

Monday, 11 March 2013

1

2 (10.00 am)

3 THE CORONER: Yes, good morning everybody. Do sit down,
4 thank you. Are there any issues to raise before we ask
5 the jurors to come in?

6 MR MAXWELL-SCOTT: Madam, just by way of housekeeping, we've
7 now updated the sequence of events and the version that
8 we have produced will replace that at tab 12 of the jury
9 bundle.

10 THE CORONER: Thank you very much.

11 MR MAXWELL-SCOTT: Mr Atkins has copies here.

12 THE CORONER: Shall we do that straight away?

13 MR MAXWELL-SCOTT: We'll do that straight away.

14 THE CORONER: Thank you, yes.

15 (In the presence of the Jury)

16 THE CORONER: Members of the jury, good morning. The
17 sequence of events which you have in your jury bundle
18 has been updated by Mr Maxwell-Scott and Mr Atkins.
19 They have put in a huge amount time and effort and
20 thought into this.

21 (Technical interruption)

22 It might be helpful if we hand it out before we ask
23 Mr Davey to give evidence. You have them there.

24 I'm told that the transcribers have a problem with
25 the computer so we'll have a short pause whilst that's

1 sorted out. Just to remind everybody that there may be
2 a fire alarm and 11 o'clock this morning. If the fire
3 alarm sounds only for a short time there'll be no need
4 for us to leave the building. (Pause)

5 I gather that we're up and running again. Thank you
6 very much. Yes, members of the jury, you're going to
7 hear from this morning from an expert in firefighting,
8 Mr Davey. Would you like to come forward Mr Davey,
9 thank you.

10 BRIAN DAVEY (sworn)

11 THE CORONER: Mr Davey, thank you. Do sit down. Help
12 yourself to a glass of water if you would like. If you
13 could switch on the two microphones in front of you that
14 would be helpful. I think you've been sitting at the
15 back of the room for part of the hearing so you'll know
16 that the sound in this room isn't very easy. Please, if
17 you could keep your voice up, that would help. If you
18 could give your answers directly across the room towards
19 the members of the jury sitting opposite you, that will
20 help them to hear your evidence and help to keep up
21 close to the microphones.

22 Mr Maxwell-Scott will ask you questions initially on
23 my behalf and then there will be questions from others.

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Questions by MR MAXWELL-SCOTT

MR MAXWELL-SCOTT: Good morning, Mr Davey. Could you give the court your full name, please?

A. Brian William Davey.

Q. You're here to assist us by providing expert evidence in relation to firefighting. Can I ask you first about your background and experience. Firstly, for how many years did you serve as a firefighter and in which country?

A. My service was close to 47 years in the New Zealand Fire Service.

Q. When did you start working for the New Zealand Fire Service?

A. I joined as a volunteer firefighter -- similar to the retained firefighters you have in the UK -- in 1965, and in 1972 I joined as a permanent or full time firefighter of the New Zealand Fire Service.

Q. Did you initially serve in operational roles?

A. I've served in -- all my time with an operational focus -- sorry, an operational role, although I did have other roles that were associated with that.

Q. Did there come a time when you worked in the headquarters of the New Zealand Fire Service?

A. I'd been serving as an area commander based in a provincial town until 1996, when I transferred to the

1 New Zealand Fire Service national headquarters in
2 Wellington, and I served there for 14/15 years, until
3 2012, when I was appointed on a secondment basis as the
4 area commander for Dunedin, bottom of the south island.

5 Q. Just pausing there and looking back over those areas.
6 From 1972 until 1996, is it right that you were a full
7 time career firefighter in operational roles, ending up
8 serving for four years as area commander and chief fire
9 officer?

10 A. That's correct.

11 Q. Then from 1996 until 2012, is it right that you worked
12 at the New Zealand Fire Service national headquarters?

13 A. That's correct.

14 Q. At headquarters, what were your particular areas of
15 responsibility?

16 A. I -- during my time at fire service national
17 headquarters I had several roles, but mainly they were
18 focussed on operational policy and procedure development
19 and review.

20 Q. The clue, of course, is in the name: "the New Zealand
21 Fire Service". Unlike in the United Kingdom, there is
22 a single national fire service in New Zealand; is that
23 right?

24 A. That's correct.

25 Q. Then you told us that after you served at national

1 headquarters, you worked back in the south island. Is
2 it right that you were asked to postpone your retirement
3 in order to fill the operational role of area commander
4 for east Otago and Dunedin?

5 A. That's correct.

6 Q. Then did you finally retire from the New Zealand Fire
7 Service a few months ago?

8 A. Yes, I retired in October 2012.

9 Q. If I ask you then about other aspects of your career,
10 firstly in terms of qualifications. Do you have any
11 formal qualifications from the Institution of Fire
12 Engineers?

13 A. Yes, I qualified by examination as a -- at member level
14 of the Institution of Fire Engineers.

15 Q. Can you explain to the court briefly what the
16 Institution of Fire Engineers is?

17 A. The Institution of Fire Engineers was formed in 1918 and
18 registered in Scotland as a charity. It has expanded
19 around the world to now include membership from over 35
20 countries, and a total membership of approaching 12,000
21 members. Membership is open to all those who active --
22 or have a role in the broader aspect of firefighting and
23 fire engineering, so that covers operational
24 firefighters, fire engineers, fire alarm systems
25 developers, researchers -- a broad spectrum across the

1 fire industry.

2 Q. If I ask you then about a couple of specific roles that
3 you had in New Zealand. Is it right that from 1990
4 until 2002 you were an examiner on the New Zealand Fire
5 Service examination board, responsible for setting and
6 marking the senior firefighters' examination?

7 A. That's correct.

8 Q. From 2007 to 2011, you were the chair of the Standards
9 New Zealand Fire Industry Advisory Group?

10 A. That's correct.

11 Q. When you worked at the New Zealand Fire Service
12 headquarters, focussing on policies and procedures, did
13 you continue to have an operational role, in that you
14 could be called upon to take operational responsibility
15 in the event of major incidents?

16 A. That's correct. I had two roles. One was -- both were
17 on a roster. One was acting for the national commander
18 of the New Zealand Fire Service, which meant I was the
19 first point of contact for any event that affected the
20 wider New Zealand Fire Service, or for any major event.
21 I was also on a roster for the Wellington region to
22 respond to major incidents in a command role.

23 Q. Did you serve operationally during the Christchurch
24 earthquakes?

25 A. Yes, I did. I started with the -- both earthquakes as

1 the fire service liaison officer based at the national
2 crisis management centre based under the Parliament
3 buildings in Wellington. For the second earthquake,
4 having spent 12 hours there, I was then posted to the
5 liaison role with the national silver defence based in
6 Christchurch, where I stayed for a week.

7 Q. Can I ask you then about your experience of dealing with
8 fires in multi-storey buildings.

9 A. My experience has not been as extensive as some of the
10 people we've heard evidence from, but I have attended,
11 in a command role, fires involving hotels, commercial
12 buildings and apartment buildings.

13 Q. Finally by way of introduction, can I ask you about your
14 current role with the Institution of Fire Engineers?

15 A. I'm currently appointed as a director and trustee of the
16 Institution of Fire Engineers, one of eight directors
17 representing the whole of the membership and the wider
18 countries that are involved in the Institution of Fire
19 Engineers.

20 Q. This is a UK-based organisation but it is international
21 in nature; is that right?

22 A. That's correct. It's based in Stratford-upon-Avon,
23 where our headquarters and office is, and where the
24 directors meet three times a year.

25 Q. The directors and trustees, of whom you are one, which

1 countries do they come from?

2 A. Directors come from England, Australia, New Zealand,
3 Malaysia and Canada.

4 Q. And based on your experience of meetings with your
5 fellow directors and your knowledge of the firefighting
6 world, can you comment on which of those countries have
7 systems of firefighting that are close to those in place
8 in the United Kingdom?

9 A. Australia and New Zealand would be the two countries
10 that closely follow the same systems or similar systems
11 to the United Kingdom.

12 Q. So although you haven't served as a firefighter in the
13 United Kingdom, your experience is that the New Zealand
14 system is closer to it than that in other countries?

15 A. That's correct, and in my role at fire service national
16 headquarters in Wellington, we closely followed all the
17 operational policies and procedures that were issued in
18 the larger centres in UK as part of our research in
19 developing our own operational policies.

20 Q. I'll then turn to ask you about the reports that you
21 have prepared for the coroner on the instructions of the
22 coroner in these inquests. I'll just put them up on the
23 screen so you can identify them. Is that the front page
24 of your first report, dated 15 January 2013?

25 A. Before I go on to that, could I just express my

1 sympathies and condolences to the families of the
2 deceased.

3 Yes, that is the report that I prepared.

4 Q. So this report was completed by you before any of the
5 firefighters whom we have heard give evidence to these
6 inquests had begun to give their evidence?

7 A. That is correct.

8 Q. In terms of some of the assumptions that you were asked
9 to make in preparing your report -- and it may assist to
10 you look at page 4 of it -- is it right that you were
11 asked to assume that the findings of the BRE fire
12 reconstruction, and the times that they attributed to
13 certain events, were accurate?

14 A. That's correct.

15 Q. You were asked to assume that the times of the 999 calls
16 were accurate, the times on photographs were accurate,
17 and the times set out in the sequence of events that was
18 in the original computer presentation that the members
19 of the jury saw on the first day of the inquest were all
20 accurate; is that right?

21 A. That's correct.

22 Q. You read the report of Professor Bion and were asked to
23 assume that his conclusions were accurate?

24 A. That's correct.

25 Q. Did you have an opportunity to make your own visit to

1 Lakanal House before completing your report?

2 A. I did.

3 Q. You were also provided with a large amount of evidence
4 by way of witness statements and documents,
5 London Fire Brigade policies and procedures; is that
6 right?

7 A. That's correct.

8 Q. You were told that there was the possibility of small
9 inaccuracies in times recorded in relation, for example,
10 to the arrival of fire appliances or the switching on or
11 closing down of breathing apparatus?

12 A. Yes, that's true.

13 Q. So you took that into account when analysing the
14 evidence?

15 A. I did.

16 Q. If I can ask you then about the conclusions to your
17 first report. These start on page 50. Is it right that
18 you were asked, for the purpose of your report and of
19 analysing the evidence of this case, to look at it in
20 two distinct ways: firstly, the possibility of
21 extinguishing the fire at some stage before the final
22 spread of the fire as we've seen it from the
23 photographs -- so in other words, whether there were any
24 methods that could have been used to halt the spread of
25 the fire -- and then, secondly and separately, you were

1 asked to analyse the possibility of rescuing people from
2 the building; is that right?

3 A. That's correct.

4 Q. Turning then to the first topic that you were asked
5 about, whether there were opportunities to prevent the
6 fire from spreading to the extent that it did, you were
7 asked firstly about whether there was any opportunity to
8 prevent the fire from spreading from flat 65 into the
9 bedroom of flat 79. What was your view on that?

10 A. My view was that there was no way to stop that fire
11 spreading from flat 65 into the bedroom of flat 79.

12 Q. The next event that you were asked to focus on was the
13 fact that we know that the fire spread within flat 79 to
14 involve the staircase in flat 79, and as a result have
15 implications for the survivability of anyone still
16 within flat 79. If you take up the latest version of
17 the sequence of events, which should be in your jury
18 bundle at tab 12.

19 THE CORONER: Has the most recent version been added yet?

20 MR MAXWELL-SCOTT: I'm told it has.

21 THE CORONER: Thank you very much. (Handed)

22 MR MAXWELL-SCOTT: If you can turn within the sequence of
23 events at tab 12 to page 18, you'll see that we are
24 putting in this document 16.48 as the approximate time
25 at which the internal staircase of flat 79 was alight.

1 So you were asked about the opportunity, if any, for the
2 London Fire Brigade to have extinguished the fire before
3 it spread to the internal staircase of flat 79 at
4 approximately 16.48. What was your view on that?

5 A. Even if the incident -- the first incident commander had
6 increased his request from four pumps to eight pumps,
7 the time needed for them to respond and establish
8 a bridgehead with sufficient crews and equipment -- they
9 wouldn't have been able to prevent that fire from
10 spreading.

11 Q. Then the next point in the chronology that you were
12 asked to focus on was the fire penetrating the boxing in
13 beneath the stairs of flat 81. Is it right that your
14 view was that in order to prevent that from happening,
15 the London Fire Brigade would have needed to have gained
16 entry to the 11th floor with firefighting crews well
17 before 17.20?

18 A. That's correct.

19 Q. In fact, if we look at the current version of the
20 sequence of events at page 29, you'll see at the top of
21 page 29 that we are putting forward 17.19 on the basis
22 of the evidence we've heard as an approximate time at
23 which the front door of flat 79 collapsed into the
24 corridor on the 11th floor. I think you've seen the
25 reconstruction video showing the door collapsing and the

1 implications of it collapsing?

2 A. That's correct.

3 Q. In summary, what would be the implications for
4 firefighters trying to access the 11th floor of the door
5 of flat 79 collapsing into the corridor?

6 A. That would have provided a route for fire to spread into
7 the corridor and involve elements within the corridor
8 itself.

9 Q. So focussing then on what, in theory, could have been
10 done before around 17.19 or 17.20, you said in your
11 report:

12 "Even if the first incident commander had
13 immediately increased his request from four pumps to
14 eight pumps, the time needed for them to respond and
15 establish the bridgehead with sufficient fire crews and
16 equipment was such that it would have been difficult to
17 achieve this unless doing so had been prioritised to the
18 exclusion of all the additional tasks resulting from the
19 rapidly developing fire."

20 A. That's correct.

21 Q. If I ask you then about the fact that fires started
22 elsewhere in the building below the original flat that
23 was on fire. So they started in flats 37 and 53,
24 although the original fire was above both of those
25 flats. What was your view on whether crews -- in

1 particular, incident commanders -- might have predicted
2 the possibility of fire spreading to lower floors?

3 A. The spread, as fire did, to the lower flats is unusual
4 and we've heard some evidence about that, but when I was
5 reading the written evidence, I also looked to see if
6 I could find any other examples of fires having
7 started -- spread downwards in a similar manner, and
8 I couldn't find anything. That would indicate it was
9 a common approach at fire sites, and I think it's not
10 unreasonable for the initial incident commanders to have
11 not thought of that particular possibility based on
12 their training and their experience.

13 Q. So as a matter of fact, it is certainly very rare and
14 you couldn't find previous instances of it; is that
15 right?

16 A. No, I couldn't.

17 Q. Although standing back now, we can see the mechanism
18 involved burning debris falling and entering open
19 windows?

20 A. Certainly.

21 Q. In your report, you said that during the initial stages
22 of directing crews and prioritising tasks, this
23 mechanism, this spread of fire downwards, would have
24 been difficult but not impossible to predict?

25 A. Yes.

1 Q. And that's your view?

2 A. That's my view, yes.

3 Q. Just pausing there and thinking about those fires on the
4 5th and 7th floors, can you return to the sequence of
5 events and page 18. In the second half of that page, we
6 can see photograph 21, which is timed at 16.49, and you
7 comment on that photograph specifically at page 37 of
8 your first report. What I wanted to ask you to comment
9 on was the ability of what we have heard described as
10 a ground monitor, so a jet at ground level, to attack
11 those fires on the 5th and 7th floors.

12 A. The use of a delivery or ground monitor is a legitimate
13 approach to trying to control fire above ground, but in
14 this case I think the height and the angle would have
15 resulted in a limited effect of that ground monitor to
16 actually control and extinguish. It may have slowed
17 fire development, it may have bought some time for crews
18 to attack from internally, but as you can see from the
19 photograph, the angle meant that it would be difficult
20 to penetrate very far into those bedrooms.

21 Q. Does it follow that in order fully to extinguish those
22 fires, one would need to mount an internal attack?

23 A. Yes.

24 Q. If I move away then from possible opportunities to
25 prevent the fire spreading to the extent that it did and

1 ask you about issues relating to rescue, and firstly
2 about whether or not it would have been appropriate to
3 attempt a complete evacuation of Lakanal House, in other
4 words to advise all residents to leave, or try and get
5 all residents out as a matter of principle. You comment
6 on this issue at page 51 of your report.

7 A. The decision to completely evacuate does not appear to
8 be a common approach by the London Fire Brigade because
9 of what I've come to understand as the early design
10 approaches, where residents are safe in their apartments
11 other than in times when they're directly impacted by
12 fire and smoke. To completely evacuate would have
13 required a method of advising all residents, some sort
14 of internal alarm system or some other method which
15 I don't see as being present in Lakanal House.

16 If there had been a decision to evacuate, and if
17 residents had been able to evacuate with the sounding of
18 some alarm, that would have created additional
19 congestion on the single staircase and possibly created
20 additional hazards and certainly delays for fire crews
21 trying to work their way up the stairs to the floors
22 that were involved.

23 Q. You concluded your section on this in your first report
24 by saying you do not consider that the
25 London Fire Brigade should have advised complete

1 evacuation by all residents of this fire:

2 "To have done this would have required both the
3 benefit of hindsight and a departure from established
4 advice."

5 A. That's correct.

6 Q. So putting complete evacuation to one side and then
7 thinking about the possibility of trying to evacuate or
8 rescue some residents, you've already made the point
9 that residents are usually safest in their flats unless
10 their flat is affected by heat and smoke; is that right?

11 A. That's correct.

12 Q. What was your view about the appropriateness of the
13 "Stay put" advice, or at least the need to reconsider
14 it, for residents in some areas of Lakanal House?

15 A. I think the "Stay put" advice was -- is appropriate for
16 probably most of the residents of Lakanal House.
17 Clearly, the flats that were directly impacted by the
18 fires would need to have been considered for evacuation.

19 Q. In your report you focussed on residents immediately
20 impacted by the fire and you said that is above and to
21 the north of flat 65.

22 A. That's correct.

23 Q. You then considered who, if anyone, would have been the
24 appropriate person to give advice to Dayana Francisquini
25 and Helen Udoaka to leave their flats. What was your

1 view on who, if anyone, could give that advice in the
2 command structure?

3 A. That advice would have needed to have originated from
4 the incident commander because that advice would have
5 impacted on the tactics that he would have adopted for
6 both firefighting and search and rescue.

7 Q. Then you said in your report that at the time of writing
8 you'd seen no evidence that any incident commander in
9 fact considered advising those in the bathroom of
10 flat 81 to make their way to the east balcony of the
11 12th floor, and at the time of writing you said there
12 were reasons why that may not have been considered.
13 Those included: limited knowledge of the layout of
14 Lakanal House by those required to make decisions and
15 brief crews and the fact that incident commanders did
16 not appear to have recognised that they could use
17 existing lines of communication by way of mobile phones
18 to Dayana Francisquini and Helen Udoaka.

19 A. That's correct.

20 Q. You then commented on the fact that, with the benefit of
21 hindsight, one can say that those within the bathroom of
22 flat 81 would have had a better chance of survival if
23 they had been on the east balcony of the 12th floor,
24 where we know the Nuhu family spent some 25 minutes or
25 so.

1 A. That's correct.

2 Q. You commented on the considerations that would need to
3 have been taken into account if somebody had in fact
4 gone through the process of thinking: "Should we advise
5 those in the bathroom of flat 81 to move onto the east
6 balcony on the 12th floor"?

7 A. That's correct.

8 Q. This is page 52 of your report. Can you just outline
9 briefly the sort of competing considerations that any
10 incident commander who got as far as thinking about
11 giving such advice would have had to reflect on?

12 A. Some of the considerations they would have needed to
13 think about was the smoke-logging or the increasing
14 amount of smoke coming into flat 82 --

15 THE CORONER: 81.

16 A. Sorry, flat 81 -- the ability of the people that were in
17 the bathroom to move through that smoke up the
18 stairways, out onto the balcony, and what would they be
19 faced with once on the balcony, the development of fire
20 that was coming out on that side from flat 79, would
21 that have created additional hazards for them, how long
22 they may have been there, what stage of fire development
23 was occurring at flat 79, and the number of resources
24 that would have been available to go up there -- up to
25 the 12th floor to assist them or rescue them.

1 Q. We know, of course, that this is essentially
2 a hypothetical discussion, and one cannot therefore say
3 exactly what information might have been available to
4 an incident commander going through the process of
5 considering whether to make such a decision, but in your
6 report you said that in the circumstances advising those
7 in the bathroom of flat 81 to move to the east balcony
8 on the 12th floor would have been a bold decision to
9 make?

10 A. Yes, I think when you look at what the incident
11 commander would have needed to have considered to make
12 that decision, along with all the other decisions that
13 he was faced with for the developing fire, deploying
14 resources, I think he was at a point where he would have
15 needed to focus on that decision only, and that's
16 probably not the most effective role of an incident
17 commander. He's got to consider the whole incident.

18 THE CORONER: If he had focussed just on that particular
19 decision, are you saying that there were too many
20 unknowns, in effect?

21 A. Yes.

22 MR MAXWELL-SCOTT: Looking at the same issue but coming at
23 it from an opposite direction, thinking about it not as
24 giving those in the bathroom of flat 81 advice to leave
25 but about tasking firefighters to rescue them, using the

1 route from the 12th floor balcony and therefore avoiding
2 the corridor on the 11th floor, you say that again, you
3 had seen no evidence of incident commanders considering
4 tasking firefighters to carry out a rescue using that
5 route. And again, the reason for that would mainly seem
6 to be the limited knowledge that the London Fire Brigade
7 had of Lakanal House?

8 A. That's correct.

9 Q. Then you commented on the evidence that you read in
10 relation to the rescue of the Nuhu family, from the
11 witness statements that you had seen and the evidence in
12 them relating to the crew being split and some of them
13 rescuing an occupant from flat 56. You said that that
14 indicated that the incident command function was not
15 effective, as the new instruction to carry out a rescue
16 from flat 56 effectively split the rescue crew and meant
17 that only a crew of two reached the 12th floor?

18 A. That's correct. I think the decision to task that crew
19 to carry out the rescue by the incident commander -- in
20 his mind, he had a crew of four to carry out that task.
21 Before they could, they were given alternate
22 instructions and they split themselves up, and I think
23 when they were faced with that decision -- I'm not
24 criticising them for that; I'm simply highlighting that
25 things changed from what the incident commander thought

1 to what actually happened in practice on the ground.

2 Q. At the time of writing your report, you said you
3 couldn't express a firm view on who, if anyone, in
4 flat 81 could have been saved if more resources had been
5 deployed or the crew of firefighters had not been split?

6 A. No, that's true.

7 Q. Then turning to the situation of Catherine Hickman and
8 the opportunities she might have had to escape, you made
9 the point that the rapid fire spread into flat 79 from
10 flat 65 meant that there was only a limited time for her
11 to escape. In your first report, you said that
12 nevertheless there were opportunities during the fire
13 survival call to explore in more detail and make use of
14 escape options available to her before it became
15 untenable.

16 A. That's correct.

17 Q. So that was your first report, completed shortly before
18 the firefighters began giving their evidence in these
19 inquests. Is it right that you then attended the
20 inquests for the first five weeks or so and had the
21 opportunity, therefore, to hear the firefighters, whose
22 statements up until then you'd only read, give their
23 evidence to this court?

24 A. Yes, that's true.

25 Q. You then prepared a second report at the end of that

1 process, a supplementary report, dated 15 February 2013.

2 A. That's correct.

3 Q. If we turn to that now. On page 3 of it, you reflected
4 on the conclusions set out in your first report and said
5 this:

6 "I confirm that the conclusions set out at pages 50
7 to 54 of my first report continue to reflect my opinions
8 on the matters considered in that report."

9 Is that right?

10 A. That's correct.

11 Q. Then you set out a section on issues relating to
12 pre-planning, on which the evidence was now more
13 developed than when you had come to write your first
14 report.

15 A. That's correct.

16 Q. If I could ask you some questions about pre-planning.
17 Firstly, you make the point that at the time of the
18 fire, appliances in the London Fire Brigade carried any
19 information that they had on the appliances on paper
20 rather than electronically.

21 A. That's correct.

22 Q. Although we have heard evidence that since the fire,
23 mobile data terminals have been installed on some if not
24 all appliances.

25 A. That's correct.

1 Q. But when you expressed your opinions in your
2 supplementary report, they were against the background
3 that any records on an appliance would have had to have
4 been held on paper rather than electronically?

5 A. That's correct.

6 Q. What, then, is your view on the level of information you
7 would have expected to be held on an appliance if it had
8 to be held in paper form?

9 A. I'm aware that there are a large number of high rise
10 buildings in the Peckham station area and that it's
11 impractical to carry information on paper on every one
12 of those, so in terms of prioritising the high risk
13 buildings, I think that's appropriate but I would have
14 expected that there were some records, even at station
15 level, to record --

16 Q. I'll stop you there because I want you to focus firstly
17 on what you would have expected an appliance to carry
18 with it when it was driving around and attending fires.
19 I think you were saying that there were many high rise
20 buildings in Peckham and it wouldn't be practical to
21 carry information on paper on an appliance in relation
22 to all those high rise premises; is that right?

23 A. That's -- that's correct. I would expect them to carry
24 information on high rise buildings and other buildings
25 that present an unusual or high hazard compared to the

1 majority of the buildings in the area that they were
2 responding to.

3 Q. Would you have expected a paper file carried on
4 an appliance at the time to have had information in it
5 about Lakanal House?

6 A. No, I wouldn't have done.

7 Q. Briefly, why not?

8 A. Lakanal House didn't have any unusual features compared
9 to other high rise buildings that would have needed the
10 firefighters to have specific or special information
11 relating to the building. Their fire attack tactics
12 would have been common to that type of building and
13 I would have expected that their normal training would
14 have provided them with the level of knowledge on the
15 London Fire Brigade policies and procedures for high
16 rise firefighting, and for that to be automatic once
17 they arrived.

18 Q. So that deals with the question of what, in your
19 opinion, the appliances should have carried on them.
20 Looking, then, at page 4 of your supplementary report,
21 what is your view on the extent to which there should
22 have been paper records created after familiarisation
23 visits and kept at the fire station?

24 A. Having listened to the evidence of firefighters on the
25 familiarisation visits, I was able to form the opinion

1 that there could have been an improvement in the way
2 they were able to access previous information from some
3 of the familiarisation visits, even if that was a simple
4 check sheet that indicated a range of checks and tests
5 had been conducted on the building and they were all
6 correct. The next crew that would have attended the
7 building could have seen that the previous visit there
8 was no problems, or, if there had been recurring
9 problems, they would be able to target the areas where
10 the recurring problems were happening. So it was
11 a paper-based record for the use of crews doing the
12 familiarisation visits on what had been happening in the
13 past.

14 Q. So this is a document, which you regard by way of
15 improvement if crews carrying out familiarisation visits
16 completed a formal document as they went round or at the
17 end, it was then kept at the fire station. Then, the
18 next time a crew went to carry out a similar visit, they
19 would take a copy from the fire station and have it
20 available as they did their own visit?

21 A. That's correct, and I think it would also provide
22 a prompt on all the areas that needed to be checked.

23 Q. In terms of what you would expect crews to look for on
24 a 72D visit or familiarisation visit, you commented in
25 your report that you would expect them to look out for

1 any information which could help them, for example signs
2 indicating important aspects of the layout of the
3 building?

4 A. That's correct. I would have expected them to look for
5 the signs that were clearly present at Lakanal House
6 above the -- the lifts, indicating the floors and what
7 flat numbers were on each floor. I would expect
8 firefighters to see that as a piece of useful
9 information that would help them get into the habit of
10 looking for that type of sign rather than recording
11 perhaps the detail within that sign itself.

12 Q. You said you'd expect firefighters to consider the
13 location of fire hydrants, access to the building,
14 including entrances and exits, escape routes, lifts and
15 stairwells?

16 A. That's correct, the information that they could get
17 visually by walking around the building.

18 Q. We heard also about home fire safety visits. What were
19 your views on those and on the possibility and
20 advantages of, to some extent, combining them with 72D
21 visits?

22 A. If the whole crew is not involved in a home fire safety
23 visit, there are opportunities for the remaining crew
24 members to carry out some of the regular checks on items
25 such as firefighting lifts, riser outlets, checking of

1 security keys, where they were carried, to make sure
2 that they did work and open the doors -- that type of
3 check that other crew members could carry out while the
4 home fire safety check was being conducted.

5 Q. You also considered whether crew members who might have
6 specific roles in an incident might approach
7 a familiarisation visit in a particular way. Can you
8 comment on that in particular in relation to those who
9 might be called upon to operate an aerial ladder
10 platform?

11 A. The drivers of the aerial ladder platforms and the
12 operators should take the opportunity of
13 a familiarisation visit to look at where they may end up
14 parking their appliance, either for rescues or providing
15 access up into the building, and identify such things as
16 narrow driveways, whether there is enough room to
17 operate the jack legs within the space between car parks
18 and the side of the road, overhanging foliage from
19 trees, aerial causeways. Any -- anything that may
20 obstruct the use of the ALP is something that the
21 operators should look for and become aware of.

22 Q. Then you commented on the possibility that there might
23 be other buildings of an identical or almost identical
24 layout within a station's ground, and the opportunities
25 that that would provide to build up a knowledge of

1 certain types of building layout.

2 A. Yes, I became aware that in some of the estates there
3 were blocks of flats that were built pretty much the
4 same, and in terms of the detail of the building,
5 I couldn't see the point in needing to visit all of them
6 to record the same detail, but certainly listing those
7 buildings that were built in a similar manner and had
8 the same features may have helped reduce the number of
9 familiarisation visits that they needed to carry out.
10 That wouldn't have meant them not attending for the
11 purpose of riser outlets and lifts et cetera.

12 Q. So there will, of course, still be a need, from time to
13 time, to visit to look for any defects, for example with
14 the dry riser, or any changes. But if one hadn't
15 visited a building for some time but knew it had
16 an identical or almost identical layout to a building
17 that one had visited more recently, one could use that
18 knowledge; is that right?

19 A. They could, yes.

20 Q. Then in summary, you expressed the view that there were
21 features of the way in which information was gathered
22 which could have been improved and which might have led
23 to more information being available on the day of the
24 fire. There would have been some scope for carrying out
25 72D visits at the same time as home fire safety visits,

1 and you would have expected a paper record of each such
2 visit to be kept, but at the fire station rather than on
3 the appliance; is that right?

4 A. Yes, that's correct.

5 THE CORONER: Before you move on from that, can I just
6 clarify two points. Once information has been
7 gathered -- normally it will be gathered just by one
8 watch, won't it? The crew from one watch who happen to
9 be on duty on the day in which they make that
10 inspection. How, if at all, should that information be
11 shared with other watches within the same fire station?

12 A. We heard in evidence that defects were reported through
13 the station log book, the station diary, and where there
14 were no defects there's no way of passing information
15 on, and what I would suggest is that if there had been
16 a paper check sheet -- and we did hear that different
17 watches were programmed to attend the same buildings
18 over time -- by taking that paper document, they had
19 some reference to what was found at the present previous
20 visit. So I see that as one way of being able to pass
21 information on between watches where there was no urgent
22 or specific defect.

23 THE CORONER: Thank you. Can I just ask you to clarify
24 another point. Your opinion is that on a visit someone
25 should have a look to see whether an ALP, an aerial

1 ladder platform, could get close to the building and
2 look out for hazards and so on. But if you have a fire
3 station like Peckham, which had one pump and one pump
4 ladder, would you expect somebody from that station to
5 have sufficient knowledge of use of an ALP to be able to
6 carry out that sort of check?

7 A. No, I wouldn't. I would expect the ALP that was on the
8 predetermined attendance to have that building as part
9 of its familiarisation for the purpose of checking those
10 points: access and ability to operate around that
11 building.

12 THE CORONER: We've heard that there are a limited number of
13 ALPs available for the whole of London, but your opinion
14 is that those who have responsibility for using those
15 ALPs should carry out that sort of inspection on
16 a really quite a wide geographical area?

17 A. That's correct, because the nature of operating an ALP
18 is quite specific, and it's those that are trained in
19 its use and those that would be operating it in the
20 event of an incident who need to accumulate that
21 knowledge. I appreciate, yes, it does create a bit of
22 a problem with the number of appliances, but it is
23 important that they do look for access ways or change
24 the predetermined attendance.

25 THE CORONER: Thank you. Yes.

1 MR MAXWELL-SCOTT: If I then ask you about certain comments
2 that you made about practices, policies and procedures
3 and then finally turn to your recommendations.

4 So firstly premises information boxes. We know that
5 there wasn't one at Lakanal House and that there were
6 very few buildings in Southwark that had them at this
7 time. Firstly, standing back, do you think it would
8 have been helpful if there had been, at Lakanal House,
9 a premises information box, in other words a specially
10 designed box that contained within it some plans and
11 information about the layout of the building?

12 A. Yes, I do, and I qualify that by my understanding that
13 that wasn't a legal requirement of the
14 London Fire Brigade; that was a building owners'
15 requirement. So there's a bit of a conflict about who
16 would provide it there, but some sort of box at the
17 premises with key information would certainly be useful.

18 Q. Then you commented on the fact that there were radio
19 communication difficulties on the day of the fire,
20 meaning that some key messages were either not
21 transmitted or were not received; is that right?

22 A. That's true.

23 Q. Then you commented on what we've heard of as "make
24 pumps" messages. You said it would be helpful to review
25 the training provided in relation to "make pumps"

1 messages. We'll come to that in your recommendations.

2 Then in terms of fire survival calls, you said it
3 seemed that some of those making operational decisions
4 had a limited awareness of the term "fire survival
5 call", which meant they may not have appreciated the
6 nature of the advice being given to the caller or that
7 this may have an impact on their own firefighting and
8 rescue decisions; is that right?

9 A. That's correct.

10 Q. Then finally, I'm going to ask you about your
11 recommendations. I'll put those up on the screen for
12 you. Page 7 of your supplementary report. You
13 introduce them by saying:

14 "The court has heard evidence about the practices
15 and procedures that were in place at the time of the
16 fire. I am conscious that at a later stage in the
17 inquests witnesses from the London Fire Brigade are
18 likely to give evidence about the extent to which those
19 practices and procedures have changed since the fire."

20 We'll be hearing some of that evidence later this
21 week. The recommendations that you put in your
22 report -- and there are five of them -- are, as you say,
23 based on the evidence that you've heard so far?

24 A. That's correct.

25 Q. If we look at those then in turn. You said that:

1 "The London Fire Brigade should review all of the
2 opportunities that exist to gather building-related
3 information and consider, in each case, what is expected
4 in terms of the information that should be obtained and
5 recorded and in terms of the sharing of information
6 between watches and between fire stations."

7 Secondly:

8 "The London Fire Brigade should review their policy
9 513 on premises information boxes. There is a need for
10 more specific guidance in relation to high rise
11 buildings and other buildings posing a high fire risk."

12 A. Yes.

13 Q. That ties in with the comment earlier in your
14 supplementary report that a premises information box
15 would have been very helpful in this case.

16 A. That's correct.

17 Q. Thirdly, you said:

18 "It would be helpful to review the training provided
19 to firefighters and potential incident commanders about
20 the sending of 'make pumps' messages."

21 Can you just explain why that is and what you mean
22 by that?

23 A. Listening to the evidence from the incident commanders
24 and why they said they made pumps, I can understand
25 their reasoning but what I didn't see is a link between

1 tasks that needed to be performed on the incident ground
2 and the number of people that are require to do them.
3 Certainly I'm not suggesting that it's a calculation
4 that incident commanders stop to make, but as part of
5 their training, I'm suggesting that if they can
6 associate the tasks with the number of firefighters
7 needed, that helps to identify why they're making pumps.
8 Are they making them for firefighters to conduct
9 specific tasks? Are they making pumps because they want
10 more ability to pump water? I just didn't see the link
11 between "make pumps", the number of pumps needed and
12 what the anticipated tasking for those pumps would have
13 been. Sorry, the tasking for the crews and the pumps.

14 Q. Fourthly, you said:

15 "The London Fire Brigade should consider whether it
16 would be appropriate to utilise additional breathing
17 apparatus communications and personal radio channels at
18 major incidents to reduce the amount of traffic on each
19 channel."

20 Which I think is self-explanatory. Then finally,
21 you said:

22 "It would be helpful for the London Fire Brigade to
23 review the training given to operational crews about
24 brigade control practices and procedures."

25 What was that specifically a reference to?

1 A. That became my view having listened to the evidence from
2 brigade control staff and operational firefighters
3 that -- it appeared that the training and the use of
4 fire survival guidance calls was not shared across the
5 whole brigade, and the danger, I think, is that the two
6 parts of the London Fire Brigade develop policies and
7 procedures without reference to the other part, and I'm
8 just suggesting that as part of the development of
9 policy and procedure that both parts consider the roles
10 of brigade control and the operational staff.

11 Q. Mr Davey, thank you very much. Those are my questions.
12 There may be questions from others.

13 THE CORONER: Thank you. Mr Hendy.

14 MR HENDY: Madam, I wonder if this would be an opportunity
15 for the jury to have a short break. There's
16 particularly a matter I'd like to raise with you.

17 THE CORONER: All right. Thank you very much.

18 Well, in that case, members of the jury, do you want
19 to have a break for coffee now. If you could be back by
20 just before 11.30, please. Thank you very much.

21 (In the absence of the Jury)

22 THE CORONER: Yes, Mr Davey, do you want to take a break as
23 well.

24 Yes, Mr Hendy.

25 MR HENDY: Madam, it's just this: everybody will understand

1 that the thrust of my questions will be directed to the
2 points raised by Mr King and not dealt with by Mr Davey,
3 where there's a difference of opinion, but I understand
4 that in fact Mr Davey's not seen Mr King's report.
5 I know Mr Maxwell-Scott told me he wasn't going to send
6 it to Mr Davey last week but I had rather assumed that
7 Mr Davey would read it over the weekend, and before
8 I ask my questions, I think it would shorten things if
9 he did see Mr King's report. That would certainly ease
10 my questioning of him.

11 Obviously it's going to take him 30 minutes just to
12 read through it and rather than take up time now,
13 I wonder whether the more sensible course might be for
14 others to ask their questions and then for him to read
15 it over lunchtime so that I can come to him this
16 afternoon. Obviously whatever suits you and other
17 parties, but I do think that he ought to have a chance
18 to look at it. He doesn't have to read every line of
19 it, and I'm certainly not going to interrogate him on
20 all parts of it, but you, of course, know the evidence
21 that I would wish to focus on.

22 THE CORONER: Well, at the moment, Mr King has no standing.
23 Mr King's report is not a document which has any
24 standing. I asked Mr Maxwell-Scott to send Mr Davey the
25 appendices to Mr King's report so that those were the

1 documents which, if he hadn't already seen, he had the
2 opportunity to have a look at, and this is going to be,
3 in large part, a way for the jury to understand the
4 points that you want to make, so are you not in any
5 event, Mr Hendy, going to have to be putting your points
6 to Mr Davey in a way that the jurors can follow? I'm
7 not quite sure that Mr Davey's reading Mr King's report
8 is going to assist with that process.

9 MR HENDY: Of course I'll have to put them in a way that the
10 jury understand them. It's just that Mr Davey will then
11 see the reasoning that's led Mr King to reaching his
12 conclusion and he may well say, "Well, for those
13 reasons, I accept what you say", or: "For other reasons,
14 I disagree." But if it's not an attractive course to
15 you, madam, of course I don't press it. I just thought
16 it might save time in the long run.

17 THE CORONER: Well, in terms of timing, we have the rest of
18 today and I think that we do have plenty of time, so
19 I don't think that timing is going to be a real issue on
20 that. Does anyone else have any observation they want
21 to make?

22 MS AL TAI: Madam, merely that if Mr Hendy is inviting
23 Mr Davey to give opinion on points upon which there
24 might be controversy, it might assist Mr Davey, purely
25 from his perspective, to see the angle at which Mr King

1 approaches his report, and that's purely from the
2 witness's perspective as opposed from anything else.

3 THE CORONER: All right, that's helpful. Anybody else want
4 to make any observation? Mr Walsh?

5 MR WALSH: Madam, it is difficult, because as you've said,
6 the report itself hasn't been adduced in evidence, so it
7 would be difficult to put extracts of Mr King's report
8 to Mr Davey and ask whether or not he agrees with it by
9 contrast with the appropriate course of action, which
10 would be simply to put to Mr Davey certain scenarios.
11 I can see why Mr Hendy would want to do that, I can see
12 why it might simplify it, but it would, of course,
13 introduce a report or parts of a report which we haven't
14 yet discussed the admissibility of being put to him as
15 though they were part of the report. We don't take
16 a particularly strong view of it, but those are the
17 difficulties I can see.

18 THE CORONER: Thank you very much. Anybody else?

19 MR HENDY: I'm sorry, just to respond to Mr Walsh, I'm
20 certainly not intending to ask Mr Maxwell-Scott to put
21 bits of Mr King's report on the screen and I shall be
22 putting conclusions -- not the section heading
23 "Conclusions" but Mr King's thinking -- to Mr Davey,
24 rather than trying to read parts of Mr King's report.
25 This is not a sort of backdoor way of getting a document

1 before the jury which you have not admitted; I'm just
2 trying to facilitate the points that I'm going to put to
3 Mr King (sic). I'm sorry to rise twice.

4 THE CORONER: That's all right. Thank you very much, that's
5 helpful. I think there's understandable desire to
6 assist Mr Davey in giving his answers, but I think the
7 better course will be simply to let matters stand as
8 they are at the moment and not ask Mr Davey to read
9 Mr King's report. Mr Hendy, I'm sure that you'll be
10 able to put your points to Mr Davey with the necessary
11 explanation so that Mr Davey can understand the question
12 that you're putting and the jury will be able to follow
13 it.

14 So I think we'll leave it like that for the moment.
15 If circumstances arise which look as if we ought to take
16 a different view, we can revisit that. But that's my
17 position at the moment.

18 MR HENDY: Madam, I'm grateful for that, and I shall follow
19 that, but I should just say that unless you tell me
20 otherwise, I'm not going to pretend that there isn't
21 such a report by not referring to, for example, Mr King
22 taking a different view. Mr Davey obviously knows that
23 Mr King has written a report, so I imagine that's
24 acceptable to you, without quoting from it?

25 THE CORONER: Well, that then immediately gives rise to

1 questions in the minds of the jurors as to why they
2 haven't seen the report and why they may not -- well, we
3 haven't yet come to that point but why they may not
4 actually be shown it or be told about it, which I think
5 would be rather muddling for them. Are you not in
6 a position where you can put the points that you wish to
7 put without specific reference back to the report?

8 MR HENDY: I'll do my best, madam.

9 THE CORONER: I'm sure you will.

10 MR HENDY: I don't want to find myself in an position where
11 I've referred to Mr King when I shouldn't have done, as
12 though it were taboo, that his very existence should not
13 be acknowledged, but I certainly do not wish to put
14 queries in the minds of the jurors that we don't need to
15 have.

16 THE CORONER: They have enough to cope with without that.

17 MR HENDY: Absolutely, madam.

18 THE CORONER: All right, thank you very much, Mr Hendy,
19 that's helpful. All right, we'll have a break now and
20 be back at 11.30.

21 (11.20 am)

22 (A short break)

23 (11.35 am)

24 THE CORONER: Thank you.

25 (In the presence of the Jury)

1 THE CORONER: Yes, Mr Hendy.

2 Questions by MR HENDY

3 MR HENDY: Mr Davey, my name's Hendy. I represent all the
4 families of the bereaved. Can I ask you first about
5 pre-planning and your conclusions in relation to that.
6 In your second report, you say that the information
7 about Lakanal House you wouldn't have expected to be
8 carried on the Peckham appliances, or indeed on the
9 appliances from other fire stations, and you say there
10 was nothing about Lakanal House that required it to be
11 identified as creating a special or unusual risk "that
12 would not be expected in a high rise apartment block".

13 Can I just put to you evidence that the jury heard
14 last week from Mr Walker, who, in considering whether
15 fire risk assessments should have been carried out on
16 Lakanal House, said that Lakanal House was a high risk
17 building which should have been prioritised in any fire
18 risk assessment programme. Now, obviously he's talking
19 about high risk from a different point of view to that
20 which you're talking about, but nevertheless can I put
21 to you the factors that he took into consideration and
22 ask you whether they are not factors that do point to
23 Lakanal House being a high risk from a firefighting
24 point of view. Height of the building, which exceeded
25 the height that ALPs could reach, over 30 metres, yes?

1 A. That in itself I don't consider as high risk.

2 Q. No. It would have to be combined with other factors.

3 Let's look at those other factors. The number of

4 residential units within the building, 98 of them.

5 I put to him -- and I put it to you -- that if one

6 assumed an occupancy of three per flat -- these were all

7 two-bedroomed flats -- that would give you some 296

8 residents at any point in time when the house was

9 completely full. Therefore the number of units combined

10 with the height of the building point towards high risk?

11 A. I don't think so, no.

12 Q. Factors which, in combination with others, might lead on

13 that conclusion?

14 A. There could be other factors, yes.

15 Q. Unusual construction. These were maisonettes which

16 we've heard described as upside down maisonettes,

17 because the bedrooms were underneath, the lounge/kitchen

18 above, in a scissor formation across the building.

19 A. If it had been a brand new building with a different

20 method of design, I would have said so, but the fact

21 that this was a building that was instructed late

22 1950s/1960s -- it was an old building -- I wouldn't say

23 that that was something they wouldn't expect.

24 Q. Well, it made it unusual, and we know that the fire

25 crews at this fire found that confusing and had to

1 ascertain for themselves that layout?

2 A. Yes, at this fire, I would agree.

3 Q. Yes. Well, doesn't that therefore suggest a factor

4 pointing towards high risk?

5 A. It may be a factor, yes.

6 Q. You've mentioned the age of the building. That was

7 another factor that Mr Walker took into account.

8 I think he said that more modern buildings have safer

9 precautions within them?

10 A. That's probably correct as well.

11 THE CORONER: He was also identifying the likelihood that

12 work had been undertaken internally.

13 MR HENDY: Absolutely, madam. I've overlooked that. He was

14 pointing out that because of the age of the building,

15 all sorts of changes might have taken place within the

16 building.

17 Previous history of fire in that building he

18 identified as a factor pointing towards high risk.

19 Would you accept that?

20 A. No.

21 Q. Is that because you don't accept there was a previous

22 history of fires or ...?

23 A. No, I base my view there on that there had been previous

24 fires and they'd all been fought successfully and there

25 had been no issues raised from any of those fires

1 relating to factors that could be seen as an additional
2 high risk.

3 Q. He added that the fact that this had a single staircase
4 was a factor.

5 A. Given that the building was designed for people to be
6 safe in their own flats, while a single staircase may
7 have presented a problem, I don't see that as a factor
8 either.

9 Q. Obviously it presents a higher risk than a building with
10 two staircases, one on either end, doesn't it?

11 A. If you're evacuating the whole building, it probably
12 would, yes.

13 Q. Well, whether you're evacuating the entire building or
14 not, it means if you have two staircases there are two
15 ways out, whereas if you only have one staircase there's
16 only one way out?

17 A. That's correct.

18 Q. Indeed, this was a building where there were escape
19 balconies on alternate floors but the escape balconies
20 themselves led to a single staircase?

21 A. (The witness nodded)

22 Q. Is that not a factor pointing towards high risk?

23 A. It would be a factor, but I couldn't say it is on itself
24 is one of high risk.

25 Q. A particular feature of this staircase, which the jury

1 will recall, is that it's a very narrow one. It's only
2 a bit over one metre in width, so if there's a fire --
3 if one takes the fire on 3 July 2009, you have people
4 coming down, self-evacuating, people being rescued,
5 firefighters going up with equipment, firefighters
6 firefighting and hoses occupying part of the staircases.

7 A. That's certainly factors that impact on firefighting
8 activities, but again, I would look at: did the building
9 meet its regulatory requirements? If it did, it clearly
10 was designed to be a safe building and -- rather than
11 a failure of the legislation or the building standards,
12 which may have indicated that it should have been a high
13 risk, but I hadn't seen anything that refers to anything
14 relating to non-compliance with being standards.

15 Q. Well, I put it to you that the narrowness of the single
16 staircase was yet another factor that pointed towards
17 high risk.

18 A. Yes, it certainly would be a factor.

19 Q. The final matter would be the uninformative flat
20 numbering system. If you didn't have the board in front
21 of you and weren't familiar with the block, it would be
22 practically impossible to tell where flat 79 was, by way
23 of example?

24 A. I don't agree with that, because the labelling did give
25 a floor number and a flat number relating to a floor,

1 and certainly the hotels I've been staying in,
2 I've looked at how they describe room numbers and it's
3 been fairly common that room numbers don't always relate
4 to floor numbers.

5 Q. No doubt that's often the case, Mr Davey. What I'm
6 doing is asking you whether the fact of the curious
7 flat-numbering system -- obviously it has its own logic,
8 but the uninformative nature of the flat-numbering
9 system is yet another factor pointing towards this block
10 being high risk?

11 A. It's certainly a factor, but it's -- again, I don't see
12 that as contributing to the high risk. It's a design
13 feature.

14 Q. With hindsight, we know that that made it a risk, don't
15 we, because the firefighters on the ground couldn't make
16 out where flats 79 and 81 were, so it was clearly
17 an important matter?

18 A. It was important, yes.

19 Q. I suggest to you, again, that taking all those factors
20 together, this was sufficiently high risk to warrant
21 appliances knowing some of those features?

22 A. I would say it was sufficiently of risk that
23 firefighters should have been more aware of those common
24 factors.

25 Q. That means the information should have been carried on

1 the appliances?

2 A. One of the issues about carrying paper-based information
3 on appliances is the volume of paper and the short time
4 available to refer to it, and I think from memory we had
5 a response time of two or three minutes. For the first
6 arriving crews to locate that information and absorb it
7 would have been difficult.

8 Q. But had it been on a Peckham appliance, even if the
9 first Peckham appliances couldn't have accessed it
10 within the journey time, it would have been available
11 for incident commanders in the minutes following?

12 A. Yes, that's true.

13 Q. In any event, this information could have been held by
14 brigade control so that they could have passed a summary
15 of that information on to all appliances attending the
16 fire?

17 A. That's possibly as well.

18 Q. Not merely possible; desirable, wouldn't you agree?

19 A. Desirable, and I think it would be dependent upon the
20 ability of brigade control to have a way to retrieve
21 that in a timely manner.

22 Q. If we can look at a risk assessment that was carried out
23 as part of an earlier exercise by the Fire Brigade.
24 This is in the risk assessment bundle at 1369. I don't
25 know whether you have had an opportunity to look at it

1 but there's only a sentence I want to draw your
2 attention to, and that's towards the bottom of the page.
3 It's probably enough, Mr Clark, for Mr Davey to see it
4 on the screen, unless he wants to see the whole thing.
5 It's just that description of the premises:

6 "Residential block of 14 floors. 14 maisonettes on
7 floors 1, 3, 5, 7, 9, 11, 13. All maisonettes over two
8 floors."

9 That is, in three sentences without verbs, something
10 that it would have been very desirable if brigade
11 control could have told the appliances of; do you agree?

12 A. I do, and that was my reference to London Fire Brigade
13 looking at all opportunities to collect information
14 about buildings.

15 Q. One might have added another sentence: "Escape balconies
16 on even floors"?

17 A. I agree.

18 Q. You talked this morning about paper records made after
19 familiarisation visits, and in answer to questions from
20 our coroner, you explained that if there was a paper
21 record after a familiarisation visit then the next watch
22 going to visit that block would take the piece of paper
23 with them to check any changes and see what had been
24 written on the last occasion. I'm sure the jury
25 understand the logic of that.

1 What I wanted to ask you about was the description
2 of this as a "familiarisation visit". Familiarisation,
3 presumably, is not simply to check the hazards and the
4 firefighting equipment and so forth; it's also to become
5 familiar with the premises, so you know what to do if
6 you have to get there in a rush?

7 A. That's my view as well.

8 Q. The difficulty there with your system of taking the
9 paper from the last familiarisation visit when the next
10 watch visit is that that doesn't necessarily give them
11 familiarisation, does it? It just gives them
12 a checklist of things to look for?

13 A. That's one way of looking at it, and I think my comments
14 were based on something that didn't happen at the time.

15 Q. Meaning?

16 A. They didn't have paper records for visits, and I was
17 suggesting that that was one way that may have helped.

18 Q. But the other thing that came across -- I can't speak
19 for the jury, but may have come across to the jury is
20 that a good number of these firefighters, even from
21 Peckham, weren't familiar with the layout of this
22 building. How do we overcome that?

23 A. I agree with what you say, and that was a suggestion
24 that I put forward for what was in place at the time.

25 I'm aware that they have now changed things, and I think

1 my comments have to be seen as what was in place in
2 2009, not what may have been changed since, and if that
3 comment can be used to improve things, that's what it
4 was there for.

5 Q. Well, I'm not asking what's happened since, but just how
6 one familiarises the crew of a fire station with
7 buildings such as this -- how is the knowledge to be
8 disseminated for familiarity?

9 A. With great difficulty. I think it depends on how each
10 officer of the -- how each manager of the crew takes
11 that task and what the crew have been taught to expect
12 when they do those tasks. I think it's a role of the
13 watch manager to ensure that the crews do look at those
14 things and follow up, and one way was with a check sheet
15 that at least people had to check off that they say they
16 had looked at it.

17 Q. One of the things that you mention should be looked for
18 on a familiarisation visit is signage, and in particular
19 you mentioned looking for the sign above the lifts which
20 showed the numbers of flats on each of the floors.

21 I think I'm being fair to the evidence in saying that
22 one of the features here is that nobody on the fire
23 ground, on the firefighting side, actually looked at
24 that sign board, or indeed even looked for it.

25 A. (The witness nodded)

1 Q. Does that point to a failure of training, training
2 firefighters that they should look for these boards as
3 an obvious source of information when it's not clear
4 what the distribution of flats on each floor is?

5 A. I think that's one possibility, yes.

6 Q. Can I entice you to go further than a mere possibility?
7 Isn't it a desirable thing?

8 A. Yes, it is desirable.

9 THE CORONER: What, desirable that there should be training;
10 is that what you're saying?

11 A. Yes.

12 MR HENDY: And that the training should include specifically
13 that firefighters, if in doubt as to the distribution of
14 flats on floors, should look for such a board, normally
15 in the lift or entrance lobby area?

16 A. I think so, yes.

17 Q. So far as ALP, aerial ladder platform, familiarisation
18 is concerned, you've described how they should look for
19 access to high rise buildings. Some fire stations have
20 an ALP and some don't, as I understand; is that right?

21 A. That's my understanding as well, yes.

22 Q. So the fire ground that an ALP would be expected to
23 cover would be wider than the fire ground that the local
24 station covered, at first instance anyway.

25 A. Yes.

1 Q. Do you suggest that when not called upon on operational
2 duties, they should visit, other things, the high rise
3 blocks in the areas that they're likely to go to?

4 A. I would say they should do that, and I realise that that
5 presents a logistical problem but I think
6 familiarisation of the response area is part of their
7 role.

8 Q. And in the course of looking for access, should they
9 also carry out training by practising to see what the
10 access is going to be like, or would they be so familiar
11 with their appliances that that wouldn't be necessary?

12 A. Carrying out training is one way of reinforcing the
13 knowledge.

14 Q. So that too would be desirable?

15 A. It would be.

16 Q. If they trained whilst in place next to a block like
17 Lakanal, put up their platform -- they don't need to
18 actually fire any water but they can make judgments
19 about how easy it is to rescue, put curtains of water
20 down, use it as a high pressure monitor -- all those
21 sorts of thoughts can go through their minds,
22 presumably?

23 A. That's what I would expect them to do.

24 Q. That knowledge that they should gain by that sort of
25 familiarisation, how would that be communicated to the

1 incident commanders? As I understand it, it's for the
2 incident commander to say, "Right, I want an ALP
3 situated over there and I want it to lay a curtain of
4 water against this flank of the building", or whatever
5 the instruction is.

6 A. That's the role of the incident commander to do that.
7 The role of the manager in charge of the ALP is to
8 assess the capability of the appliance to do exactly
9 what is requested and to pass that information back, if
10 it's not possible.

11 Q. The incident commander presumably might not think of
12 using an ALP in the way that an ALP operator, who's
13 familiar with the building because he's been on
14 familiarisation visits and practised there, might be.
15 So how's that to get from the operator to the incident
16 commander?

17 A. I think as part of the incident commander's training is
18 to understand the role and functions of special
19 appliances, which would include an ALP, and build that
20 into the tactics that he's selecting for a particular
21 incident.

22 Q. We'll come back to the use of the ALPs at Lakanal House
23 in a minute, but just to finish on the pre-planning
24 heading, pre inspection boxes, you said, would be useful
25 on a building such as Lakanal House. Here, of course,

1 in this fire, it might actually have saved lives, might
2 it not? Sorry, I should have asked that as a question.

3 A. It possibly could have helped reduce the loss of life.

4 Q. So again, can I entice you to see whether you could go
5 a bit further than "useful"? Critical?

6 A. I wouldn't say critical. It certainly would provide
7 additional information to those attending which would
8 help them make some tactical decisions.

9 Q. Well, let's put it another way round: if the coroner
10 said to you, "What would you recommend for the future in
11 relation to a block like Lakanal House?" would you say,
12 "Well, I would recommend that a premises inspection box
13 with a plan of the flats should be situated outside the
14 block of flats, accessible to the Fire Brigade, just in
15 case there's another fire"?

16 A. Yes, I would say that.

17 Q. Going to the fire itself in 2009, the first point you
18 were asked about this morning was that there was no way
19 in which the Fire Brigade could have prevented the
20 spread of the fire from flat 65 to 79. That presumably
21 is because we know that the Fire Brigade attended at the
22 fire ground a few seconds before 16.24, and the panels
23 of flat 79 were alight, according to the jury's sequence
24 of events, by 16.26. That's page 2 of the jury's
25 sequence of events, and we know from page 3 that the

1 curtains had caught fire in flat 79 by 16.29.

2 A. Yes.

3 Q. So five minutes after the first appliances got to the
4 fire ground, the fire was established within flat 79?

5 A. Yes.

6 Q. And that's why you say there simply was not time?

7 A. Yes.

8 Q. But by the same token, by those five minutes after the
9 appliances got to the fire ground, it must have been
10 evident to the incident commanders on the ground that
11 the fire had jumped from one compartment into another?

12 A. They should have noticed that, yes.

13 Q. Yes. Do you agree, therefore, that it was incumbent on
14 them either to start fighting the fire in 79 as soon as
15 they had the resources to do so, or to ascertain whether
16 or not anybody was in that flat, 79?

17 A. Yes.

18 Q. If they didn't know whether somebody was in flat 79 --
19 we accept that they didn't know that this was flat 79,
20 but if they didn't know whether or not somebody was in
21 there, should they have made attempts, by sending a crew
22 up to that floor, to see whether there was anybody
23 there?

24 A. I would have expected that that would have been part of
25 their tactics once they'd established a firefighting

1 crew for where the fire was.

2 THE CORONER: Sorry, once they what, sorry?

3 A. What?

4 THE CORONER: I missed what you said.

5 A. I would have expected that that would have been a tactic
6 they would've considered once they'd commenced their
7 firefighting in flat 65. So it was a prioritisation of
8 the resources that they had available.

9 MR HENDY: In your report, you say that the fire spread
10 within flat 79 to the staircase, which we established
11 this morning was at 16.48, could not have been prevented
12 by the Fire Brigade?

13 A. No.

14 Q. The jury can do the additions for themselves because we
15 know the crews and the appliances that arrived. Our
16 calculation is that by 16.45 -- that's three minutes
17 earlier -- there were 38 London Fire Brigade personnel
18 on site.

19 A. (The witness nodded)

20 Q. Do you agree that that provided sufficient resources, if
21 not to fight the fire within 79, as well as 65, at least
22 to send a snatch squad up to see if there was anybody
23 there?

24 A. I tried to do similar calculations based on the number
25 of tasks and listening to the evidence from the

1 firefighters, I found it very difficult to pick the
2 number of tasks that were being carried out or expected
3 to be carried out. I was surprised we didn't see some
4 of the information that had been collected and written
5 on their command board, so trying to second guess that
6 is difficult. Depending on just what those resources
7 had been tasked to do -- and that's why I tend to agree
8 that that is a possibility.

9 You talk about a snatch rescue. That's not a term
10 that I have come across in my reading for this inquest
11 but we use a similar term in New Zealand called a snap
12 rescue, and I suspect that they both mean the same
13 thing. To carry out a snatch rescue, you're looking at
14 a high level of risk, you're looking at probably not
15 following guidelines, you may not have the correct level
16 of personal protective clothing, the right protection
17 for firefighting -- all those factors weigh up about
18 carrying out a snatch rescue. It's something I think
19 that the instant commanders should have thought about.
20 I wouldn't criticise them if they had thought about it
21 and thought that the risk was too high. That's
22 a decision they would need to make, based on everything
23 they saw and were faced with at that time.

24 Q. Just put one other factor in there, hypothetically. If
25 it wasn't simply a case of not knowing whether there was

1 somebody in flat 79 but actual knowledge that there was
2 somebody in flat 79, that that flat was on the 11th
3 floor and that it was directly above the original fire
4 flat, would you then have expected that a snap rescue,
5 to use your term, would have been attempted?

6 A. Again, I can't judge what the incident commander would
7 have done, but it's certainly something I would have
8 looked at if I was the incident commander.

9 Q. The fire-spread to the staircase of flat 79 obviously
10 happened before the fire spread to the upstairs in
11 flat 79, to the lounge unit and to the kitchen. Can we
12 therefore assume that up until at least 16.48, it would
13 have been possible to escape along the escape balconies
14 past flat 79?

15 A. Yes.

16 Q. So as far as the people in flat 81 were concerned,
17 whatever the conditions might have been within flat 81,
18 escape along the balcony was tenable until sort of
19 4.50-ish at least?

20 A. That's correct.

21 Q. Again, had the incident commander known that there was
22 a group of people within the bathroom of flat 81 on the
23 11th floor, it would have been relatively easy to
24 establish that the escape balconies on the 11th floor
25 were still passable until, say, 4.50?

1 A. Yes.

2 Q. And therefore it would have been possible, had the means
3 of communication been available -- which we'll talk
4 about in a moment -- to have advised the occupants of
5 flat 81 to get out by the escape balconies?

6 A. Yes.

7 Q. At 17.19, the estimate is -- and Mr Maxwell-Scott took
8 you to it at page 29 -- that the door of flat 79
9 collapsed into the corridor of the 11th floor, which
10 means it was then impassable from the inside, yes?

11 A. It would have been impassable because of the fire, but
12 possibly just before that, impassable because of the
13 smoke as well.

14 Q. I was just going to put that to you. That must be the
15 case, must it not, that at least a few minutes before,
16 possibly longer, it would have been impassable as
17 a means of exit?

18 A. Yes.

19 Q. If one took it back to 5 o'clock-ish, it might have been
20 possible to get out via the 11th floor?

21 A. Yes.

22 Q. Of course, nobody knew that, neither the occupants of
23 the flats nor the firefighters, because nobody looked to
24 see?

25 A. That's right.

1 Q. Had the ALP, which was on the fire ground, been deployed
2 to the west side of the building as soon as it got
3 there, do you agree that it would have been useful to at
4 least put down a curtain of water on flats 79 and 65?

5 A. It is something that the incident commander should have
6 thought about. The decision to do so probably would
7 have needed to take into account if anybody was in any
8 of the flats because of the volume of water that would
9 go in. But yes, it's certainly something that should
10 have been considered.

11 Q. Just on that last point about a consideration of whether
12 there was anyone in those flats, more consideration than
13 was actually given as to whether there was somebody in
14 flat 79 or not?

15 A. Can you say that again?

16 Q. Yes, you say you have to think about whether there was
17 somebody in flat 79 before you put down a curtain of
18 water because of the volume of water involved. We have
19 heard evidence about what was believed on the fire
20 ground about the occupancy of flat 79, or rather what
21 was not known about the occupancy, so with the knowledge
22 that they actually had, wouldn't it have been reasonable
23 to deploy the ALP and put down a curtain of water?

24 A. I think it would have been, yes.

25 Q. Of course, had the ALP been in that position, it might

1 have been easier to attack the fires on the 5th and 7th
2 floor, might it not?

3 A. It might have been, yes.

4 Q. Have you seen the photographs in the jury bundle of the
5 Greenwich ALP, which was much, much later, which did
6 deploy on the west side, fighting the fires on the west
7 side?

8 A. Yes, I have seen those.

9 THE CORONER: Do you want to be taken to it again?

10 A. It would be useful, if we could do that.

11 MR HENDY: Right. It's jury bundle, tab 14, for members of
12 the jury, at page 11. This is much, much later in the
13 evening, of course. There we can see the Greenwich ALP
14 with its jet directly --

15 THE CORONER: Sorry, could you just wait for the members of
16 the jury to get their pages.

17 MR HENDY: Of course, madam, I'm sorry. Tab 14, page 11.

18 (Pause)

19 There we have the Greenwich ALP, later on in the
20 evening. It's a jet directed at the 5th floor. Then if
21 one goes on to page 12, not so clear now but you can see
22 the ALP has gone up in height and we can see the jet is
23 now directed onto the 7th floor. There's a clearer
24 picture of that at page 13, with the burnt out remains
25 of flat 65 above, and at page 14 -- this is a still

1 taken from a video so not very clear -- we can see that
2 jet in action from a position a little bit further away.
3 Again at page 15. It's now at the level, I think, of
4 the 9th/10th floor with the 11th floor burnt out above.

5 Then there's a picture at ground level at page 18.
6 I should have put that to you before asking the
7 question, but I've asked the question in advance. So if
8 I could go to something else. You spoke about the "Stay
9 put" advice and you said that was appropriate for most
10 residents. The flats that were impacted upon and needed
11 to be considered for evaluation were those above and to
12 the north of flat 65. They were immediately flats 79
13 and 81, weren't they?

14 A. That's right.

15 Q. The fact is that it took nearly an hour from the first
16 appliances arriving to any attempt made to actually get
17 to those flats. Do you agree with me that that was far
18 too long?

19 A. Yes, I do.

20 Q. The crew that was sent to evaluate conditions above the
21 9th floor, which you spoke about earlier, we know were
22 directed by the bridgehead commander to assist on the
23 9th floor and then split between two of them. Do you
24 agree that the instruction to evaluate the situation
25 above the 9th floor is one that the incident commander

1 should have conveyed to the bridgehead commander, and
2 that the crew should then have followed those
3 instructions?

4 A. That's the way that I would expect the chain of command
5 to work, yes.

6 Q. Do you agree that the search and rescue on the 9th
7 floor, south, was an unfortunate waste of resources?

8 A. Yes.

9 Q. Madam, can I just take a moment.

10 THE CORONER: Of course you can, yes.

11 MR HENDY: Thank you. (Pause)

12 Yes, one other matter I wanted to ask you about,
13 Mr Davey, was this situation where we have brigade
14 control knowing that people need rescue -- because
15 they're giving fire survival guidance -- that people
16 need rescue in flats 81 and 79, that they're situated on
17 the 11th floor, that certainly in the case of flat 79,
18 it's above the fire flat, and yet that information does
19 not actually reach the incident commander. Now, the
20 jury has heard lots of evidence about lists that were
21 made and kept in somebody's pocket or not acted upon and
22 so forth. Leave all that aside. How do we ensure for
23 the future that that information gained by brigade
24 control gets to the incident commander who can then act
25 on it instantly?

1 A. I'm not sure how we could ensure that happens. In
2 a normal fire, the incident commanders follow a fairly
3 structured approach to deciding their tactics and
4 issuing instructions. This fire, we were faced with
5 an abnormal fire and different aspects of that fire
6 impacted on the decision-making of the incident
7 commanders, in my view, and I think that's what
8 compounded their ability to sort through, in a very
9 short space of time -- I mean, we're talking about the
10 numbers of decisions that incident commanders make
11 within minutes and seconds, and it's not, I would think,
12 unexpected that sometimes they just get overwhelmed with
13 information and lose the most important. So training is
14 probably one way -- and experience the other way -- to
15 help them focus on what is important in making those
16 decisions.

17 Q. One thing that nobody seems to have thought about on the
18 fire ground was this: "I'm told that there are people
19 needing rescue in flats 81 and 79. I don't know where
20 they were. Somebody get onto brigade control and ask
21 them to ask the people on the line where they are so
22 that we can see." That just didn't happen. Is that
23 something that should be rectified by training, to make
24 this suggestion that where there's a line of
25 communication, it should be used?

1 A. Yes.

2 Q. Where there's information held by the incident commander
3 or those adjacent to him standing on the ground outside
4 the arena of fire, that information doesn't appear to
5 have been communicated to the bridgehead. It was in one
6 case, in the form of a list that was put into somebody's
7 pocket and not referred to again, but do you agree that
8 it's important, where the incident commander or those
9 next to him have information, that it should be
10 communicated to the bridgehead?

11 A. Yes.

12 Q. Mr Cartwright, who we've heard evidence from, did
13 have -- he was not apparently briefed on what we might
14 call the fire guidance survival flats, the FSG flats,
15 but he didn't seek that information either. Do you
16 agree that an incident commander in that position should
17 seek whatever information there is about people that
18 need rescue and where they are?

19 A. He should be asking those questions, yes.

20 Q. We know that Mr Rafael Cervi, one of my clients, was in
21 touch with both his wife and the brigade control and
22 spoke to firefighters at the fire ground, not
23 surprisingly with some agitation, about his family being
24 in flat 81. But that information, too, didn't seem to
25 get to the incident commander. It should have done,

1 obviously, shouldn't it?

2 A. It should have done, yes.

3 Q. How do we make sure that doesn't happen in the future?

4 A. Again, I think it comes down to how people are trained,
5 what resources are there to support them -- as
6 increasing information comes in, it's possible to
7 overload a person. I think being able to sift out the
8 important information and match it up with other
9 information is a clear skill that is needed by incident
10 commanders.

11 Q. Somebody should have said, "This guy, bring him over
12 here. He knows where this family are. He actually
13 knows this building, he lives there, he knows where they
14 are. This is how to get to them"?

15 A. Yes.

16 Q. Somebody should have said that?

17 A. Somebody should.

18 Q. I understand what you say about incident commanders
19 being overwhelmed with information, and I'm sure the
20 jury well understands that, particularly the compression
21 of time within which they have to make decisions.
22 Nevertheless, do you agree that there appears to have
23 been a lack of priority given by the incident commanders
24 to locating and rescuing the FSG flats?

25 A. Yes, I think there was.

1 Q. We know the Clarke crew, part of the split team, failed
2 to reach the 11th floor because they ran out of air,
3 understandably. The evidence seems to suggest that the
4 fact that they hadn't got to the 11th floor, even though
5 the incident commander had told them to reconnoitre
6 above the 9th floor -- no criticism of them, but the
7 fact that they hadn't been able to do that doesn't seem
8 to have been related back to the incident commander on
9 the ground. Do you think that should have been?

10 A. It should have been, yes, or certainly to the bridgehead
11 commander.

12 Q. Does it follow that had it been, another attempt should
13 have been made as soon as practically possible?

14 A. Yes.

15 Q. I take it it goes without saying that the officer who
16 had a paper list in his pocket of the flats needing
17 rescue should have taken that paper out and acted upon
18 the information within it?

19 A. He should have done.

20 Q. Mr Howling, who was incident commander for nearly half
21 an hour, had a search and rescue plan and had, in his
22 own mind, established, I think, the crews of four
23 appliances and how he would use them for search and
24 rescue and so on. But then his command was overtaken by
25 a subsequent incident commander and his search and

1 rescue plan was never acted upon. Do you agree that it
2 would have been preferable that that plan should have
3 been carried out?

4 A. Yes, it should have done.

5 Q. Mr Howling stayed next to the incident commander,
6 I think, for the next turn of duty, so to speak, but was
7 then sent off on other tasks. Do you agree that with
8 his extended knowledge that he had acquired during his
9 half hour in command, he should have been kept close to
10 the incident commanders?

11 A. In an ideal command situation, yes, he should have done.
12 Where you are running short of resources, you get the
13 competing priorities. Are they better to be used with
14 another task or to stay and assist?

15 Q. There appears to be some waste of resources, though,
16 because we know of one crew that got kitted up in BA and
17 spent half an hour before they, under their own
18 initiative, finally made their way to the bridgehead,
19 then on the ground, and were sent to work, and indeed
20 they were being jibed by the crowd for not going into
21 action, which naturally was very distressing for them.
22 I suppose in any incident errors can be made and the
23 incident commander doesn't realise that he has the
24 resources on hand that he has, but nevertheless,
25 clearly, with hindsight, that should never have

1 happened, should it?

2 A. With hindsight, no, it shouldn't have done. There
3 should have been a good control over the available
4 resources.

5 Q. Once you have a command unit there, the command unit
6 should be aware of all resources reporting to the fire
7 ground and making sure that the incident commander knows
8 what's available to him?

9 A. Yes.

10 Q. We know Mr Cartwright brought the bridgehead down from
11 the 7th floor to the 3rd floor, and when it got there it
12 was found that it had to go out on the ground, but the
13 consequence of moving the bridgehead down was that for
14 some 30 minutes there was effectively no search and
15 rescue going on at all. Do you agree that that was
16 unfortunate and could have been avoided?

17 A. It was unfortunate. I don't know whether it could have
18 been avoided because the action of bringing the
19 bridgehead and the resources that were stored on the
20 bridgehead down to ground level so they could be reused
21 was a resource-intensive and a time-based action and --
22 that needed to be done.

23 Q. Well, we know when the bridgehead moved down from the
24 9th to the 3rd floor that a crew were left firefighting
25 on the 9th floor above the level of the lower fires, and

1 of course their equipment needed to remain in position.
2 So the proposition I put to you is that a search and
3 rescue could have been attempted during that 30 minutes
4 above the level of the 9th floor.

5 A. In hindsight, it could have been. I think if we take
6 the experience and knowledge at the time -- this was the
7 first time, as I understand it, that a bridgehead had
8 been moved down, so the crews were faced something --
9 with something outside their previous training and
10 experience.

11 Q. Well, we know that snatch rescues, or snap rescues, to
12 use your phrase, were attempted subsequently, even
13 though there were fires on the 11th, 9th, 7th and 5th
14 floors. Do you agree that they should have been
15 attempted earlier?

16 A. Again, I think I'd say what I said before. Judging what
17 the incident commander would do is difficult after the
18 event. It is certainly something that he should have
19 considered.

20 THE CORONER: You're saying during the period whilst the
21 bridgehead is being moved down and taken outside? It's
22 brought down for safety reasons, isn't it?

23 A. That's right, yes.

24 THE CORONER: So you're saying that that would have been
25 something that an incident commander would have thought

1 about doing, even though you now had the fire moving
2 down in the building so you had fires on a number of
3 floors?

4 A. If not the incident commander, the bridgehead commander
5 could have thought about it. Whether he would have
6 decided based on the circumstances he was faced with at
7 the time I think is a decision that only he would know
8 how to do, but it's certainly something that he should
9 have considered.

10 MR HENDY: We know that Mr Freeman and Mr Foster did
11 organise snatch rescues after this time. All I put to
12 you is that incident commanders before Mr Freeman could
13 have attempted it too, and should have done.

14 A. Yes.

15 Q. The Nuhu family were rescued from the 11th floor. As
16 you recall, they'd made their own way out of flat 81
17 onto the escape balcony on the east side, where they
18 were seen, and a crew immediately were sent to try and
19 get them off. I wanted to ask you about the Nuhus, but
20 before I do, the fact that an attempt was made to rescue
21 them as soon as they were seen, does that not make the
22 point that had it been appreciated that there was
23 somebody else in flat 81 and somebody in flat 79, the
24 likelihood is that the incident commander would have
25 attempted to rescue them as well?

1 A. Yes, and I think it shows the impact of visual
2 information versus other methods of providing
3 information.

4 Q. The Nuhus were rescued from the 12th floor escape
5 balcony and we've heard the evidence that as they were
6 brought down by the team rescuing them, they mentioned
7 there were still other people in flat 81, and those that
8 followed them didn't appreciate that a route -- or the
9 route that the Nuhus had taken was via the 12th floor
10 escape balcony. One can understand that the pressures
11 on the chaps rescuing the Nuhus, the pressure and
12 intensity on the chaps coming up the stairs, but
13 nevertheless, do you agree that the crews coming up
14 should have been told that the route that had just been
15 taken was via the 12th floor escape balcony?

16 A. Yes, there was a missed opportunity.

17 Q. One of the problems that the jury have heard about many
18 times from many witnesses is that the air ran out in the
19 standard BA kits. Do you agree that extended duration
20 breathing apparatus crews should have been sought
21 earlier in this fire?

22 A. It would have been an advantage if they had have been,
23 yes.

24 Q. EDBA crews, of course, come on search and rescue
25 vehicles. I have the wrong term, haven't I? Fire

1 rescue units.

2 A. Fire rescue units.

3 Q. And their primary job is search and rescue, hence the
4 extended air?

5 A. Yes.

6 THE CORONER: What would have been the trigger for
7 an incident commander to have been looking for a vehicle
8 with crews who could wear EDDBA? In this instance, what
9 would have been the trigger for that?

10 A. I think it's part of the assessment for making pumps and
11 understanding that if there's a role for search and
12 rescue, a specialist unit should be part of that make
13 pumps, and it's just making that link between tasks that
14 are likely to be performed or anticipated and the
15 resources and the capability of the resources.

16 Q. Would not one of the triggers be that brigade control
17 has given fire survival guidance to people in the block
18 of flats and the incident commander has not yet located,
19 still less rescued, them?

20 A. That's one way of looking at it, I think, yes. The
21 other issue, I think, was that they were probably still
22 believing they were dealing with a fire in one flat, and
23 that spread up and down was only just occurring, and
24 they were caught up in that whole rapid change.

25 Q. Well, save that we've established, Mr Davey, haven't we,

1 that within minutes -- a couple of minutes, indeed -- of
2 the first appliances arriving, it was evident that the
3 fire had gone into another floor?

4 A. Yes.

5 Q. So wouldn't that then be the trigger?

6 A. It could have been a trigger, yes.

7 Q. Should have been the trigger?

8 A. Should have been the trigger.

9 Q. So far as the brigade control operator who was speaking
10 to Catherine Hickman was concerned, do you agree that
11 refresher training was critical to reinforce that the
12 operator should explore means of escape before -- or as
13 well as -- committing to a "Stay put" policy?

14 A. Yes.

15 Q. Do you agree that training, whether original or
16 refresher, is critical to ensure that brigade control
17 operators extract from the information given to them by
18 the person they're talking to things like "I'm in the
19 flat above the fire flat", "I can go onto an escape
20 balcony which leads to the stairwell", that sort of
21 information?

22 A. Yes, as well as a review of the policies and procedures
23 that apply to giving that advice.

24 Q. Madam, I think I only have a few more questions, but
25 I would prefer not to conclude having asked those

1 questions and then realise that I've missed something
2 over the lunchtime adjournment. Would it be possible,
3 madam, to have an earlier hour for lunch, so I can be
4 sure that I've covered everything?

5 THE CORONER: I think so.

6 Members of the jury, is that going to be convenient
7 to you? Does that give rise to any difficulty for
8 anybody? All right. Well in that case, what I suggest
9 is that we have a break now for lunch and we continue at
10 about 1.55, just give you an slightly longer lunch than
11 usual. Thank you very much. Do leave your papers
12 behind if you want to.

13 Mr Davey, because you're part way through giving
14 your evidence, the strict rule is you must not talk to
15 anyone else about your evidence, so the safest option is
16 to have lunch by yourself. Do be back for about.1.55,
17 please.

18 THE FOREMAN OF THE JURY: Sorry, madam, you're okay with
19 jurors leaving their papers over lunch?

20 THE CORONER: Yes, that should be all right. The security
21 guards are around. They should be all right.

22 THE FOREMAN OF THE JURY: Okay.

23 (In the absence of the Jury)

24 THE CORONER: Yes, thank you.

25 (12.41 pm)

1 (The short adjournment)

2 (1.54 pm)

3 (In the presence of the Jury)

4 THE CORONER: Yes, Mr Hendy.

5 MR HENDY: Mr Davey, I just have a few, as it were, random
6 points, most of which I overlooked before. I'll just
7 clear them up now. I think we've probably covered this
8 in general terms, but can I just put it to you
9 specifically.

10 The use of brigade control to communicate. We know
11 that those in flat 81 who remained after the Nuhus had
12 gone were in contact with brigade control, and brigade
13 control had mobile telephone numbers and so on. Do you
14 think that it would have been useful if brigade control
15 had communicated to those who remained in flat 81 that
16 they should follow the Nuhus who had been rescued from
17 the escape balcony?

18 A. If they were to have done that, the timing would have
19 been very critical, I think.

20 Q. They would have had to have done it before that route
21 became more precarious than it was for the Nuhus?

22 A. And certainly in consultation with the incident
23 commander.

24 Q. Yes.

25 THE CORONER: Brigade control would have had very little

1 information as to what was going on in the fire ground,
2 wouldn't it?

3 A. That's right.

4 MR HENDY: That leads on to the more general point that in
5 some way the communication between brigade control and
6 the incident commander on the fire ground or one of his
7 assistants is crucial, isn't it?

8 A. It is, yes.

9 Q. And the communications in this fire were, would you
10 agree, pretty poor?

11 A. Yes, I would.

12 Q. If we're looking towards the future, this is one area
13 for improvements of training not just for firefighters
14 on the ground and not just for operators in brigade
15 control but for both of them, so that they can
16 understand the sorts of message each are receiving and
17 each need to act upon?

18 A. Yes, and that was my comment about both -- both parts of
19 the London Fire Brigade working together, was the
20 development of policy, procedures and probably training
21 in this area.

22 Q. Yes. Because one of the things that stands out here is
23 that the brigade control operator, particularly the
24 operator who was speaking to Catherine Hickman, had
25 a particular belief not merely about the response of the

1 Fire Brigade but also about the qualities of the
2 building and the length of compartmentalisation. The
3 incident commander, looking at the building, had he been
4 told about it, would have said immediately: "No, that's
5 not true. It's not staying in its compartment."
6 A. That's right.
7 Q. So that communication has to improve for the future?
8 A. Yes, it does.
9 Q. I think we have probably established it with other
10 witnesses but let me put the proposition to you: a fire
11 survival guidance policy of "Stay put" is a reasonable
12 one on the understanding that the Fire Brigade are on
13 the way and that the fire will stay in the compartment
14 and that the person they're speaking to is not in the
15 compartment where the fire is and there's no smoke
16 coming into that compartment?
17 A. Yes, it is.
18 Q. But that policy must be revised once the victim, if
19 I can use that expression, reports that smoke or fire is
20 coming into the apartment?
21 A. Yes, that should cause a reevaluation of the advice.
22 Q. At that point it's critical to explore the possibilities
23 of escape?
24 A. Yes.
25 THE CORONER: Would that reevaluation be something that you

1 would expect to be part of the dynamic risk assessment
2 process?

3 A. No, I think the dynamic risk assessment is more relative
4 to the actions on the fire ground by firefighters.
5 I think it's --

6 THE CORONER: Yes, I'm so sorry, I was just out of space
7 there. We were talking about fire survival guidance
8 calls. My apologies, yes. Forget that, thank you.

9 MR HENDY: Our coroner does raise an important point:
10 whether the information comes from the incident
11 commander on the ground or one of his team that the fire
12 has escaped from one compartment and is impinging on
13 another, or whether that information comes from the
14 victim, that fire or smoke is coming into the apartment,
15 the brigade control operator at that point must
16 reevaluate "Stay put"?

17 A. Yes.

18 Q. We spoke earlier about information gained from people
19 concerned in the incident like Mr Cervi, but also the
20 jury have heard evidence that information came
21 indirectly through the London Ambulance Service,
22 a Mr Ed Daly, whom they've had a statement from. I take
23 it it goes without saying that obviously the incident
24 commander and his team should act upon information from
25 the ambulance service as to people trapped or at risk?

1 A. That's correct, and that should be incorporated within
2 the command and control system.

3 Q. Yes, and that would go for any of the emergency
4 services? Police as well?

5 A. Yes.

6 Q. If I could just ask you to clarify one point about
7 snatch rescue or snap rescue, just to make sure that
8 we're talking the same language. This is an urgent
9 rescue carried out. You postulated that it might need
10 to be carried out by somebody without protective
11 clothing. In the circumstances of the fire at Lakanal
12 House, of course, all firefighters had protective
13 clothing, but some, of course, didn't have standard BA,
14 and those that did obviously didn't have extended BA --
15 sorry.

16 A. Yes, my reference to the appropriate personal protective
17 equipment is more aligned to snap rescues or snatch
18 rescues where there are hazardous substances involved
19 and there is a different type of clothing, although the
20 standard firefighting clothing does provide a limited
21 level of protection, so that's part of the whole
22 assessment.

23 Q. A snatch or a snap rescue is one that's attempted
24 urgently when the firefighters concerned may or may not
25 have all the equipment necessary that they would like to

1 have had they had more time to prepare?

2 A. That's right, and I would also add that they needed --

3 there would need to be some knowledge of where the

4 victims were, otherwise it becomes a search and rescue,

5 and we're not talking about search and rescue. So there

6 are some qualifying aspects to that.

7 Q. Yes. So before attempting that, you have to be

8 reasonably sure where, in this case, the particular flat

9 is before you attempt the snatch rescue? Otherwise

10 you're simply just committing firefighters to risk?

11 A. Yes, and you would need to have some -- at least

12 a general idea of the location within the flat.

13 Q. Yes. Well, I wonder -- I mean, it all depends on the

14 circumstances, doesn't it?

15 A. It does, yes.

16 Q. Of course. If you know that somebody is in flat 79 and

17 if you believe, as the incident commander, that access

18 is possible, or may be possible, and that the risks are

19 not too great for the firefighters with the equipment

20 that they have, it's not unreasonable to at least

21 consider that option?

22 A. Yes.

23 Q. And as the jury have heard, Mr Freeman and Mr Foster did

24 consider that option with a crew that didn't have

25 extended breathing apparatus and sent them in?

1 A. Yes.

2 Q. That involved, of course, undertaking some risk to those
3 firefighters, didn't it?

4 A. Yes.

5 Q. But that, of course, is necessary sometimes?

6 A. Yes.

7 Q. One option for those who were in flat 79 and 81 -- just
8 leave aside the potential times of rescue for the
9 moment. Assuming you got to the escape balcony but you
10 couldn't get past flat 79 to get to the stairwell
11 because of flames or maybe just extensive smoke or
12 broken glass or whatever dangers there might be, one
13 option would be to tell them to go to the other end of
14 the escape balcony, where although there's no staircase
15 you might be away from danger. Is that an option that
16 should be considered?

17 A. That's an option that should be considered, along
18 with -- if there is a way of getting into one of the
19 other flats to add to the protection level. But I'd see
20 that as an awareness of knowing where those people have
21 gone.

22 Q. Yes, you have to keep your eye on them then, once you've
23 sent them to a place that they can't actually escape
24 from.

25 A. Yes.

1 Q. You have to make sure that they're not going to be in
2 danger from spreading fire or smoke?

3 A. Yes.

4 Q. We spoke earlier this morning about the trigger for
5 calling on more fire rescue units with extended duration
6 BA kit, and I've put to you a potential trigger.
7 I think we raised the question of what the trigger might
8 be. Can I put to you another trigger for that, being
9 the moving of the bridgehead downwards, because the
10 effect of moving the bridgehead downwards is that you
11 have to commit your teams to starting their BA at
12 a lower level and therefore using more air before they
13 actually get to wherever they have to be?

14 A. Yes, that would definitely be a trigger.

15 Q. We've heard evidence about sprinklers, that there were
16 obviously no sprinklers in this block and that
17 sprinklers are quite expensive to retro-fit to blocks of
18 flats. Do you have views on the benefits of sprinklers,
19 obviously to residents in the case of a fire but also to
20 firefighters themselves?

21 A. Yes, the benefit of sprinklers would be to reduce the
22 effect of the -- reduce the seriousness of the fire and
23 provide protection for both the occupants and a smaller
24 fire for firefighters.

25 Q. Of course, there are downsides to sprinklers, that they

1 come on when there's no fire and damage furniture and so
2 forth?

3 A. I wouldn't agree with that.

4 Q. Right.

5 A. The only reason they would come on if there was no fire
6 was if there was some form of mechanical damage.
7 Sprinklers are designed to operate directly over the
8 source of heat, so you would only get them operating
9 directly over the fire rather than across a wide area
10 within a building.

11 Q. Thank you.

12 Then I think the last two points are really rather
13 connected. Looking over the evidence which you've seen
14 about the firefighting at Lakanal House, do you agree
15 that the arrival of General Manager Freeman brought
16 a sort of change of pace to the operation?

17 A. Yes.

18 Q. He was prepared to take risks with his firefighters by
19 sending in snatch teams?

20 A. Yes.

21 Q. Do you agree that before he came, there was a need
22 for -- I'm using somebody else's phrase, but some more
23 out-of-the-box thinking in the way this fire was
24 handled?

25 A. I think the early incident commanders were focussed on

1 complying with what they were trained to do and building
2 up the building blocks of how the fire was going to be
3 attacked, so setting the ground level tactics in place
4 so that as -- if the fire had escalated, the basic
5 building blocks were firm and in place and providing the
6 level of support to escalate fire attack.

7 Q. It's really, then, what we spoke of earlier; the lack of
8 priority that was given to search and rescue unit that
9 attracts your criticism?

10 A. In its basic analysis, I think that's right.

11 Q. Yes. Then the final matter is this: the phrase "persons
12 reported", a phrase used in New Zealand, no doubt?

13 A. It is.

14 Q. A short form of communicating to those who need to know
15 that people are either trapped, need rescue or are
16 unaccounted for?

17 A. Yes. In New Zealand, it's used slightly differently.
18 It's normally initiated by the brigade control, based on
19 the information they receive, and that then signals to
20 the incident commander that there is a level of priority
21 needed to be given to assess and to check out where
22 those people may well be.

23 Q. And that's really exactly the point I was coming to:
24 what it communicates is some prioritisation needs to be
25 given to finding and rescuing those people?

1 A. That's right.

2 Q. I'm very grateful to you. Thank you.

3 THE CORONER: Thank you. Mr Dowden? Ms Al Tai?

4 Questions by MS AL TAI

5 MS AL TAI: Good afternoon, Mr Davey. Can you hear me?

6 A. Just.

7 Q. Just. Okay. I think it's my microphone, so I'll try to
8 speak as loudly as I can. I don't have that many
9 questions for you; my learned friend Mr Hendy has
10 covered the majority of them. It's just in respect --
11 I apologise, I didn't introduce myself. I act on behalf
12 of Mark Bailey.

13 It's just in respect of a topic we've just been
14 discussing, and that's the urgent rescue, or the snap
15 rescue, as you've referred to it today. My
16 understanding is that your evidence is that as
17 an incident commander you would have considered it as
18 an option; is that correct?

19 A. I would have considered it. Whether I would have had it
20 performed, I couldn't tell without having the
21 information that was presented to the incident commander
22 at the time.

23 Q. Thank you, Mr Davey. If you would permit me, I'm going
24 to just run through some timetabling to enable the jury
25 just to get a better understanding and a more full

1 context in respect of the urgent rescue or snap rescue,
2 as we've referred to it. The evidence we've heard is
3 that the fire started at 16.15, and I'm assuming that's
4 your understanding as well, from what you've heard?

5 A. (The witness nodded)

6 Q. And that in fact Miss Hickman was on the phone to the
7 London Fire Brigade control operator at 16.21, so within
8 six minutes. Then at 16.26, a message was received by
9 the pump ladder E371 -- that's the Peckham pump
10 ladder -- that a caller was trapped in flat 79. So
11 between the fire breaking out and the receipt of that
12 call, that's 11 minutes.

13 We now understand from the transcripts we've both
14 heard and read that the last indication of Miss Hickman
15 breathing was at 16.49. But we've also heard evidence
16 from Professor Bion, who came earlier -- I'm not sure if
17 you were here during his evidence?

18 A. Yes, I was.

19 Q. You were. Well, his evidence, as you remember, was that
20 the last indication of Miss Hickman possibly being
21 rescued was at 16.55.

22 THE CORONER: Professor Bion's evidence, in fact, was that
23 it's likely that Catherine Hickman would have died
24 somewhere between 1650 and 1700 hours.

25 MS AL TAI: Thank you, madam.

1 Just one last factual matter. You've been taken to
2 this earlier today. At 16.48, the internal staircase of
3 flat 79 had caught alight at that point. I apologise,
4 I won't go through too many more factual matters. It's
5 just so we can get a better understanding. So from the
6 time that the Peckham pump ladder had received a call at
7 16.26 to the time by which the internal staircase had
8 caught fire was 22 minutes?

9 A. (The witness nodded)

10 Q. That's a significant period of time, isn't it?

11 A. I think that needs to be qualified by what needed to be
12 done within that time by the resources available.

13 I imagine that there were a number of tasks that were
14 given to firefighters that needed to be completed in
15 order to allow further firefighting activities, and I'm
16 talking about charging the riser, establishing the
17 bridgehead, moving equipment up to the bridgehead, and
18 then tasking BA crews with both firefighting and search
19 and rescue, and that time will need to be taken within
20 that 11/12 minutes that you were talking about.

21 Q. Of course, I understand, Mr Davey, and I believe the 11
22 to 12 minutes was in reference to the time between when
23 the fire started and the receipt of the call. The time
24 which I refer to is the time between the time at which
25 the call was received at 16.26 and the time at which the

1 internal staircase was alight at 16.48. That's the 22
2 minutes to which I refer.

3 Perhaps if I put it into context. We also know that
4 at 16.38 there were 26 firefighters in attendance, and
5 then we know that within a sort time period, 16.50,
6 there were then 39 firefighters in attendance. So with
7 that as a backdrop, those 22 minutes, given the number
8 of firefighters in attendance, that's still
9 a significant period of time in which to attend to
10 something quite urgent, I would imagine?

11 A. Yes, it does appear that way. We didn't hear any
12 evidence that I can recall on the number of tasks that
13 that number of firefighters were performing, and without
14 that we're, I suppose, making an assumption that because
15 there were that many firefighters there there would have
16 been some spare ones to do some additional work.

17 Q. Thank you. Thank you, Mr Davey. That's all my
18 questions.

19 THE CORONER: Mr Matthews?

20 MR MATTHEWS: No thank you.

21 THE CORONER: Mr Compton?

22 MR COMPTON: No thank you.

23 THE CORONER: Mr Leonard?

24 MR LEONARD: No thank you.

25 THE CORONER: Ms Canby? Ms Petherbridge? Mr Walsh.

1 Questions by MR WALSH

2 MR WALSH: Yes, please, madam. Good afternoon, Mr Davey.

3 Mr Davey, I may be a little while with you, because of
4 course, you've been taken to various parts of the
5 evidence over the last few weeks, and inevitably when
6 you've been taken through those parts of the evidence,
7 it's been selective. It's inevitable because we can't
8 go through eight weeks of evidence with you. But what I
9 want to take you to are some general issues which
10 impacted upon the decision making of firefighters and
11 indeed of incident commanders on the day.

12 Can I ask, just by way of a pre-ambler, whether you
13 would agree with this: that firefighters all over the
14 world have to train for a very wide variety of
15 situations, whether it's fires in high rise blocks or in
16 factories or in underground stations and so on, whatever
17 it is? A huge variety of activities?

18 A. That's correct.

19 THE CORONER: Mr Walsh, can I just stop you a moment.

20 There's a lot of noise outside. Members of the jury,
21 can you hear what's happening outside? You can't.

22 MR WALSH: I think it's my microphone.

23 THE CORONER: Mr Walsh, could you borrow a microphone from
24 someone.

25 MR WALSH: I think I've had a defective one for eight weeks.

1 THE CORONER: It seems to work better with two.

2 MR WALSH: It does, thank you. I just want to take you to
3 general issues of training and of matters that impact
4 upon decision-making. With that kind of wide variety of
5 matters that have to be trained for and considered, the
6 best practice is to develop training and procedures so
7 that firefighters, incident commanders can be trained so
8 that what they're doing when they attend an incident
9 becomes almost second nature. That's the basis of
10 training, isn't it?

11 A. That's right.

12 Q. But there will obviously be situations where established
13 policies and procedures don't assist because of the
14 unique nature of the situation, and in those
15 circumstances it obviously has to be left to the
16 individual incident commander or firefighter to make
17 difficult decisions, often very rapidly, in very
18 pressurised circumstances?

19 A. I would agree with that.

20 Q. All right. It's those kinds of decisions that I want to
21 ask you about, because Mr Hendy took you to those kinds
22 of decisions this morning and for part of this
23 afternoon. I'm assuming that you stand by the primary
24 conclusions which Mr Maxwell-Scott took you to this
25 morning?

1 A. Yes.

2 Q. Just in the context of those individual decisions which
3 have to be made by incident commanders where there may
4 not be a procedure to deal with it, I was looking at
5 your report again over lunch, and you repeatedly warn
6 against -- and on one occasion you use the word
7 "excessive" -- use of hindsight when looking at
8 an incident of this kind and determining what should and
9 what should not have been done. What did you mean by
10 cautioning against the use excessively of hindsight?

11 A. It's very easy, in the cold, hard light of day following
12 an event, to take it apart step by step over time and
13 look at the decisions that were made, whereas on the day
14 of the event, we're probably talking one or two minutes
15 where a large number of decisions were made. So
16 hindsight is very easy to -- to put it into that context
17 of plenty of time, when in fact there were multiple
18 avenues of information, conflicting areas to be
19 prioritised and a range of information on which the
20 incident commander has to assimilate, informing his
21 tactics.

22 Q. Yes, and that's why you caution the way that you do.
23 Just as an example of that -- and it was put to you just
24 a few moments ago in relation to control -- that
25 control, for example, in relation to the 11th floor,

1 might have been told by the incident commander, if
2 control were relying upon compartmentation, that this
3 building is not following the rules of compartmentation,
4 just to tell control that.

5 Now, that was put to you, and you sort of agreed
6 with that. But just think about that again. We know
7 what the position now is in hindsight, but the incident
8 commander, just as an example, whether it was
9 Mr Cartwright or Mr Freeman or the earlier incident
10 commanders, outside the building, looking up at what was
11 going on and perhaps looking at the 11th floor/12th
12 floor balcony, would not have known what was happening
13 to the boxing in between the stairway and the central
14 corridor and would not have known that that was failing
15 and could not have communicated that fact?

16 A. That's right.

17 Q. That's just an example of why care has to be taken.

18 A. Yes.

19 Q. Can I take you then, as quickly as I can, to certain
20 elements of the incident. My understanding of what's
21 been put to you is that when Mr Freeman took over then
22 decision-making was appropriately carried out.

23 Mr Freeman took over at just after 5 o'clock, and it was
24 he who issued the order, for example, for EDDBA?

25 A. Yes.

1 Q. Yes. So I'm going to concentrate on the first half
2 hour, if I may, but just before I do that, would you
3 agree that it was not until the bridgehead had to be
4 moved outside, this being a unique set of circumstances,
5 that the trigger for EDBA use would have been engaged
6 for the first time?

7 A. Yes, that's correct.

8 Q. All right. I'm going to ask you very quickly, if you
9 wouldn't mind -- in relation to the early parts of this
10 incident, we know that the call slip at Peckham Fire
11 Station indicated there was a flat fire, flat 65 on the
12 9th floor. The PDA was engaged and the appropriate
13 pumps were committed. Would you agree that up until the
14 point that, for example, firefighters were at the door
15 of flat 65 with jet ready to fight the fire, at about
16 16.36, according to the sequence of events, what was
17 done was done in accordance with policy and
18 expeditiously by the fire service?

19 A. Yes, I would agree with that.

20 Q. You'll recall the evidence of Mr Willett, who was the
21 first incident commander, on -- if it wasn't the first
22 day, it was one of the first days. He said that when he
23 arrived his expectation was that the fire would be dealt
24 with and extinguished in its compartment. That was his
25 expectation on arrival?

1 A. Yes, that was my assessment.

2 Q. And indeed, you'll remember -- because you were here for
3 that period of evidence -- that there was a fire in 1997
4 in flat 81, actually, and that fire remained within its
5 compartment and was -- we looked at the documentation.
6 It was under control within half an hour?

7 A. Yes.

8 Q. Well, I suppose what one needs to look at then is what
9 happened which then required the decisions dynamically
10 risk-assessed by incident commanders that happened
11 between then and 5 o'clock which had a fundamental
12 impact on what happened thereafter. Actually, I'd
13 better ask that properly, as a question rather than as
14 a statement. Would you agree that it was the events
15 which occurred up until 5 o'clock -- in fact, up until
16 the fires took hold on the 5th and 7th floors, at about
17 16.48 -- that dictated more or less what happened for
18 the rest of the incident?

19 A. I would agree with that.

20 Q. All right. So when Mr Howling took over at about 16.27,
21 according the sequence of events, the bridgehead was
22 being established?

23 A. Yes.

24 Q. I'm going to suggest, because we heard evidence to that
25 effect, that each firefighter who was present at the

1 time was engaged in one or more tasks, whether it was
2 setting into the dry riser, bringing the high rise
3 equipment to the lift to try to get it up to the
4 bridgehead -- that was all being done appropriately?

5 A. That was.

6 Q. Obviously we've heard that firefighters were at the draw
7 ready to fight the fire. But I'm going to list now just
8 a few key events and changes in circumstances which
9 occurred after arrival of the pumps originally at 16.23.

10 First of all, the bedroom panel of flat 79 ignited,
11 and Mr Crowder tells us that if it followed the course
12 of his own assessment, that would have been ignited
13 about a minute from exposure to flame, and within four
14 minutes it had burned through?

15 A. Yes.

16 Q. That's factor number 1. Factor number 2 is that
17 Mr Willett, or indeed Mr Howling, when he arrived, will
18 have seen residents self-evacuating, coming down the
19 stairs, and the reason for that was -- and I certainly
20 will not go through all the evidence about this, but
21 there was ample evidence of smoke-logging, even at the
22 very earliest stages, both north and south of the
23 central stairway along the corridors on the upper
24 floors?

25 A. Yes.

1 Q. Some residents could not self evacuate -- like, for
2 example, Mrs Obanyano in flat 68 on the 9th floor --
3 A. Yes.
4 Q. -- but they described quite severe conditions?
5 A. Sorry, they ...?
6 Q. They described quite severe conditions from quite
7 an early stage?
8 A. In the corridors, I believe it was.
9 Q. In the corridors and indeed in the stairwell?
10 A. Yes.
11 Q. And the smoke-logging in the stairwell, would you agree,
12 on the evidence of the firefighters and indeed those
13 coming down the stairs, was such that the bridgehead
14 began to be compromised before the fires started on the
15 5th and 7th floors below?
16 A. Yes, it was.
17 Q. All right. Then the incident commander, Mr Howling,
18 from the exterior, will have observed, at about 16.48,
19 fires taking hold on those lower floors.
20 Now, I want you to consider this factor: just after
21 that can be seen from the photographs, but unbeknown to
22 him, according to his evidence -- Watch Manager Payton,
23 who was up at the bridgehead, managing the bridgehead,
24 requested of Mr Howling further BA crews. He wanted,
25 I think, four or five BA crews to come up so that they

1 could be used on the 9th floor and the floor above. Had
2 those BA crews been able to be dispatched, no doubt they
3 may have been used for that purpose?

4 A. I would imagine so, yes.

5 Q. But the bridgehead had to be moved. Just in case
6 there's any doubt about this, with a compromised
7 stairwell -- they tried to move it to the 3rd but that
8 didn't work. But assuming that the evidence is correct
9 that the stairwell was compromised by smoke all the way
10 down its length, there was no option, was there, but to
11 move the bridgehead out of the building, because you
12 cannot start up BA crews in anything but clean air?

13 A. That's right.

14 Q. All right. I'm going to ask you now about what might
15 have been done. With all of those things happening, all
16 of that information coming in in that short space of
17 time, which Mr Howling had to deal with, how he might
18 have acted or thought out of the box, to use Mr Hendy's
19 words, and perhaps, for example, have used an aerial
20 ladder platform -- that's the first possible thing that
21 he might have done differently. You would agree,
22 though, first of all, that fires of this kind in high
23 rise buildings, with dry rising mains, are designed --
24 the buildings are designed to be fought from the inside,
25 primarily?

1 A. Yes, they are.

2 Q. The Old Kent Road aerial ladder platform, according to
3 the sequence of events, arrived at 16.29.56. By then,
4 according to the sequence of events, the curtains in
5 flat 79 were alight, that's how quickly it happened. It
6 obviously takes some time to establish an aerial ladder
7 platform but I'm going to ask you what you think of the
8 reasons that were given by Mr Sharpe, particularly, for
9 not wanting to use it.

10 There was an issue about access -- parked cars and
11 so on -- which I'll come back to in necessary, but the
12 primary reason he gave -- and indeed Mr Cartwright
13 agreed with him specifically -- for not using the aerial
14 ladder platform was that there was burning debris coming
15 down from out of flat 65, certainly, and then from 79.
16 Do you remember him saying that?

17 A. Yes.

18 Q. And it was his view that it was inappropriate and
19 dangerous to use the aerial ladder platform, first of
20 all directly underneath. Would you have agreed with
21 that view?

22 A. Directly underneath, yes.

23 Q. He was asked by Mr Hendy: "Well, why didn't you put it
24 a little further on, where the Greenwich ALP was used
25 later?" And he made the point that debris was blowing

1 along the length of the wind and he took the view that
2 it was inappropriate to put the aerial ladder platform
3 up because it was dangerous with burning debris blowing
4 along the length of the building. So that was the view
5 he took. What did you think of that?

6 A. I don't think that was a correct assessment. It would
7 have been an area of greater risk but I think he could
8 have positioned his appliance further away and still
9 allowed the reach of the hydraulic arms to gain the
10 level of the fire in the flats.

11 Q. Yes, but of course -- don't forget that when you're
12 putting up the aerial ladder platform, it is necessary
13 to extend the jacks. You need firefighters out on the
14 ground doing that. You then have to engage the platform
15 and that has to come up. His assessment of the risk was
16 that debris was blowing across into that area, and that
17 was why he decided not to. Does it make any sense to
18 you that he might have felt that?

19 A. I think we've seen the use of a handheld delivery
20 working from the ground into the 7th floor, which --
21 that or another delivery could have been used to provide
22 some sort of extinguishment on that burning debris.

23 Q. Yes, a ground-use monitor?

24 A. Yes.

25 Q. Let me ask you about how it might actually have been

1 used in any event, because arriving, as they did, at
2 16.29 -- and at that stage, of course, the high rise
3 policy is engaged and people are fighting fires from the
4 inside -- it would have taken time to establish the
5 aerial ladder platform. Then, even if it is
6 established, one then has problem about the use of a jet
7 from a platform to fight a fire in circumstances in
8 which there is internal firefighting going on. It's
9 a point that you make in your report actually.

10 A. Yes.

11 Q. Let's just take flat 65. The whole of the front of
12 flat 65 went pretty quickly. The panels melted away,
13 everything fell out. It was fully ventilated and things
14 just fell out of it, there being no barrier to prevent
15 them, and there were firefighters inside that flat
16 fighting that fire. There would have been a risk at
17 least, would there not, that putting a curtain of water
18 across the facade of flat 65, fully ventilated in the
19 way that it was, would force flame and gasses back
20 inside the building, impinging upon the firefighters
21 fighting the fire in that fully ventilated area?

22 A. Yes, and I think the reference needs to be to what the
23 incident commander was wanting to use the ALP for, not
24 what it could have been used for.

25 Q. No.

1 A. And I think my comments are based around the incident
2 commander seeking to use it and was given advice that it
3 wasn't or couldn't be used, whatever the purpose was
4 for.

5 Q. Right. But in actual fact, it would have been very
6 difficult to use it in order to try and fight fires
7 either in flat 79 or 65, because the reality is that it
8 forces flame and gasses back inside the building?

9 A. If that is what it had been used for, yes.

10 Q. Right. What else might it have been used for?

11 A. It could have been used for observation, in terms of
12 detecting fire spread that people couldn't see from
13 corridors or from the ground. It could have been used
14 to cool debris that was falling. There are a number of
15 uses it could have been put to.

16 Q. But not to actually fight the fires in the flats?

17 A. That would have been the incident commander's decision
18 based on what he knew, but if there were people in
19 there, it would have been the wrong decision to make.

20 Q. Right, okay. Thank you very much indeed.

21 But of course in the event --

22 THE CORONER: Just so I've understood there, there are
23 different ways of directing water at or into a building
24 from an ALP, yes?

25 A. Yes.

1 THE CORONER: One is using a jet to direct water into the
2 building, and one is using it a put up a curtain spray.
3 A. Yes.
4 THE CORONER: Can we take your answer in relation to both of
5 those?
6 A. I wouldn't have expected it to be used to direct
7 water -- a water jet into the burning building if people
8 were inside, but I might have expected it to be used as
9 a water curtain to cool fallen debris and as
10 an observation platform.
11 THE CORONER: Thank you.
12 MR WALSH: Just to be very clear about that, if you're
13 putting a spray of water -- never mind a jet straight
14 into the thing but a spray of water across the front of
15 the void to try and, for example, douse flames in the
16 flat itself, even if it's a spray, that runs the risk of
17 forcing gasses and fire back in over the firefighting?
18 A. Yes, it does depend on the skill of the operator and
19 where the operator is directed to apply the water, so
20 it's what does the incident commander want it to be used
21 for and for the operator to comply with that request.
22 Q. All right. Of course, later on in the incident, when
23 the Greenwich ALP was used, at that stage -- it was
24 later on in the fire -- there weren't firefighters
25 inside the units fighting fires and the debris had

1 stopped falling, so one could see why it was used later
2 on, certainly.

3 A. Yes.

4 Q. All right. In any event, of course, it was diverted for
5 use on the east side to try and provide some sort of
6 cover for the Nuhus, who were on the balcony. Do you
7 remember that?

8 A. That's right, yes.

9 Q. Do you remember the evidence given by Mr Sharpe about
10 that? See whether you agree with it: he was very
11 concerned that directing the jet at the vent at the end
12 of the building -- the north end of the building -- he
13 was concerned that it might force gasses back inside, so
14 what he tried to do was direct it over the end of the
15 building to prevent smoke coming round and impinging
16 upon the Nuhus on the balcony?

17 A. Yes.

18 Q. Do you think that was an appropriate use?

19 A. That was an appropriate use of it, yes.

20 Q. All right. Thank you. So that is the position. I'm
21 going to turn to the fires on the 5th and 7th floors,
22 which, the best evidence that we have from the
23 photographs, we can see starting at about 16.48. Would
24 you agree that that introduced probably the most
25 significant difficulty experienced by the incident

1 commanders on the day?

2 A. Yes.

3 Q. It's already been put to you that it's not happened in
4 the collective memory of the London Fire Brigade, or
5 indeed of BRE, who investigate fires of this kind. Did
6 I get it right that you carried out research to see if
7 you could find an incident of this happening and you
8 couldn't?

9 A. Yes, it was a general search and a general question of
10 my colleagues around the world: had they had any
11 experience? And they came back with: no, they hadn't.

12 Q. All right. Of course, it introduced this very unique
13 factor, in particular to Mr Howling, who was there
14 watching it going on, and others who saw it happening.
15 It introduced a new priority, wouldn't you say? There
16 were many priorities, priorities of all sorts, which had
17 to be prioritised, but there was then a real need to
18 address the fires on both the 7th and the 5th floors,
19 for fear that what might happen on those floors would go
20 above into the floors above in the same way that flat 65
21 had gone into 79?

22 A. Yes, it did.

23 Q. So would you agree that it was crucial that those fires
24 were addressed as soon as possible?

25 A. Yes.

1 Q. It's been put to you that after the bridgehead came out,
2 really nothing was done. There was no search and rescue
3 going on in the building of any kind until firefighters
4 were committed back into the building when the
5 bridgehead was set up outside. I'm going to suggest
6 that that's not quite right. I'm going to ask you to
7 comment on some of the evidence, especially on
8 priorities.

9 First of all, you'll remember that firefighters
10 Clarke and Bennett were committed to the building, and
11 we know that they carried out search and rescue on the
12 9th floor, both south and north. The reality is that we
13 know that there were fire survival guidance calls and
14 calls from both north and south of the central stairway,
15 from people who wanted rescuing?

16 A. Yes.

17 Q. Mr Hydar was one of those in flat 57, I think it was.
18 He was rescued on the south corridor on the 9th floor by
19 Mr Bennett and Mr Clarke, but also Mrs Obanyano in
20 flat 68. This is a difficult question to ask you but
21 Messrs Bennett and Clarke came out and shut down at
22 about 16.57, just as the bridgehead was coming out.
23 Mrs Obanyano described the smoke that she was
24 experiencing, the fact that she could not have left on
25 other own and was choking. There were many priorities,

1 but it was a priority to get Mrs Obanyano out as well,
2 was it not, in those circumstances?

3 A. Yes, it was a priority, that -- all those people who had
4 indicated that they needed assistance were priorities,
5 and I think what we're talking about is the opportunity
6 to have crews go in to their assistance.

7 Q. All right. Then after the bridgehead was moved, still
8 in the building, we had firefighters Mason and Mechen
9 fighting the fire in flat 65. They shut down their BA,
10 on the evidence we've heard, at 17.17. Firefighters
11 Ismail and Crowley and one other were committed from the
12 7th floor when the bridgehead was being pulled out -- so
13 this was a risk to them -- to fight fire on the 7th
14 floor to prevent that from spreading, and they shut down
15 at 17.17. And of course we know that four
16 firefighters -- firefighters Hull, Ford and so on --
17 were committed into the building at about 17.14 to do
18 what effectively was a snatch rescue of the Nuhus when
19 they were seen on the balcony, and they came out after
20 that.

21 Crews began to be committed back into the building
22 about every three minutes or so from 17.22, so you'll
23 appreciate it isn't right to suggest there was nothing
24 much going on in the building for a full half an hour.
25 Would you agree with that?

1 A. I would, and I think what we need to keep in mind is the
2 time the order was given to pull the bridgehead out
3 until it effectively was relocated. There were a number
4 of tasks being committed by firefighters within, but
5 they were also simultaneously withdrawing the
6 bridgehead, so there was a range of tasks, depending on
7 which part you want to look at, where firefighters were
8 pulling out or where they're carrying on with their task
9 whilst the bridgehead was removed.

10 Q. It was obviously a very complex set of circumstances,
11 with crews arriving, needing to be deployed and so on.
12 By the way, I in no way suggest that other key decisions
13 which Mr Hendy has put to you were not also priorities
14 and may even have been greater priorities, but what the
15 incident commanders were trying to do is make decisions
16 as things were changing rapidly. Do you agree with
17 that?

18 A. Yes.

19 Q. Just three other quick topics to ask you about. The
20 11th floor rescue of the Nuhus from the balcony on the
21 12th floor. Of course, first of all, the conditions on
22 the 11th floor corridor from about 17.15 or so were
23 primarily the result of fire and smoke escaping from
24 flat 79 through the failed boxing in. We've already
25 confirmed that incident commanders outside could not

1 have known about that. Nonetheless, when the crews went
2 up and eventually got up to the 12th floor balcony and
3 took the Nuhus out, it is suggested that there was
4 a missed opportunity to inform the crews that were
5 coming up the stairs, as the crew took the Nuhus down
6 the stairs, that there were people in flat 81. Of
7 course, that is an interpretation and perhaps
8 a legitimate interpretation to put to you, and you
9 agreed with it, but I want to put that in context.

10 Firefighter Hull and his associate, bringing
11 Mrs Nuhu down the stairs, were in the situation where
12 she was distressed and partially collapsed as she came
13 down the stairs. He was taking her down. He informed,
14 you'll recall, the crew going up that there were people
15 up on the top floor but he would not have known that
16 they were in flat 81 -- because that wasn't expressed to
17 him, as I understand it -- in the bathroom. Do you
18 agree with that? If you can't remember, then don't
19 answer.

20 A. I don't remember the detail, no.

21 Q. But even if they had been told: "Go in via the balcony",
22 as opposed to the corridor itself, they'd have found
23 themselves on the balcony without other firefighters,
24 and on the balcony, of course, we have entrance doors
25 into various flats but there's no indication of the

1 numbers on the balcony. Obviously there is in the
2 corridor, if they hadn't been burned off or there was
3 too much smoke. So that is a difficulty they would
4 faced had they been able to do that?

5 A. Yes, unless they were able to observe conditions within
6 one of the flats that might have indicated.

7 Q. All right. There are so many different interpretations
8 I could put to you. I'm going to stop putting all the
9 different interpretations. But you accept that there
10 were many difficulties and many split decisions which
11 had to be made on that day?

12 A. Yes.

13 Q. One of them, of course, was control. Now, there is no
14 doubt that the point came with Catherine Hickman when
15 the exploration of potential routes of escape was
16 appropriate, and I won't ask you to speculate about what
17 might or might not have been said, other than to ask you
18 to speculate a little bit about the potential for --
19 which is always a dilemma for control officers.
20 A control officer is remote from the situation; you
21 would agree?

22 A. Yes.

23 Q. The control officer only has the benefit of what the
24 caller is telling the control officer, and unless
25 an incident commander or a firefighter is in the

1 compartment with that person, the control officer is
2 really reliant upon the caller?

3 A. Yes.

4 Q. It's one thing to give advice about a fire that's one
5 floor up, or whatever it may be, but in the situation
6 where one is nine floors up, do you agree that it is
7 very difficult for a control officer, even presented
8 with the scenario which is threatening within a flat, to
9 advise a person to go through, for example, a front door
10 into a burning corridor, or an escape balcony door into
11 a central stairway when they don't know what the
12 conditions are?

13 A. Yes, and I think this is an example of hindsight and
14 hypothetical situations and the level of knowledge and
15 training that the control operators had about the giving
16 of that advice.

17 Q. Yes, because whatever the training is, a control officer
18 would have to be pretty bold to say to a caller: "I want
19 you to go through that door, which will close behind
20 you. I want you to go down nine floors through
21 a central corridor" -- which she and others would know
22 is essentially smoke-logged, with fires on floors below.
23 That would be a difficult decision to make?

24 A. It would be a difficult decision.

25 Q. It might have been the right decision, and in the

1 circumstances of this particular case people will draw
2 their own conclusions, but it would have been a very
3 difficult decision to make?

4 A. It would have been.

5 Q. Just a brief question about the snatch rescue to the
6 11th floor later on. We've heard about the snatch
7 rescue with Firefighter Hull going to get the Nuhus on
8 the balcony. I don't think it is being suggested, but
9 just in case it is, I'll ask you whether it would be
10 appropriate, even in EDBA, to dispatch a crew to do
11 a snap rescue up four floors onto the 11th, into
12 a corridor which may well be alight, without jets,
13 without water, to carry out a rescue by just searching
14 generally the flats. That wouldn't be an appropriate
15 course of action at all?

16 A. No, I think I mentioned before: if you have to search,
17 on my understanding of what the term means, you're not
18 actually performing a snatch rescue or a snap rescue;
19 you're carrying out search and rescue.

20 Q. All right. Well, just before I ask you about the final
21 matters, which really have to do with the future -- and
22 there's only two areas I want to ask you about --
23 actually, I'm going to move straight to asking you about
24 those. You mention that it might be appropriate for
25 aerial ladder platform operators to do 72D visits of

1 high rise premises where possible?

2 A. If it's associated with the 72D, that's one way, but it
3 could be associated just with familiarisation of their
4 response area.

5 Q. You will accept that -- actually, there will be evidence
6 in due course, but I think there are 11 aerial ladder
7 platforms available in the whole of London, and
8 obviously for the operators of those 11 to do 72D visits
9 in all high rise, on top of the commercial premises and
10 the industrial premises that they have to visit as well,
11 would be a very tall order?

12 A. It would be, and I think I referred to the logistic
13 difficulties of that.

14 Q. Indeed. It would have to be managed by prioritising it
15 in some way or another.

16 Premises information boxes, you said, would be
17 potentially of benefit. That is a box, a secure box, on
18 the external face of the premises. Many firefighters
19 thought that would be a good idea as well, but that
20 would have to be the responsibility of the occupier of
21 the building, obviously, to place relevant information
22 within it?

23 A. I couldn't comment on that, because I think that's
24 a local knowledge matter. I just referred to the
25 benefit of having something like that.

1 Q. Fair enough. It would certainly be right that the
2 information that was in it would have to be up to date?

3 A. Yes.

4 Q. Because it would probably be worse to have out-of-date
5 information than no information at all, potentially?

6 A. Potentially.

7 Q. Yes, and specific and agreed as to the form of it so
8 that it would mean something to the Fire Brigade when
9 they arrive?

10 A. Yes.

11 Q. Yes. Would you just wait there for a minute.

12 Madam, can I just ... yes, thank you very much
13 indeed.

14 THE CORONER: Thank you. Members of the jury, do you have
15 any questions for Mr Davey?

16 Questions from the Jury

17 THE FOREMAN OF THE JURY: Thank you. Just three, I think.

18 Mr Davey, we've heard a large amount of evidence
19 detailing how many different incident commanders there
20 were on the day as the incident escalated and how
21 sometimes it was a quick handover, sometimes there was
22 an incident commander in charge for longer. Do you feel
23 that the system used at the time for incident commanders
24 to be in charge -- sorry, I'm phrasing this badly. Do
25 you feel that there could be a more effective system for

1 maintaining a consistent line of control across incident
2 commanders at the incident? Is there a more practical
3 way of doing that?

4 A. I think an incident command system such as this relies
5 on people with more experience and knowledge taking over
6 as the incident escalates and there's more resources,
7 and I don't think there's any way of overcoming that,
8 other than assessing the need for pumps -- as we saw,
9 there was a "make pumps four, "makes pumps six", "make
10 pumps eight" and so on. If the earlier incident
11 commanders had assessed a greater need of pumps, we may
12 have skipped one of the incident commanders because
13 there would have been one of a higher rank there as the
14 resources arrived.

15 THE CORONER: Does that answer your question?

16 THE FOREMAN OF THE JURY: Thank you, that does.

17 In your expert opinion, Mr Davey, would you agree
18 more with the suggestion that there were not enough
19 resources/personnel available on the day, or would you
20 be more inclined to agree that there were plenty of
21 resources and it's just that they weren't deployed
22 effectively enough?

23 A. I think, given what was expected as -- in terms of
24 a flat fire and the predetermined attendance, those
25 initial resources were adequate. What happened with the

1 rapid development of the fire downwards suddenly changed
2 expectations and that changed the adequacy of the
3 resources that were on site.

4 In terms of were there enough there, generally
5 I think there were, but the incident commanders and the
6 sector commanders were still catching up with the fire
7 development and the range of tasks that were needed to
8 be carried out.

9 THE FOREMAN OF THE JURY: Thank you.

10 Just one last question. This is a question that was
11 being asked of a number of the firefighting personnel
12 much earlier, but I was interested in what your answer
13 might be: with the research that you've undertaken and
14 the evidence that you've heard, what one additional
15 resource do you feel would have made the greatest
16 difference on the day of the fire?

17 A. From what I was asked to do, I don't think I could
18 identify one specific. I think there are a range of
19 things. Asking me is quite different to asking the
20 firefighters who were actively involved.

21 THE FOREMAN OF THE JURY: Thank you.

22 THE CORONER: Thank you very much.

23 Mr Davey, thank you very much for your evidence and
24 thank you very much for all the help that you've been
25 able to give us. You're welcome to stay if you would

1 like, but you're free to go if you would prefer. Thank
2 you very much for your help.

3 A. Thank you.

4 THE CORONER: Would it be sensible if we just had a short
5 break at this stage? Members of the jury, would you
6 like to have a five/ten minute break? You're welcome to
7 leave your papers if you would like.

8 (In the absence of the Jury)

9 THE CORONER: Yes.

10 Housekeeping

11 MR MAXWELL-SCOTT: I think we can probably safely let the
12 jury go for the day.

13 THE CORONER: Yes, I think we probably can. I just wanted
14 to have a quick look at -- well, there's not going to be
15 anything else today but just have a quick look at
16 tomorrow before we actually send them out of the
17 building.

18 MR MAXWELL-SCOTT: Certainly.

19 THE CORONER: Mr Hendy, are you in a position to pursue your
20 application, or do you want a few minutes to think about
21 it, or how do you want to do it?

22 MR HENDY: You're kind to ask, madam. We've listened
23 carefully to Mr Davey's evidence and in the light of it
24 we don't wish to pursue our application.

25 THE CORONER: All right. Well, that's helpful. Thank you

1 very much. Thank you for your help with that.

2 All right then, just very briefly, Mr Maxwell-Scott,
3 looking at tomorrow then.

4 MR MAXWELL-SCOTT: Yes, Mr Nick Coupe will be giving
5 evidence.

6 THE CORONER: Mr Coupe tomorrow. Then Wednesday.

7 MR MAXWELL-SCOTT: Wednesday at the moment is free, but
8 there's the possibility of Mr Brian Martin, and we are
9 hoping to receive something from treasury solicitors on
10 behalf of him and DCLG today. It hasn't arrived yet.

11 THE CORONER: Okay. All right, so is everyone comfortable
12 with us asking the jury to go now and come back tomorrow
13 morning? All right, thank you very much. Would you
14 mind telling them, Mr Clark. Thank you.

15 Yes. Does anyone want to raise anything then before
16 we continue tomorrow morning? Ms Al Tai?

17 MS AL TAI: Madam, it was just a question I had put to
18 Mr Davey earlier in his evidence. It's just a small
19 matter and it doesn't affect the substance of my
20 question to him, but I believe I was specifying the time
21 in which it would have been possible for Miss Hickman to
22 have been rescued, and I stated that Professor Bion's
23 evidence was that she could have been rescued at 16.55.
24 I've had an opportunity to look through the transcript
25 and I believe we were correct, both of us, in our

1 interpretation of his evidence, but I believe at page 24
2 of his transcript, Professor Bion mentioned that 16.55
3 would have been the last possible occasion but that in
4 fact she would have died some time between 16.50 and
5 17.00.

6 It doesn't alter the substance of my question to
7 Mr Davey, but I'm just concerned that the impression the
8 jurors might have is that she wouldn't have been able to
9 have been rescued after 16.50. I know it's a matter of
10 minutes, madam, but I just thought I would draw it to
11 your attention.

12 THE CORONER: All right, are you asking me to do anything?

13 MS AL TAI: If you might be minded just to draw it to the
14 jury's attention tomorrow morning that in fact both
15 premises are correct, I would be grateful.

16 THE CORONER: All right, I'll find a time to do that and
17 apologies if I jumped in unfairly on your question.

18 MS AL TAI: Not at all, madam. Thank you very much.

19 THE CORONER: All right then, 10 o'clock tomorrow morning.
20 Thank you very much.

21 (3.03 pm)

22 (The Court adjourned until 10 o'clock the following day)

23
24 BRIAN DAVEY (sworn)2
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