (3) 36:3 176:4	33:9,16 34:14 35:21 37:21	163:11,12 166:6,18 185:12	163:11,12 166:6,18 185:12	forerunner (1) 61:25		115:7 189:24 195:21
184:13	38:11,17 80:7 133:15	196:9,11,13	196:9,11,13	foreseeable (1) 143:6		group (7) 12:12 96:10
ever (7) 29:12,15 116:5,18	143:8 192:14	197:11,13,17,23	forever (1) 60:14	form (5) 10:11,21 139:9		100:11 126:17 162:21
149:23 150:9 199:11	expectation (7) 22:25 29:4	198:4,10,12,15 204:1	forgive (1) 36:19	formal (1) 147:1		163:1 168:11
every (36) 22:17 23:12 24:5	30:18 37:24 45:20 47:22	firefighter (9) 3:20 33:5	gathered (1) 5:14	formalised (1) 107:9		guarantee (1) 84:17
26:14 31:10 32:8,10 51:9	59:22	37:24 92:6 95:9 98:8	gathering (10) 19:25 92:7	formally (2) 78:9 146:21		guess (9) 22:3 25:17 53:15
54:15 55:1,5 56:9 64:2	expectations (4) 189:7,15,19	123:16 124:2,14	127:12 131:20 139:17	format (2) 26:9 98:20		95:20 97:10,15 167:5,7
69:21 84:20 87:12,12	194:19	firefighters (20) 15:2 16:1,12	140:14 156:1,10 159:2	formatted (4) 7:11 40:20		174:2
88:24 91:10,11,20 92:1	expected (10) 28:15 33:20	18:7 30:10 33:6 35:7 45:19	161:16	former (3) 31:22 41:21 100:1		guidance (43) 19:23
95:3 96:16,17 97:6	34:4 49:19 53:16 58:21	46:10 73:15 74:3 75:2	foolish (1) 111:25	formula (1) 195:1		29:20,23 34:11 39:21 61:5
101:9,24 103:22 112:1	59:14 79:20 118:14 127:22	123:24 125:20 131:18	153:17 157:6	formulated (2) 12:15 88:3		73:6 89:23 121:20 122:20
113:4,7,8,10 179:21	expecting (2) 98:7 205:7	174:12 184:7 17:23 185:5	former (3) 31:22 41:21 100:1	formulation (1) 71:19		134:6,10,14,24,25
193:17						

179:23 180:15 184:5 185:19,24 186:1,4 188:24 <b>guide (1)</b> 111:14 <b>guv (2)</b> 131:10 184:25	<b>hes (5)</b> 78:24 79:10 91:15 98:5 129:14 <b>heston (1)</b> 27:13 <b>hey (1)</b> 151:23 <b>hi (1)</b> 107:25 <b>hierarchy (1)</b> 178:25 <b>high (69)</b> 15:17 21:24,24 27:23 44:2,8,25 52:5,13,15 57:18,21 58:1 59:2 63:4,14 66:24 67:1 68:24 69:3,6 74:2 76:12 77:9,10,11,13 81:6,11 84:5,14,20 88:24 90:10,17 100:17,21 104:16 103:3 119:23 126:24 127:5,21,25 131:11,12,23 132:19 133:3,13 156:18 159:10 161:17 177:9 178:17 181:21 183:21,24 184:5 186:20,23 187:24 188:12 190:1 191:1 195:23 196:7,11 204:22 <b>higher (2)</b> 177:3 197:19 <b>highest (1)</b> 184:22 <b>highlevel (1)</b> 38:12 <b>highlight (4)</b> 42:11,19 81:11 85:18 <b>highlighted (3)</b> 52:25 128:23 139:22 <b>highlighting (1)</b> 165:13 <b>highpriority (8)</b> 13:4 71:13 175:13,16,18 176:11 184:9 191:6 <b>highrise (126)</b> 12:4 18:23 22:5,23 28:3,6,9,15,17,23 29:5,12,21 33:24 34:18,20 38:15 39:21 42:3,12,20,23,25 45:9,22 51:23 52:20 53:11,25 54:6,15,24 55:1,10 57:9 58:10,18,20,22 59:11,17 60:3 62:14 63:17,24 64:3,6 65:6,17 66:11,17 69:9,13,23 70:18,21 72:16 73:14 74:2,12 76:20,21 77:16 78:19,20 80:12 82:25 85:3,25 86:2,7,22 87:2,12 88:1,10 89:12 91:7,10 92:13 93:3,13,19,21,24 94:17 95:15,17,21 96:23 97:7 98:1 99:2,3,4,12 100:4 101:3,7,10,12 102:7,8 103:2,3,5,14,19 104:1 113:5 126:5 128:25 129:10 130:23 132:4,7 133:15 134:8 163:10 169:2 178:5,8 183:6,11 197:19 198:6 <b>highrises (11)</b> 52:25 55:14 59:4,14,20 60:7 86:4 91:22 94:1,12 141:8 <b>highrisk (8)</b> 51:7,11 97:25 175:20 176:5 184:15,16 185:4 <b>himself (4)</b> 49:14,16 89:9 131:8 <b>hiya (1)</b> 149:22 <b>hoarder (1)</b> 91:25 <b>hoarding (1)</b> 28:22 <b>hom0004536448 (1)</b> 136:5 <b>hom0004536450 (1)</b> 137:4 <b>hom0004536451 (1)</b> 137:11 <b>hom0004536454 (1)</b> 138:2 <b>hom0004536458 (1)</b> 138:9 <b>hom0004536459 (1)</b> 138:18 <b>home (7)</b> 115:16 155:21 156:14 157:2 159:17 161:20 198:15 <b>honest (3)</b> 61:2 78:17 86:16 <b>honour (1)</b> 154:20 <b>hope (4)</b> 14:14 126:24 204:20 205:8 <b>hopefully (3)</b> 73:11 124:11 138:4 <b>hopes (2)</b> 204:22,24 <b>horse (1)</b> 147:6	<b>hose (1)</b> 130:17 <b>host (1)</b> 26:13 <b>hours (1)</b> 7:5 <b>house (28)</b> 11:14,17,18,22 12:12 14:6,8 43:10,24 44:17 46:25 100:11 108:6,21 110:6,13,16,21,23 147:10 148:7 154:20 156:4 160:6,19 178:16 181:14 187:23 <b>housing (12)</b> 44:23 45:1 55:16 89:10 91:21 102:19,24,24,25 103:22 104:4,5 <b>however (7)</b> 35:21 40:3 112:4 132:23 141:22 190:23 191:11	<b>h</b>	<b>icon (1)</b> 118:11 <b>icons (1)</b> 121:8 <b>id (18)</b> 3:16 27:10 29:8 66:7 71:10 72:22 82:16 86:25 106:15 121:7 122:5 136:7 142:3,14 174:2 181:11 184:6 203:16 <b>idea (8)</b> 62:1 84:16 109:16 128:13 146:25 153:25 198:9 199:15 <b>ideal (2)</b> 128:5 191:17 <b>ideally (1)</b> 47:24 <b>ideas (1)</b> 103:6 <b>identical (7)</b> 24:16 89:13 91:23,23,24 92:4 112:2 <b>identification (3)</b> 19:16,19 149:9 <b>identified (25)</b> 11:18,21 20:1 21:20,23 32:19 36:18 51:19 52:12 74:7 75:23 80:12 82:19 118:16 121:5,16 147:20 157:2 158:18,22 159:17 160:21 185:15 201:23 203:14 <b>identifies (2)</b> 11:4 159:9 <b>identity (24)</b> 11:9 26:9 32:20 33:10 60:7 75:14 81:21 106:17 136:22 142:19,20 143:3,13,15 144:1,25 147:7 149:8,14 152:22,22 157:12 177:10 185:22 <b>identifying (10)</b> 100:4,17 101:3 102:6,8 104:15 119:22 121:21 127:12 174:8 <b>ie (25)</b> 16:12 32:19 34:23 45:2 48:7 52:11,17,20 79:6 83:5 105:11 116:14 130:22 132:7 149:7 150:22 153:18 161:13 164:14 165:6 172:15 174:11 180:24 185:5 197:12 <b>ignore (1)</b> 97:25 <b>ii (2)</b> 137:5,15 <b>iii (1)</b> 137:12 <b>ill (7)</b> 50:24 105:12 111:16 126:25 138:18 146:11 188:16 <b>im (63)</b> 14:14 16:15 18:12 24:2 31:19 37:7,8 41:11,17 42:7 50:19 52:16 53:15 55:4 58:20 61:10,13 62:8 66:8 70:2 71:25 73:20 78:17 79:5 80:1 82:9,18 86:17 88:15,15 89:14,15,24 90:4,4,13 94:17 108:20 109:22 114:6 118:25 120:7 130:7,8 134:1 136:17,18 138:4 151:5,5,22 154:7 171:6 173:19 174:2,3 175:19 187:8 188:17,18 199:23 204:12,24 <b>image (1)</b> 202:5 <b>images (1)</b> 128:4	<b>imagine (9)</b> 61:17 73:2 74:3 77:25 114:14 134:17 141:9 142:6 198:5 <b>imagines (1)</b> 18:17 <b>immediate (2)</b> 58:3 189:2 <b>immediately (3)</b> 66:25 80:12 200:13 <b>immense (1)</b> 98:9 <b>impact (8)</b> 29:25 32:15,21 33:21 34:14 35:19 38:8 106:18 <b>impediment (4)</b> 100:21 101:13,17,20 <b>implement (5)</b> 15:3,6 154:4 163:18 165:10 <b>implemented (2)</b> 144:15 165:4 <b>implementing (1)</b> 160:20 <b>implicit (1)</b> 185:16 <b>importance (6)</b> 57:8 88:10 98:19 104:15 185:18 191:24 <b>important (8)</b> 80:3 99:3 100:19 106:23 107:6 127:13 137:24 167:11 <b>impractical (2)</b> 30:6 196:9 <b>impression (2)</b> 84:4 89:6 <b>impressive (1)</b> 133:19 <b>improve (6)</b> 54:11 109:6 144:23 145:25 188:11 190:15 <b>improved (1)</b> 92:24 <b>improvement (2)</b> 93:2 186:18 <b>improvements (2)</b> 164:18 192:10 <b>improving (2)</b> 156:24 165:7 <b>impulse (1)</b> 88:11 <b>impulsive (2)</b> 88:13,15 <b>inadvertently (1)</b> 193:2 <b>inaudible (1)</b> 122:8 <b>incentive (1)</b> 16:1 <b>incident (19)</b> 35:3 74:11,16,24 75:1,2,16 81:2 88:5 98:10 128:2 130:14 138:10,13,24 139:2 143:6 155:6 169:6 <b>incidents (11)</b> 5:20 7:5 104:23 109:12 113:14 138:13 164:15 180:24 184:21 187:23 200:16 <b>include (14)</b> 5:2 12:5 13:2 27:8 29:14 45:4 63:1 68:25 108:25 129:15 131:13 143:20 168:7 190:7 <b>included (17)</b> 7:22 9:12 25:4 26:2 62:19 67:25 69:22 72:14,17 100:14 107:5,17 118:5 129:18 133:17 144:20 145:7 <b>includes (2)</b> 51:20 181:14 <b>including (7)</b> 45:24 69:3 76:16 119:23 130:23 132:1 188:25 <b>inclusion (4)</b> 132:20,24 133:13 185:22 <b>inconsistencies (3)</b> 144:19 145:6,18 <b>inconsistency (2)</b> 113:20 174:15 <b>inconsistent (2)</b> 92:12 174:7 <b>incorporate (1)</b> 168:23 <b>incorporated (2)</b> 160:9 163:7 <b>incorrect (2)</b> 53:4 202:8 <b>increase (4)</b> 54:14 146:2 149:16 168:21 <b>increasing (7)</b> 108:15 132:3 133:5 134:4 152:4 156:20 177:24 <b>incredible (1)</b> 198:5 <b>independent (1)</b> 102:25 <b>index (1)</b> 206:1 <b>indicate (5)</b> 86:21,25 200:18 203:2,6 <b>indicated (2)</b> 42:2 95:14 <b>indicating (1)</b> 35:12	<b>indication (1)</b> 204:19 <b>indicator (1)</b> 180:17 <b>indicators (2)</b> 179:22 180:6 <b>individual (5)</b> 6:9 12:5 34:22 51:14 131:14 <b>individually (1)</b> 165:13 <b>industrials (1)</b> 6:4 <b>industrial (6)</b> 171:14,16,22 172:2,25 173:22 <b>inequitable (1)</b> 196:13 <b>inequity (1)</b> 197:9 <b>inertia (1)</b> 177:5 <b>influence (2)</b> 15:6 191:14 <b>info (1)</b> 131:11 <b>inform (3)</b> 43:4,23 81:11 <b>information (139)</b> 5:6,11,15,19 6:16 13:16,22 14:17,20,22 15:20,24 16:2 17:17,21,21,25 18:1,4,8,24 19:25 20:4,7,8,11,21 22:3 40:6 47:16 48:6,7,12,13,19,23 49:2,3,10,15 50:17 51:1,11 52:9 54:20 61:13 62:11 69:1,2 73:1,24 74:6 80:15 81:10,14,18,25 84:24,25 85:14,18,22 86:13,22 87:2 88:5 89:23 90:5 92:7 93:5,7 94:24 95:8 96:2,6 100:15 106:19 109:11 113:15 115:6 125:8 127:5,10,13,14 130:12,13,19 131:19,24 132:25 135:5,11,18,23 136:3,13 138:6,11,12,23 139:1,18 140:4,9,14 141:7 143:5,7,21 144:14 147:12 155:20 156:10,13,16 157:20,21,24 159:1 161:15 162:18 163:7,8 164:4,9,11,12,13,19,21 165:1,19 166:10 167:17 169:4 181:16 200:21 202:5 <b>informationgathering (8)</b> 73:14 113:9,11 115:12 166:1 169:6 180:23 181:1 <b>informed (4)</b> 36:6 77:13 84:5 99:19 <b>initial (13)</b> 19:22 70:4 80:5,18,22 106:25 113:9 124:8 128:5 136:11,19 177:19 185:8 <b>initially (5)</b> 4:2 18:5 40:17 59:11 69:25 <b>initiated (2)</b> 83:14 118:1 <b>initiative (1)</b> 166:10 <b>inner (2)</b> 199:17,18 <b>input (1)</b> 163:11 <b>inquest (1)</b> 161:3 <b>inquests (6)</b> 11:19,23 12:25 46:25 154:18 160:19 <b>inquiry (13)</b> 1:18 2:13 3:9 16:15 55:12 61:11 118:16 125:19 128:22 133:22 148:7 202:17 206:5 <b>insertion (1)</b> 194:22 <b>insight (1)</b> 166:8 <b>insisting (1)</b> 90:9 <b>insomuch (1)</b> 16:18 <b>inspect (5)</b> 36:23 37:5 63:25 95:17 198:1 <b>inspected (9)</b> 69:10,25 70:3 80:17 93:7 97:7,12,20 104:16 <b>inspecting (4)</b> 36:16,23 49:16 63:25 <b>inspection (30)</b> 13:3 69:12 70:4 71:12 80:5,6,18,22 95:4,4 100:22 124:3,3,10 156:18 159:9 161:17 175:12 176:13,22 177:23 178:17 181:20,25 182:9,14,19 188:12 191:1,5 <b>inspection83 (1)</b> 187:24 <b>inspections (8)</b> 13:18 60:12	64:1 70:5 97:22 103:22 146:3 198:14 <b>installations (1)</b> 107:7 <b>installed (2)</b> 45:2 54:20 <b>instructed (1)</b> 178:14 <b>instruction (3)</b> 14:3 54:11 58:9 <b>instrumental (2)</b> 127:6 140:5 <b>insufficient (1)</b> 95:16 <b>integrity (1)</b> 26:25 <b>intelligent (2)</b> 131:17 147:23 <b>intended (3)</b> 12:24 38:6 58:12 <b>intends (1)</b> 75:23 <b>intent (1)</b> 60:6 <b>intention (2)</b> 25:11 133:1 <b>intentions (2)</b> 182:8,25 <b>interaction (1)</b> 192:2 <b>interest (1)</b> 44:5 <b>interested (1)</b> 151:5 <b>interesting (1)</b> 190:22 <b>intermittently (1)</b> 34:2 <b>internal (1)</b> 160:6 <b>interpreted (3)</b> 63:16,18 182:21 <b>interpreting (1)</b> 122:4 <b>interrupt (3)</b> 55:4 88:11 193:20 <b>interrupted (1)</b> 12:21 <b>intervene (1)</b> 23:17 <b>interventions (3)</b> 143:9 156:25 165:8 <b>interview (1)</b> 10:18 <b>intimated (1)</b> 12:21 <b>into (33)</b> 4:23 7:20 8:3,9 9:19,25 10:8 16:16 17:9 28:21 30:21 33:3 39:24 43:24 45:4 83:1 85:15 98:8 102:19 154:18 162:19,23 163:7 164:11 166:8 175:18 176:1 180:17 188:1 189:22 196:14 200:2 203:24 <b>introduce (1)</b> 166:11 <b>introduced (7)</b> 50:3,3 66:15 70:22 136:2 150:13 194:22 <b>introduction (4)</b> 13:15 71:2,8,14 <b>invariably (3)</b> 29:7 64:21 172:19 <b>investigate (1)</b> 145:19 <b>investigation (7)</b> 43:24 74:15 75:8,11,20 119:20 145:20 <b>investigations (3)</b> 44:3 85:9 153:23 <b>invite (1)</b> 89:16 <b>involve (4)</b> 34:21 35:25 96:16 199:3 <b>involved (27)</b> 6:24 8:11 35:1,17 38:15 41:17 42:6 43:5 45:21 46:16,19 64:20 65:22 67:18 72:10 75:8 76:14 95:22 96:14 99:13 134:19 140:12 147:15 166:10 167:17 172:25 176:4 <b>involvement (12)</b> 34:12 35:5,8,13 36:11 47:13 96:12 126:12 155:4 163:3,14 166:7 <b>involves (2)</b> 43:16 137:13 <b>involving (1)</b> 155:6 <b>irrespective (1)</b> 79:17 <b>isnt (20)</b> 12:18 40:10 60:9 73:17 78:6 86:23 87:7 111:15,21 115:3 122:3,9 148:3 164:24 165:8 192:16 193:2,7,8 195:15 <b>issued (7)</b> 13:23 71:3 74:8 125:4,4 135:22 139:19 <b>issues (31)</b> 32:10 38:1 40:23 41:6 43:4,6 45:11,13 46:11 48:1 62:25 91:8,15,18 97:4 103:15 131:11 139:22 142:10 144:5 150:4 151:21 161:6 162:25 172:18 174:1,20 175:9 179:13	185:15 186:16 <b>issuing (1)</b> 171:7 <b>iswas (1)</b> 135:4 <b>italicised (2)</b> 127:20 129:6 <b>italics (1)</b> 76:18 <b>item (1)</b> 149:18 <b>items (6)</b> 30:2,8 31:25 72:14 121:5,10 <b>iteration (2)</b> 65:24 73:6 <b>iterations (4)</b> 24:11,12 28:20 171:1 <b>iterative (3)</b> 170:14,20 184:10 <b>itll (1)</b> 130:2 <b>its (107)</b> 14:3,12 15:8 19:5 21:21,24 23:25 25:17 33:4,17 36:19 37:10 38:15 40:23 43:3,6,14 45:19 50:5 53:18 55:1,2,4,25 56:4 57:12 63:21 66:19 69:17 71:4 75:13 78:10,23,24 80:2,6,16 83:3,7,14 85:12 86:18 90:13 91:19 93:25 95:6 99:3 100:7,8 101:11 106:5,14 112:17 114:19 115:2,11,12,14,21 117:4 118:19 120:14 116:7 123:22 124:2 125:15,15,23 129:20 131:7 132:14 135:5,17 138:1,6 139:15 140:1 145:13,22 152:7 155:17 157:20 158:16 160:5,16 164:16 165:17 166:12 167:3 169:3,9,14 176:1 180:15 184:16 190:25 194:1,5,8,10 199:7 201:19,20 204:1,4,9,12 <b>itself (11)</b> 16:6 21:10 22:14 57:10 68:21 106:2 129:16 136:11 137:19 139:4 158:11 <b>iv (1)</b> 138:3 <b>ive (23)</b> 23:22 24:4,8 32:3 33:13 43:5 61:4,5,10 66:1 111:1 114:19 116:7 128:19,21 146:10 149:23 151:19,25 153:25 182:18 188:9 202:6 <b>iwe (1)</b> 109:15	<b>J</b>	<b>james (1)</b> 62:18 <b>january (3)</b> 2:15 106:7 133:8 <b>janek (3)</b> 84:19 87:20 88:11 <b>job (3)</b> 94:1,1,22 <b>jobs (1)</b> 35:23 <b>john (20)</b> 141:24 142:3 177:16 179:4 180:5 188:4,6,8 192:21,22,23 197:5 198:21 201:11 204:6 <b>johns (5)</b> 188:13 190:23 191:14 198:19 203:17 <b>join (1)</b> 47:24 <b>joined (1)</b> 3:20 <b>joining (1)</b> 124:9 <b>joint (8)</b> 12:13 153:8 162:7,8 163:3,6,12 172:6 <b>jointly (2)</b> 11:14 163:17 <b>jon (4)</b> 58:16,19 59:11 82:25 <b>judgement (5)</b> 22:9 23:14 26:1,21,25 <b>july (8)</b> 3:24 13:23 71:4 74:8,11 75:2 126:11 172:9 <b>june (6)</b> 4:5 7:9,19 19:4 65:12 172:9	<b>K</b>	<b>keen (2)</b> 109:15 168:19 <b>keenly (1)</b> 193:21 <b>keep (3)</b> 2:6 72:21 168:20 <b>keeping (1)</b> 26:17 <b>ken (5)</b> 41:21,22 42:10,18 43:4
--	--	---	----------	---	---	---	--	---	----------	--	----------	---

<p>key (12) 14:19 18:1 33:8 62:24 109:11 139:10 141:23 143:13,24 144:1 167:19 171:12 kicks (1) 147:24 kind (7) 37:4 86:6 90:2 135:11 177:17 192:2 195:14 kingston (3) 178:19,22 179:4 kinnier (37) 1:6,7,17,19 23:2 24:6 55:23 56:18,25 57:1 116:19,25 117:3,13,22,23 157:12,16,25 158:3,6,8,11 169:8,13,23,24 170:6,7 173:4 204:9,11,18,21,23 205:19,21 kirkham (1) 154:21 knee (3) 84:19 87:20 88:11 kneejerk (3) 87:16 88:14,16 knew (10) 101:9 148:14 192:22,23 193:17,19 197:1 199:15,21 200:4 knight (3) 41:21 42:18 43:4 knighton (1) 62:18 knock (2) 34:4 176:8 know (60) 16:13,23 29:7 43:3 46:8,8,11,14 47:23 50:8 61:13,15,19 70:10,11 71:23 72:20 73:8 74:20 82:5 83:4 89:8,25 90:4 91:12 95:10 101:22 108:12 113:24 115:19 124:21 128:20 132:10,10,12 140:13 141:3,9 146:25 150:25 151:16,20 160:11 166:2 172:13 179:24 180:11 181:19 184:13 185:3 188:15 192:20 195:7 199:7,14,20,22 201:13 205:3 knowhow (1) 167:18 knowing (2) 46:18 197:18 knowledge (23) 15:5 30:11 32:8,24 36:4 37:24 38:16 46:13 70:20 78:18 82:3 86:11 89:9 93:3 108:15 118:11 128:3 147:17,18 156:2 193:11,15 195:4 known (6) 48:16 80:9 157:1 159:16 160:5 168:1 knows (1) 199:23 kpis (2) 180:14 190:7</p> <hr/> <p>L</p> <p>lack (3) 200:19 203:3,15 lacked (1) 32:7 laid (2) 34:7 66:1 lakanal (50) 11:14,17,18,22 12:12 14:6,8 40:22,23 41:1,8,10,13,13,17,19 42:1 43:5,10,10,24 44:17 46:25 51:17,20 100:11 108:6,21 110:6,13,16,21,23 147:10 148:7,25 154:12,20 156:4 157:8,13 160:6,19 161:2,5,24 167:21 178:16 181:14 187:23 lambeth (3) 74:13 77:4 109:14 land (2) 15:11 112:6 landlords (1) 44:8 language (1) 150:1 large (7) 55:10 143:3 196:5 197:16 198:10,16,18 largehigh (1) 91:1 largely (1) 139:18 larger (1) 167:13 last (7) 12:1 27:23 69:6 103:17 118:7 146:10 194:14 late (2) 14:11 111:10 later (13) 4:2 11:10 22:4 45:7 53:2 71:15,16 88:2 108:16 114:16 132:8 167:20 190:20 latest (2) 98:13 106:7</p>	<p>latter (4) 127:24 129:23 130:22 188:20 lay (2) 97:23 137:22 layers (1) 138:23 layout (2) 107:5 188:23 layouts (1) 37:16 lead (32) 12:13,13 13:15,25 71:8,14,19 72:3,5,8 141:25 149:18 155:1 162:4,4,7,8 163:3,4,6,12,17,17 177:16 178:19 179:7,18 180:19 181:9 187:25 191:16 193:4 leading (2) 112:16 180:21 leads (3) 163:24 180:17 182:20 learned (1) 156:3 learning (3) 75:17 120:24 124:10 least (12) 22:17 23:12 46:1 68:6 73:22 75:21 91:6,12 101:1 176:2 183:4 192:17 leave (3) 56:10 188:16,18 led (6) 63:25 75:15 80:7,24 158:16 168:11 left (6) 8:15 10:14 63:8 158:17 168:3 203:16 lefthand (2) 52:2 159:8 legal (1) 31:16 legislation (2) 34:23 166:19 lengths (1) 130:16 less (5) 22:21,25 53:2 111:20 199:20 lessons (1) 156:3 let (5) 47:23 105:12,13 138:18 188:15 lets (11) 21:10 35:9 49:25 54:5 93:11,23 123:1 165:25 176:20 191:19 193:20 194:20,22 201:13 letter (15) 41:20,22,24 42:4 43:20 45:6 154:21 158:13 159:4,12 160:1 162:15,20 181:13 187:22 level (21) 10:13,25 12:3 20:6,8 32:2 33:7 45:17,21,24 49:22 51:3 102:22 114:3 123:6,8 129:17 130:5 132:3 160:7 193:20 levels (1) 200:21 lfh (38) 3:20 5:14 13:15 15:5,19,22 16:7 28:14 35:18 41:9 42:2 46:21 47:17 51:20 52:19 57:2,8 63:19 69:1 75:14,25 104:3,6,7,8 119:9 135:18,25 139:5,17,25 143:12 144:17 145:20,20 153:18 154:23 161:14 lfh0001025518 (1) 38:23 lfh00001256 (2) 19:3 65:13 lfh0000125619 (1) 29:18 lfh000012567 (1) 65:14 lfh00003116 (1) 201:19 lfh000031163 (1) 202:9 lfh000031164 (1) 202:11 lfh000031167 (1) 202:7 lfh00004801 (2) 51:18 158:12 lfh0000480125 (1) 158:16 lfh0000480127 (1) 159:7 lfh0000480128 (1) 51:22 lfh000125619 (1) 37:14 lfh00029307 (1) 160:14 lfh0002930717 (1) 161:10 lfh0002930718 (1) 161:21 lfh00031066 (1) 167:22 lfh0003106622 (2) 167:25 170:9 lfh0003106623 (2) 170:12 171:2 lfh0003106624 (1) 170:16 lfh0003212811 (1) 166:14 lfh00032161 (1) 57:11 lfh000321612 (1) 57:17 lfh00032166 (1) 2:16</p>	<p>lfh0003216615 (2) 15:15 57:5 lfh0003216622 (3) 13:13 166:4 167:2 lfh000321663 (2) 4:10 7:7 lfh000321664 (2) 6:23 8:21 lfh000321665 (1) 11:13 lfh000321667 (2) 12:1 154:14 lfh000321669 (1) 12:10 lfh000323638 (1) 100:6 lfh0003282317 (1) 178:12 lfh00032825 (1) 185:10 lfh000328252 (1) 191:21 lfh000328253 (2) 195:17 200:8 lfh000394854 (1) 63:12 lfh00041360 (1) 187:8 lfh0004136010 (1) 187:10 lfh000413609 (1) 187:18 lfh00041365 (2) 148:19 153:13 lfh000420894 (3) 155:14 158:16 162:15 lfh00042252 (1) 181:3 lfh000422521 (1) 183:17 lfh000422522 (1) 181:6 lfh00047224 (1) 66:22 lfh00050215 (1) 106:1 lfh000502151 (3) 106:12 108:18 114:8 lfh000502152 (1) 106:14 lfh000502153 (1) 106:5 lfh00082695 (1) 62:16 lfh00083849 (2) 13:20 17:14 lfh0008384913 (1) 20:25 lfh0008384914 (1) 27:22 lfh0008384917 (1) 24:6 lfh000838492 (1) 19:12 lfh000838493 (1) 20:3 lfh000838497 (1) 25:2 lfh000838498 (2) 21:11 24:19 lfh00084020 (1) 2:22 lfh0008402015 (1) 196:1 lfh00091785 (1) 135:16 lfh0009178514 (1) 142:25 lfh0009178515 (2) 144:9 146:8 lfh000917852 (2) 142:13 152:18 lfh0009178520 (1) 139:13 lfh000917853 (1) 141:12 lfh000917855 (1) 139:6 lfh00095042 (1) 104:12 lfh00095342 (1) 83:14 lfh000953421 (1) 84:9 lfh000953422 (1) 83:17 lfh00102299 (1) 74:17 lfh0001022997 (1) 76:7 lfh001022998 (1) 76:17 lfh001022999 (1) 76:24 lfh00104291 (1) 41:23 lfh001042912 (1) 44:13 lfh00104535 (1) 60:19 lfh001066151 (1) 105:10 lfh001066152 (1) 98:11 lfh0011359912 (1) 131:7 lfh001135992 (2) 126:8 128:18 lfh001189594 (1) 118:7 lfh0011984928 (1) 74:22 lfh0095042 (1) 81:1 lfhs (22) 4:14,21 5:10,18 6:6 7:18 8:25 9:22 17:19 51:17 134:24 139:11 142:8 143:10,25 154:24 155:13 160:6,15,20 191:10 192:18 lfepa (1) 12:18 lfepas (1) 12:12 lfh (1) 108:20 liaise (1) 58:5 liaison (1) 37:9 lies (1) 197:9 life (7) 5:12 15:21 18:6 95:6,12 156:25 165:8</p>	<p>lift (4) 33:25 57:23 75:3 130:16 like (22) 3:16 62:21 71:10 81:3 83:4 95:24 97:5 106:15 110:23 121:18 122:5 136:8 137:23 142:14 148:12 155:9 157:12 170:24 181:11,22 198:9 205:3 liked (2) 31:14 197:14 likelihood (7) 32:15,21 33:21 34:14,18 35:10,18 likely (3) 143:14,22 144:1 likes (2) 92:15 110:15 limited (5) 84:18 131:24 142:13 166:8 167:5 lindridge (16) 108:5,20 110:5,12,19,20 111:6,9,11 126:15 128:11,12,23 129:12 131:22 132:16 lindridges (1) 130:22 line (17) 12:5 38:24 59:9 69:6 76:10 107:4 126:7,19 131:13 132:25 133:4 135:14 145:24 186:23 197:24 200:3 203:7 linear (3) 122:6,11,21 lines (2) 7:8 194:15 link (1) 102:19 linked (1) 20:11 list (42) 30:8,9 33:18 37:13 38:6,25 58:19 61:8 72:14,17 79:20 82:24 83:7 84:15,19 85:10,11,15 86:6,7,10 87:16,17 88:16,19 89:21 90:11,13,23 101:7 103:16 109:9 114:11,17,20,23,25,25 115:22 116:17 140:8 200:20 listed (5) 119:4 121:11 133:3 188:9,19 listen (1) 127:1 listening (1) 100:9 lists (2) 73:3 103:1 little (6) 90:19 93:15 94:5,9 116:24 200:1 live (2) 37:8 91:23 living (1) 28:22 loaded (1) 95:23 local (12) 37:3,9 45:16 51:3 55:16 102:12,15 109:13 115:18 135:21 155:23 181:18 located (3) 86:23 87:3,4 location (5) 39:4 44:19 69:1 100:20 131:14 locations (1) 101:7 lockwood (1) 83:24 lodged (1) 187:12 log (1) 76:3 logical (1) 204:14 london (38) 1:5 3:18 4:16,23,25 5:7 7:13,19,25 9:3,23 12:18 31:3 34:17 50:5,7 52:15,21 54:16 55:14 63:5 89:11 91:22 100:4 101:13 102:23 103:14,20,25 115:20 179:16 185:12 193:16 196:3,5 197:14 198:4 199:16 londoners (1) 4:15 londonwide (1) 6:11 long (15) 2:4 87:25 152:14 161:5 171:12,12,24 172:1 173:14 187:8 188:6 190:17 191:3 196:17 204:12 longer (2) 103:9 116:22 look (67) 21:10 22:13,14 24:20 30:19 32:8,13,13,25 35:9 37:14 40:19 43:20 45:8 46:2,18 47:4,8 51:17 58:17 60:18 62:13 67:12 68:21,22 71:10 74:15</p>	<p>79:13 90:6 93:22 95:20 96:13 104:12 105:10 106:15 111:14 113:6,11 118:7,18 119:13 121:2 123:1 124:19 133:8 136:4 143:10 148:18 149:20 161:6,12 165:25 167:20 179:24 183:15 184:4 187:7 188:1 191:19 193:20 194:13,14 195:16 196:1 199:16 200:7 201:18 looked (8) 14:24 17:15 19:11 20:14 23:5 105:9 113:13 174:21 looking (39) 29:8 30:22 32:2,5 33:19 34:2,25 43:15 46:6 53:24 58:24 62:8 69:6 79:6 86:12 93:11 96:17 97:13,23 98:24 99:10 103:17 107:23 109:14 113:17 121:22 126:19 129:6,16 144:6,17 146:8 147:25 149:7 159:8 164:23 165:3 170:12 191:21 lookout (1) 38:7 looks (2) 111:19 137:23 loop (2) 68:16 125:13 lost (1) 76:5 lot (12) 31:3 55:15 82:13 85:8 89:22 92:18 102:20,22 110:2 133:8 147:17 197:8 lots (3) 31:4,10 153:22 low (6) 22:15 24:8 107:17 112:16 114:2 133:16 lower (1) 177:1 lunch (1) 2:11 lunchtime (1) 117:24</p> <hr/> <p>M</p> <p>main (4) 41:14 57:23 108:19 202:3 maintain (4) 21:17 81:8 98:25 99:8 maintained (5) 77:11 84:4 98:17,23 144:15 maisonettes (3) 90:20 96:25 98:6 maisonettestyle (1) 39:4 major (1) 7:4 majority (1) 29:9 makes (3) 79:11 164:21 204:6 making (14) 60:16 69:21 72:5 80:21 82:14 83:6 99:13 101:24 109:15 115:7,20 182:10 183:3 193:5 man (1) 14:16 manage (3) 5:19 10:1,17 managed (3) 61:22 119:7 179:15 management (41) 5:6,17 6:15 13:16,22 14:17,23 15:7 17:17 48:23 49:2 62:11 81:14,18 82:1 84:24 85:3 89:23 90:5 100:15 108:10 109:22 125:6,8 135:15 138:3 140:2,5,7,17,18,20 162:21 174:17,23 175:2,7 187:4 189:8 203:25 204:24 manager (27) 22:10,19,20 23:7,11,13,21 48:16,18,20,21 49:5,14,18,19,21 51:15 70:20 108:2 115:3,4 126:17 168:11 192:24 197:25 200:22 202:1 managerial (3) 10:11,20 96:12 managers (40) 24:10 25:24 26:5,10,19 27:17 50:1,16,20 51:5 57:15,25 58:1 59:1,2 79:25 80:1,7,20 89:17,21 90:9</p>	<p>91:6,8 108:23 126:22 127:3,16 128:1,4 134:8 189:5 191:25 192:12 193:19,23 194:3,3,4 managerstation (1) 200:22 managing (11) 4:21 6:6 7:18 9:22 40:9 49:21 50:9 60:15 62:6 82:1 91:17 mandatory (1) 118:13 manner (3) 180:13 189:9 190:11 many (16) 54:10 55:14 72:22 94:18 101:12 130:15,16 143:6 145:15 156:2 182:5 199:6,9,14 200:5 201:6 march (9) 4:19 9:5,8 10:23 18:14 105:18 154:20 167:23 170:8 margins (1) 92:19 mark (1) 97:10 marked (1) 21:2 martin (38) 1:3,9,11,16 23:3,10 19:56,3,14,22,24 116:23 117:1,9,14,18,21 157:16 158:2,4,7,10 169:11,14,20,25 170:4,6 172:4,8 204:10,15,19,22 205:2,10,16,22 masse (1) 27:5 massively (3) 16:16,18 184:20 master (4) 25:6 89:20 90:11,13 materially (3) 92:24 95:16 96:7 mathematically (1) 53:3 matrices (1) 24:15 matrix (35) 21:8,10,12,14 22:14 23:14,24 26:11,20,24 27:3 28:20 50:11 107:1,9,17 108:1,20 109:25 110:6,9,10,12 112:13,23 113:20 131:20 132:21 133:14,16 142:22 143:17 144:22 145:25 176:19 matter (6) 37:20 44:4,6 67:11 68:3 173:25 matters (14) 6:14 14:14 30:6,16 32:9 33:11,19 92:11 94:15,22 120:21 124:1 166:2 204:11 maximise (1) 156:15 maybe (10) 27:11 32:13 34:4 82:7 92:4 108:8 109:22 124:12 129:24 172:9 mdt (4) 90:18 91:1 93:14 164:17 mdts (2) 112:25 127:9 mean (16) 7:17 22:20 41:9 53:25 58:18,19 65:24 78:18 98:3 141:5 157:25 167:6 186:23 192:20 193:25 199:6 meaning (1) 133:16 meaningful (1) 186:10 means (12) 5:14 18:3,8 31:16,17 35:9 36:18 38:2 114:15 144:12 177:10 194:20 meant (9) 33:5 70:13 84:21 88:25 114:13 172:22 175:23 176:11 184:18 measurement (1) 190:8 measures (3) 75:22 112:21 113:13 measuring (1) 180:13 mechanics (1) 124:16 mechanism (3) 77:12 157:4 164:17 medium (1) 22:15 meet (8) 12:16 27:10,13 28:17 122:23 164:3 190:5 200:12 meeting (6) 27:4,6 100:10 119:18 144:16 189:9</p>	<p>meetings (14) 16:22 26:13 50:24 68:6,8 92:20 182:15 189:4 191:24 192:22,23 193:6,15 195:10 meets (1) 45:2 member (6) 1:5 37:6 67:4 140:17,19,21 members (8) 66:9,13 72:9 89:24 127:7 163:20,23 174:11 memoire (1) 30:19 memory (3) 85:5 105:12 174:18 mention (1) 17:24 mentioned (2) 40:1 197:8 mentioning (1) 116:18 mere (1) 73:3 message (13) 57:13 84:13,19 87:10,11 88:24 108:12 126:20 127:2 128:9,15 132:16 133:1 messages (1) 108:8 met (4) 6:12 28:15 193:17,18 method (5) 106:22 196:22 197:7,10 199:3 methodology (5) 189:25 195:21 198:25 199:4,11 metres (1) 27:24 michael (1) 119:12 mick (3) 119:5,6 126:18 middle (8) 68:22 76:23 108:17 139:10 149:10 161:13 198:12,13 might (38) 19:20 27:13 36:24 37:5,6 41:2 42:3 55:13 70:17 75:15 85:13 87:19 89:10 92:12 94:25 95:5,11 103:4 111:24 112:7,8 116:14 122:2 127:21 128:19,20,21 131:1 132:12,18,19 133:7,12,13 142:20 144:25 152:23 177:2 mind (14) 15:1,2 38:10 40:3,11 41:20 53:9 54:21 78:25 79:1 126:25 136:19 146:7 198:21 minded (1) 161:6 mindful (6) 52:16 66:8 94:17 107:21 145:19 204:12 minds (1) 88:9 mine (4) 2:4 54:9 61:12 173:21 minimum (1) 72:22 minor (1) 167:5 minutes (2) 116:22 204:12 misrepresented (1) 151:19 misrepresenting (1) 41:19 miss (3) 95:11 115:23 148:16 missed (3) 123:18,22 124:12 missing (5) 73:23 165:14 185:25 191:2 200:5 misunderstanding (1) 86:5 misunderstood (1) 23:4 mixture (1) 34:21 mmhm (1) 42:21 mobile (3) 88:4 127:8 164:9 mobilising (11) 4:7,13,16 5:23 7:10,13 9:1,10 57:14 84:8 109:21 model (7) 133:18 136:2,5,6 137:17,17 184:1 modified (1) 156:3 module (1) 155:8 moment (3) 78:11 107:23 157:12 moments (1) 105:10 monitor (3) 60:11 186:13 203:23 monitored (2) 76:1 186:17 monitoring (8) 48:5 60:15 98:12 105:9 160:15,20 181:13 183:18 month (5) 27:11,13 52:6 53:4 88:2</p>
---	---	---	---	--	---	--

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130:12	practical (9) 25:7 29:4 30:5	principal (1) 18:3	proportion (1) 55:7	71:19 72:3,10,13 73:5,20	quite (12) 24:2 28:25 31:12	recently (2) 3:4,18
plates (5) 109:11,15	42:9 45:23 66:10 122:17	prior (9) 26:15 64:10 68:2	proposal (2) 178:23 182:1	74:6,10,15	43:3 58:21 59:13,19	recognise (1) 115:14
163:7,9,9	139:21 195:15	124:7 128:3 145:10 195:3	proposed (4) 156:5 162:20	75:1,7,11,13,19,25 76:6	122:18 129:21 175:19	recognition (2) 196:20 197:2
play (2) 68:14 109:11	practicalities (1) 166:9	202:17 203:21	176:13 177:11	77:22 78:1,12,23 79:12	197:5 198:21	recollection (5) 91:14 120:5
please (33) 1:11,20 2:4,9	practically (1) 94:16	prioritisation (1) 58:5	proposing (1) 187:2	80:10,24 81:16,18,21	quote (1) 183:6	134:21 149:2 166:22
31:1 39:14,17 42:16	practice (9) 64:19 66:1 75:24	prioritise (1) 127:16	proposition (5) 78:16 80:17	82:2,4,10,19 83:8,11 85:23	quoted (3) 79:3 114:19	recommendation (50)
56:8,10,15,17 69:15	120:18 122:11,22 140:24	prioritised (2) 13:18 51:10	87:17 93:18 122:19	86:12,17,25 87:6,11,16,19	146:10	142:16 149:6 150:22
117:5,6,10,12 120:8	189:16 194:16	priority (11) 156:19 159:10	protecting (2) 5:12 15:21	88:11,15,22 89:6,14,23		151:8,18 152:15,19,19
128:19 137:22 144:9	practices (2) 16:4 66:15	161:18 178:9,17 181:21	protection (1) 17:9	90:6,15 92:9,22 93:11		153:4,7 154:4
166:24 169:16,16,21	pras (1) 52:21	183:21 184:5 186:20	protective (1) 92:15	94:4,15 95:13 96:4,22		155:1,3,5,6,9,16 157:19
170:23 181:12,22,25	precedes (1) 128:20	187:24 191:1	provide (6) 7:1 11:9 179:18	97:13,23 98:10		158:5,15 162:17 163:2
188:15 205:11,12,17	preceding (2) 79:3 144:3	proactive (1) 36:24	188:1 189:15 190:14	99:13,16,19,25		164:2 165:4 188:14,21
plus (1) 24:21	predecessor (1) 71:19	proactiveness (1) 36:8	provided (18) 2:12 7:3 29:20	101:5,11,16 102:1		189:2,11,21,23 190:3,6,10
pm (5) 117:15,17 170:1,3	predeterminessic (1) 86:5	probably (26) 11:8 20:19	69:3 81:5 109:9,16 114:10	103:17,24 104:6,9		192:2,4,16 193:5,8
205:23	predominance (1) 93:24	32:1 33:16 38:14 40:1,9	120:13 124:23 125:1,15,20	105:3,5,7,16,22,24		194:1,1,7,13 195:16
pmb (3) 187:21 188:4,17	predominant (1) 38:18	50:24 59:19 64:23 67:16	135:6 142:17 166:17 190:3	107:13,16,20 108:11		198:20,23 200:8,14 201:11
pn800 (18) 127:10,24 129:22	preference (1) 114:9	78:8 100:8 111:8 117:4	200:10	109:19,21,24		203:18 204:7
130:10 131:20 168:6,8	pregnant (1) 97:13	124:11 139:15 146:20	provider (2) 103:22 120:12	110:5,9,12,22,24		recommendations (27)
170:15 181:18 183:23	preinquest (2) 11:20 148:7	148:17 163:13 166:12	providers (8) 44:24 55:17	111:3,6,11 112:10,21		12:16,24 51:21,25
185:19,24 186:1,25 188:22	premise (1) 132:21	171:2 182:16 195:25	102:19,24,25,25 104:4,5	113:17 114:4,19,22		139:23,24 142:11,14
189:6,11,16	premises (115) 5:13 19:20	201:10,20	provides (6) 25:2 39:2	115:2,25 116:9 118:4,16		154:28 155:19 168:7 195:19
pointless (1) 91:2	20:1,17,19	problem (12) 2:10 42:11	121:19 137:18 143:17	119:2,9,13		196:19 200:9
points (9) 12:11 27:25 28:16	21:6,6,15,20,23,25	94:15 132:18 133:12	188:22	120:3,8,11,20,23 121:12		record (5) 1:21 16:2 114:24
39:14 62:25 111:23 112:7	22:3,8,16 24:21,22,25	193:2,3 198:11,13	providing (7) 19:17 60:24	122:1,16,25 123:8,13,17		128:1 149:14
136:21 139:9	25:3,5,8,8,25 27:24 28:23	201:2,12 203:1	99:10 166:8 167:5 177:10	124:16 125:2,16		recorded (22) 20:7 21:25
police (2) 102:13 115:18	29:21 44:3 48:2,9 51:23	problems (4) 42:19 100:16	186:7	126:1,4,19 128:14,17		28:2 29:5 49:10 52:5,14
polices (10) 72:22,23,24,25	52:5,10,13,13,15 53:11,25	144:2 203:14	provision (9) 25:7 28:1 50:14	129:6,16 130:2,5,20		54:24 55:5 95:22 97:4
144:16 156:1 168:21	54:15,19 57:18,22 58:2,10	procedural (1) 124:16	114:20,22 135:5 136:3	131:3,6 132:10,14 133:22		99:11 119:23 127:22
186:15 190:13 194:21	59:2,18,25 61:7 62:2	procedures (7) 5:18 39:23	140:9 147:11	134:6,12,21,23 135:3,13		129:11 130:6 131:23,25
policy (106) 13:16,17,19,21	63:4,17 69:1,21 70:22	54:13 151:9 155:20 162:17	provisional (1) 104:8	136:21,25 137:3,10,17,21		134:9 141:7 146:5 202:9
14:1,2,5,7,10	76:20 77:5 79:21 81:11	181:15	provisions (2) 76:16 189:6	138:2,9,16,22 139:3		recording (12) 20:11 49:11
17:11,12,14,19 18:19,22	82:25 83:6 93:9 95:15	proceed (1) 111:6	public (7) 16:22,23 37:6 44:5	140:16,23 141:1,6,12		98:19 106:22 126:5,23
19:2,9 20:16,18 23:25 25:2	100:4,17 101:23 103:2,7	proceeding (1) 74:18	127:8 155:5 184:22	142:5,11 144:7,9 145:17		127:4,14 131:11,18 143:21
27:21 31:10 39:23 40:2,9	104:16,21 106:21 107:2	proceedings (1) 160:18	publication (7) 105:17 125:4	146:7,17 147:5,20		200:20
49:25 50:1,15 62:14	108:3 109:10 110:16	process (63) 10:18 20:14	126:10 127:10 189:12	148:3,17		records (2) 156:20 177:24
63:7,10,16,19 65:11 66:6	111:14 112:1 114:11	21:5 28:1,5 35:14,16 47:9	190:12,14	150:5,10,12,20,25		rectified (1) 124:11
67:17 71:2,15,20	122:6,8,11 126:5	58:3 62:4 65:23 71:5 72:11	published (10) 17:16 65:12	151:5,13 152:14,18 153:11		rectify (2) 55:3,22
72:6,14,17	127:17,22,25 128:6,25,25	75:8 80:11,14 83:2,2 96:9	66:20 67:6,10 68:7,17	154:2,10 155:12 158:25		red (4) 96:4 118:8 125:10
73:3,6,7,12,13,22 74:5	129:3,10 130:12 131:23	106:20,24 107:9 123:25	118:4 134:25 170:22	159:6,14,22 160:3,11,25		159:8
76:16 106:18 107:1,9	132:7,25 133:3,6 136:14	132:23 136:12	pumped (1) 103:12	161:9 162:2,8,11		redefining (1) 190:7
108:2 109:25 110:10	145:10,11,14,16 146:4	137:5,13,19,24 138:3,11	pungent (2) 96:22 116:2	163:3,13,17,25 164:6,16		reduce (1) 29:2
126:10,13 129:25	149:17 152:5 156:20	139:25 140:10,15	purely (2) 10:10 173:21	165:3,15,25 167:3,9,14,20		reducing (1) 127:7
134:11,20 140:11,13	163:6,8 177:5,24	141:11,19 143:2,12,25	purest (1) 145:13	168:13,15,24 170:24 171:2		reengage (1) 129:2
142:22 143:12,17 144:22	183:2,23,24 185:22,25	144:4 145:23 146:5	purported (1) 165:9	173:13,16,23		refer (7) 78:6 84:14 106:24
145:2,23,24 147:3 156:9	186:6 188:13 190:2 195:23	170:14,17,17,20 171:15,16	purpose (14) 15:20 16:7	174:4,13,21,24		115:15 161:24 183:25
157:1 159:1 161:15,19	preparation (1) 128:22	173:6,9 174:5,18 178:8	62:15 71:4 72:6 75:13	175:1,10,22 176:4,8,13		195:24
164:8,8 165:18 166:1	prepare (1) 12:6	179:25 184:10 189:1	94:20 100:21 104:20 146:6	177:7,21 178:5,10 179:4,7		reference (18) 63:10
168:8,9,18,22 169:2,5	prepared (4) 58:17,19	190:4,15 192:13 200:11,22	160:19 185:19 189:10	180:9,11,18 181:2		73:3,5,9,10,17 77:15 87:13
170:21 171:8,12 173:8,25	61:3,11	203:8 204:7	192:13	182:11,24 183:2,5,15		107:8 118:5 121:4,6,7
174:12,17 175:6 176:15	preplan (1) 68:25	processes (5) 54:13 95:25	purposes (4) 5:11 43:1	184:16,25 185:5,8		122:3 183:5,6 190:13
186:22,22 189:17,18	preplanning (11) 11:6 12:3	96:20 142:8 145:22	103:21 141:1	187:7,16 191:8,19		200:24
191:15 194:16,18 195:3,11	15:16 57:8 67:2 76:9,16,25	produced (5) 112:12 135:15	pursuant (1) 155:2	192:4,9,16 193:2,20		referred (16) 39:10,11 50:2
201:9	131:12 132:3 156:12	160:18 185:9 188:4	push (1) 129:2	194:13 195:1,16 196:23		59:11 60:18 99:14 107:8
policyguidance (1) 159:16	prescriptive (1) 70:23	production (1) 52:8	pushback (1) 91:12	197:2,7 198:23 199:11,13		110:9 117:25 146:14
poor (5) 200:19 203:2,5,8,14	presence (2) 39:4 45:8	professional (10) 22:9 23:14	putting (6) 73:20 93:5 96:19	200:6 201:2,12,17		151:2,10 157:7 168:15
popular (2) 66:17 198:8	present (12) 39:7 42:3	26:1,21 63:23 92:14 95:9	133:7 138:4 200:2	202:18,22 203:1,12		184:10 197:2
poris (7) 134:24,25 135:4	100:10 108:3 142:20	116:16 132:11 186:10		qualification (2) 122:2,5		referring (16) 25:17 77:19
136:6 139:4 144:11 154:3	143:14 144:1,25 152:23	professionalism (3) 49:23		qualify (3) 121:25 151:13		78:10,20,24 79:9 81:22
portal (1) 83:4	154:9 184:7 188:23	95:2 113:25		191:11		85:3,10 87:20 94:10 98:5
pose (3) 69:4,7,25	presentation (5) 43:10 52:23	professionally (1) 97:19	q (443) 1:23 2:15,18,20,24	quantity (6) 186:18 189:4		99:1 104:1 106:11 114:21
posed (3) 42:19,23 70:14	68:15 100:13,14	programme (13) 27:6 40:15	3:2,6,8,11,15,22 4:2,5,9	190:8,16 192:6,10		refers (5) 87:11 96:23
position (23) 8:2,8 10:2,22	presentations (3) 45:13,14	46:23 51:6 120:13	5:1,6,9,17,22	quarter (1) 26:14		118:19 133:11 153:8
15:6 42:22 53:18 54:21	98:1	124:17,22 126:1 181:25	6:4,6,9,14,18,21 7:22	quarterly (1) 27:5		203:12
64:2 85:23 91:18,19	presented (6) 22:22 26:22	182:9,14,19 188:12	8:2,7,17,20 9:21 10:3,6,22	question (27) 15:13 38:21		reflected (1) 203:10
92:4,6,23 98:13 125:22	38:12 51:4 140:6,16	programmed (2) 36:24 96:13	11:3,17,22,25	40:1 42:16 43:8 55:7 74:23		reflection (2) 70:6 148:9
126:1 139:11 184:14 185:3	presenting (1) 127:23	progress (2) 60:15 160:20	12:9,17,21,24 13:2,6,11	99:7 113:14,25 124:6		reform (2) 35:6 100:13
203:19,22	presents (2) 28:11 184:17	progressing (2) 3:23 125:10	14:12,14 15:1,11,13 17:10	128:9 130:5 134:14 143:24		refresh (1) 105:12
positions (2) 3:23 10:25	press (1) 151:5	prominence (1) 168:16	18:2,8,12,19,22 19:2,8,11	156:5 155:22 163:13		refreshed (1) 85:5
possibility (1) 107:6	pressure (1) 64:12	prompt (1) 37:17	20:23 21:4,10,14,19	164:1,23 169:1 175:3		regard (13) 14:15 21:4 46:22
possible (4) 30:20 34:8	presumably (7) 9:21 19:5	promoted (1) 4:5	22:6,11,13 24:14,18,25	177:8 181:17 190:18 191:4		92:8 99:25 113:23 122:24
168:20 182:5	35:12 90:9 109:21 115:3	prompt (1) 47:6	26:4,9,18 27:20 28:5,8,14	196:18		150:19 157:9 163:10
possibly (3) 28:25 68:2	200:16	prompted (3) 10:12 92:10	29:4,12,16 30:22 31:1,21	questioning (2) 126:7 135:14		164:23 167:6 175:9
129:21	pretty (2) 84:17 91:2	113:18	32:5,13 33:8,19 34:12,17	questions (10) 1:18 2:3		regarded (1) 143:13
post (4) 4:5 54:6,10 193:13	prevalence (1) 197:19	prompting (1) 8:17	35:9,16 36:8,18 37:12,25	46:5 47:25 116:21 206:5		regarding (8) 86:22 87:2
postdates (2) 53:7 148:20	prevent (4) 16:20 17:4,5	promulgate (1) 103:18	38:4,11,21 39:15,18	queue (1) 48:16		regardless (2) 83:6 97:18
postfire (2) 35:4 37:2	75:17	promulgated (2) 31:10	40:11,22 41:8,20	quick (3) 16:22 108:8 131:22		regards (2) 142:2 150:16
postingquest (2) 12:22 13:7	prevention (6) 7:15 16:17	189:12	42:9,17,22 43:20 45:23	quickly (3) 95:23 128:6		regime (18) 13:3 71:12 80:6
pot (2) 199:23 200:1	17:8 126:21 153:9 154:25	properly (5) 61:4 92:15	46:21,25 47:6,11 48:3,5	170:25		
potential (5) 32:16 46:17,19	preventionbased (1) 16:16	94:22 144:15 175:3	49:5,10,14,25 50:14			
112:19 203:14	preventions (1) 9:13	properties (19) 28:2 42:3	51:4,10,14,17			
potentially (2) 19:20 148:16	previous (6) 9:12 25:13	44:18 45:5 51:5 52:20 54:6	53:7,9,13,18,24 54:4,21			
pra (3) 20:2,17 147:3	65:16 66:9 126:2 140:8	61:8 72:16 84:7 85:25 86:2	55:4 58:9,14,24 59:7,9,16			
practicability (5) 64:5 65:2	previously (2) 66:5 71:3	97:3,3 107:16 113:21	60:1,6,11,18 61:8,15,20,22			
70:9 91:7 93:12	primarily (2) 5:14 15:10	183:5,6,7	62:6,9,12 64:4,8,17			
practicable (5) 30:20,23	primary (8) 4:11 6:25 8:23	property (6) 5:12 15:21,23	65:1,4,8,10,22 66:4,8,19			
31:8,24 60:3	18:3 166:16 167:9,11,14	106:17 107:10,13	67:6,9,18,21 68:3,18,21			
			69:17 70:6,9,13,19,25			

156:18 159:10 161:17 175:12 176:14,14 16:22 177:11,23 178:17 181:20 187:24 191:1,5 <b>region (1)</b> 128:24 <b>register (9)</b> 25:14,16,22 61:24 62:2,3 77:20 78:9 82:23 <b>regular (9)</b> 24:23 35:3 78:7 109:18 143:16 156:2 182:15 192:22,23 <b>regularity (2)</b> 66:6 107:11 <b>regularly (2)</b> 151:21 160:18 <b>regulation (5)</b> 34:21 35:5 162:9 166:7 201:14 <b>regulations (2)</b> 33:1 45:3 <b>regulatory (9)</b> 9:2,15,17,19 17:8 35:6 100:13 163:11,12 <b>regurgitated (1)</b> 164:13 <b>reinforce (1)</b> 189:6 <b>reinforced (1)</b> 108:13 <b>reintroduce (1)</b> 179:14 <b>reintroduced (1)</b> 179:13 <b>reissued (1)</b> 148:2 <b>relate (2)</b> 52:17 176:14 <b>related (6)</b> 12:3 36:19 134:23 159:1 161:15 166:1 <b>relates (5)</b> 5:10 23:7 81:9 104:21 138:12 <b>relating (9)</b> 6:14 11:5 51:11 56:11 143:21 149:5 156:10 170:15 205:13 <b>relation (26)</b> 5:17 13:14,25 14:16 24:25 34:18 49:10 62:18 71:8,9 72:4 74:16 93:3 98:13 103:24 105:25 106:3 116:21 118:8 125:16 155:5,16 173:22 174:6 194:13 202:18 <b>relations (6)</b> 31:13 171:14,17,23 172:2,25 <b>relationship (1)</b> 102:14 <b>relevant (14)</b> 18:24 21:1,25 27:9 44:2 45:5 73:24 76:15 143:4 166:21 185:22,23 186:15 200:20 <b>religiously (1)</b> 26:14 <b>remain (2)</b> 62:24 92:3 <b>remained (1)</b> 9:22 <b>remains (1)</b> 70:2 <b>remedial (1)</b> 148:5 <b>remedied (3)</b> 73:12 126:2 147:22 <b>remedy (1)</b> 203:13 <b>remember (44)</b> 47:10 52:23 58:7 60:24 61:2,22 65:1,22 66:3 74:23,25 82:10,11,17 83:8,10 87:19 99:9,13,19,21 110:7,22 111:1,11 114:6 116:9 120:16 123:5,7 131:4,5 134:2,6,16 141:17,19,20 149:3 160:7 173:16,23 174:13 175:1 <b>remind (7)</b> 69:15 127:2 128:4 129:24 166:24 170:25 201:21 <b>remit (5)</b> 33:5 43:18 85:20 90:3 116:12 <b>removed (3)</b> 107:2 132:22 133:6 <b>renamed (1)</b> 7:14 <b>renumbered (1)</b> 160:10 <b>reoccurring (1)</b> 75:18 <b>repeat (3)</b> 8:6 80:1 86:24 <b>rephrase (1)</b> 42:16 <b>replaced (1)</b> 149:11 <b>replicates (1)</b> 149:6 <b>replied (1)</b> 184:2 <b>report (38)</b> 47:14 74:16 75:7 76:6,15 79:1 80:24 98:10 12:10 104:11 105:9 125:12 135:15 139:5,8 140:4 141:14,18 142:12 145:5 149:7 154:2 160:15	163:24 181:13 183:18 187:12,14 188:3,5,6,13,20 191:4,8 195:19 200:7 202:20 <b>reported (9)</b> 4:17 9:3,6 100:12,16 119:6,8 163:21 179:1 <b>reporting (2)</b> 165:13,23 <b>reports (4)</b> 125:9 135:20 142:11 145:17 <b>represents (1)</b> 62:23 <b>requested (1)</b> 172:22 <b>requesting (1)</b> 78:4 <b>require (11)</b> 2:9 19:23 22:17 36:10 62:25 77:13 94:16 130:6 140:2 143:7 196:8 <b>required (34)</b> 20:8 23:8,20 33:15 44:18 51:19 65:16 69:9 79:21 104:13 112:22 125:14 131:16 132:3 134:9 136:15 138:23 142:7 143:16 163:5 175:4,15 177:20 189:3,7,9,20 190:5 192:11,12 194:19 198:16 200:12 202:1 <b>requirement (3)</b> 59:17 119:19 190:25 <b>requirements (3)</b> 44:12 45:3 52:7 <b>requires (6)</b> 20:5,16 70:12 94:24 106:21 119:17 <b>requiring (3)</b> 21:20 63:17 203:13 <b>requisite (1)</b> 47:1 <b>read (1)</b> 120:7 <b>rescue (7)</b> 15:18 30:1 52:8 76:12 104:17 135:10 155:3 <b>rescued (1)</b> 75:4 <b>rescues (1)</b> 32:17 <b>research (2)</b> 44:16 140:12 <b>reservations (1)</b> 64:5 <b>resident (1)</b> 34:5 <b>residential (26)</b> 12:4 15:17 29:5,13 34:18,20 42:23 52:4,13,15 57:9,22 84:5 95:15 107:3 126:23 127:4,25 131:12 156:19,19 163:10 183:12 196:7,12 199:19 <b>residents (1)</b> 185:5 <b>residing (1)</b> 111:19 <b>residual (1)</b> 86:5 <b>resilience (4)</b> 7:2 71:22,23,25 <b>resolve (2)</b> 196:22 197:7 <b>resolved (2)</b> 177:20 196:21 <b>resource (2)</b> 197:10,15 <b>resources (2)</b> 139:2 199:21 <b>respect (9)</b> 83:18 141:7 153:9 163:4,4 164:4 178:11 201:13 204:5 <b>respond (1)</b> 156:16 <b>responded (3)</b> 144:17 177:22 190:19 <b>responding (1)</b> 104:23 <b>responds (1)</b> 159:3 <b>response (27)</b> 4:3 7:15 9:13 51:24 108:22 109:21 126:21 130:5 134:24 135:8,18 143:11 153:9 154:25 155:13,15,24,25 157:25 158:2 159:12,20 160:1 165:4,6 182:3 183:16 <b>responsibilities (11)</b> 3:17 4:11 8:4,10,23 9:12 10:7 11:9 15:1 72:3 166:18 <b>responsibility (13)</b> 5:2 6:25 7:12,23 9:14,18 10:19 39:22 166:16 167:8,10,13,14 <b>responsible (22)</b> 4:20 6:6,9 7:18 9:22 10:3 11:6,14 13:6 34:9,12 36:6 47:13,18,23,24 62:6 67:6,9 71:11 97:19 111:22 <b>rest (2)</b> 38:9 133:19	<b>restructure (1)</b> 7:14 <b>restructuring (1)</b> 8:18 <b>result (11)</b> 14:5 43:10 92:11 95:17 154:19 155:20 156:13 157:21 162:18 181:16,18 <b>resulting (1)</b> 52:8 <b>resume (4)</b> 56:8 117:5 169:16 205:11 <b>retired (5)</b> 18:14,18 19:6 52:17 103:17 <b>retirement (4)</b> 9:5 10:23 53:7 148:21 <b>review (60)</b> 18:17 51:18 52:3 64:17 81:6 82:2,21 83:9 136:13 141:6 145:19,21 110:20 111:10 113:7,8,11 120:21 127:3 132:23 133:2 136:13 141:6 145:19,21 146:17 148:4,11,25 151:17 153:3 155:19 156:2,9,11 157:8,14 158:11,16 159:1,7,14 161:15,24 162:17 164:7 165:25 168:6,9 174:4 176:4 181:15,22 187:3 188:2,21 189:8,23 195:20 196:18,20,23,25 198:24 <b>reviewaudit (3)</b> 144:24 147:7 151:14 <b>reviewdeadline (1)</b> 133:7 <b>reviewed (5)</b> 13:23 18:16 72:6,8 181:19 <b>reviewing (1)</b> 60:24 <b>reviews (3)</b> 153:23 204:1,2 <b>revised (2)</b> 17:13 189:11 <b>revision (1)</b> 65:23 <b>revisit (1)</b> 204:5 <b>revisited (1)</b> 186:4 <b>revisits (3)</b> 18:5 106:25 143:19 <b>rewording (2)</b> 30:8 32:1 <b>rfs (1)</b> 109:17 <b>rich (1)</b> 187:1 <b>richard (5)</b> 126:15,16,17 141:22 142:4 <b>rick (1)</b> 188:18 <b>righthand (5)</b> 98:16 139:12 146:9 158:18 168:4 <b>rightly (2)</b> 197:5 198:22 <b>rightwards (1)</b> 143:10 <b>rfs (1)</b> 111:19 <b>rings (1)</b> 199:17 <b>ripple (1)</b> 16:11 <b>rise (50)</b> 15:17 19:20 27:23 44:1,2,8 45:1 52:5,13,15 57:18,21 58:1 59:2 63:15 66:24 67:1 68:24 69:3,6 76:12 77:9,10,11,13 81:6,11 84:5,14 20 88:24 90:17 97:3,24 100:17,21 104:16 107:3 119:23 126:24 127:5,21,25 131:11,12,23 132:19 133:3,13 196:11 <b>riser (6)</b> 61:18 90:21 96:25 103:9,10 104:7 <b>riserdry (1)</b> 104:7 <b>rises (1)</b> 90:10 <b>rising (2)</b> 57:23 98:9 <b>risk (196)</b> 5:6,18 6:16 13:16,17,22 14:17,20 15:7,9,24 17:17,20 19:16 20:1,4,10,15,17,19 21:5,6,8,10,24 22:1,8,13,15,22 23:18 25:4,8,12,13,16 26:3,11,20,21,24 28:12,19 29:6,14 36:1,3 38:11 39:20 40:20 45:5 48:2,10,11,24 51:4 52:3,6,13 53:1 54:16,17 59:25 61:24,25 62:2,3,4,10 69:4,7,25 70:12,14,22 71:5 73:23 74:6 77:20,21 78:9 80:16 82:23,24 83:1 85:12,16,16 86:8 87:5 88:3,6 92:1,16	93:9 95:5,22 96:4 99:6 103:7 106:20,23,24 107:1,9 108:4 109:22 110:5,10,12,16,18 111:14,24 112:1,6 113:1,7,10,16,20 115:16,16 116:15 119:22 121:15 122:4,6,11,20 124:1 126:24 127:6,7,13,15,15,23 129:4 131:17 134:5 135:5,8,17,23 136:3,11 137:12 138:3,6,6,12 139:17 140:2,9 142:21,22 143:16 144:13,22 145:1,10,11,12,12,25 152:23 153:1 156:22 164:12 174:18 176:18,22,25 177:2,3,9 183:9,9,23,24 184:7,17,20,22,23 185:5 186:6,23 187:4 188:13,22 195:20 197:20 198:2 200:21 <b>riskbased (1)</b> 59:24 <b>risks (1)</b> 148:13 <b>risks (22)</b> 19:21 20:1 28:11 42:23 70:16 86:1 91:24 121:16,21 127:3 131:18 143:6,14,15 144:2 149:15 157:2 159:17 161:20 189:24 196:18 198:24 <b>rita (6)</b> 4:19 8:15 10:14 100:1 101:2 102:22 <b>river (2)</b> 4:25 6:7 <b>robotic (2)</b> 26:19,24 <b>robotically (1)</b> 26:11 <b>robust (1)</b> 139:18 <b>role (42)</b> 3:24 4:11,17,20 5:2,23 6:2,3,19,25 7:9,11,17,21,22 8:3,11,14,15,23 9:3,12,25 10:8,10,10,20 16:16 17:9 36:21 73:15 89:22 109:11 155:1 167:6 179:7,8 180:5,15,18 190:4 200:11 <b>roles (3)</b> 3:17 7:20 8:12 <b>roll (1)</b> 203:23 <b>rolled (3)</b> 148:5 201:10 203:20 <b>rolling (2)</b> 76:3 164:9 <b>ron (2)</b> 9:4 155:12 <b>roof (1)</b> 103:11 <b>room (3)</b> 56:10 117:7 169:18 <b>rota (1)</b> 10:17 <b>roughly (4)</b> 57:20 76:8 146:9 173:7 <b>round (3)</b> 84:15 94:19 96:13 <b>route (1)</b> 35:18 <b>routes (1)</b> 34:24 <b>routinely (1)</b> 192:18 <b>row (11)</b> 12:1 13:2,7 22:14 24:20 81:5 98:13 109:3 143:1 144:10 202:3 <b>roy (2)</b> 4:18 10:14 <b>rro (2)</b> 36:19 100:13 <b>run (4)</b> 89:16 146:24 197:12,17 <b>runup (3)</b> 190:17 191:3 196:17	161:20 162:8 163:11,12 166:6,18 171:15,18 172:3,7,11 173:3,9,20 196:16 197:15 198:15 <b>sai (10)</b> 75:7,11,25 76:6 80:25 83:18 85:2 104:11,20 105:8 <b>sais (1)</b> 76:4 <b>salamanca (10)</b> 74:11,12,24 76:6 80:24,25 83:19 98:10 104:11 119:20 <b>same (20)</b> 19:8 24:7 27:13 35:6,7 52:11,19 55:7 90:16 94:13 108:17,20 116:7 123:20 158:18 175:23 179:25 180:1 183:25 198:15 <b>sample (2)</b> 49:20 50:21 <b>sampling (4)</b> 50:2,16 51:4,10 <b>sandwich (3)</b> 37:18 38:4 39:5 <b>sat (2)</b> 22:4 169:7 <b>satisfactory (1)</b> 122:13 <b>satisfied (9)</b> 48:18 95:25 97:11 101:9 112:5 118:25 146:1 164:25 175:7 <b>satisfy (3)</b> 27:15 93:10 160:21 <b>satisfying (1)</b> 172:12 <b>save (1)</b> 95:11 <b>saving (2)</b> 156:25 165:8 <b>saw (6)</b> 36:20 41:1 59:25 103:7 140:7 203:16 <b>saying (16)</b> 18:12 25:23 31:22 35:21 41:17 69:23 72:20 73:16 87:6 89:2 91:1 95:1 97:9 100:25 112:3 151:14 <b>scale (3)</b> 127:24 129:22 130:9 <b>schedule (5)</b> 24:13 25:6,18 90:12 143:16 <b>scheduled (11)</b> 20:5,13 21:16 25:10 27:5 28:10 53:13,21 54:1,8 72:7 83:17,25 84:15 85:24 <b>score (16)</b> 21:5,8,24 22:8 24:21,25 25:8 27:25 28:12 29:2,3 107:13 112:16,23 132:20 133:16 <b>scored (4)</b> 22:16 107:10,16 113:22 <b>scores (3)</b> 25:3 112:20 121:15 <b>scoring (2)</b> 25:5 114:3 <b>screen (5)</b> 6:22 21:7 23:6 76:7 114:6 <b>scroll (1)</b> 86:20 <b>scrutiny (2)</b> 29:20 82:13 <b>sd (1)</b> 90:11 <b>se (1)</b> 65:7 <b>search (1)</b> 30:1 <b>second (25)</b> 2:21 36:18 38:24 52:1 63:2,9,12 76:10 81:5 94:4 100:10 118:7 119:3,14 148:23 155:15,17 159:11 171:11 184:3 195:17,25 198:24 199:17,19 <b>secondly (5)</b> 2:6 21:23 25:9 125:4 202:4 <b>section (48)</b> 5:3,10 6:15 7:24 15:13,18 18:2,25 19:14 21:16,20 30:15 43:1 45:10 48:13 51:23 52:7 53:13 57:16 65:15 67:13 70:9 72:16,18 73:24 76:13 77:14 84:4 86:6 94:21 95:15 96:6 101:14 104:17 118:20 119:13 125:17 127:19 142:23 146:18 155:10,21 156:13 157:22 162:19 168:15 175:5 181:16 <b>securing (1)</b> 73:24 <b>see (81)</b> 11:25 12:1,11 13:2,7,21 17:15 19:13	22:15 24:2 27:12,23 28:21 29:22 31:7 34:5,6 37:5,6 39:13 41:8,9 49:16 52:1 57:5,11,18 62:17 63:11,23 66:22 74:1 76:8,18,24 77:23 78:17 83:17,25 88:23 91:2 94:25 98:12 102:16 106:5,11,12 110:15 118:19,25 119:3 120:14 121:14 124:4,17 126:8 130:7 135:17 137:6 139:14 141:6,9 143:10 148:22 155:15 158:22 159:15 160:16,25 161:6 162:3 163:16 164:24 166:13 167:23 168:2 170:13 171:7 178:12 187:11 202:2 <b>seeing (1)</b> 41:6 <b>seek (4)</b> 46:21 125:6 177:9 184:5 <b>seeking (1)</b> 174:11 <b>seem (5)</b> 53:10 55:13 78:10 85:13 103:4 <b>seemed (1)</b> 192:24 <b>seems (6)</b> 24:6 71:15 97:13 172:8 173:6 182:24 <b>seen (20)</b> 12:3 23:22 24:4,8 42:5,6,17 45:13 71:3 72:14 77:2 81:4 100:19 115:12 128:20 139:7 148:20 149:23 166:22 202:7 <b>send (2)</b> 48:20 198:7 <b>sender (1)</b> 129:15 <b>sending (1)</b> 88:17 <b>senior (11)</b> 10:13 14:15,19 15:4 71:8 74:15 75:11,13 85:8 153:22 162:21 <b>seniority (1)</b> 40:12 <b>sense (5)</b> 26:2 123:18 144:7 167:9 200:4 <b>sensible (5)</b> 94:17 95:8 116:23 137:25 138:1 <b>sent (26)</b> 45:7,15 48:22 57:3,3 60:1,11,25 62:15 83:17 125:84 15:85 24 96:12 127:2 128:15 132:4 133:9,24,25 134:1,15,18 154:21 183:15 195:11 <b>sentence (4)</b> 63:13 87:8 97:13 102:1 <b>separate (10)</b> 6:2 50:9 65:7 71:1 74:10 134:23 148:18 154:11 168:8,18 <b>separately (1)</b> 6:9 <b>september (2)</b> 52:23 53:2 <b>series (1)</b> 189:13 <b>serious (3)</b> 7:4 115:16 192:5 <b>served (1)</b> 16:7 <b>service (61)</b> 4:2,6,12,15,16 5:23,24 6:11 7:9 9:1,1,2,15 16:24 26:15 36:14 50:4,12,15,19 57:13 64:20 123:66 126:10,11,14 119:7 126:18 135:9 141:24,25 150:13,14,17,20 151:2,9,20 153:6 177:17 178:19 179:8,9,17,19,20 180:3,9,19,25 181:9 186:14 189:1 190:7,10,12,14 191:16 193:4 200:15 <b>services (7)</b> 15:19 50:10 52:8 76:13 104:17 135:10 155:3 <b>set (27)</b> 13:8 30:16 31:25 52:11 53:7 57:19 62:20 76:15 77:16 81:8 102:18 106:9 120:24 129:6 130:10 142:11 149:22 154:16 157:5 158:15 159:24 161:22 165:5 171:20 173:1 179:17 196:10 <b>sets (9)</b> 13:17 19:15 24:20 30:2 44:11 75:22 89:1 149:4 185:14 <b>setting (4)</b> 139:9 154:22 155:13 193:9	<b>seven (5)</b> 7:5 193:13,14 201:11 203:20 <b>several (1)</b> 49:8 <b>shall (2)</b> 82:13 177:2 <b>shame (1)</b> 179:12 <b>shape (2)</b> 10:11,20 <b>share (4)</b> 101:1 112:11,18 167:13 <b>shared (3)</b> 164:14,22 166:6 <b>sharing (11)</b> 155:20 156:12 157:21,24 162:18 164:2,4,18,22,25 181:16 <b>sheer (1)</b> 47:21 <b>sheet (1)</b> 20:2 <b>shepherds (2)</b> 41:3 47:6 <b>shift (1)</b> 197:12 <b>shifts (1)</b> 197:17 <b>shirley (5)</b> 161:3,5 167:21 181:14 187:22 <b>shop (3)</b> 99:23 171:20 188:24 <b>short (5)</b> 56:20 117:16 170:2 191:3 196:17 <b>shorten (1)</b> 2:5 <b>should (80)</b> 2:2 21:15 23:15,16 25:5,18,20,22 29:24 31:3,5,6,7,17,20 38:7 40:13,19 45:7,20 47:15 58:3,5 62:20 63:14,25 64:3 68:24 69:4,7,25 70:6 72:15,19 75:21 79:16 80:8 85:18 90:21 91:20 97:1,7,9,10,17,20,21 104:16 106:20 107:5 109:10 114:11 121:6,20 123:23 131:21 135:10,12,12 138:12 143:18 145:2,14 146:12 149:18 150:21 168:18 179:12 180:16,16 181:24 188:14,23,23 189:4,15 193:6 194:2 196:11 198:12 <b>shouldnt (4)</b> 73:19 97:21 145:13 194:9 <b>shout (2)</b> 105:19 137:22 <b>show (3)</b> 47:25 53:10,11 <b>showing (2)</b> 12:5 131:13 <b>shown (1)</b> 114:16 <b>shows (2)</b> 12:11 52:3 <b>side (28)</b> 31:13 52:2 66:14,18 77:23 112:20,24 139:4,12 146:9 158:13,13 168:4 171:14,19,23 172:1,12,21,23 173:3,24 174:10,17,19 175:2,7,9 <b>sides (1)</b> 172:15 <b>sighted (1)</b> 59:19 <b>sign (1)</b> 124:20 <b>signals (1)</b> 96:5 <b>signature (2)</b> 2:18,25 <b>significance (2)</b> 21:19,22 <b>significant (9)</b> 55:20 62:24 63:5 106:17 139:21 140:3 142:7 191:9 196:4 <b>significantly (1)</b> 93:21 <b>signoff (2)</b> 124:20,25 <b>similar (2)</b> 54:22 55:9 <b>simple (2)</b> 128:9 132:1 <b>simplification (1)</b> 137:23 <b>simplify (1)</b> 184:24 <b>simplifying (1)</b> 99:22 <b>simplistically (1)</b> 73:21 <b>simultaneously (1)</b> 189:13 <b>since (2)</b> 131:16 202:16 <b>single (16)</b> 7:11,21 9:20 51:9 54:15 55:1 64:3 91:20 92:2 101:9 103:22 112:1 131:13 132:25 133:4 193:17 <b>sir (59)</b> 1:3,7,9,11,16,19 23:3,10,19 41
--	---	--	--	---	--	--

169:9,11,13,14,19,20,24,25 170:4,6,7 172:4,8 204:9,10,15,19,22 205:2,9,10,16,21,22 <b>sit</b> (3) 1:12 32:11 96:15 <b>site</b> (10) 19:22,23 20:1,5,7 127:13 136:11 137:7,12 143:7 <b>sitebuilding</b> (1) 143:18 <b>sites</b> (4) 71:6 143:3 149:9 184:22 <b>sitesbuildings</b> (3) 142:20 144:25 152:23 <b>sits</b> (2) 39:13 48:15 <b>sitting</b> (1) 177:3 <b>situation</b> (2) 109:6 134:18 <b>six</b> (4) 7:8 103:8 154:19 203:20 <b>size</b> (2) 50:6 68:15 <b>skills</b> (3) 38:16 190:5 200:11 <b>skip</b> (1) 139:13 <b>sleeping</b> (1) 122:9 <b>slide</b> (5) 120:24 121:2,23 123:2 128:16 <b>slides</b> (1) 120:16 <b>slideshow</b> (1) 120:13 <b>slightly</b> (8) 31:21 32:13 33:19 80:22 95:13 116:20 171:6 205:4 <b>small</b> (1) 202:5 <b>smoke</b> (1) 75:3 <b>sms</b> (1) 90:8 <b>snwm</b> (1) 189:6 <b>sole</b> (2) 162:4 163:4 <b>solution</b> (1) 28:24 <b>someone</b> (3) 15:10 94:25 150:10 <b>something</b> (28) 22:2 26:5,14 32:18 33:2 36:25 37:23 42:13,14 46:18 50:3,22 73:11,18 89:8,15 95:11 148:16 173:10 179:9,11 191:2 193:24 194:5 197:4 198:20 201:19 203:10 <b>sometimes</b> (4) 31:11 172:22 194:25 195:1 <b>somewhat</b> (2) 40:25 162:12 <b>somewhere</b> (3) 53:6 67:16 203:7 <b>soon</b> (1) 16:25 <b>sort</b> (5) 24:20 36:16 92:22 125:17 174:1 <b>sorted</b> (1) 110:1 <b>sought</b> (4) 151:13 177:14 179:14,18 <b>sound</b> (2) 26:25 194:1 <b>sounds</b> (2) 56:4 205:8 <b>source</b> (1) 54:4 <b>sources</b> (1) 64:14 <b>south</b> (7) 4:24,24 5:25,25 6:7 7:13 179:15 <b>spandrel</b> (1) 41:4 <b>specialty</b> (1) 75:13 <b>specific</b> (20) 11:5 20:7 33:15 39:7 43:11 50:14 73:9 90:25 95:19 99:1,12 122:3 124:4 131:20 143:7,21 150:14 152:19 153:4 184:16 <b>specifically</b> (17) 5:4 9:25 12:4 39:11,25 40:10 51:24 66:3 83:10 99:9 110:25 118:22 165:15 177:23 183:7 187:23 189:10 <b>specification</b> (2) 44:25 45:2 <b>specifics</b> (1) 72:8 <b>speculate</b> (2) 66:8 83:9 <b>speculating</b> (2) 66:7 174:2 <b>speed</b> (3) 47:2 156:24 165:7 <b>spent</b> (1) 172:23 <b>sphere</b> (1) 191:14 <b>split</b> (3) 4:23 55:11 167:7 <b>spoke</b> (1) 182:16 <b>spoken</b> (3) 80:14 113:3 131:15 <b>spread</b> (9) 32:15,21 33:21	34:15 35:10,19 37:18 38:9 46:3 <b>spreadsheet</b> (5) 77:17 79:1,23 81:23 87:5 <b>square</b> (1) 148:11 <b>squarily</b> (1) 180:25 <b>sri</b> (1) 127:13 <b>ss7</b> (1) 187:25 <b>staff</b> (69) 14:9 16:12 25:23 27:18 31:11,13,18 32:23 35:22 40:5 54:12 57:25 58:17 61:6 64:12 66:9,13,14,15,17 72:9,25 76:19 81:9 103:21 104:15 115:22 123:6 124:7 132:5 140:23 143:23 146:21,23,25 152:12,13 156:21,23 163:20,23 164:10 165:6 167:16 171:14,19,23 172:1,12,15,21,22 173:24 174:10,18 175:2,8 176:16 177:25 184:21 186:9 192:12 195:7,11,13 196:9,11,13 203:5 <b>stage</b> (20) 2:9 19:19,22,24 20:4,9,16,20,20 116:10 136:10,22 137:5,12,15,17,24 138:3,10 178:25 <b>stages</b> (7) 19:15 22:11,12 136:6 138:24 139:2 150:21 181:9 98:9 <b>stairways</b> (1) 130:15 <b>stairwell</b> (1) 33:3 <b>stairwells</b> (1) 34:24 <b>stand</b> (5) 26:25 27:18 108:9 154:6,8 <b>standalone</b> (1) 168:18 <b>standard</b> (25) 47:1 50:19 64:19 96:11 142:1 150:14,17 151:2,9,20 177:17 178:20 179:8 180:3,19,25 186:14 189:1 190:7,10,14 191:16 193:5 200:15 202:22 <b>standardisation</b> (1) 50:11 <b>standardise</b> (1) 179:13 <b>standardised</b> (1) 146:3 <b>standards</b> (18) 50:4,13,15 96:10,14 150:13,20 153:7 179:9,18,19,20,21 180:6,9,12 181:9 190:12 <b>stands</b> (3) 75:11 119:25 132:2 <b>start</b> (16) 2:1 13:25 43:21 62:21 116:1 126:7 135:14 147:13 148:11 150:5 154:14 171:17 175:14 183:4 186:16 204:13 <b>started</b> (7) 3:24 8:2,8 125:11,11 126:13 132:3 <b>starting</b> (1) 204:14 <b>starts</b> (4) 39:1 90:7 106:12 183:16 <b>stated</b> (6) 30:7,9 43:21 71:4 119:17 202:9 <b>statement</b> (27) 2:16,21,24 4:9 6:21 7:7 8:20 11:4,11,25 12:10 13:12 15:14 57:5 63:7 74:21 95:20 99:25 100:2 131:2 154:13 157:10 166:3,12 167:1 178:11 195:25 <b>statements</b> (4) 2:12 3:4,8,13 <b>states</b> (3) 76:25 118:8 119:14 <b>stating</b> (1) 192:24 <b>station</b> (85) 16:10 20:5,12,13 22:10,19,20 23:7,11,13,21 24:10 25:24 26:4,6,9,19 27:17 48:16,18,20,21 49:5,14,18,19,21 50:1,16,20 51:5,15 57:14,15,24,25 59:1,18 63:3,14 65:16 70:20 71:5	76:19 79:15,25 80:13,20 81:9 89:17,20,21 90:9,12 91:6,8 96:16 104:15 106:16 115:3,7 123:6,12 126:22 127:16 132:4 134:8 143:15 149:8 155:22 181:17 189:14,17,24 192:24 193:19 194:4,17 195:21 196:9,11,13 197:25,25 202:1 <b>stationbased</b> (7) 16:12 32:23 35:22 54:12 61:6 127:2 140:23 <b>stations</b> (59) 4:21 6:7 7:18 9:7,23 10:1 14:9 16:13 31:19 32:23 35:7,22 57:3 58:2,11 59:3,5,12,14 60:3 63:4,6,17 64:6 76:21 77:12 78:3,5 79:7 84:15 93:19,20,21,23 95:3 96:13 115:11 126:4 127:3,17 131:19 142:20 143:15 144:20,25 145:6 147:18 149:14 152:22 153:1,24 155:23 181:18 186:6 190:1 195:23 197:9 199:17 <b>stationwatch</b> (1) 186:2 <b>statutory</b> (1) 16:5 <b>stay</b> (2) 11:11 68:21 <b>stayed</b> (1) 54:17 <b>staying</b> (1) 38:21 <b>step</b> (6) 10:4 62:24 110:3,3 173:4 187:1 <b>steps</b> (1) 82:20 <b>steve</b> (4) 100:12 162:9 166:7 167:18 <b>still</b> (17) 37:5 42:22 44:4 54:5 81:20 85:24 91:19 108:1 109:8 112:5 129:9 130:11,13,18 184:5 199:8 204:4 <b>stock</b> (1) 45:1 <b>stood</b> (1) 40:18 <b>stop</b> (10) 49:5 86:17 116:23 117:2,4 128:14 134:12 169:15 188:24 205:5 <b>store</b> (1) 15:20 <b>storing</b> (1) 15:23 <b>straight</b> (1) 55:17 <b>straightaway</b> (1) 111:23 <b>straightforward</b> (2) 122:21 168:20 <b>strange</b> (1) 55:13 <b>strategic</b> (6) 4:13 8:24 10:13 45:17 197:10,15 <b>strategies</b> (1) 18:6 <b>strategy</b> (4) 14:23 15:7,9 51:2 <b>structure</b> (2) 102:18 177:4 <b>structured</b> (2) 139:8 150:15 <b>struggling</b> (1) 199:9 <b>stuck</b> (1) 172:8 <b>study</b> (1) 189:21 <b>subheading</b> (1) 202:11 <b>subject</b> (26) 19:8 21:15 24:23 25:10 26:12,21 29:19 51:14 53:13,21 54:1,7,25 55:23 56:1 67:11,12 69:4,7 70:1 78:14 79:17 97:21 173:25 192:16 201:17 <b>subsequent</b> (1) 24:11 <b>subset</b> (1) 165:12 <b>substance</b> (5) 43:20 83:8 105:16 136:4 173:25 <b>substandard</b> (8) 200:18,24 201:2,5,5,12,14 203:2 <b>substantive</b> (5) 72:10 95:13 114:22 139:9 174:13 <b>subsumed</b> (3) 8:4,10 10:8 <b>subtle</b> (2) 31:21 69:19 <b>suburbs</b> (1) 199:20 <b>successful</b> (3) 10:18 143:8 171:21 <b>sufficient</b> (6) 73:4 112:22 113:15 128:8 189:19	194:18 <b>sufficiently</b> (2) 21:24 32:20 <b>suggest</b> (8) 46:11 70:15 78:23 101:17 129:8 165:17 169:17 193:7 <b>suggested</b> (4) 23:15 95:14 128:12 154:1 88:15,16 116:3 151:23 <b>suggestion</b> (1) 192:17 <b>suggestions</b> (2) 181:12 188:1 <b>suggests</b> (13) 23:21 24:4 59:4 79:19 116:17 123:2 138:22 150:2,10 154:3 167:5,11 195:1 <b>suitable</b> (1) 107:4 <b>summarise</b> (1) 33:9 <b>summarised</b> (1) 182:25 <b>summarises</b> (2) 51:19 144:11 <b>summarising</b> (1) 89:3 <b>summary</b> (22) 5:20 8:5,10 9:16 12:7 17:22 18:4 60:8 66:12 72:3 75:1,7 105:19 120:4 135:20 137:6,25 138:1 160:22 164:19 187:1 196:21 <b>supplied</b> (1) 44:21 <b>supplies</b> (1) 130:17 <b>supply</b> (2) 123:23 125:8 <b>support</b> (8) 14:22 89:19 96:11 118:11 150:18 151:20 166:17 171:9 <b>supported</b> (1) 25:21 <b>supporting</b> (1) 127:14 <b>suppose</b> (6) 23:11 31:21 33:19 94:4 177:7 204:15 <b>supposed</b> (2) 46:6 82:15 <b>supposition</b> (1) 193:9 <b>suppression</b> (2) 29:1 133:19 <b>sure</b> (56) 16:15 18:11 24:3 26:18 41:11 48:17 49:4 50:23 55:18 58:21 60:16 69:21 71:25 72:5,20,24 76:4 78:15,17 79:5 80:21 82:5,6,14 83:3,6 84:15,25 90:13 91:10 93:6 95:7 96:1,20 97:7,19,20 98:4 99:21 101:10,22 108:14 109:23 110:4 111:23 126:12 130:4 134:3,21 146:4 164:21 175:19 178:3 183:3 190:22 199:23 <b>surface</b> (1) 39:6 <b>surprised</b> (1) 171:6 <b>surprising</b> (1) 53:3 <b>suspect</b> (1) 19:14 <b>suspended</b> (1) 152:3 <b>synonym</b> (1) 176:5 <b>system</b> (13) 47:17 48:5 84:8 93:10 114:22 123:17 135:6 136:3 144:14 146:2,4 157:20 188:25 <b>systemic</b> (1) 75:15 <b>systems</b> (27) 5:18 14:21 25:15 29:1 38:12 39:5,10,25 40:13 45:25 46:2,23 47:4 89:19 90:5 91:10 96:19 109:8 113:3 114:13 133:19 144:14 156:7 186:8 187:5 190:13 197:21 <b>systemsbased</b> (1) 114:10	<b>taking</b> (8) 53:16 80:11 92:12 130:22 173:4 187:1 196:14 203:12 <b>talk</b> (5) 27:14 56:10 117:6 169:17 205:12 <b>talking</b> (13) 36:16 55:16 87:25 92:5 101:5 104:3 114:6 117:24 133:18 136:21 160:11 175:23 184:14 <b>targeted</b> (9) 13:3 71:12 141:6 159:10 175:12 178:17 181:21 187:24 191:1 <b>targeting</b> (2) 161:17 191:6 <b>targets</b> (6) 13:8 156:18 157:4 159:24 161:22 196:10 <b>tarnished</b> (1) 101:17 <b>task</b> (4) 59:23 63:5 94:2 177:12 <b>tcap</b> (6) 118:16,19,21,25 124:21 146:15 <b>team</b> (7) 68:14 89:16,18 129:8,12 174:23 175:2 <b>technical</b> (6) 30:10 32:7,24 33:7 166:17 167:18 <b>technological</b> (1) 89:19 <b>technologically</b> (1) 25:21 <b>telephone</b> (1) 182:17 <b>telling</b> (3) 26:19 122:16 177:7 <b>template</b> (1) 21:7 <b>templates</b> (1) 137:18 <b>temporary</b> (1) 3:24 <b>ten</b> (2) 179:17 204:12 <b>tended</b> (1) 171:23 <b>tends</b> (2) 129:8 193:7 <b>tenor</b> (1) 182:11 <b>tenth</b> (1) 32:14 <b>tenure</b> (1) 61:12 <b>term</b> (7) 62:1 81:9 104:20 183:21 184:18 186:20,23 <b>terminals</b> (3) 88:4 127:9 164:10 <b>terminology</b> (7) 31:4,15 70:15 120:22 167:4 183:22 186:24 <b>terms</b> (115) 5:8,9 9:11 14:18,20 15:5,12 18:7 20:21 21:14 27:17 31:5 32:11,25 33:17 34:7,11,20,24 35:2,25 38:13,17 39:25 40:3,8 41:11,25 42:24 43:7,14 45:16 46:5,12 49:1 51:8 52:20 58:20 60:16 61:6,18 64:11 66:2 68:14,18 69:8 70:11 72:8 80:19 87:4 91:12 96:17 98:5,7 101:1 102:8,22 103:16 114:16,17 116:6,16 124:4,13,14,16,17 123:22 125:9,11,23 129:3 130:18 135:11 136:4,9,12,21 137:6,13,15 138:12,22 140:13 141:23 144:5 147:18 148:12 152:3,4 153:22 165:12,23 169:4 170:13 171:11,13 172:12 173:23 174:12,17 176:19 179:19 182:25 184:24 186:2 193:15 195:6 199:6,16 201:4 203:17,24 204:7,24 <b>test</b> (2) 110:15,18 <b>tester</b> (1) 110:23 <b>tests</b> (3) 43:25 44:1,15 <b>text</b> (10) 38:4 66:25 76:18 78:14 106:10 127:20 149:6 158:17 159:8 161:12 <b>thames</b> (1) 4:25 <b>thank</b> (94) 1:9,11,15,16,19,23,24 2:20 3:2,11,15 5:1,22 10:6 11:3 13:11 17:10 20:23 22:6	23:2 27:20 28:8 29:16 37:12 40:11 56:13,14,17,18,23,24 57:1 60:23 62:12 65:10 70:25 72:13 75:19 77:3,22 99:7 104:9 105:7,22 108:11 114:4 116:19 117:8,9,12,13,14,20,21,23 120:3,11 121:12 135:13 137:3,10,21 138:16,21 139:3 153:11 154:10 158:7,10,14,21 159:22 160:3 161:9 162:2,11 169:8,13,19,20,23,24,25 170:5,7 171:4 200:6 205:9,10,15,16,19,21,22 <b>thanks</b> (1) 182:5 <b>thats</b> (82) 2:6,10,14,23 3:21 4:1,4,8 5:16 6:20 11:24 12:23 17:1 21:3 22:2 23:16 25:17 36:15,25 37:23 40:1,2 49:18 56:1 60:10 61:20 64:16 67:5,8 70:15 71:18,22 73:10,11,18 74:9 79:3 80:15 83:18 87:6,21 89:8 98:4 101:10,16 103:10 112:17 114:21 119:11 123:25 125:24 129:2 130:10 131:2 145:15 146:14 147:23 152:14 153:20 157:11 158:8 165:14,23 166:15 169:1,7 170:9 171:2 172:6 177:7 179:3,4,6 180:15 182:22 187:1 190:17 191:3,7 195:24 201:17 205:2 <b>themselves</b> (6) 30:16 35:25 115:8 116:15 123:13 139:24 <b>thereafter</b> (2) 58:4 125:24 <b>therefore</b> (20) 7:22 10:22 37:25 53:21 54:1,7,12 69:11 73:7 84:18,24 91:24 92:19 101:25 113:10 134:11 151:15 178:21 186:23 188:14 <b>theres</b> (19) 17:1 34:21,23 43:2 46:16 47:22 69:19 70:16 111:3 122:9 123:10 129:19 142:13 150:4 194:10 197:8 199:17 203:6,7 <b>theyd</b> (4) 37:2 48:13,14,15 <b>theyre</b> (10) 12:14 35:23 36:9 48:19 65:7 77:19 78:20 89:12 94:21 146:24 <b>thing</b> (15) 23:22 52:22 71:10 78:19 103:4 110:8 148:13 154:1 177:7,17 180:2 192:25 194:8,11 204:14 <b>thinking</b> (6) 35:14 94:15 128:21 136:12 147:19 177:21 <b>thinks</b> (2) 111:20,21 <b>third</b> (35) 6:19,24,25 7:3 10:7,9,17,22 11:1 13:2,6,21 30:14 44:10,13 59:9 74:21 76:8 81:16 105:5 106:15 145:24 149:16 155:24 161:12 165:5,11,16,20,22 166:15 178:14,21 181:24 185:13 <b>thirdly</b> (2) 2:9 202:8 <b>thorough</b> (2) 148:4 188:4 <b>through</b> (13) 45:23 56:4 71:9 73:5 86:13 109:16 110:1 111:13 112:4 141:22 191:9 193:3 205:8 <b>thought</b> (6) 61:10 126:11 171:7,9 179:12 203:10 <b>thoughts</b> (1) 182:4 <b>thread</b> (1) 108:17 <b>three</b> (12) 2:1 10:12,25 22:17 23:12 24:5 132:8 155:6 163:4 177:18 194:14 199:17	<b>threeplus</b> (2) 85:23 92:22 <b>threeyear</b> (2) 18:15 19:8 <b>threshold</b> (2) 28:16,18 <b>through</b> (36) 11:7 19:17 22:13 28:20 31:11,12,15 50:14 56:7 89:18 96:6 102:20,23 104:14 105:17 118:10 121:8,13,17,18 127:8 129:3 157:2 159:17 161:20 162:13 166:21 171:13,16 172:24 185:17 195:9,9,12 201:24 204:3 <b>thrust</b> (2) 87:6 105:16 <b>thursday</b> (1) 205:25 <b>thus</b> (3) 25:2 81:5 144:11 <b>tick</b> (2) 94:20 151:24 <b>ticking</b> (1) 90:25 <b>ticksheet</b> (2) 20:17,25 <b>tim</b> (1) 71:24 <b>timber</b> (1) 39:5 <b>timberframed</b> (1) 37:18 <b>time</b> (81) 3:18 15:1 18:7,13,18,19 19:6 23:5 24:15 25:15 27:13 28:14 30:13,14 31:13,16 34:3 35:11 45:6 52:19 54:23 56:1 59:19 62:5 63:19 64:2,4,9,24 65:3 71:23 72:1 74:7 75:25 78:8,22 81:16,18 82:17 84:8 90:18 91:9 92:5 93:1,15,18 100:18 101:5 105:3 110:17 111:9 113:19 116:1,4 120:6 126:11 131:3 139:8 144:23 146:1,20,22 147:4 162:9 163:24 165:2 169:14 171:24 172:23 173:18 176:2 179:10 180:11 181:18 192:11 193:12 197:13 199:9,22 203:17 204:24 <b>timed</b> (1) 106:6 <b>timely</b> (3) 143:4 190:11,14 <b>times</b> (2) 6:3 108:4 <b>timewise</b> (1) 204:18 <b>title</b> (2) 17:17 118:19 <b>tmo</b> (1) 47:17 <b>today</b> (6) 1:4,25 3:16 18:10 134:13 174:7 <b>today's</b> (1) 1:4 <b>together</b> (5) 141:15 161:8 176:9 179:16 180:17 <b>to</b> (3) 26:10 56:6 90:10 <b>tom</b> (13) 9:10 177:13,14 178:11,25 181:4,6 182:6,19 183:15 184:12 187:13 190:21 <b>tomorrow</b> (8) 95:10 204:14,20 205:1,7,8,11,20 <b>too</b> (7) 2:4 72:22,25 92:18 93:5 200:2 201:6 <b>took</b> (10) 10:4,18 14:10 39:24 59:24 66:17 163:13 170:19 171:11 203:22 <b>toolkits</b> (1) 45:15 <b>tools</b> (1) 186:13 <b>topic</b> (8) 68:18 71:1 74:10 116:21,22 134:23 148:17 154:11
--	---	--	---	---	---	---

68:9 105:23 112:21 113:2,4,6 117:25 118:2,6,10,11,12,13,23 120:1,12,13 121:19 122:16,24 123:3,4,5,9,10,14,23 124:6,7,8,9,13,17,21,22 125:1,5,7,14,16,19 126:1 142:23 145:3 146:13,14,18,23 147:1,8,12,14,21,24,25 148:2,5,12,13 152:10 174:11 175:8 190:3 194:24 195:5,9,14 196:15 197:14 200:10 201:10 203:13,18,20,21,23 204:2,4,8 transcriber (1) 2:7 transfer (1) 82:22 transferring (1) 25:16 translate (1) 175:20 trapped (1) 75:3 travelled (1) 41:15 travelling (1) 109:12 trawl (2) 131:22 162:12 tread (1) 31:15 trial (4) 109:14 157:14 159:6 160:12 triangulating (1) 140:14 tried (2) 108:5 171:19 trigger (1) 88:16 triggered (1) 87:19 tripartite (1) 102:13 trouble (1) 115:15 true (6) 3:6 55:1,2 89:3 130:25 157:11 truly (1) 114:1 trunking (1) 39:6 try (7) 16:20 17:5 18:6 93:2 111:25 174:2 177:4 trying (12) 16:18 53:15 54:11 55:15,21 79:10 102:23 103:1,5,16 136:18 172:24 turek (6) 100:12 162:9 166:7,14 167:9,18 tureks (1) 166:22 turn (44) 2:24 11:25 15:13 17:11 20:24 28:12 57:2 66:19 71:1 74:10 76:7,17 83:16 96:23 98:3 99:25 104:10 118:1 119:2 120:14,23 121:1,13 126:4 134:23 136:5 137:4,11 138:2,9,17 139:24 152:7 154:11 161:10,21 166:3 167:25 170:11,16 175:11 181:2 185:8 204:11 turning (1) 96:22 twice (1) 23:24 twofold (1) 21:22 twothirds (1) 146:9 type (6) 37:20 44:20 46:20 81:10 123:8 172:19 types (3) 97:2 186:6 188:22 typical (1) 202:23	understand (15) 21:19 31:2 63:6 91:18 113:24 146:23 157:6,17 164:23 175:16,22 176:5,13 199:2 203:5 understandably (2) 91:16 92:14 understanding (22) 3:19 31:18 38:5 85:9 97:2 125:21,23 128:6 140:6,15,16,25 145:9 175:15 178:1,24 184:18 194:7 200:19 203:2,5,15 understood (13) 25:23,24 26:5 27:15 31:19 84:25 85:21 86:20,25 89:1 101:21 104:8 175:3 undertake (4) 40:17 156:9 164:7 177:14 undertaken (8) 53:5 58:4 119:21 189:1,7,22,23 195:20 undertook (2) 6:2 131:22 undoubtedly (1) 144:4 undue (2) 97:25 137:23 unfair (1) 53:18 unfortunately (2) 171:21 188:17 unhelpful (1) 165:21 unified (1) 103:19 unilaterally (2) 99:16,18 union (2) 31:11,18 unique (2) 40:23 98:3 unknown (3) 176:21,21,24 unless (3) 33:1 90:25 130:7 unlikely (2) 78:6,14 unnecessary (1) 176:3 unoccupied (1) 28:23 unreasonable (5) 59:22 60:10 74:9 110:8 182:23 until (11) 3:23 4:18,19 9:4,5,8 10:23 70:22 92:5 125:24 205:24 unusual (5) 41:13 84:22 89:25 104:21 108:3 update (2) 168:4 171:1 updated (3) 65:11 77:11 84:17 updating (1) 14:4 upon (5) 22:21 28:10 31:23 100:3 203:12 upping (1) 16:18 upside (2) 90:20 96:25 upside-down (1) 98:5 urgent (1) 189:9 usage (2) 144:21 145:8 used (21) 14:22 21:17 26:13 27:16 31:17 33:13 44:19 68:24 95:2 103:9,12 106:20 128:7 129:16 131:20 150:21 163:6 167:4 175:24 186:20 198:15 usedefinition (1) 183:20 useful (11) 24:1 127:21 130:18 142:2 144:12,23 166:9,12 195:25 201:20 204:13 user (1) 188:23 uses (1) 38:4 usher (4) 56:15 117:10 169:21 205:17 using (6) 20:4,17 21:6 52:11 101:20 164:8 usual (3) 123:8 169:16 205:4 usually (1) 194:21 utopia (1) 54:15	valueless (1) 90:24 variable (2) 144:21 145:8 variation (1) 196:4 varies (1) 163:19 variety (2) 14:19 35:23 various (16) 6:3 28:20,21 30:19 31:15 45:11 67:24 76:3 88:10 89:18 95:25 96:14 103:1 137:18 139:2 140:10 varying (1) 164:20 vast (2) 29:9 50:6 vent (1) 33:3 vents (2) 33:11,13 verified (2) 20:2 113:2 verify (2) 50:17 53:19 version (16) 17:13,16 18:12,13 19:4 24:14 62:18 65:12 71:15,16 74:20 118:4 134:7,15 141:15 167:21 versions (3) 23:23 24:8 186:24 versus (1) 31:5 vested (1) 26:4 via (2) 17:21 90:18 viable (1) 81:7 views (3) 65:1 92:20 94:6 virtue (1) 191:14 visit (50) 19:123 20:6,13 21:23 22:17 23:10 24:3,12 33:22,24 36:25 40:14,18 42:25 43:16 46:23 47:20,25 48:18 50:18 54:18,19 58:1,10 59:17 63:17 68:24 76:13 77:7,8 79:17,21 84:20 87:12 88:24 90:18 92:1,13 93:15,18 94:1,16 109:10 114:11 121:3,21 125:21 136:14 137:7,15 visited (11) 54:16 58:22 59:15 60:4 64:3 65:7 69:21 91:1,20 177:2,4 visiting (10) 21:2 27:8 36:8 37:21 63:3 64:5 66:16 106:21 127:25 128:4 visits (99) 5:4,13 6:15 7:24 11:5 12:6 14:16,18 15:14,23,23 16:2,8 17:22,23,25 18:2,25 20:6,22 21:16,21 22:7,21 24:23 25:10 28:10 29:21,24 30:15 42:15 45:10 47:14,15,19 48:6 49:20,24 50:21 51:23 52:4 53:4,13,21 54:2,8 57:16 58:6 65:2,6 66:6,11 69:5,23 70:1,9,12 72:6,18 73:25 76:21 77:14 81:12 90:10 95:15 96:6 98:19 100:22 104:17 106:13 107:11,13 118:6 119:18,21 120:15 123:14,19 125:17 143:16 149:17 155:2,10,22 156:14 157:3,22 159:18 161:20 162:19 174:6,8 175:5 176:15 181:17 186:10 196:10 198:16 vital (1) 51:1 voice (1) 2:6 voids (3) 37:19 39:6 46:8	94:3 95:19 99:4 101:9 113:23 129:12 153:10 160:8 175:6 192:17 198:8 watch (21) 57:25 59:1 76:14 96:17 108:2,23 115:4 118:10,12 123:11,12,13,20,23 124:2,14 125:9 127:16,25 194:3 200:22 watches (4) 49:22,23 79:16 118:13 watching (2) 135:3 160:17 water (2) 103:10 130:17 watermarked (1) 74:19 way (38) 10:11,11,20 13:17 15:21 25:22 26:16 27:3 33:9,23 34:7 35:7 41:1 50:13 55:19 60:9,10 62:3 74:9 77:1 83:4,7 85:12 97:15 112:24 123:20 133:2 140:15 143:17 146:9 154:6,7,8 171:16 172:24 176:1 182:23 184:19 ways (4) 17:24 41:16 50:12 162:22 wayside (1) 179:11 webb (4) 57:20 58:16,19 82:25 webbs (1) 59:11 wed (12) 16:17,22,23 17:1 37:1 87:23 103:24 130:10 146:20 147:25 148:8 169:11 wednesday (2) 1:1 188:18 weed (1) 172:24 week (1) 7:5 weeks (1) 182:4 weight (2) 31:3 180:12 welcome (1) 1:3 wembley (2) 27:11,12 went (3) 40:16 93:7 151:23 werent (13) 29:10 33:6 55:10,21 61:6 67:18 72:10 95:23 113:21 126:12 154:3 171:21 200:2 west (11) 4:7,12,15,22,24,24 5:7,25 7:10 27:10,10 wet (3) 57:23 103:9 104:7 weve (21) 40:3 53:20,24 71:3 72:14 80:14 110:10 113:3 116:14,20 121:17 124:22 125:3,4 141:22 149:7 164:21 167:4,20 169:3 174:6 whatever (3) 62:4 111:23 179:10 whats (2) 48:16 125:2 whatsoever (2) 28:19 173:20 whenever (3) 27:1 82:12 107:3 whereas (3) 31:8 93:5 196:6 whereby (1) 94:19 whilst (6) 23:14 54:5 85:13 112:19 113:24 169:3 white (1) 191:19 whoever (1) 34:9 whole (11) 4:16 7:24 9:2 35:23 70:16 113:12 115:9 176:7,22,25 183:12 whom (2) 36:20 82:4 whose (1) 24:25 wide (2) 7:1,4 widely (1) 128:7 wider (1) 82:22 willing (1) 154:4 windows (1) 40:24 wise (2) 109:16 177:18 wish (3) 188:16 204:11,23 wishing (1) 171:25 wit (1) 33:5 witness (18) 1:6,15 4:9 6:21 12:9 56:13,23 57:5 99:25 100:2 117:8,20 166:3 167:1 169:19 170:5 205:9,15 wont (2) 99:2 204:11	work (31) 13:25 16:17 17:3 22:13 48:16 55:15 62:25 100:23,24 102:3,9 108:24 109:7,16 110:22 115:17,24 149:13,14,16 152:4 153:8 163:17,17,25 178:15 180:21 181:11 182:12 186:8 191:18 worked (8) 64:22 82:8 102:11 103:9 126:17,18 153:21 204:8 working (11) 12:12 14:9 16:3 17:4 55:2 100:11 102:14,24 103:7 204:1,4 workload (1) 196:13 works (2) 122:14 140:15 workshops (4) 189:13,14 191:24 194:23 workstream (1) 13:6 workstreams (1) 102:5 world (1) 191:18 worth (4) 63:7 91:19 133:7 188:7 worthy (3) 80:2 132:19 133:13 wouldnt (27) 22:25 33:15 34:13 35:24 37:21 41:15 68:11 74:4 80:7 86:3,15 87:21 88:13 90:3 97:11 19:23 18 110:8 120:18 122:23 124:12 129:13,19 134:18 184:19,23 198:17 wrestling (1) 103:15 write (3) 39:23 42:10,17 writing (2) 43:23 102:21 written (4) 67:23 68:10,12,13 wrong (8) 27:1 53:5 111:2,4 166:22,23 167:3 203:9 wrote (4) 40:2 41:21 155:12,24 wyatt (7) 81:19 82:7 83:15,17 99:15 131:15 140:5	0 (3) 25:3,5,25 0055 (2) 118:16 146:15 04072013 (1) 168:6	111:10 126:10,11 129:9 134:25 135:23 139:20 2013 (25) 11:23 14:11 52:23 53:2 100:11 105:9,18 106:7 111:10 116:1 135:16 139:5 143:20 149:7 154:2,18,20 160:17 171:8 178:14 181:4 187:12 190:20 193:12 203:18 2014 (3) 52:10 150:13,19 2015 (14) 4:19 8:2,8,15 13:24 17:16 18:16 19:4 65:4,11,12 68:1 170:17,22 2016 (5) 9:4,8 47:6 167:23 170:8 2017 (7) 9:5 10:23 18:14 52:11,12,17 148:21 2018 (1) 18:17 2019 (2) 2:15,21 2021 (2) 1:1 205:25 21 (2) 1:15 12:2 22 (12) 12:10 13:12 30:2,16 31:25 81:2 83:15,18 121:5,9 167:25 170:24 23 (4) 155:13 170:11,24 171:2 24 (11) 7:5 105:18,25 117:25 118:5,11,17,20,23 119:14 170:16 25 (5) 2:18,24 158:16 170:17,22 250 (3) 22:16 131:23 132:7 250260 (1) 128:24 27 (6) 100:7 102:2 135:16 159:7,14,23 28 (3) 51:22 100:11 154:20 282 (2) 80:25 83:18 28912 (1) 98:17 29 (1) 2:15 2a (8) 157:7 158:17,22 163:8 164:7 165:15 166:15 168:1 2a18a (1) 165:25 2b (9) 13:2,14 71:9 157:7 159:9,11 175:11 177:12 180:21 2c (2) 157:7 159:14 2d (3) 13:8 157:8 159:23	3	3 (13) 7:6 19:14,24 20:20 106:4 141:12 189:11 191:22 192:2 194:13 195:17 200:13 202:9 30 (1) 202:13 31 (7) 4:19 9:4,5 63:10,18 65:15 66:5 315 (1) 169:9 316 (1) 170:1 32 (3) 38:22 39:10,20 33 (3) 139:14,16 196:3 330 (2) 169:16,23 332 (1) 170:3 34 (2) 11:20 166:14 3912 (1) 119:18	4	4 (12) 6:23 8:21 20:4,16,20 65:15 74:21 149:18 158:12 162:14 189:21 202:11 40 (4) 52:4 53:4 195:24 196:2 400 (1) 53:3 41 (2) 15:15,18 41212 (1) 98:21 42 (2) 15:15 16:1 420 (1) 204:9 421 (1) 205:23 43 (7) 57:6 154:12,23 160:15 167:21 181:13 187:22 48 (2) 136:7,10 49 (1) 136:7 499 (1) 22:16	5
---	--	--	--	--	---	---	---	--	---	--	---



5 (9) 7:6 11:12 20:9 155:8 188:6 189:23 195:16,19 198:23 50 (1) 137:4 500 (4) 111:18,20 112:7 122:8 5000 (2) 54:6 55:6 51 (1) 137:11 5200 (1) 53:25 521 (1) 76:16 54 (1) 138:2 55 (1) 74:21 550 (1) 112:7 58 (1) 138:9 59 (1) 138:17	169:5 176:15 186:22,22 191:15 201:9 82 (1) 25:1 828 (1) 144:10 842 (1) 108:18
	9
	9 (5) 8:20 12:9 76:23 187:18 190:19 911 (1) 83:18 919 (1) 106:6 950 (1) 83:25
6	
6 (7) 1:1 4:10 27:24 121:1 131:25 190:3 200:8 600 (1) 112:8 61 (1) 131:24 633 (22) 17:12 18:22 19:2,11 29:17 39:12 46:1 62:14,19 63:10 64:18 65:11,24 72:14 73:7,8,13 74:5 76:16 121:6 168:25 169:2 69 (2) 178:12,13 6900 (2) 52:15,16	
7	
7 (19) 11:25 12:2 25:1 65:14 76:7 121:14 178:20 179:8 180:3,19,25 190:6,7,14 191:16 193:5 200:16 202:7 205:25 7000 (3) 181:23 183:5 185:23 71 (2) 166:4 167:2 72 (1) 13:13 72d (115) 5:3,10 6:15 7:24 11:5 12:6 13:9 14:16,18 15:13,18,23 16:2,8 17:21,23,25 18:2,10,25 21:16,20 28:5,10 29:21,24 30:15 33:22,24 35:8 36:1 40:14,17 42:14 43:1,16 45:10 46:23 47:8,15,19,20 48:6 50:18 51:23 52:7 53:13,21 54:1,8,25 57:16 69:5,7,23 70:1,9 72:16,18 73:24 76:13 77:7,8,14 79:17 81:11 84:20 87:12 94:21 95:4,15 96:6 98:19 100:22 101:14 104:17 106:13 118:6,8,17,20 119:18,20 120:15 121:2 122:17,24 123:14,19 124:22 125:17 142:23 146:18 147:1,18 148:12 155:10,21 156:13 157:5,22 159:24 161:22 162:19 168:7,15,17,18,23 174:6 175:5 176:15 181:16 186:9 188:12 72ds (8) 96:15 124:7 146:21 147:16 150:16 180:5,22 181:1 75 (1) 27:25 750 (1) 112:7	
8	
8 (9) 6:22 21:11 24:16,19 50:19 76:17 119:2,13 190:10 800 (46) 13:16,21 14:1,2 17:11,14,19 18:13 19:9,11 20:16 24:14 71:2,9,15 72:4,17 73:6,13 74:7 106:18 107:1,9 108:2 110:10 126:10,13 134:11,20 140:11 142:22 143:12,17 144:22 145:2,24 147:3 165:18 168:9,22	