SHERIFFDOM OF NORTH STRATHCLYDE AT PAISLEY

[2023] FAI 1

B38/21

DETERMINATION

BY

SHERIFF THOMAS MCCARTNEY

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

SIMON MIDGLEY AND RICHARD JOHN DYSON

PAISLEY, 16 August 2022

DETERMINATION

The Sheriff, having considered the Joint Minutes of Agreement, the evidence, and the submissions of parties, Determines in terms of Section 26 of the Inquiries into Fatal Accidents and Sudden Deaths Etc. (Scotland) 2016 ("the Act") that:

F1. **In terms of section 26(2)(a) of the Act (when and where the deaths occurred):**

Simon Midgley was born on 27 February 1985. He died at between 06.41 and 09.13 hours on 18 December 2017 at Cameron House Hotel, By Loch Lomond, Balloch ("the Hotel").

Richard John Dyson ("Richard Dyson") was born on 8 May 1979. He died at between 06.41 and 09.35 hours on 18 December 2017 at the Hotel or en route to/at Royal Alexandra Hospital, Paisley.

F2. **In terms of section 26(2)(b) (when and where any accident resulting in the deaths occurred):** The accident resulting in the deaths of Simon Midgley and Richard Dyson was a fire that occurred at some time between approximately 04.00 hours and 06.39 hours on 18 December 2017 at the Hotel. The seat of the fire was within the concierge cupboard in the main reception area. The time period specified is the time period between when ashes were placed into that cupboard and the time when it was first identified that there was a fire ongoing there.

F3. **In terms of section 26(2)(c) (the cause or causes of deaths):**

The cause of death for both Simon Midgley and Richard Dyson was inhalation of smoke and fire gases due to the Hotel fire.

F4. **In terms of section 26(2)(d) (the cause or causes of any accident resulting in the deaths):**

The cause of the accident resulting in the deaths of Simon Midgley and Richard Dyson was a fire which began in the concierge cupboard of the Hotel, as a result of hot embers within ash igniting combustibles within said cupboard. The fire spread from the cupboard through voids and cavities in the structure of the building, and escaped into the reception area once the door to the cupboard had been opened, thus causing fire and smoke and fire gases to spread extensively throughout the old part of the Hotel. The

ashes were within the cupboard having been placed there by Mr Christopher O'Malley, who was employed as a night porter at the Hotel.

F5. **In terms of section 26(2)(e) (the taking of precautions which could reasonably have been taken, and, had they been taken, might realistically have resulted in the deaths, or any accident resulting in the deaths, being avoided):**

(a) It would have been a reasonable precaution for there to have been a clear system of work for the safe cleaning and removal of ash from the open fires at the Hotel. A clear system of work could have been implemented by way of a written Standard Operating Procedure (SOP) for the safe cleaning and removal of ash from open fires at the Hotel, together with the provision of appropriate training and equipment for those responsible for the task.

(b) It would have been a reasonable precaution for an active fire suppression system (a sprinkler system) to have been installed at the Hotel.

F6. **In terms of section 26(2)(f): (defects in any system of working which contributed to the deaths or any accident resulting in the deaths):**

The following are defects in the system of working at the Hotel which contributed to the accident resulting in the deaths:

(a) The careless disposal of ash in unsuitable receptacles and areas culminating in hot embers being placed within the concierge cupboard by night porter Christopher O'Malley;

(b) The lack of a written Standard Operating Procedure re-enforced by staff training, notwithstanding the opportunities to remedy that situation;

(c) The absence of appropriate equipment for safe disposal of ash;

(d) The full ash bins in the service area, and lack of a coherent system to regularly empty same, and the absence of instructions to staff relating what to do with ash when bins were full;

(e) The presence of combustibles within the concierge cupboard, notwithstanding a warning that such should have been removed.

F7. **In terms of section 26(2)(g) (any other facts relevant to the circumstances of the deaths):**

The following matters are relevant to the circumstances of the deaths:

(a) Due to the delay in obtaining a guest list there was a delay in carrying out an accurate roll call.

(b) The alteration of the 2017 Fire Assessment Report by Veteran Fire Safety Ltd to state that all of the recommendations identified in the previous report have been recorded as complete without sight of evidence thereof.

(c) The presence and impact of hidden voids at the Hotel, in respect of the detection and spread of smoke and fire there.

(d) Building and Fire Safety Standards in respect of hotels, and, in particular, the application of same to older buildings.

RECOMMENDATIONS IN TERMS OF SECTION 26(1)(b)

The Sheriff, in terms of Section 26(1)(b) of the Act, and having regard to the matters mentioned in section 26(4) of the Act, Recommends that:

1. Owners or operators of hotels or similar sleeping accommodation in Scotland should, where appropriate to their operation, have in place up to date and robust procedures, informed by an assessment of risks, to ensure that ash from open fires in hotels is removed and disposed of in a safe manner, thereby avoiding the risk of fires being started by the careless disposal of ash.

2. Owners or operators of hotels or similar sleeping accommodation in Scotland should ensure that clear and robust arrangements are in place for promptly ensuring all persons are accounted for in the event of evacuation of such accommodation in the event of a fire, such arrangements, where possible, to address foreseeable contingencies such as difficulties in accessing guest lists, or inclement weather.

3. Owners or operators of hotels or similar sleeping accommodation in Scotland should ensure that robust arrangements are in place to ensure that all staff (including in particular night shift staff) have experience of evacuation drills which may, for example, involve night-time staff being asked to attend a day-time evacuation drill and/or mock drills taking place during "night shift" hours.

4. The Scottish Government should consider introducing for future conversions of historic buildings to be used as hotel accommodation a requirement to have active fire suppression systems installed.

5. The Scottish Government should constitute an expert working group to more fully explore the special risks which existing hotels and similar premises may pose through the presence of hidden cavities or voids, varying standards of

workmanship, age, and the variance from current standards and to consider revising the guidance provided by the Scottish Government and others.

6. Scottish Fire and Rescue Service should reduce the time period between a fire safety audit inspection and the issue of a written outcome report.

NOTE

Introduction and Contents

[1] This determination follows an inquiry into the death of Simon Midgley and Richard Dyson who died on 18 December 2017. It is made up of thirty four chapters and two appendices, namely:

1. Introduction and Contents
2. The Legal Framework
3. Participants and Representation
4. The Inquiry Process
5. Simon Midgley and Richard Dyson
6. Cameron House Hotel
7. Circumstances of the Fire
8. Post-Fire Investigations
9. Relevant Circumstances preceding the Fire
10. Evidence
11. Submissions
12. Where and when Deaths Occurred

13. Where and when the Accident resulting in the Deaths Occurred

14. Cause of Deaths

15. Cause of the Accident resulting in the Deaths

16. Disposal of Ash from Open Fires

17. Emptying of Ash Bins at the Hotel

18. Evacuation of the Hotel, Assembly, and Roll Call

19. Training of Night Staff in Fire Evacuation

20. The Spread and Fighting of the Fire

21. Attempts made by SFRS to locate the Deceased, their Discovery and Removal from the Hotel

22. Roll Call Liaison Officer

23. Fire Alarm System

24. Electrical System

25. Fire Detection System in place at the Hotel

26. Absence of Fire Detection in the Concierge Cupboard

27. The Potential Impact of Sprinklers in Suppression of Fire at the Hotel

28. The Presence and Impact of Hidden Voids

29. Building Standards in respect of Fire Safety at the Hotel, and more generally in Hotels in Scotland, including the Application of such Standards to Older Buildings

30. Fire Risk Process and Implementation of Identified Issues

31. The Regulatory Regime for Fire Safety at the Hotel and Enforcement thereof by SFRS

32. Improvements and Changes since the Fire

a. Cameron House Hotel (Loch Lomond) Ltd

b. Scottish Fire and Rescue Service

33. Submissions for Ms Jane Midgley

34. Conclusion

Appendices:

1. Witnesses to the Inquiry

2. Location and Floor Plans:

a. Hotel location plan

b. Upper ground floor plan

c. First floor plan

d. Second floor plan

The legal framework

[2] This Inquiry was mandatory in respect of Simon Midgley as he died as a result of an accident whilst he was acting in the course of his self-employment. The Inquiry was discretionary in respect of Richard Dyson as the Lord Advocate considered that the death occurred in circumstances giving rise to serious public concern and that it was in the public interest an inquiry be held. A single inquiry was held into the deaths of

Simon Midgley and Richard Dyson because it appeared to the Lord Advocate that the deaths occurred as a result of the same accident.

[3] Fatal Accident Inquiries and the procedure to be followed in the conduct of such inquiries are governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. In terms of section 1(3) of the Act the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances. Section 26 requires the Sheriff to make a determination which in terms of section 26(2) is to set out the following factors relevant to the circumstances of the death, insofar as they have been established to their satisfaction. These are:

(i) when and where the deaths occurred;

(ii) when and where any accident resulting in the deaths occurred;

(iii) the cause or causes of such deaths;

(iv) any precautions that could reasonably have been taken, and had they been taken, might realistically have resulted in the deaths, or any accident resulting in the deaths, being avoided;

(v) any defects in any system of working which contributed to the deaths;

(vi) any other facts which are relevant to the circumstances of the deaths.

[4] In terms of section 26 subsections (1)(b) and (4), the inquiry is to make such recommendations (if any) as the Sheriff considers appropriate as to:

(a) the taking of reasonable precautions;

(b) the making of improvements to any system of working;

(c) the introduction of a system of working, and;

(d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

[5] In order to identify precautions which, had they been taken, might realistically have avoided the death, or to identify defects in the system of working which contributed to the death it is necessary that the Sheriff is satisfied on the balance of probabilities that those precautions or the defects in the system of working contributed to the death. Likewise, in order to make recommendations the Sheriff has to be satisfied that there is a reasonable possibility that the recommendations may prevent deaths in similar circumstances. The 2016 Act does not contain a definition of the term "accident" for these purposes. However it is clear that the accident which resulted in the death of Mr Dyson and Mr Midgley was the fire in the early hours of 18 December 2017 within the concierge cupboard at the Hotel which then spread rapidly within the building.

[6] The Procurator Fiscal represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The Court proceeds on the basis of evidence placed before it by the Procurator Fiscal and by any other party to the inquiry. The determination must be based on the evidence presented at the inquiry and is limited to the matters defined in section 26 of the Act. Section 26(6) of the Act provides that the determination shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death, while

also reflecting the position that it is not the purpose of a Fatal Accident Inquiry to establish civil or criminal liability (section 1(4)).

[7] The scope of the inquiry extends beyond mere fact finding. It looks to the future and seeks to prevent deaths occurring in similar circumstances. Where the circumstances have given cause for serious public concern an inquiry may serve to restore public confidence and allay public anxiety.

Participants and representation

[8] The Crown represents the public interest in a Fatal Accident Inquiry and Mr Jessop KC, Advocate Depute, appeared, assisted by Mr McCrone, Advocate.

[9] Other Participants and representation were as follows:

Cameron House Resort (Loch Lomond) Limited: Mr Gray KC.

Fiona Meek: Mr MacLeod KC.

Christopher O'Malley: Mr Stewart KC.

Andrew Roger: Mr Smith KC.

Scottish Fire and Rescue Service ("SFRS"): Ms Black, Solicitor.

[10] I am grateful to all those appearing at the Inquiry and to those instructing them for their professionalism and assistance in the conduct of this Inquiry. The contributions of all those appearing and in particular the agreement of substantial and significant matters by Joint Minute have greatly assisted the inquiry.

The Inquiry Process

[11] The Notice of an Inquiry was received on 29 November 2021. Sheriff Principal Murray made a first order on 1 December 2021 fixing a preliminary hearing for 11 January 2022. Further preliminary hearings were held on 3 May 2022, 22 June 2022, and 2 August 2022. The Inquiry heard evidence over ten days between 15 and 26 August 2022. Written submissions were lodged and a hearing on submissions took place on 7 November 2022.

[12] Evidence was led by the Advocate Depute for the Procurator Fiscal, in accordance with the duty under section 20(1)(a) of the Act. No witnesses were called by any other participant. A list of witnesses who gave oral evidence is included as an appendix.

Simon Midgley and Richard Dyson

[13] Simon Midgley and Richard Dyson were partners. They lived in London. Mr Midgley worked as a freelance travel journalist. Mr Dyson worked as a freelance television producer. It was in the course of Mr Midgley's travel writing work that they were booked to stay at the Hotel for two nights arriving on 16 December 2017.

[14] A victim impact statement of Ms Jane Midgley, Simon Midgley's mother, was read. This informed the Inquiry of the devastating impact of her son's death on Ms Midgley and other family members. It also provided the Inquiry with some understanding of the character and personalities of both young men. They were clearly talented young men with a great deal to contribute. They were committed to each other

and to their families. It is not surprising that their passing has had a devastating impact on family and friends.

Cameron House Hotel

Corporate structure

[15] The Hotel was owned and operated by Cameron House Resort (Loch Lomond) Ltd, a company incorporated under the Companies Acts, with registered number 06126450. The registered office at the time of the incident was One Fleet Place, London, EC4M 7WS and the current registered office is 3rd Floor, 63 St James Street, London, SW1A 1LY. Cameron House Resort (Loch Lomond) Ltd had owned and operated the Hotel since November 2015. Cameron House Resort (Loch Lomond) Ltd was owned by another company, CMH investment II (UK) Ltd.

[16] Cameron House Resort (Loch Lomond) Ltd was an employer for the purposes of the Health and Safety at Work etc. Act 1974.

[17] Cameron House Resort (Loch Lomond) Ltd, as owner and operator of the Hotel, had a duty in terms of the Fire (Scotland) Act 2005 to take reasonable fire safety measures to ensure the safety of guests, visitors, and staff at the Hotel.

Premises

[18] The Hotel is located on the banks of Loch Lomond, approximately two miles from the town of Balloch.

[19] The Hotel was comprised of the main building, which was an 18th century "B" listed building, with modern extensions built to both sides and also to the rear. The main building of the Hotel contained the main reception area, some bedrooms, function rooms and office space. This part of the Hotel spanned a number of floors.

[20] The extension to the left of the main building (as viewed when facing the main entrance) contained numerous bedrooms across four storeys. The Hotel had, in total, 136 bedrooms which were in the main building and aforementioned modern extension. The extension to the right of the main building contained leisure facilities, a restaurant, bar and grill, and other function rooms.

[21] The entrance foyer of the main building was located on the upper ground floor. This was accessed via steps and swing doors at the front of the building which provided access to a small lobby where a rotary door afforded access to the foyer. Within the foyer area was an open fire, typically used for the burning of logs. There were two open fires within the Hotel, one located within the main reception area and the other in the Cameron Grill Restaurant.

[22] The reception desk was directly opposite the main entrance door. A small concierge desk was to the right of the reception desk. Located in the corridor, just off the entrance foyer to the right, was a small concierge cupboard. It was unmarked and unlocked. It contained an electrical consumer unit, and the controls for a music system. That was the seat of the fire on 18 December 2017.

Circumstances of the fire

[23] Mr Christopher O'Malley was employed as a night porter at the Hotel. He began his employment in around April 2017. He worked from 11pm to 7am five days out of seven. One of the duties of the night porters at the Hotel was to remove the ash from the open fires in the front reception area and the Cameron Grill restaurant, ready for them to be reset and lit the next day by day shift concierge staff. Mr O'Malley was working as a night porter at the Hotel on the night of 17/18 December 2017.

[24] On the morning of 18 December 2017 Mr O'Malley removed the ash from the open fire in the Cameron Grill. He then placed that ash in a plastic bag containing the ash from the previous night. He then placed the plastic bag containing the ash within the concierge cupboard shortly before 4am and closed the door.

[25] At 06.39 hours a "pre-alarm" fire alarm sounded within the Hotel reception area. This was designed to afford staff a 3 minute window to check the source of an alarm prior to the full alarm sounding. The fire alarm system is programmed to go into full alarm mode when two devices from different zones or the same zone are activated, unless manually overridden. Mr O'Malley and the night manager, Darren Robinson, immediately responded to the pre-alarm and attempted to find the cause. Mr O'Malley went to the floor above via the main stairwell and saw smoke at the end of the corridor. He informed Mr Robinson of this by radio. Mr Robinson sounded the full alarm. Checks were made in different areas around the reception and then they noted that smoke was coming from the concierge cupboard which was where Mr O'Malley had placed the bag of ash several hours earlier. Mr O'Malley opened the cupboard door and

flames immediately took hold and spread from there to the hallway. Mr O'Malley, Mr Robinson, and a member of the health club at the Hotel (who happened to be in the reception area at the time) attempted to fight the blaze with fire extinguishers. They quickly realised that they would be unable to stop the spread of the fire and retreated. The night manager made a "999" call to Scottish Fire and Rescue Service ("SFRS") and exited the Hotel building at 06.41 hours.

[26] In response to the call reporting the fire within the Hotel, SFRS Operations Control in Johnstone dispatched four rescue appliances and one aerial rescue appliance to the Hotel. Whilst en route to the Hotel the fire crews were made aware that there were persons trapped within.

[27] Guests heard the full fire alarm sound and began to evacuate the building. This proved to be difficult for guests in the main building. The situation was rapidly deteriorating and the corridors, including designated fire escape pathways, were filling with smoke and fire gases. Guests in the modern wings largely had no difficulty in making their way to fire exits and evacuating the building quickly.

[28] At 06.51 hours, the first SFRS appliance arrived at the Hotel. It was from Balloch and led by Watch Commander Graham Atwell. The crew observed smoke issuing from the main building and a well-developed fire within the upper ground floor (where the concierge cupboard was located). The fire had begun to spread to the floors above it where the guest bedrooms were located.

[29] A family of three (mother, father, and their infant child) had been staying in Room 10 on the second floor of the main building. They had been unable to safely leave

their room due to the presence of fire, smoke, and gas in the corridor outside of their room. They had attempted to block the ingress of smoke and fire gases from the corridor under their room door using bedding to prevent smoke from entering but this had not been successful. SFRS rescued all three family members using a 13.5 metre ladder from outside the building. The family were taken by ambulance to hospital for a precautionary check-up. They did not sustain any physical injuries.

[30] Firefighters wearing breathing apparatus were committed into the main building of the Hotel for the purposes of fighting of fire and search and rescue procedure. Fire crews were committed on the basis that it remained a search and rescue operation until confirmed otherwise. A further eight fire appliances arrived to assist as the SFRS level of fire emergency was upgraded.

[31] The night manager, Mr Robinson, had exited the building without removing the guest list or the evacuation bag containing the items in the comfort box from reception. These were to be removed in the event of an emergency evacuation. However due to the rapid spread of the smoke throughout the reception area, the guest list and fire box items which he had picked up were in error left in the reception area when he left the building. He alerted SFRS Watch Commander Atwell to this. Mr Atwell was able to enter the reception area of the Hotel and retrieve the guest list from the reception.

[32] Guests had been assembling outside the Hotel building at the assembly/muster area which was the lawn outside the Hotel building. Many of the guests were barefoot and/or wearing nightclothes. It was cold and dark. Comfort items, which were held in a box at reception for this purpose, were not available for distribution having been

inadvertently left behind by Mr Robinson. A decision was made to relocate the guests to the Boat House Restaurant (a separate building within the Cameron House resort area, 471 metres from the main building) being a more comfortable location. Guests were directed to the Boat House Restaurant by a combination of hotel staff, police officers, and firefighters.

[33] Once there a roll call of guests was carried out in order to establish if there were any unaccounted for. This was a difficult and prolonged process. It was established that 96 rooms had been occupied by a total of 214 guests (189 adults and 25 children). It was not until 08.09 hours that the occupants of Room 8 (Mr Midgley and Mr Dyson) were recorded on the SFRS log as being missing.

[34] That information was passed to SFRS who carried out a search of their room (Room 8) gaining entry by way of pitching a ladder externally. A search of Room 8 by firefighters from within was also carried out. No persons were found within but personal items remained within the room.

[35] A team of firefighters wearing breathing apparatus climbed the right-hand side fire escape staircase between the main Hotel and the leisure complex etc. Due to thick smoke, visibility was almost nil. On reaching the landing at the second floor, Richard Dyson was found by firefighters. He had heavy deposits of soot on his face. He was unresponsive and was carried from the building. He was passed to a waiting paramedic crew who immediately began attempts to resuscitate him. He was not displaying any sign of life. He was taken to the Royal Alexandria Hospital, Paisley

where doctors there attempted to revive him. These efforts were unsuccessful and life was pronounced extinct at 09.35.

[36] Shortly after Mr Dyson was removed from the building, another team of firefighters wearing breathing apparatus found Simon Midgley lying in the fire escape passageway behind the door to the landing where Mr Dyson had been. Mr Midgley was unresponsive and was carried from the building by firefighters who passed him over to a waiting paramedic team. The paramedics carried out advanced life support techniques. These efforts were unsuccessful and life was pronounced extinct at 09.13.

[37] The fire within the Hotel continued to develop. Firefighters described seeing flames inside the walls on the first floor above the reception and flames emanating from the third floor. A wooden staircase situated directly above the seat of the fire was still intact. This indicated that the fire had not broken through in an expected manner but had spread via voids above the concierge cupboard. The smoke spread from a fire in a building which does not have voids would be expected to be from one compartment to the adjacent compartment, meaning from the ground floor (where it originated) to the first floor, then up to the second floor.

[38] Firefighters withdrew from the building as it was showing signs of structural instability. This culminated in the roof of the main building collapsing. Efforts continued to put out the fire throughout the day of 18 December 2017 and it was not until the early hours of the morning of 19 December 2017 that the fire was brought under control.

Post-fire investigations

[39] A multi-agency investigation commenced involving Police Scotland, SFRS, and West Dunbartonshire Council. The initial investigation was hampered due to the structural instability of the building which had to be made safe before any physical gathering of evidence from within could take place. Thereafter scene examination work was conducted by the Scottish Police Authority ("SPA"), and SFRS.

[40] The forensic examination by the SPA and the fire investigation department of SFRS both concluded that the fire had originated in the concierge cupboard where Mr O'Malley had placed the ash several hours prior to the fire starting. It was concluded that an ember or embers within the ashes had melted the black plastic bag and then gone on to ignite other combustible items within the cupboard, such as the kindling (stored there for the concierge staff who set and lit the fire during the day shift).

[41] The continued storage of old newspapers and bags of kindling in the concierge cupboard was contrary to an earlier SFRS warning that combustible material should not be stored within cupboards, such as the concierge cupboard, because it contained mains installation apparatus thereby giving rise to a risk of fire if combustible materials came into contact with such electrical apparatus. From this cupboard the fire, smoke, and fire gases had spread throughout the main building of the Hotel.

Relevant circumstances preceding the Fire

Clearing of open fires

[42] The duty of emptying/clearing the open fires in the main reception and Cameron Grill restaurant was with the night porters. The fires, when in use, were usually allowed to burn out around 23.00 hours, with the last logs being added to the fire no later than 22.30 hours. They were usually cleared between around 02.00 and 05.00.

[43] On the night of 15/16 December 2017 Christopher O'Malley was on duty with night porter, Raymond Burns, and night manager, Ann Rundell. In the course of that shift Raymond Burns emptied the ash from the open fire in the reception area into a plastic bag which appeared to contain water. Ms Rundell saw this and reprimanded him in strong terms. Mr O'Malley was present during this occurrence.

[44] On the night of 16/17 December 2017 Mr O'Malley was on duty. Mr Darren Robinson was the night manager. In the course of his duties Mr O'Malley emptied the ash from the open fire into an ice bucket which he took outside to deposit in the ash bins. However the ash bins were full. He brought the bucket containing the ash back into the hotel and left it next to the reception desk. Mr O'Malley said in evidence that he reported the full bins to Mr Robinson just before he finished his shift at about 7am. Mr O'Malley emptied the ash into a plastic bag which he left within the concierge cupboard. It was that plastic bag into which he placed the ash the following night because the outside bins remained full. That ash resulted in the fire.

Fire risk assessment and procedure for clearing open fires

[45] In January 2016, Veteran Fire Safety Limited ("Veteran"), fire risk assessors, carried out an assessment of fire risks at the Hotel. Their written fire risk assessment dated 14 January 2016 noted that there was no written policy in place covering the emptying of the josper ovens (an enclosed charcoal oven where food is cooked at high temperature) and open fires. This observation was highlighted in the action plan section recommending that the Hotel prepare a written policy to explain the correct way to empty the hot ash from open fires and josper ovens. The recommendation was that the hot ashes must be transferred to a metal container and wetted down and that the metal container should be kept away from combustibles until the refuse was hauled away.

[46] The Hotel resort manager, Mr Andrew Roger, delegated implementation of this action plan recommendation to the deputy general manager. The deputy general manager delegated the preparation of a written procedure to the head chef. The head chef prepared a written policy for emptying hot ash from josper ovens which were the responsibility of the kitchen. The head chef was not responsible for the open fires. No-one was assigned the task of preparation of a written procedure for the open fires. As a result, the recommendation in respect of the open fires was never actioned.

[47] In January 2017, Veteran again assessed the Hotel and prepared an updated fire risk assessment. The 2017 written fire risk assessment again identified the lack of written procedure for emptying of hot ash from open fires and recorded that this action was still outstanding from the 2016 fire risk assessment.

[48] The statement that this action had not been completed was challenged by Mr Roger, the resort manager, who stated in an email communicated to Veteran via Fiona Meek (who provided *inter alia* health and safety services to the Hotel) that all actions from 2016 had been completed. He did that because the recommended action in respect of open fires and josper ovens had been signed off as completed in March 2016. The need to differentiate between the kitchen ovens and public area fires had been overlooked. Despite not having sight of evidence of completion of this action, on the basis of the assurance given by Mr Roger, Veteran re-issued their fire risk assessment report amended to show all of the recommendations identified on the previous report having been recorded as complete.

[49] Consequently awareness of the need for a written policy in respect of the open fires was lost. Whilst it remained within the body of the 2017 report, the practice of Mr Roger was to go to the action plan. Thus the *ad hoc* and improvised methods used in emptying ash from the open fires by night porters, untrained and lacking direction in the task, continued. By its nature, the work of night porters was carried out while few managers would be in the Hotel and therefore with minimal supervision and direction. This was the context and contributing circumstance in which the night porter placed the ash within the concierge cupboard causing the fire.

[50] As at the date of the fatal fire there was no written procedure for the disposal of ash and embers from the open fires in the reception and the Cameron Grill restaurant. There was no set operating procedure for cleaning the open fires in the reception and Cameron Grill restaurant. As there was no operating procedure to follow individual

members of staff improvised. If a formal, safe procedure had been in place together with appropriate training and equipment this would have significantly lowered the risk of improvisation by individual staff members.

Ash bins in refuse area

[51] The rear yard of the Hotel contained a refuse area. There were two metal bins there that were used for disposing of ash collected from the open fires. The arrangements for provision of and emptying of these bins was not effectively organised and structured. In October 2017 Lyle Davidson, head groundsman, was asked by a member of the Hotel purchasing team to empty the ash bins at the rear of the Hotel, which he did. After emptying the ash bins, Lyle Davidson advised the purchasing manager, Karen McCurrich, and the assistant purchaser, Graham Colquhoun, that the ash bins were rusted at the bottom, that they were not fit for purpose, and that his team would not empty the ash bins again until the bins were replaced. The ash bins were not replaced and not emptied again after October 2017.

[52] On the night of 16/17 December 2017, the day before the fatal fire, Christopher O'Malley emptied ash from the open fires into an ice bucket. He took the bucket and ashes outside and found the two metal bins to be full. He brought the bucket containing the ash back into the hotel and left it at the reception desk. He reported to Mr Robinson, the night manager, that all the ash bins were full. Just before he finished his shift at 7am he emptied the ash into a plastic bag which he had placed in the concierge cupboard.

[53] Had the bins not been full, there would have been a safe place to deposit ash from the Hotel's open fires. It was that plastic bag into which, on the following night, Mr O'Malley deposited the ash containing hot embers from the open fire, and which, in turn, ignited combustibles in the cupboard resulting in the fatal fire.

Staff training on clearing open fires

[54] There was no formal method for the instruction, training, and supervision of staff in relation to the emptying of the open fires. Instruction for the cleaning of the open fires was passed on from the senior concierge of the day to any new members of the night porter team. There was no common understanding of procedures for this task which should have involved the use of equipment such as a brush, dust pan, and metal containers for collecting the ash and immediate transfer to an external location. The absence of a formal procedure gave rise to inconsistencies in practice and methods used varied from using a variety of receptacles, namely schaefer trays, chiggon trays, chaffing dishes, ice buckets, general waste buckets, and plastic bags filled with water. There was no consistent method applied for emptying ash from the open fire in the reception and Cameron Grill restaurant. Staff were not allocated task-specific tools and there was little oversight as to how the task was being carried out.

[55] If staff had been provided with formal training, instruction, and supervision this would have significantly lowered the risk of improvisation by individual staff members. A safe system of formal instruction and training combined with a Standard Operating

Procedure would have impressed upon staff that ash, even though appearing cold, could still contain hot embers which have the potential to re-ignite.

SFRS Audit and storage of combustibles in the concierge cupboard

[56] On 22 August 2017 SFRS carried out their annual audit of the Hotel. The audit highlighted the issue of combustibles being stored within the concierge cupboard. Mr James Clark, the SFRS watch manager who carried out the audit informed the resort director, Mr Roger, and head of maintenance, Mr McKerry, that it was unacceptable to have combustibles stored adjacent to a source of ignition, namely the mains electrical installation apparatus within the concierge cupboard and the danger of a fire spreading rapidly through the building due to its age and construction and the threat of voids being present.

[57] Assurances were given at the time that the combustibles would be removed. An email was sent by the resort director to relevant managers the following day containing bullet points covering the issues raised in the previous day's audit. The bullet point in relation to the concierge cupboard did not make mention of a fire risk or the storage of combustibles. It simply stated: "Concierge cupboard to be tidied and holes filled". The holes were filled within forty eight hours by contractors already on site for other works.

[58] On 21 November 2017, SFRS issued a letter to the Hotel addressed for the attention of the resort manager. The letter set out the findings of the SFRS audit in August 2017. After receiving the letter, the resort director delegated the task of dealing with the issue of the combustibles within the concierge cupboard to the general manager

for action. The general manager attended at the concierge cupboard on 23 November 2017 and noticed storage of combustible material, namely newspapers on a shelf adjacent to mains installation apparatus. The general manager took photographs of the interior of the cupboard with his mobile phone and sent an email to the concierge mailbox, the head concierge, and resort director. The email contained a photograph of the cupboard and stated: "Can you make safe and speak to team, highlighted previously by fire safety inspection and evidently still an issue". Later on the same day the general manager spoke to the assistant head concierge and requested that the newspapers be removed, and instructed that the concierges be informed that the shelf was to be kept clear of combustibles in the future.

[59] Despite the above email and verbal instructions to "make safe", the practice of using the concierge cupboard to store combustibles continued. Items including jackets, kindling, newspapers, dustpan, brush, and bucket were stored in the cupboard.

[60] The identified risk posed by combustibles was not appropriately addressed. Had steps been taken to ensure that the concierge cupboard was not being used by concierge staff to store combustibles this would have had a direct impact on reducing the risk of a fire spreading from the concierge cupboard albeit the source of ignition, i.e. the bag containing ashes, was not the type of ignition source which the fire safety auditor had in mind when making the requirement that combustibles be removed.

[61] On 18 December 2017, when Christopher O'Malley emptied the ash and embers from the Cameron Grill open fire ultimately into a plastic bag which he placed in the concierge cupboard, the cupboard still contained various combustibles including

kindling and newspapers. Subsequent investigation determined that an ember or embers within the ashes ignited and fire spread to the kindling and other combustibles causing the fire in consequence of which Simon Midgley and Richard Dyson lost their lives.

Evidence

[62] The Inquiry heard oral evidence from forty witnesses. Two Joint Minutes of Agreement were lodged. The witnesses included hotel guests, SFRS officers, hotel employees, police officers, others with professional involvement in issues relevant to the Inquiry as well as expert and skilled witnesses.

[63] Understandably the evidence of some witnesses was impaired by a lack of clarity and precision resulting from a number of factors. The passage of time is a factor in this. However for hotel guests, firefighters at the scene, and hotel employees the main factor is that this whole situation unfolded quickly and unexpectedly and the events were taking place in an atmosphere of extreme stress and drama. It is asking too much of witnesses in such a situation to provide an exact timeline as to what they and others were doing in a precise sequence. Nonetheless by piecing together the whole of the evidence it has been possible for the Inquiry to assemble a clear narrative in respect of most of the significant events and factors.

Hotel guests

[64] Hotel guests who gave oral evidence were Andrew Logan, Alan Pilkington, Hannah Munns, Paul Dear, Lorna McGregor, Pauline Booth, and Chloe Marchbank. They were each guests within rooms in the main building above the reception area and concierge cupboard. Each gave an account of their experience of being involved in the fire emergency and evacuation.

[65] On the first floor of the main building Rooms 6, 7, and 8 were on one side of a central library and Rooms 3 and 5 were on the other side. Rooms 2, 4, 10, and 11 were located on the second floor. Mr Midgley and Mr Dyson were guests in Room 8 on the first floor.

Mrs Hannah Munns

[66] Hannah Munns with her husband and their ten year old son were in Room 7 on the first floor immediately next to Room 8. Mrs Munns described seeing smoke coming under the door and through the sanitary ware in the bathroom within 30 seconds after the alarm sounded. She and her family left their room and ran down the main staircase which led down to the main reception foyer. They saw that the Christmas tree in the reception area was on fire and there was smoke on the stairway. They realised that they could not proceed in that direction due to the fire and decided to go back upstairs. She described it as quite a maze trying to find a way out. They encountered the family who were in Room 6 as they tried to find their way out. The corridors were dark and smoky.

They heard a staff member calling from outside a side door. They went in that direction and exited the building.

[67] I concluded from Mrs Munn's evidence that she and her family were indeed fortunate to escape the fire. I considered this evidence particularly significant as Mrs Munns and her family were in the room next to Mr Midgley and Mr Dyson on the same corridor. The conditions with which Mrs Munns and family were confronted are likely to have been the same if not worse when Mr Midgley and Mr Dyson left their room.

Mrs Pauline Booth

[68] Mrs Pauline Booth and her husband were in Room 5 on the first floor. They were awakened by the fire alarm which was loud and piercing. On opening the room door into the central library area they were confronted with dense and black smoke. They had to crawl to stay below the smoke. They went towards the main staircase down to reception but saw fire and realised they could not go that way. They searched around the central library area on all fours seeking an exit. They managed to find a door which they went through where there was no smoke, and met other guests from the newer bedroom extension who were entirely unaware of the situation. That led to a staircase which led to an exit from the building.

Paul Dear

[69] Mr Paul Dear and his wife were in Room 3. They were fortunate in that their room was separated from the other first-floor rooms by the doors at the central library area. There was no smoke in their bedroom or in the outside corridor. They could see smoke and flames in the foyer through the glass door panels. They were able to proceed in the other direction towards a fire exit where the main building joins the modern accommodation block.

Alan Pilkington

[70] Alan Pilkington and his wife were in Room 4 on the second floor which is approximately above the room occupied by Mr and Mrs Dear. Mr Pilkington described his wife opening the door after being awakened by the alarm and seeing and smelling smoke, albeit not thick. On leaving their room and descending a few steps they heard a member of staff shouting and leading them out of the building by a fire exit.

Lorna McGregor

[71] Lorna McGregor and her partner were in Room 2 on the second floor which is located above the room occupied by Mr and Mrs Booth. Immediately upon being awakened by the fire alarm they saw smoke in their room rising from below. They were fortunate to have direct access to an exit from their room by which they immediately exited the building.

Chloe Marchbank

[72] Chloe Marchbank and a friend were in Room 11 on the second floor. On opening their room door after being awakened by the fire alarm they saw smoke in the corridor. They went in the direction of the smoke as there was no exit in the other direction from their room. They had to turn back due to the volume of smoke. Their movements from then until being escorted out of a side door by a staff member were described by her as being "a blur".

Andrew Logan

[73] Mr Andrew Logan and Mrs Louise Logan were located in the Room 10 along with their 2 year-old son. Room 10 was on the second floor above the rooms of the Munns family and Mr Midgley and Mr Dyson. On opening their room door following the alarm, Mr Logan described being greeted with thick smoke outside the room to the extent that they were trapped within their room. Mrs Logan telephoned the emergency services and the recording of that call - which lasted approximately 11 minutes, during which time the family were trapped within their room - was heard by the Inquiry. The calmness demonstrated by Mr and Mrs Logan during that traumatic experience was remarkable. Mrs Logan is a paramedic by profession and clearly utilised her training and professionalism to remain composed.

[74] The first firefighters on the scene rescued the Logan family by ladder from outside the building. Of particular relevance in this Inquiry is the evidence from Mr Logan as to the extent of smoke and fumes within the corridor outside their

second-floor room within a short period of the alarm sounding. Again this is illustrative of the situation likely to have been faced by Mr Midgley and Mr Dyson on opening their room door on the floor below.

[75] One significant and consistent theme in the hotel guests' evidence was the speed by which smoke and fumes spread upwards through the building. For some there was already smoke within their room upon hearing the alarm, and others very soon after. The extent to which smoke was found to have spread within the corridors of the old building, thereby hindering escape from the building, was a common thread. This was later explained as being due to the existence of voids within the main building.

[76] Following evacuation the Logan family were taken directly to hospital. The other guests gathered on the lawn and were then directed to the Boat House Restaurant. All were aware of a roll call being carried out at the Boat House but their recollections of the details of that were generally disjointed and unclear. All described an anxious and fairly chaotic situation at the Boat House. None of the witnesses were critical of how matters proceeded at the Boat House and seemed to accept that it was an extremely challenging situation for all involved.

Scottish Fire and Rescue Service ("SFRS")

[77] A large number of firefighters and senior officers of SFRS attended the scene. Evidence was heard from Firefighters Grant McDonald, James Musset, Philip Douglas, and Joseph Langford. More senior officers of SFRS who attended the fire and who gave evidence are Watch Managers Russell Mackay and Graham Atwell, Crew Managers

James Armstrong and Andrew Rodger, Assistant Chief Officer Paul Stewart, Group Commander Paul Blackwood, and Area Commander David Proctor. Other senior officers of SFRS who gave evidence are Group Commander Gary Marshall, Area Commander Mark Duffy and Group Commander James Clark. Some have retired, left the service or changed rank since December 2017.

[78] Fire officers attending this emergency incident were faced with a complex, challenging, and dynamic situation. They responded with professionalism, commitment, and courage. With hindsight one can see that had officers proceeded in one direction rather than another at various points it is possible that Mr Midgley and Mr Dyson could have been located and safely removed from the building. However that is entirely speculative and would have been more luck than anything else.

[79] Specific reference is made to the evidence of the officers of SFRS where significant in consideration of the issues arising. Area Commander Mark Duffy provided a report containing an overview of the firefighting procedures adopted by SFRS. Group Commander Gary Marshall provided an Audit Strategy Report for SFRS in respect of the Cameron House fire. Group Commander James Clark carried out a SFRS Fire Safety Audit at the Hotel in August 2017. I discuss the evidence of these witnesses when considering the issues to which they relate.

Police Scotland

[80] Retired Inspector Allan Orr and Police Constable Steven Prentice were officers of Police Scotland in attendance at the fire scene. Inspector Orr was the officer in charge of

police responsibilities and was able to provide some overview of the situation presenting emergency workers.

[81] The evidence of Constable Prentice principally relates to the issue of moving the guests to the Boat House and the subsequent roll call.

Hotel employees

[82] Nine past or present employees at the Hotel gave evidence. In approximate descending order of seniority they are Andrew Roger, Resort Director, David McKerry, Property Director, Craig Paton, General Manager, James Brown, Director of Golf Courses and Estates, Sebastian Pinn, Deputy General Manager, Alan Grimes, Head Concierge, Darren Robinson, Night Manager, Anne Rundell, Night Manager, and Christopher O'Malley, Night Porter.

[83] In summary, their respective roles and involvement with the issues for this Inquiry are as follows:

> Andrew Roger is the resort director. He has held that position for 7 years. He reports to the chief executive of the management company, Village Hotels Limited.
>
> David McKerry is currently property director and in December 2017 was property manager. He was on holiday at the time of the fire. His evidence was relevant in respect of some of the surrounding issues considered in this Inquiry.
>
> Craig Paton was employed as general manager in 2017. He started employment on 1 March 2017.

James Brown is director of golf courses and estates. His responsibility is maintenance and presentation of all external areas except for the lodges.

Sebastian Pinn was deputy general manager from September 2014 to June or July 2016. His role was involved in the day-to-day running of various departments.

Alan Grimes was head concierge for 10 years and he held that position at the time of the fire.

Darren Robinson was the night manager on duty on the night of the fire.

Anne Rundell was the other night manager. She and Darren Robinson worked alternate four days on and four days off. She was not working on the night of the fire.

Christopher O'Malley was the night porter on duty who placed the hot ash in the concierge cupboard which resulted in the subsequent fire. The other night porter on duty on the night of the fire was Alan Napier who died on 19 February 2019.

Fiona Meek

[84] Fiona Meek is Risk and Safety Manager with Village Hotels Ltd. Village Hotels Ltd currently has 33 hotels. In 2017 that number was 29. Cameron House Hotel is owned by an investment company and there is a management agreement in place whereby Village Hotels Ltd provide health and safety and other services to the Hotel. That was the arrangement as at the date of the fire and that continues.

[85] Ms Meek stated that she was not responsible for fire safety at the Hotel. Her role is to provide a framework and that is then made bespoke to Cameron House by the Hotel management. She likened her role to that of a consultant. Her evidence was that she had no direct involvement in or responsibility for the Hotel fire safety plan or fire evacuation plan. A Fire Risk Assessment Report was done annually and Village Hotels Ltd appointed Veteran Fire Safety Ltd to carry out these assessments. They were initially appointed in 2012. On Ms Meek's evidence her role appears to have been little more than an intermediary passing communications back and forth.

[86] Ms Meek could not comment on the training of staff at the Hotel but her evidence was that she had been advised that training had been carried out. She had no role in overseeing that training. Her evidence was that Andrew Roger as resort director had the responsibility for all these matters. Indeed on her evidence, it is difficult to discern what service she actually provided beyond provision of template documents given that she considered that she had no responsibility for any health and safety related matters at the Hotel. In my assessment she downplayed and minimised her role in arrangements and procedures at the Hotel to the extent that her evidence was of little assistance.

[87] Despite what she presented as a limited role, on the morning of the fire she was telephoned by Andrew Roger, the resort director, within ten minutes of the alarm and she attended at the scene herself, arriving shortly after 8am.

Mark Webster-Claytonand David Woodward

[88] Mark Webster-Clayton is joint managing director of Veteran Fire Safety Ltd ("Veteran") who are accredited to carry out fire safety risk assessments. Following discussions between Fiona Meek and Mr Webster-Clayton, fire safety advice was provided to the Hotel in the form of Fire Safety Risk Assessment Reports. Each report includes an "*Action Plan*" containing observations and recommendations which should be implemented in order to reduce fire risk to, or to maintain it at, a tolerable level.

[89] An assessment was carried out by Mr Webster-Clayton at the Hotel on 13 and 14 January 2016 and a Fire Risk Assessment Report was produced by Veteran and provided to the Hotel.

[90] Mr David Woodward is a fire risk assessor with Veteran. He carried out the Fire Risk Assessment and consequent Report at Cameron House in January 2017. The evidence of both of these witnesses related to Fire Risk Assessments carried out at the Hotel by Veteran and is considered under the discussion of the issue of the fire risk assessment processes and implementation of identified risks at the Hotel.

Dr Julie McAdam, MB ChB FRCPath DipFM

[91] Dr McAdam as forensic pathologist carried out post-mortem examinations on both of the deceased on 20 December 2017. She spoke to her reports in respect of these examinations and her evidence is discussed in consideration of the cause of death.

Reports and evidence of expert/skilled witnesses

[92] There were reports and oral evidence from Gary Love, a Fire Investigator with SFRS, Richard Vallance, a Forensic Scientist with the Scottish Police Authority Forensic Services, Mike Wisekal, Senior Investigator, Jensen Hughes, and Peter Drummond, Architect. I discuss the evidence of each of these witnesses under the heading of the issues to which they relate.

Submissions

[93] The Crown and all Participants helpfully lodged written submissions which were adopted and supplemented during the hearing. Specific reference is made to submissions in consideration of the relevant issues.

[94] While Ms Jane Midgley was not a participant in the Inquiry, the Crown annexed to their own submissions an appendix with submissions prepared on her behalf and I comment thereon in a separate Chapter.

Where and when death occurred

[95] Simon Midgley died at between 06.41 and 09.13 hours on 18 December 2017 at Cameron House Hotel. His life was pronounced extinct at 09.13 hours by the Scottish Ambulance Service who had carried out Advanced Life Support Protocols following Mr Midgley's removal from the hotel building by firefighters. However it is not possible to make any finding as to the precise time at which Mr Midgley died having regard to:

(a) the evidence of Dr Julie McAdam, Forensic Pathologist, that in her opinion Mr Midgley's death had been caused by the inhalation of smoke and fire gases but she was unable to comment on the time it may have taken for Mr Midgley to have succumbed to their effects;

(b) there being no evidence as to the precise time at which Mr Midgley was first exposed to the effects of smoke and fire gases; and

(c) the evidence of firefighters that, on discovery of Mr Midgley, there were no signs of life.

[96] Richard Dyson died at between 06.41 and 09:35 on 18 December 2017 at the Hotel, or en route to/at the Royal Alexandra Hospital, Paisley. His life was pronounced extinct by a medical practitioner there at 09.35. However it is not possible to make any finding as to the precise time at which Mr Dyson died having regard to:

(a) the evidence of Dr Julie McAdam, Forensic Pathologist, that in her opinion Mr Dyson's death had been caused by the inhalation of smoke and fire gases but she was unable to comment on the time it may have taken for Mr Dyson to have succumbed to their effects;

(b) there being no evidence as to the precise time at which Mr Dyson was first exposed to the effects of smoke and fire gases; and

(c) the evidence of firefighters that, on discovery of Mr Dyson, there were no signs of life.

Therefore in respect of Mr Midgley and Mr Dyson my finding as to when the death occurred cannot be more precise than between the activation of the full fire alarm and formal pronouncement of life being extinct.

Where and when the accident resulting in the deaths occurred

[97] The narrative as to where and when the accident resulting in the deaths occurred is set out in chapter 7 of this Note.

Cause of death

[98] The immediate cause of death of both Simon Midgley and Richard Dyson was inhalation of smoke and fire gases due to hotel fire.

[99] Dr Julie McAdam, Forensic Pathologist, in her reports of the post-mortem examination of each deceased found the primary cause of death in respect of each deceased as being inhalation of smoke and fire gases due to hotel fire.

[100] The post-mortem examination of Simon Midgley revealed relatively heavy soot staining on the face and on the back and palm of each hand and the top and soles of the feet, with a smaller amount of soot staining on the trunk and an absence of soot staining on the legs, consistent with Mr Midgley being clothed during the fire.

[101] There was heavy soot staining of the tongue and throat with soot extending down the major airways into both lungs, consistent with Mr Midgley being alive during the fire. Analysis of post mortem blood revealed a high level of carboxyhemoglobin

confirming inhalation of toxic carbon monoxide produced by the fire. No other drugs or alcohol were detected.

[102] There was no evidence of burns or any injury that would have contributed to death, but there were numerous superficial and deeper short incised wounds (cuts) on both hands, presumably sustained as the result of attempts to escape the fire.

[103] The post-mortem examination of Richard Dyson revealed relatively heavy soot staining on the body, particularly around the nose and mouth and on the top and sole of the left foot, with less pronounced soot staining of the back, a transverse band of soot staining across the lower part of the abdomen and relative sparing of the legs, the latter consistent with Mr Dyson being partly clothed during the fire.

[104] There was heavy soot staining of the tongue and throat with soot extending down the major airways into both lungs, consistent with Mr Dyson being alive during the fire. Analysis of post-mortem blood revealed a high level of carboxyhemoglobin, confirming inhalation of toxic carbon monoxide produced by the fire. A level of promethazine (antihistamine, antiemetic and sedative) within the therapeutic range was also detected in blood, but no other drugs or alcohol.

[105] There was no evidence of burns or of injury that would have contributed to death, but there were numerous superficial and deeper short incised wounds (cuts) on both hands and forearms, presumably sustained as the result of attempts to escape the fire.

[106] Dr McAdam explained that carboxyhemoglobin is formed by the inhalation of carbon monoxide which is produced by smoke and fire. In respect of Simon Midgley

the level was 58%. In respect of Richard Dyson the level was 61%. Levels in excess of 50% are life-threatening and the level found in each was incompatible with life.

[107] She confirmed that the cuts found on the hands and forearms of each deceased were consistent with having been caused by broken glass from a smashed window.

[108] Dr McAdam was asked about the time that it would take for a person to be overcome by the fumes from smoke and fire. She explained that it depends on a variety of factors and it is not possible for her to say how long a person could be alive in that situation before being overcome by the fumes.

[109] A major gap in the evidence of what happened is the whereabouts or movements of Richard Dyson and Simon Midgley between the full alarm sounding at around 06.41 hours and their location within the Hotel recorded at 08.36 and 08.57 respectively. Despite the large number of eyewitnesses who gave evidence to the Inquiry there is an absence of evidence on that.

[110] Their room was located on the first floor of the Hotel above the reception area. On the second floor landing where each was located there was a double glazed window, the inner pane of which had been smashed. Simon Midgley was subsequently found to have cuts to his hands. Richard Dyson's body was found to have cuts on both hands and forearms.

[111] On 18 December 2017 an iPhone belonging to Richard Dyson was recovered outside Room 8, being the room which had been occupied by Simon Midgley and Richard Dyson.

[112] On 20 December 2017 a search was carried out of the stairwell area, where Simon Midgley and Richard Dyson had been found. A single tan coloured boot and a pair of white canvas shoes, together with a blue/orange hat were recovered from that area. Both men, when recovered, had bare feet.

[113] Room 8 was searched by police officers on 27 December 2017. Various personal items were recovered from within the room including Simon Midgley's wallet and iPhone, which were located on a bedside table.

[114] From these pieces of evidence and the evidence of other hotel guests as to the rapid spread of smoke to the floors above the concierge cupboard I conclude that at some point after the alarm sounded both men left Room 8 on the first floor and could not locate an exit route due to fire, smoke, and gases. Their attempts to exit the building ended on the second floor landing where they unsuccessfully attempted to break the window with a view to accessing clear air or attempting to exit.

Cause of the accident resulting in the deaths

[115] Extensive investigations have been carried out as to the cause of the fatal fire. To assist in consideration of this issue I had the benefit of reports instructed by SFRS and the Scottish Police Authority Forensic Services.

Gary Love, Watch Manager, Scottish Fire and Rescue Service (Retired)

[116] Gary Love was a fire investigator with the rank of watch commander employed by SFRS. He carried out an investigation into the fatal fire on behalf of SFRS. The report

of his investigation is dated 20 July 2018. The findings of his investigation were not challenged by any participant and are accepted by me. Mr Love concluded that the fire originated within the concierge cupboard on the upper ground floor. It spread within the cupboard to fully involve the contents. Once the cupboard door was opened this enabled the well-developed fire to spread outward into the entrance foyer, reception area and beyond. The fire continued to spread within the various wall and ceiling voids situated throughout the Grade B listed building. Further fire development beyond the Grade B listed building was halted as a result of the firefighting actions taken by the attending fire crews.

[117] He noted the following information as relevant in determining careless disposal of ashes from the fireplace as a potential cause of the fire:

- There was evidence of previous fire activity having occurred within the large metal bin, used to hold ash, along with paper and a clear plastic bag.
- The CCTV footage has shown a Hotel member of staff, decant a large quantity of ash and embers into a large black plastic bag and then place the bag directly inside the concierge cupboard.
- After a duration of around two and a half hours, smoke is then seen issuing from the cupboard.
- A brief time later, once the cupboard door is opened, a well-developed fire is discovered within.

[118] Therefore taking all of the information contained within his report, he concluded the cause of this fire was accidental, most probably as a consequence of a careless act.

[119] He found that was most likely a result of the hot, smouldering embers within the ashes having melted/ignited the black plastic bag. The burning material has then ignited the timber kindling and other ignitable items within the cupboard.

Richard Vallance, Forensic Scientist, Scottish Police Authority

[120] Mr Richard Vallance is a Forensic Scientist with Scottish Police Authority Forensic Services. He specialises in investigation of the origin and cause of fires. He carried out a fire examination in respect of the Cameron House fire for the Scottish Police Authority along with his colleague, Dorothy Souter, and they have provided a joint report.

[121] From their review of the Hotel CCTV footage and information from SFRS personnel it was their opinion that the fire had originated within the concierge cupboard. Based on their review of CCTV, excavation of the concierge cupboard, including the examination of the electrical components contained within it, and the excavation of the contents of two metal ash bins including the identification of melted plastic remains, their opinion was that the most probable cause of the fire is a result of the careless disposal of hot ash being placed within a plastic bag and left in the vicinity of combustible material within the concierge cupboard. In their opinion, the plastic bag has ignited as a result of hot embers being present within the ash which in turn has led to the ignition of the combustible material surrounding it. The resultant fire has continued to develop within the cupboard. Following the door being opened, the fire

has spread to the foyer/reception igniting the Christmas tree located across from the cupboard. This has facilitated the rapid development of heat and smoke in this area.

[122] In their opinion, the timeframe from the ash being recovered from the open fire(s) within the Hotel to being placed inside a plastic bag was not sufficient to allow the embers to cool to such an extent that they were no longer a viable ignition source.

[123] The short timeframe, coupled with the fact that the ash has not been disposed of within a suitable container such as a metal bin has directly contributed to this being a viable ignition source.

[124] The examination of the ash contained within the metal bins from the rear of the Hotel and the burned/melted remains of plastic within one of the bins, supported the proposition that hot embers within ash can cause ignition / burning / melting of plastic.

[125] Mr Vallance stated his opinion that ashes should be left for between twenty four and forty eight hours to cool. Anything less provides a potential for igniting and causing fire. A metal bin with a lid would lower the risk as the metal is non-combustible.

[126] He said that the majority of published material states 48 hours should be allowed for ashes to cool sufficiently for disposal. In cross examination on behalf of Christopher O'Malley, Mr Vallance said that he took this from widely available open source material such as fire service or local authority advice.

[127] The conclusion of both Mr Love and Mr Vallance in their respective reports was that the most probable cause of the fire was the disposal of hot ash by being placed

within a plastic bag and left in the vicinity of combustible material within the cupboard. That being the cause of the fire was not disputed by any participant.

[128] I have determined that the cause of the accident resulting in the deaths of Simon Midgley and Richard Dyson was a fire which began in the concierge cupboard of the Hotel as a result of hot embers within ash igniting combustibles within said cupboard. The fire spread from the cupboard through voids and cavities and escaped into the reception area, once the door to the cupboard had been opened, causing fire, smoke, and fire gases to spread extensively throughout the old part of the Hotel.

Disposal of ash from open fires

[129] In his report for Scottish Fire and Rescue Service, Mr Gary Love in considering the issue of careless disposal of ashes from the fireplace referred to the following extract from what he described as authoritative writings on fires:

> "Ashes have a low thermal conductivity, consequently it is not rare for an individual to believe that ashes are 'dead' while in reality hot or smouldering embers are still contained therein. No study has established the maximum limits, but one case history has been published where an individual collected and placed ashes in a plastic bucket upon a wood floor. Seven hours afterwards, flaming erupted. Another investigator reported examining with an infrared camera a container of ashes four days after the ashes were deposited in the container and still finding high temperatures.
>
> Embers from fireplaces, campfires, and barbeques have been identified as the cause of numerous 'delayed ignition' fires remote from the fireplace campfire or grill. Due to low heat rate release and slow combustion and the insulation properties of ashes, they are undetected when they are removed. Usually the ashes have been cleaned out then placed in a combustible box, bag, or bin assuming they are 'out'. Wood or charcoal embers, insulated by ashes, can continue to smoulder for 3 to 4 days under the right conditions and can result in ignition after being removed."

[130] This highlights the risk presented by apparently dead ashes with hot embers concealed within and consequently the need for a clear system of work for clearing and disposal of ash from open fires.

[131] At the Hotel the removal of ash from the open fires within the entrance foyer and the Cameron Grill restaurant was the responsibility of the night porters. However there was no safe system of work in respect of removal and disposal of ashes. Employees were not given instruction, training, and supervision in the safe removal and disposal of the ash and embers.

[132] There was no written statement of procedure, or SOP, prepared by Cameron House Resort (Loch Lomond) Ltd in respect of the disposal of ash from fires in the main Hotel.

[133] Staff used a variety of receptacles to carry ash from the fires to the bins outside, which included stainless steel sugar chiffon trays from the kitchen, ice buckets, metal buckets, and plastic bags. Although not his responsibility, the Hotel security officer, Mr Bulut Ash, having noticed another night porter on 16 December 2017 clearing the reception fireplace and using an ice bucket to hold the ash - had later that day purchased a metal bucket from B&Q for the night porters and left it in the back office at reception.

[134] The absence of training or a Standard Operating Procedure for clearing ash from the open fires was clear from the evidence of a number of Hotel employees including the night manager, Mr Darren Robinson. He confirmed that it was the duty of the night porters to clean and empty the two open fires. Once the open fires had cooled down

they were cleaned out. The day staff keep the fires going during the day and once they had been allowed to cool down for a few hours they were cleared out by the night porter. There was no set time for allowing the open fires to die down. Mr Robinson agreed that there was no training on a safe system of work for cleaning fires or specialist equipment provided. There was nothing available to monitor or test the temperature of ash.

[135] The night porters carried on this function on the basis of a new night porter being shown how it was done by another more experienced night porter. This was given the somewhat elevated description of "peer to peer" training, but in reality it was not recognised as a task for which training was required, despite the Veteran fire safety audit which is considered in a separate chapter. The need for a Standard Operating Procedure for the ash from open fires was lost sight of, resulting in unskilled workers at night doing manual tasks without a standard operating procedure or training. They were left to their own devices and as a result they improvised and did not appreciate the potential risk posed by hot embers within ash.

[136] Mike Wisekal is a senior fire investigator with Jensen Hughes. He has qualifications and experience such as to make him an expert within the field of fire investigation. He was instructed by West Dunbartonshire Council to prepare a report setting out his opinion on matters of good practice in relation to the safe disposal of ash from solid fuel fires. His report is dated 25 June 2019.

[137] Mr Wisekal noted that staff appeared to have a varying understanding of the procedure for disposal of ash which may indicate a lack of appropriate instruction and

supervision. It is the conclusion of Mr Wisekal that had a formal Standard Operating Procedure for the disposal of hot ash been in place, it is likely that there could have been less variance in staff practice and a clear understanding of the safe instruction and practice when disposing of ash. A suitable and sufficient risk assessment would identify the control measures necessary to mitigate the fire risk and dispose of the fireplace ash safely. Appropriate control measures would involve a formally written Standard Operating Procedure for the safe disposal of ash from solid fuel fires. Having identified the hazard and risk, training of staff in a set of procedures to be followed by all is a control measure against the identified hazard.

[138] Mr Wisekal noted that in the absence of a formally written procedure to instruct staff about the safe method for disposal of hot ash from the solid fuel fires it appeared that staff and management accepted the procedure and equipment used as being a simple matter of common knowledge.

[139] Mr Wisekal listed safety precautions to take when disposing of hot ash as follows:

- allow the ashes and any solid fuel remnants to cool completely in the fireplace before disposal;
- treat all ash as hot;
- do not add obvious embers to the ash bucket;
- do not let ash collect in the metal ash bucket for longer than the task requires;
- do not mix or add any combustibles with the disposed ash;

- outside metal containers should be away from other combustible materials;
- never store or dispose hot ashes in a combustible plastic bag or container.

[140] Mr Wisekal stated in his report that the correct and safe fireside tools for disposing of ash are as follows: metal ash can with a lid, metal ash shovel, brush, gauntlets (fire resistant safety gloves) to prevent accidental burns, and a dust mask (optional) which reduces risk of inhaling ash.

[141] His report and opinion were not challenged in any significant way. I accepted his evidence. I have therefore found that it would have been a reasonable precaution for there to have been a clear system of work for the safe cleaning and removal of ash from the open fires at the Hotel together with appropriate training and equipment. I have also identified the lack of a written Standard Operating Procedure re-enforced by training and the absence of appropriate equipment for safe disposal of ash as defects in the system of working at the Hotel which contributed to the accidents resulting in the deaths.

Emptying of ash bins at the Hotel

[142] There were two metal bins at the rear of the Hotel building which would have provided a means of safe disposal of ash. Whatever limited arrangements for emptying of the metal bins there were, they had ceased to function by October 2017. By the time of the fire the bins were full.

[143] Gary Love of SFRS in his fatal fire investigation found that there were two large metal bins full of ash and a wheelie bin containing ash located at the rear of the Hotel. The bins were impounded and examined in detail. Within the ash contents of one of the metal bins, were the fire damaged remains of a clear plastic bag, cigarettes, and fire damaged newspapers (which had been twisted as if being used as kindling).

[144] Mr Robinson, night manager, confirmed that it was Christopher O'Malley who had told him about the exterior ash bins being full which was within 36 hours before the fire occurred. CCTV of the night before the fire showed Christopher O'Malley put the fire ash in a bucket and take it to put in the ash bins. He then brought the bucket back because the ash bins were full and other bins outside were not suitable for ash. He placed it at the end of the reception desk where it remained for 3 hours. He then moved it out of sight into the cupboard before finishing his shift. Mr Robinson stated that when he was told that the ash bins outside were full he communicated that by email to David McKerry, the property manager, and Bulut Ash, the security manager.

[145] On the evidence I have determined that the full ash bins and the lack of a coherent system regularly to empty same, and the absence of instructions to staff relating to what to do with ash when bins are full was a defect in the system of working at the Hotel which contributed to the accident resulting in the deaths.

Evacuation of the Hotel, assembly, and roll call

Overview

[146] Mr Mark Duffy is an Area Commander responsible for operation strategy and development in SFRS. Mr Duffy explained that the incident commander would normally be met on arrival by the duty holder of the premises. This duty holder could be an owner or manager but they should have some responsibility for the premises. A duty holder should be fully aware of the premises fire risk assessment, fire evacuation plan, how to raise the fire alarm if required, and be able to provide the SFRS with an accurate roll call.

[147] The duty holder should be aware if persons are unaccounted for. They would find out if persons were unaccounted by taking a roll call at the assembly point and the duty holder should then report that back to SFRS. The responsibility to ensure that a roll call is undertaken is placed on the duty holder. The duty holder has responsibility for evacuation and roll call. Rescue is the responsibility of SFRS.

[148] The importance of the availability of an accurate roll call was emphasised by Area Commander Duffy. That enables the fire service to direct breathing apparatus crews to the appropriate area for search and rescue. An accurate roll call is hugely important to the tactical plan for entering the building for the purpose of search and rescue.

[149] At the commencement of his Report Area Commander Duffy explained:

> "Firefighting and other emergencies attended by fire and rescue services are by their very nature hazardous operations and in some situations, can be very challenging and difficult to resolve".

In cross-examination he confirmed that the Cameron House fire was a hazardous and challenging incident. He agreed that the rapidly developing nature of the situation would provide immense challenges not only to the fire service but also to the duty holder and that the time taken to produce an accurate roll call could be impacted by various challenging factors.

Hotel Evacuation Plan

[150] There was a written Fire Evacuation Procedure for the Hotel. Chapter 8 of the Fire Evacuation Procedure detailed the specific procedure to be followed when the Night Duty Manager was the Fire Controller i.e. for a late-night/early morning evacuation. The written procedure to be followed was set out by sequentially numbered paragraphs.

[151] A fire box and a comfort box were kept at the reception area. The contents of the fire box were listed as *inter alia* a clipboard with a plastic cover to protect it from the rain, a pen, highlighter pen, two high visibility jackets, one torch, an umbrella, a loud hailer, and a "dect" (digitally enhanced cordless telecommunications) phone. The contents of the comfort box were listed as a first-aid kit, supply of hotel slippers, supply of foil blankets – sufficient for one per guest, a number of material blankets for small children, umbrellas, two chocolate bars – for diabetics – rain ponchos, and anything else felt appropriate in the event of an emergency.

[152] The Fire Evacuation Procedure provided that the Night Duty Manager would assume the role of Fire Controller and take control of the Fireboard Checklist. The written procedure was that the Fire Controller would hand out sweep cards/packs to the attending fire team members as appropriate. Sweep cards set out designated tasks to individual members of the fire team which would be comprised of such staff as were on duty.

[153] Paragraph 9 of the night-time procedure provided as follows:

> "**Sweep card 2**. Night Porter to begin the roll call at assembly point. They must bring with them the Comfort Box, loud hailer, radio, guest list, pen and clipboard, torch and umbrella if raining. Ask a hotel guest to assist if required."

[154] Paragraph 15 provided:

> **"Note:** If the fire is at reception – the fire team are to evacuate taking whatever resources that are safe to bring and locate themselves at a safe distance at the front of the hotel. The DM's (Duty Manager) dect phone has access to an outside line which can be used to call the Fire Brigade. – Direct the allocation of duties as above from an external point ensuring that guests are directed (where safe to do so) to exits away from the main entrance."

[155] None of the equipment listed at paragraph 9 was available at the muster/assembly area. Darren Robinson, the hotel night manager, had activated the full fire alarm at 06.41 hours. After attempting to use a fire extinguisher he picked up the fire bag and in-house guest list. Owing to the fire spreading from the concierge cupboard into the reception area of the Hotel, the reception area became dark and smoky very quickly. Mr Robinson put the fire bag and guest list down to phone the emergency services and then went to a fire exit to try to get people out of the Hotel. In error he forgot to pick up the fire bag and in-house guest list before exiting the Hotel

building. It was impossible to carry out a roll call of guests without any of the equipment listed at paragraph 9 including, most significantly, the guest list.

[156] So while Mr Robinson had the guest list at the reception desk, when the reception area became dark and smoky quickly he left the building in a panic and forgot to take it with him. The only thing he had was a mobile phone. It was not until he was outside and was going to do a roll call that he realised he did not have the guest list. Once out of the Hotel building he could not get back in to retrieve the guest list.

Evacuation, recovery of guest list and removal to Boat House

[157] As set out earlier many of the guests in the main building faced a very challenging environment in attempting to exit. After activating the alarm Mr Robinson assisted in the evacuation by shouting to guests from the stairs between the old building and the modern accommodation block directing them to the fire escape there. Christopher O'Malley, the night porter, went to the accommodation wing banging on doors, opening them, and directing guests to the fire exit. As guests started to evacuate Mr O'Malley led guests down to the fire exit located between the new accommodation block and the main Hotel building. After leading guests outside he directed them to the assembly point area. The fire service arrived shortly after he had left the Hotel building.

[158] The assembly/muster area for guests was on the lawn area outside the Hotel building. The Hotel guests gave evidence about gathering on the lawn before being directed to the Boat House Restaurant. Many of the guests were barefoot and/or wearing bedclothes. It was cold and dark that December morning. The items in the

comfort box were not available for distribution. A roll call could not proceed there at that time due to the absence of a guest list.

[159] As the guests evacuated the Hotel and gathered on the lawn the Logan family were trapped within Room 10. The first fire service appliance arrived at 06.51 hours and directed their attention to their rescue.

[160] A number of witnesses gave evidence relevant to the issue of the period from evacuation of the Hotel to completion of the roll call.

Police Constable Steven Prentice

[161] PC Steven Prentice is a police officer with 19 years' service. He arrived just after 7am. On arrival there were already other police officers and several fire appliances there. There were Hotel guests standing all over the grounds in night clothes and pyjamas. In his evidence Police Constable Prentice took ownership of the decision to have the Hotel guests moved from the lawn in front of the Hotel to the Boat House. He explained that because it was still dark and very cold he decided that there was a need to get all the guests to a central location and out of the cold. It was his idea to look for an area to put the guests. He spoke to whom he believes was a night manager (Mr Robinson) to ask about accommodation which could be used. Mr Robinson suggested the Boat House. With the assistance of a firefighter entry was forced to the Boat House. His colleague, Constable Aikman, and others assisted in having everyone move to the Boat House.

[162] Constable Prentice explained that the plan at the Boat House was to make sure everyone was accounted for, which would be easier with everyone in the one location. He said that in the Boat House efforts were made to get the guests into groups together at tables and then to gather room numbers and names to work out if any persons were missing. This was done by PC Prentice, his colleague Constable Aikman, and two or three Hotel staff.

[163] Constable Prentice could not remember if anyone from the fire service was there. Regarding recording the names he believed he was noting them on a piece of paper to pass on. Once the day shift staff came in from the Hotel, a female member of staff who seemed to be some kind of manager was involved.

[164] While trying to do this other guests were asking questions and interrupting. People were looking to get back to the Hotel building for items such as medicine and phones and there were other needs, such as babies needing nappies or food. Constable Prentice passed these requests to members of Hotel staff. Constable Prentice agreed that it was a challenge getting everyone to the Boat House and to get them to stay in groups in the Boat House. Guests were in a state of distress or anxious. There were many disturbances and interruptions. It was put to him that the situation was fairly chaotic and challenging and he agreed.

[165] Initially there was no list of Hotel guests or manifest. There was a computer at the Boat House but it was not possible to access a guest list from that. It had to be brought by another member of the Hotel staff. He did not know the timescale until the

guest list was obtained. Once it was obtained he went round the tables ticking off names.

[166] While this was being done other members of Hotel staff started to prepare and put out food and hot drinks. This did make things more difficult as people were getting up and down for food. Other requests for nappies, baby food, clothing, and medication were dealt with by members of staff who went to the supermarket to buy items. Another difficulty was other people (non-guests) were attending with things like car keys and house keys for family and friends, although they were not allowed access into the Boat House.

[167] At some point Constable Prentice realised that not all guests were accounted for. As soon as he knew that he broadcast it on his radio. Constable Prentice was unable to help with timescales for these events. He agreed that the timings recorded in the police incident log indicating a period of about 47 minutes between the guests being at the Boat House and confirmation that two men were missing could be relied upon as to the time period.

Mr Graham Atwell, SFRS Watch Commander

[168] Mr Graham Atwell was SFRS Watch Commander stationed at the Balloch. His crew was first in attendance at the fire. Mr Atwell stated that having spoken to the night manager on arrival he formed the distinct impression that everyone was out of the building other than the Logan family. The first task of his crew was the rescue of the Logan family from the upper room in which they were trapped.

[169] Once that was successfully achieved Mr Atwell's evidence was that he then went to locate the duty manager and asked about a roll call. He was told that a formal roll call had not been done. Mr Atwell wanted a roll call in order to check if anyone remained in the building. The night manager told him that he did not have a guest list but was able to tell him that the guest list was located in the door of a cupboard to the rear of the reception. By that time fire crews had already been in the foyer/reception area and Mr Atwell could not see any fire continuing in that area. Therefore Mr Atwell entered the Hotel and retrieved a folder with the guest list in a "V" shaped drawer on the door at the reception. It was not on the floor. Mr Atwell said that he left the building and gave the guest list to the duty manager, although it was in fact Mr Roger to whom he gave the guest list.

[170] By this time the guests had been moved to the Boat House. Therefore Mr Atwell instructed Firefighter McLean to go with the duty manager to the Boat House, take a formal roll call, and then immediately return to him with the roll call results.

[171] Just after this SFRS Area Commander David Proctor arrived at the scene and Mr Atwell briefed him as to the situation and resources. Mr Proctor assumed the role of incident commander as the senior officer in attendance.

Andrew Roger, Resort Director

[172] Mr Roger gave evidence that he received a call from the night manager, Darren Robinson, at about 06.40 hours telling him about the fire at the Hotel. Mr Roger immediately travelled to the Hotel arriving at about 07.15 hours. He described on

arrival seeing guests beginning to move away from the muster point. A few minutes later he discovered that they had been instructed to go to the Boat House Restaurant.

[173] Mr Roger spoke with night manager, Darren Robinson, and then with the senior fire officer. The fire service and police were already well established at the scene. Mr Roger told the fire officer (Mr Atwell) that the guest list for a roll call had not been removed from the Hotel. He said that a fire officer (Mr Atwell) then went into the hotel reception area, brought out the guest list, and gave it to him.

[174] At that point Mr Roger did not know whether all guests had evacuated. Mr Roger had assumed that the decision to move guests to the Boat House was made by emergency services. It was a decision that had been taken before he arrived. The guest list was handed to him by the fire officer within minutes of his arrival. Mr Roger then went directly to the Boat House as that is where the guests were and it was necessary to have a roll call completed.

[175] Mr Roger stated that on his arrival at the Boat House it was clear that a manual roll call had been started by other members of staff. There were quite a few members of staff there to support at that time. Mr Roger co-ordinated the checking of the manual lists which had been taken against the printed hotel guest list. Once that manual check was completed they had a list of those not on the manual roll call and a number of people including staff and others went round trying to locate those not yet identified.

[176] While this was going on there was quite a bit of coming and going, for example guests going to the toilet. There were members of staff trying to look after guests, but they were not the ones involved in the roll call.

[177] At some point Mr Roger was given a message by the emergency services to focus on the old building. It was then identified that there was one room for which the occupants were not accounted for and that was Room 8. Once he was aware of that, that information was communicated via radio to the emergency services.

Area Commander David Proctor

[178] Mr Proctor's evidence was that he arrived at about 07.05 and that is consistent with his evidence that the rescue of the Logan family was ongoing when he arrived. He obtained a briefing from Mr Atwell within about 5 minutes of arrival and then took charge of the incident. His evidence was that he asked Mr Atwell to obtain an accurate roll call.

Group Commander Paul Blackwood

[179] Group Commander Paul Blackwood was an SFRS Station Commander at Castlemilk and Polmadie and was on call as first call officer as at the date of the fire. He attended the incident arriving at around 7.20am. There were already several fire crews in attendance. Mr Proctor was the senior officer in charge and Mr Blackwood took on the role as operations commander in which capacity his task was to determine tactics in fighting the fire.

[180] He appointed a firefighter to act as roll call liaison officer, but he did not know the name of that firefighter. The roll call liaison officer was to work with the Hotel management team to establish whether all persons were accounted for. His evidence

was that at this point there were still persons making their way to the Boat House and it was necessary to wait until all guests were there before progressing the roll call. He had not been involved in the decision to remove the guests to the Boat House and that was happening before he arrived. He spoke to the Hotel duty manager and told him that he needed to know as soon as possible if all persons were accounted for as he was committing breathing apparatus crews for search and rescue purposes. The duty manager told them that the roll call was still ongoing and they were still taking names.

[181] Group Commander Paul Blackwood's evidence was that around 15 to 20 minutes after his arrival, he went to the Boat House himself to find out what the situation was with the roll call. He could see some people in the grounds still making their way to the Boat House. He described the situation inside the Boat House as fairly disorganised with guests in night clothes and a little frightened. The manager had a list in his hand and was collating the names. He did not know whether it was Mr Robinson, the night manager, or Mr Roger, the resort director.

Retained Firefighter Grant McDonald

[182] Mr Grant McDonald attended the fire scene in his capacity as a retained firefighter. He was assigned as roll call liaison officer. In that capacity he was directed, together with firefighter Ian Middleton, to attend the Boat House restaurant where the guests and staff members had gathered.

[183] Mr McDonald stated that a roll call procedure had started by the time he reached the Boat House which he estimated as at about 7.20am. He described who he

understood to be the hotel night manager as being in charge. Someone was shouting out the room numbers and asking people to put up their hands if they had been staying in the rooms so that they could ascertain if anyone was missing. There was a guest list but he could not remember who had it or who was shouting out the room numbers or names.

[184] He said that it took about ten minutes to do the roll call. However in his police witness statement dated 19 April 2018, he had estimated that it took about one hour to do the roll call. In his evidence he accepted that to be more accurate. He described guests using the toilet facilities, children in distress, and other guests standing outside the building trying to contact relatives and friends on their mobiles to let them know they were safe. Guests were talking and "trying to get to grips with" what had happened. He agreed in cross examination that all these factors and others made the whole situation fairly chaotic and difficult to manage. He agreed that given the external conditions it had been a sensible practical approach to move the hotel guests to the Boat House.

[185] Upon completion of the roll call it became apparent that two people were unaccounted for. Room 8 was the only room from which there had been no response. Mr McDonald left the Boat House to return to the hotel along with the resort director, Mr Roger, who was at the Boat House by this point. Mr McDonald sent a radio message to fire service control that two persons were unaccounted for. While returning to the Hotel with Mr Roger, Mr Roger was trying to contact the missing guests by mobile phone with no success.

Police Inspector Allan Orr

[186] Inspector Allan Orr was on duty as police inspector stationed at Dumbarton on the night of the fire. He received the report of the fire at about 6.50am and travelled to the incident arriving at about 7.10am. On arrival he saw about two hundred people outside, some on the road and some on the grass. They appeared to be walking to the Boat House. Mr Orr was the most senior police officer in attendance. He made contact with the senior officer from the fire service. Police strategic priorities were preservation of life and protection of the inner cordon. A priority was to identify where everyone was and to see who was not accounted for. He had discussions with the senior fire officer and a Hotel representative was also there. He was not sure who it was but believes it to be the Hotel night manager.

[187] He recalled that the night manager identified that the guest log was still at reception. There was a discussion about the need to get it and it was decided that a firefighter would enter to retrieve it. It was retrieved not too long after.

[188] Once retrieved it was necessary to make sure everyone was accounted for. Mr Orr understood that the computer system in the Boat House could access the hotel computer system and that would have a note of mobile phone numbers of guests. The purpose of telephone calls would be to confirm the whereabouts of people not identified in the roll call. His evidence was that he tasked a police officer to go with a firefighter and a member of the Hotel staff to the Boat House.

Darren Robinson, night manager

[189] Mr Robinson's evidence was that he contacted the resort director, Mr Andrew Roger, by mobile telephone and he recalled Mr Roger arriving shortly after the first fire service appliance. Mr Robinson said that Mr Roger decided to move everyone to the Boat House Restaurant and use the computer there to do a roll call due to the weather conditions and most guests being in night clothes. He could not remember who had made the original suggestion of going to the Boat House and he could not say if the fire service or police were involved in that decision.

[190] Mr Robinson was involved in assisting in the movement of guests to the Boat House, some of whom were transported by mini bus. He did not know how long it took to get everyone to the Boat House. He did not know how the guest list was obtained.

[191] Mr Robinson described assisting with settling guests at the Boat House along with a hotel receptionist. They were taking names and room numbers so they could match them up with a guest list. He did not remember who was in charge of the roll call, but confirmed that Mr Roger, the resort director, was present. He could not remember if police and fire service personnel were there.

[192] Mr Robinson stated that access could not be obtained to the computer system at the Boat House as the main servers were in the Hotel building. Once a guest list was obtained it was found that the occupants of Room 8 had not been confirmed as accounted for. Mr Robinson and Mr Roger informed fire services of that.

[193] From the evidence of Mr Roger and Police Constable Prentice I have concluded that Mr Robinson is mistaken in his recollection as to who made the decision to move guests to the Boat House and that it was a police decision.

Joint Minute

[194] It was agreed by Joint Minute that the distance from the front door of the Hotel building to the entrance archway of the Boat House was 471 metres, and the time taken to walk, at the mid-level standard pace, was 5 minutes and 17 seconds.

Hotel guests

[195] The guests who gave evidence were aware of a roll call having been carried out at the Boat House Restaurant but their recollections of the details were generally disjointed and unclear. All described an anxious and fairly chaotic situation at the Boat House. None was critical of how matters proceeded at the Boat House and seemed to accept that it was an extremely challenging situation for all involved.

SFRS Message Log and Police STORM Log

[196] The eye witness evidence is supplemented by timings recorded on the SFRS message incident log and the police STORM log. It was explained that the actual time of the events to which the entries relate is probably a few minutes earlier to account for the time necessarily required to relay and record the information. In respect of SFRS Logs Group Commander Blackwood explained that it can take some time to collate and pass

back a message. On being pressed as to the time period between him being informed about persons unaccounted for in Room 8 and the entry being recorded in the log, he accepted an estimate of 5 to 10 minutes. Nonetheless the log entries are of assistance in determining the course of events.

[197] The Police STORM Log records the following entries:

07.16.01: "Officers are breaking in to boat shed to get guests out of the cold."

07.22.43: "Now have guests within boat house. Will do head count."

08.09.33 states in part: "All persons accounted for except for two occupants of Room 8."

08.13.43: "Fire are now effecting entry via a window to Room 8 to establish if anyone within"

08.33.06: "The two persons outstanding from Room 8 are not within the room."

08.36.48: "Fire have located a casualty within the building. Unable to confirm condition at this time."

08.49.54: "Fire service confirmed Room 8 was searched and no persons were within. Casualty was traced on 3rd floor. Will update on his status shortly."

08.56.23: "fire service have located a second casualty from third floor."

The SFRS Message Log contains the following entries:

07.09.06 states in part: "Informative from WM Atwell – 3 rescues have been carried out from 2nd floor using 13.5 ladder -6BA (breathing apparatus in use at stage 1)."

07.10.18: "From WM Atwell - still trying to ascertain if a roll call has been carried out."

07.18.14: "AM (area manager) Proctor now OIC (officer in charge) at this incident."

07.27.45: "SM Blackwood is now operations control at this incident."

07.56.13: "DACO (Deputy Assistant Chief Officer) Stewart now in attendance at this incident."

08.14.12: "From AM Proctor make level 4 HVP required – confirmed"

08.16.20: "From AM Proctor – DACO Stewart now officer in charge. Persons unaccounted for from Room 8, BA (breathing apparatus) team involved in search- HRJ (hose reel jet) in use – roll call liaison officer appointed – roll call still ongoing – FF's (firefighters) remain in offensive mode."

08.36.03 states in part: "Persons reported 1 casualty in 3rd floor rescue now in progress – firefighters in offensive mode."

08.41.22: states in part: "1 casualty located in premises removed by fire service personnel"

08.57.04: "1 casualty has been found in sector 4 and removed by BA teams."

Submissions regarding evacuation, assembly and roll call

[198] The submission for the Crown invited a finding that it would have been a reasonable precaution to have an efficient procedure for establishing whether all persons were accounted for. Such a finding is supported by the Scottish Fire and Rescue Service and opposed by Cameron House Hotel, Andrew Roger, and Fiona Meek. I have determined that such a finding cannot be made.

[199] The Crown point to the evidence of Mr Roger that fire drills, which occurred during the day did not exceed 30 minutes while the evidence of Constable Prentice is that the roll call took approximately 45 minutes to establish that two persons were

unaccounted for. It was submitted for the Crown that the overall period from the alarm activating at around 06.40 hours until it was established that Simon Midgley and Richard Dyson from Room 8 were unaccounted for shortly after 08.00 is a period in excess of one hour twenty minutes which far exceeds that anticipated by reference to previous drills.

[200] The Crown submitted that the evacuation procedure ought to foresee that the essential equipment for completion of the roll call may be inaccessible to the fire marshal and there ought to have been a contingency plan for obtaining the essential equipment. For example it was suggested that it would have been simple for the Hotel to have stored a duplicate set of the essential equipment including the in-house guest list at the Boat House or other location which the fire marshal could have obtained immediately upon arrival there and commenced a roll call.

[201] It was also submitted that there were insufficient staff available and allocated to the roll call task. The evacuation plan envisaged one night porter being responsible for a roll call in excess of 200 guests. It was submitted that it ought to have been obvious at the planning stage that to efficiently complete a roll call for that number of guests more than one member of staff would be required and it would not be realistic to expect a guest to assist as was envisaged by the evacuation plan.

[202] The Crown submitted that the decision to move the guests to the Boat House was not consistent with the envisaged evacuation procedure and the approach thereafter did not sufficiently prioritise accounting for all persons over providing comfort to the evacuated guests. It was submitted that the roll call process could have been more

efficiently carried out by taking names and room numbers of guests as they arrived at the Boat House. It was further submitted that the provision of comfort for evacuated guests at the Boat House slowed down the process of completing the roll call and delayed the opportunity for SFRS to carry out a targeted search for the missing guests.

[203] The Crown invited the Court to consider that there is a real and lively possibility that if the roll call procedure had been completed more efficiently it would have precipitated an earlier targeted search of the area around Room 8 which might have avoided the deaths. In the event of not being so satisfied, it was submitted that the Court may consider it appropriate to record any observations or views in respect of the roll call under section 26(2)(g).

[204] The submissions of the Crown in this regard were adopted in full on behalf of SFRS.

[205] For Cameron House it was submitted that, by reference to the evidence led, there is no proper basis upon which to conclude that there was a failure to establish as quickly as was reasonably practicable whether there were any guests or staff unaccounted for.

[206] Reference was made to the evidence of Area Commander Duffy as to the challenging and rapidly developing situation presented by the fire. There were numerous factors presented by the fast changing and dynamic situation such that a period of about 45 minutes to complete a roll call once a guest list was obtained was entirely reasonable. The decision to remove the guests to the Boat House was both a sensible and practical approach to a difficult situation. It was pointed out that none of the alternative or additional measures suggested in the Crown submission were put to

any of the witnesses from SFRS and no adverse comment was made as to the adequacy of the evacuation procedures either in the course of evidence or in the various reports lodged on behalf of SFRS.

[207] For Andrew Roger it was submitted that there was no evidence that anything other than a roll call would achieve an efficient procedure for establishing whether all persons were accounted for. The thrust of the Crown submission was that the roll call ought to have been completed more quickly. However from the time the guest list was made available to the time when it was clear that the deceased were unaccounted for was approximately 45 minutes. Any reference to the overall period from about 06.40 until 08.00 is otiose. A roll call could not be effectively completed without the guest list. It was submitted that the Inquiry should conclude that all those involved in the roll call process were doing their best in difficult and distressing circumstances and completion of that roll call within 45 minutes of a guest list being available was "not at all bad" to quote the evidence of Constable Prentice.

[208] It was submitted that there is no evidence that any purported inadequacies in the night-time evacuation procedure are of any direct consequence to the circumstances of the accident or the deaths. Crucially there is a complete absence of any evidence necessary to establish a "real and lively possibility" that the deaths might have been avoided, even had the roll call been completed within thirty minutes of the alarm. The necessary causal connection could not be established on the evidence given the uncertainty as to the times of death.

[209] For Fiona Meek it was submitted that the surrounding circumstances would not have been conducive to an orderly roll call with some guests having departed from the assembly point and others being in a state of shock. It was submitted that it was reasonable for the guests to be relocated to the Boat House and once they were there, 45 minutes for a roll call could not be said to be excessive or unreasonable. It was again pointed out that none of the various alleged inadequacies or suggested alternatives were put to SFRS witnesses who could have commented on the alleged inadequacies and the practicability, or otherwise, of alternative measures.

Conclusion regarding evacuation, assembly and roll call

[210] From the evidence of witnesses it is clear that the need for an accurate roll call was an urgent priority but could not be achieved without a guest list. The decision to move the guests to the Boat House was taken before a guest list had been recovered from the Hotel building.

[211] The fact that it took about one and a half hours from the activation of the full fire alarm until identification that there were two Hotel guests unaccounted for is of serious concern. However the root cause of that was the initial unavailability of a guest list to allow an accurate roll call. The cause of that was human error at the time and not the absence of a measure taken beforehand or other reasonable precaution.

[212] Given the absence of a guest list it would almost certainly have been untenable to retain outdoors in excess of 200 guests in nightwear on a cold, dark, December morning. That was the reason for the decision to relocate to the Boat House. No one who gave

evidence was in any way critical of that decision or suggested the situation should have been dealt with otherwise in the prevailing circumstances.

[213] Once a guest list had been recovered and taken to the Boat House, it took approximately forty minutes to conclude the roll call. A number of challenges were present while undertaking the roll call. These included guests being in a state of panic and distress, guests seeking to return to the Hotel building to retrieve personal items such as medication and mobile phones, guests with babies requiring food and/or nappies, guests using the toilets rather than remaining in place, and family members of guests arriving at the Boat House. It is likely that most, if not all, of these complicating factors would have presented themselves in the course of a roll call at the designated assembly point. These are factors that would not be present during a pre-arranged fire evacuation drill.

[214] Given the almost inevitable additional difficulties of a real night-time emergency as opposed to a planned day-time drill, it is not surprising that the estimated length of a day-time planned drill would be exceeded. I conclude that all involved in the evacuation and roll call were doing their best in difficult and distressing circumstances. There was no criticism of the evacuation procedure by any Scottish Fire and Rescue Service Report or in the evidence of any witness.

[215] The Crown suggestion that names could have been taken as guests entered the Boat House was not an option that found support in the evidence. Such an approach would not have removed all of the difficulties that existed within the Boat House and may have caused other difficulties.

[216] The Crown submission that there should have been a contingency plan for obtaining the essential equipment for completion of the roll call was not a criticism put to Scottish Fire and Rescue Service witnesses who could have commented on these suggested inadequacies and the practicability, or otherwise, of alternative arrangements. Given the evidence that computer systems were inaccessible it is not obvious where an accurate up-to-date guest list would be held other than the reception area. In respect of this issue I am being invited to draw conclusions founded upon non-evidence based speculation.

[217] I agree with the submissions of the various Participants opposing the finding proposed by the Crown that the evidence does not on the balance of probability establish a real or lively possibility that the deaths might have been avoided had a different procedure been followed. There is uncertainty as to the precise time of death of both Mr Midgley and Mr Dyson. The evidence does not support a finding in respect of the evacuation and roll call that there were precautions which could reasonably have been taken which, had they been taken, might realistically have resulted in the deaths being avoided.

[218] Nonetheless looking at matters more broadly there are important lessons to be learned from this tragic incident in respect of evacuation and roll call. The importance of having clear and robust arrangements in place for promptly ensuring all persons are accounted for in the event of fire evacuation of a hotel cannot be overestimated. So far as practicable such arrangements should be tested having regard to foreseeable

contingencies such as time, weather conditions and the varied actions and reactions of guests who may well be disorientated or anxious.

[219] Therefore I do adopt the Crown's alternative position and identify the delay in carrying out an accurate roll call due to the absence of a Hotel guest list as a fact which is relevant to the circumstances of the deaths. I also recommend in terms of section 26(1)(b) that owners or operators of hotels or similar accommodation should ensure that clear and robust arrangements are in place for promptly ensuring all persons are accounted for in the event of evacuation of such accommodation in the event of a fire, such arrangements, where possible, to address foreseeable contingencies such as difficulties in accessing guest lists, or inclement weather.

Training of night staff in fire evacuation

[220] There was training on fire emergency and evacuation of the Hotel. Anne Rundell, night manager, gave evidence about this training. New staff were asked to read the relevant Standard Operating Procedures as part of induction training. Thereafter ongoing training was by online training modules known as "UpSkills". That was done in week one and thereafter at six monthly intervals for day staff and three monthly intervals for night staff. No details of the content of those training modules were provided in evidence but the evidence was that they include a module on fire safety training.

[221] The effectiveness of this training is uncertain. There were two fire drill planned evacuations each year. However these took place during the day between 10am

and 4pm. There had been no mock drills at night. Nor had there been role-play at night. The night staff were not involved and so had no practical experience of a fire drill.

[222] Fiona Meek of Village Hotels Ltd indicated that at hotels in the Village Hotels Ltd portfolio they would role-play emergency procedures at night rather than sound the alarm. Alternatively the night team would be brought in during the day to have experience of a fire drill. However that did not happen at Cameron House.

[223] Night shift staff received no training on the specific issues encountered in a night-time hotel evacuation. The evidence of Christopher O'Malley was that he understood his role in the event of a fire evacuation as night porter was to do what the fire marshal told him.

[224] As with consideration of the process followed for evacuation, assembly, and roll call, it is not established on the evidence that had there been additional or different staff training that there is on the balance of probability a real or lively possibility that the deaths might have been avoided. Nonetheless looking at matters more broadly there are important lessons to be learned from this tragic incident in respect of the importance of having robust arrangements in place for training of night staff in evacuation procedures.

[225] Therefore I do recommend in terms of section 26(1)(b) that owners or operators of hotels or similar accommodation should ensure arrangements are in place to ensure that all staff (including in particular night shift staff) have experience of evacuation drills. This can be achieved by involving night-time staff in the day-time evacuation drill and/or mock drills taking place during the night shift hours.

The spread and fighting of the fire

[226] Following activation of the full fire alarm at the Hotel the first call was received at SFRS Operations Control, Johnstone, at 06.41 hours. A crew of firefighters from Balloch, being the nearest location, arrived at the Hotel within 10 minutes. They were led by Watch Commander Graham Atwell. There were six firefighters in total within the appliance. Mr Atwell stated that several bits of information were being passed whilst they were en route to the Hotel including "Persons Reported" (meaning that persons were potentially within the building and unable to get out and may require assistance). Mr Atwell stated that two of his crew had been told to don sets of breathing apparatus to be fully equipped if required. When they turned into the Hotel it became obvious that would be required and he told them to get ready to make an internal rescue using breathing apparatus.

[227] He described the scene on their arrival. There was a combination of smog and smoke and there were a lot of guests standing on the grass. He estimated the number as between fifty and one hundred. Mr Atwell went towards the reception area and was met by the night manager. Mr Atwell and his crew then attended to the rescue of the Logan family from Room 10. As they were doing so a fire crew from Dumbarton arrived.

[228] Mr Russell McKay was Watch Commander of the Dumbarton crew. He committed two crews of firefighters wearing breathing apparatus to find and extinguish the fire through the reception. Mr McKay could see heavy smoke logging through the open doorway.

[229] One of the crew members committed to the reception area was firefighter James Armstrong. He described poor visibility inside. Initially he saw on the right-hand side that a fire had already been extinguished by firefighters from Balloch who were immediately in front of them. He described seeing small pockets of fire. After extinguishing them he became aware of a fire above him. He used a hook to pull plasterboard down to allow for a jet of water to be sprayed into the void. When the plasterboard was pulled away he could see that every area in the void had some degree of burning. The fire was more developed than he had anticipated but they extinguished as much as they could before having to exit after a period of 10 to 15 minutes due to the limit of their breathing apparatus. When they exited they handed over to another crew.

[230] Area Commander David Proctor arrived at about 07.05. After a quick briefing from Mr Atwell, Mr Proctor took formal charge. He remained in charge until the arrival of Assistant Chief Officer Paul Stewart about one hour later. Mr Atwell was instructed to raise the response level to level 3, the effect of which was to have more resources allocated to the fire. SFRS response levels are graded from level 1 to level 4 or 5.

[231] It was explained that in a major fire incident the building is divided for fire service organisational purposes into sectors. Watch Commander Russell McKay was instructed by Mr Proctor to set up a specific sector being sector 4 which was to the right-hand side between the old hotel building and the leisure complex etc. It was within sector 4 that Mr Dyson and Mr Midgley were ultimately located.

[232] Group Commander Paul Blackwood was SFRS Station Commander at Castlemilk and Polmadie and was on call as first call officer as at the date of the fire. In that

capacity he attended the incident arriving at around 07.20 hours. There were already several fire crews in attendance. Mr Proctor was the senior officer in charge and Mr Blackwood took on the role as operations commander in which capacity his task was to determine tactics in fighting the fire. He was proceeding on the basis that there were still persons unaccounted for within the building. Breathing apparatus crews were already committed to the building. Sector 4 was set up to the right-hand side of the main Hotel entrance and he committed breathing apparatus crews to that sector for search and rescue. Crews were starting to enter that side of the building within 5 minutes of that sector being established.

[233] Mr Andrew Rodger was crew commander based at Helensburgh. On arrival he saw between 100 and 200 people congregating on the lawn. The fire crews from Dumbarton and Balloch were already in attendance. He and firefighter John Joyce were tasked to enter the reception area and carry out a left-hand search. That was explained to be the procedure where a firefighter goes to a room and keeps his hand on the left-hand side of the wall all the way round. On entering he could see flames at 2pm if looking at it as a clock face which was being attacked by a breathing apparatus crew (that would have been towards the concierge cupboard).

[234] He was searching for fire spread and anyone who had not made their way out of the building. He left others to deal with the fire at reception. He and his partner reached doors to a stairwell and went upstairs to the first floor by the main stairwell. They continued their left-hand search and could see flames behind skirting boards. He could see through a window that the fire was spreading rapidly and taking a hold in

another part of the building. They banged on bedroom doors and shouted but there was no response. The next stage would have been to go through the first door they came across to continue the search and rescue. They did not go through that door because from the window they could see a lot of flames coming from the turret structure. It is likely that at that point he was looking towards the corridor where Rooms 7 and 8 were located. At this point firefighter Joyce felt the floor was "spongy", which is an indication that the integrity of the floor may be compromised. They left the building as they could not make contact with the breathing apparatus control.

[235] They went back into the building within five minutes but the conditions had deteriorated and visibility was non-existent. After going through doors firefighter Joyce put his foot through the floor which indicated that its integrity had been compromised. They had to exit the building as it was unsafe for them to continue.

[236] After reporting back they became aware that two persons were unaccounted for. By this time the fire had broken through the roof of the building. Firefighter Rodger then made his way to sector 4 and saw the first casualty being removed by firefighters. He was also informed by radio that another casualty had been located and he assisted by going up the stairwell to assist other firefighters in bringing the casualty out of the building. Firefighter James Musset attended with the fire crew from Helensburgh. He entered the building in breathing apparatus along with firefighter Gavin Granger with instructions to proceed to the first floor. They entered the building by the fire exit at the right hand side being within sector 4. He described dealing with a well-developed fire with very smoky conditions on the stairwell. He described a well-developed fire which

engulfed the whole corridor. He also recalled the floor being spongy. They continued to fight the fire until they had to withdraw due to the limit of their breathing apparatus. When outside servicing his breathing apparatus he learned that other firefighters had located a casualty.

[237] Other firefighters gave similar evidence as to the challenging conditions due to fire and smoke within the hotel building. On the evidence presented I am satisfied that all firefighters and other officers of Scottish Fire and Rescue acted with due speed, professionalism, and considerable bravery in their efforts to save life and fight the fire. There is no suggestion in the evidence that they did other than follow due practices and procedures throughout the incident. I have no recommendations to make in respect of the involvement of the emergency services at the scene of the fire.

Attempts made by SFRS to locate the deceased, their discovery and removal from the Hotel

Overview

[238] Mark Duffy, Area Commander, SFRS, provided a report containing an overview of the firefighting procedures adopted by the SFRS whilst attending an operational fire incident. His report focuses on what procedures and actions SFRS would undertake whilst searching to rescue people who are trapped in a fire situation.

[239] He explained that upon arrival at an incident the Incident Commander has a wide base of information to consider and this will become even more complex and onerous as the incident escalates. It is therefore essential that consideration is given to

start laying the foundations of the Incident Command System early to provide a clear framework to structure and organise an incident. Part of these foundations includes the ability to formulate a tactical plan based on all relevant information. This can include information provided on the scene detailing the extent of the fire, the location, areas that are on fire, if persons are unaccounted for, and any other additional hazards and risks within the building. This process is called a Dynamic Risk Assessment.

[240] In a fire situation where persons are trapped within the premises on fire and are unable to escape by their own means this is referred to as "Persons Reported". As soon as a "Persons Reported" message is received all SFRS personnel involved in the fire are informed of this, and the main priority for SFRS is to save the lives of those who are trapped.

[241] If persons require rescuing in a fire situation it is more than likely that Breathing Apparatus (BA) crews will carry out this rescue and these Breathing Apparatus crews will be briefed on how best to achieve this prior to entering risk areas. Breathing Apparatus crews will be informed by the Incident Commander or Entry Control Officer on where any persons missing were last known to be located (if this information is available) and then they will be instructed how best to locate them. Breathing Apparatus crews could be made up of two or three person teams and as a minimum will have suitable firefighting media with them for protection.

[242] Although a Breathing Apparatus crew may be briefed to carry out search and rescue they may need to be involved in firefighting before proceeding to their allocated task. The reason for this is that if a fire is not dealt with by a Breathing Apparatus crew

who are searching for casualties the fire then has the potential to increase in size and intensity. This would then have the potential to compromise the escape route, destroy firefighting equipment, and ultimately firefighting water supply. Area Commander Duffy explained the methodology for deploying operational personnel in breathing apparatus and search procedures.

[243] He reiterated that the priority is to save life and that is the fundamental objective. There is a balance between ensuring firefighter safety and carrying out the role of the fire and rescue service. If lives are in danger then a higher risk to firefighters may be accepted. In cross examination Area Commander Duffy confirmed that the fire at Cameron House was a hazardous and challenging operation. He accepted that it was a dynamic and rapidly changing situation both for the fire service and the duty holder. He accepted that the fire service do not want to expose firefighters to unnecessary risk and that an accurate roll call which can take time to produce is essential.

[244] It was after 08.00 hours when SFRS were made aware that the occupants of Room 8 were not accounted for. Nonetheless it was the evidence of the fire officers in charge of the incident at different points that it remained a "persons reported" incident until confirmed otherwise.

[245] The officer initially in charge was Watch Commander Graham Atwell. While he understood that following the evacuation from Room 10 everyone was out the building, he did not consider that impacted on any decisions which he made and his evidence was that he continued to proceed on the basis of rescue and firefighting. Commander David Proctor who assumed command from Mr Atwell confirmed that he made it clear

that he needed confirmation that there had been an accurate roll call and all persons were accounted for. Assistant Chief Officer Paul Stewart assumed command on arrival around the same point at which it was identified that the occupants of Room 8 were not accounted for. He explained that until that point the fire service were attempting to suppress the fire and seeking to commit crews to every room. Information that two persons were missing from Room 8 allowed resources and personnel to be directed to that particular area of the building rather than a strategy of searching the whole Hotel.

[246] Very quickly after the information was received by Mr Blackwood that the occupants of Room 8 were not accounted for firefighters entered and searched Room 8 via the window from outside by way of a ladder. Mr Blackwood also had that information passed to the breathing apparatus crews who were to enter and investigate from inside. When in the corridor outside Room 8 Firefighter James Musset had forced entry to the room, although he had not done so because he was instructed to. He and his partner thoroughly searched Room 8. There was no one within but they noted personal possessions there. That was communicated via their handheld radio. The result of the search of Room 8 was that there were personal belongings within but no persons. Shortly thereafter Mr Dyson and Mr Midgley were located on the second floor landing.

[247] Mr Paul Blackwood who had assumed the role of operations commander gave evidence of committing fire crews to sector 4 within five minutes of it being established as a sector for the purposes of search and rescue. Mr Blackwood confirmed that until a roll call was complete SFRS continued to proceed as a search and rescue operation. The

incident was treated as a "Persons Reported" incident throughout. Due to the difficult conditions with heat and smoke at times it was necessary to withdraw the fire fighters. If it had been confirmed that all persons were accounted for it would have made a difference to the number of crews committed as it would then be just a building on fire. Because that had not been confirmed, search and rescue continued for the whole building. When informed of the location of the two missing persons he was able to re-direct crews to focus on the area of their room.

[248] Richard Dyson was located by firefighter Phillip Douglas on the landing of the second floor stairwell at the right-hand side of the main building where it abuts the leisure complex being within the sector 4 referred to. The time of this is recorded in the SFRS incident log at 08.36.03.

[249] Mr Douglas attended as part of the fire crew from Garelochhead. He arrived at about 08.15. Along with other firefighters he formed a breathing apparatus team. His instructions were to go to the first floor with a fire hose and then continue to the second floor to create a fire break in an attempt to stop the fire spreading. On reaching the first floor there was a call to evacuate which they did. After a couple of minutes they re-entered.

[250] Visibility up to first floor level was clear but they could not see up from there to the second floor due to smoke which was completely filling the space. As he proceeded up from the first floor he was sweeping the stairwell, a term used to mean he was using his feet to identify hazards in front of him. As he arrived on the landing of the second floor he found Mr Dyson. Other members of the crew assisted in removing Mr Dyson

from the building. Firefighter Joseph Langford located Simon Midgley on the same landing about 5 minutes later.

[251] Mr Langford was instructed by Watch Commander McKay to go to the top of the stairway and fight the fire there. It was dark and smoky as they proceeded to the second floor, although there was slight visibility. As soon as they reached the top landing they found Mr Midgley behind the door on that landing. With the assistance of colleagues Mr Midgley was removed from the building and passed to the attention of paramedics.

[252] It was approximately 20 minutes after SFRS were advised that the two occupants of Room 8 were unaccounted for that Richard Dyson was found and another 5 minutes or so until Simon Midgley was found. As has been noted, the information that the two missing persons had been in Room 8 allowed the search by SFRS to be narrowed down to Room 8 and the surrounding area. Watch Commander Russell McKay also spoke in his evidence of the change in approach to focus on the area around Room 8 once the information as to the room number of the unaccounted for guests was known.

Roll call liaison officer

[253] Watch Commander Graham Atwell stated that he appointed firefighter McLean to go with the duty manager to the Boat House, to take a formal roll call and report back to him.

[254] Group Commander Paul Blackwood stated that he tasked one of the firefighters to be roll call liaison officer. He did not know the name of that officer. He explained that the remit of the roll call liaison officer would be to work with the hotel management

team to establish that all guests were accounted for and inform the commanding fire officer if everyone was accounted for or not.

[255] Firefighter Grant McDonald gave evidence that he was asked to be roll call liaison officer. In that capacity he went to the Boat House where the guests were. He arrived there around 7.20am. He did not appear to take an active role in the roll call and regarded his task as being to listen and respond back. Once the roll call was completed the outcome was reported back. In cross examination Mr McDonald confirmed that he had a general understanding of the role of roll call liaison officer from his training.

[256] The appointment of, and what was actually done by, the roll call liaison officer is on the evidence lacking in clarity and on the evidence there has been some duplication. Mr McDonald is a retained firefighter and therefore presumably one of the most junior officers of SFRS present at the fire.

[257] The benefit of a trained roll call liaison officer is surely to assist and advise the duty holder of the premises. While legal responsibility lies with the duty holder the input and advice of a professional trained roll call liaison officer is likely to be of considerable value, particularly in circumstances of great stress and pressure. However there was no evidence that any issue in respect of roll call liaison officers was a contributing factor and the issue was not explored in evidence to support any recommendation being made in this Inquiry.

Fire alarm system

[258] There was installed at the Hotel a fire alarm system. Cameron House Resort (Loch Lomond) Ltd entered into a contact with Procyon Fire and Security Ltd to provide services related to the system. The fire alarm system was serviced and tested appropriately and no issues arise in relation to the activation of the fire alarm system within the Hotel. It was described by hotel guests as a noise that could not be slept through.

Electrical system

[259] A search and examination of the concierge cupboard where the fire started was carried out on various dates in April 2018. Various items were located in and recovered from the cupboard. In particular, the remains of electrical equipment which had been within the cupboard was examined by Danny Neill, HM Specialist Inspector (Electrical Engineering) of Health and Safety. The conclusion of his report is in the following terms:

> "Based upon my visual inspection and examination of DBLP12(MG), its components and the cabling within the Reception Lobby cupboard, I could find no evidence of electrical arcing or electrical failure that could have initiated the fire.
> In my opinion, from my inspection of the other electrical equipment and cabling found within the Reception Lobby covered, I could find no evidence of electrical arcing or electrical failure that could have initiated the fire."

[260] Mr Gary Love of SFRS also considered electrical activity as a possible cause of the fire. He noted that the concierge cupboard housed a range of electrical equipment. All of the electrical equipment within the cupboard had been severely damaged by fire.

Throughout the course of the scene examination, all of the electrical equipment within the concierge's cupboard was looked at in detail, with the assistance of the HSE Specialist Electrical Inspector. The potential cause of the fire being as a result of a fault or failure within the electrical equipment could not in his view be eliminated. However he found no clear evidence which would indicate this being the cause of the fire.

[261] Examination of the electrical components within the cupboard was also carried out by the forensic scientists with the Scottish Police Authority, Richard Vallance and Dorothy Souter. They found no evidence that the fire started as a result of an electrical fault and state the opinion that their observations and findings make a cause of the fire being due to an electrical fault less likely.

[262] I conclude that the fire was not caused by an electrical failure or defect.

Fire detection system in place at the Hotel

[263] The main fire alarm panel was located at the rear of the reception area. The fire marshal box and comfort box were also located there. The Hotel had an addressable fire alarm system fitted which consisted of manual call points and automatic operated fire detection. There was a three minute pre-alarm signal incorporated into the system which allowed time to investigate the cause and to reduce unwanted fire signals. If a second detector head operated within the first three minutes, then the full alarm sounded automatically. If a manual call point was activated within the Hotel, there was no investigatory period and the full alarm sounded throughout the Hotel. If a heat detector was activated in the Hotel there was no investigatory period and the full alarm

sounded. The recent SFRS audit of the Hotel had assessed that the fire warning and detection system was adequate.

Absence of fire detection in the concierge cupboard

[264] This issue was considered by Group Commander Gary Marshall in a supplementary note to his report dated 1 August 2022. It was the opinion of Group Commander Marshall that it would not be reasonable to expect sprinkler protection within the cupboard. He explained that when considering sprinkler protection within the concierge cupboard a number of factors should be considered. First the small size of the concierge cupboard and secondly that the cupboard opened onto a larger circulation space in the reception area of the Hotel. He stated in his report that even if the contents of the cupboard had been limited to an electrical distribution board, with the rest of the cupboard maintained as sterile, it would not be reasonable to expect sprinkler protection within the cupboard. British Standards (BS EN12845 2015) detail an exception that specifically allows for the omission of a sprinkler head in an area containing electrical power distribution. He is of the view that the system designer and/or Fire Risk Assessor would determine that a sprinkler head would not be required within the concierge cupboard.

[265] It was also the evidence of Mr Drummond, architect, that a fire alarm system would not necessarily require the installation of detectors within smaller cupboards in the absence of any credible fire risk. He stated that one would not normally have been provided in the concierge cupboard, nor did he consider it practicable to provide

detectors in all such locations unless there is a reason to consider it as high risk. Instead the focus is to provide a detector in the adjacent apartment, room, or corridor which will trigger and allow firefighting to commence.

The potential impact of sprinklers in suppression of fire at the Hotel

[266] Group Commander Gary Marshall had been asked to provide a Note on the issue of automatic fire suppression on behalf of SFRS and he spoke to this Note in evidence. In his Note he explains that automatic fire suppression systems help control and suppress a fire, and in some cases, may even extinguish it. It can provide occupants with the additional time necessary to escape following the outbreak of fire.

[267] An automatic sprinkler system is designed to detect a fire and extinguish it with water in its early stages or hold the fire in check so that extinguishment can be completed by other means. A sprinkler system consists of a water supply (or supplies) and one or more sprinkler installations. Each installation consists of a set of control valves and a pipe network fitted with sprinkler heads. The sprinkler heads operate at predetermined temperatures to discharge water over the affected part of the area below. The flow of water through the system also initiates a fire alarm.

[268] When considering the potential impact of an automatic sprinkler system, the extent to which the building would be covered by the system itself must be taken into consideration. In general where sprinkler protection is installed within a building it would extend throughout the premises with only limited exceptions.

[269] In respect of the fire at the Hotel, in the absence of a sprinkler system within the concierge cupboard itself it is anticipated that the first sprinkler head(s) to activate would have been around the circulation space beside the reception area. This would be due to the heat released at the time the concierge cupboard door was opened. Notwithstanding the possible activation it is likely that the fire would have continued to develop within the cupboard, within the voids and cavities surrounding the cupboard, and into the ceiling/floor voids where no sprinkler heads would have been present, allowing fire and smoke to affect other areas of the building, compromising escape routes.

[270] The opinion of Group Commander Marshall is that an automatic sprinkler system would likely have had a positive effect in suppressing the fire within the reception area for a period of time although it is unclear what effect it may have had on the fire spread. While it is likely that it would have had a positive effect - the uniqueness of the fire itself, the construction of the building and the process of fire risk assessment present a number of variables that make it difficult to determine the full impact.

[271] Group Commander Marshall confirmed that SFRS would always encourage the use of automatic fire suppression systems where appropriate within buildings given the long established and proven record of the effectiveness of sprinkler systems in suppression in the vast majority of foreseeable fires. Sprinkler systems provide considerable benefits to life safety.

[272] Mr Peter Drummond, architect, in his report expressed the opinion that there is a need for other measures to control the initial flame spread in historic buildings of the nature of the Hotel in order to protect occupants. He noted that the property contained an operating fire alarm system and nothing in the documents passed to him suggested that this failed to perform, although he acknowledged that he is not an expert on the design and installation of such systems. It is clear that there were hand-held extinguishers available in the reception area. These appear, based on the CCTV, to have been inadequate for the rapid spread of flames following opening of the cupboard door.

[273] The Hotel fire showed that an alarm system and early instigation of firefighting operations were not, in themselves, sufficient to prevent rapid spread of flame or tragically loss of life. He stated the view that there is therefore a need for other measures to control the initial flame spread.

[274] One option may be for fire escape routes to be realigned to ensure the integrity of the linings against fire. In some straightforward buildings that may be practicable. In very complex historic structures, it may not be.

[275] An alternative, and one which in his opinion has potentially significant merit, would be to consider the installation of automatic fire suppression systems in cases such as this. Whilst it would not necessarily prevent a fire from breaking and/or spreading out in a cupboard or concealed cavities/voids, such systems would significantly slow the spread of flame within the adjacent apartments and rooms which in turn provides a longer window for the commencement of firefighting. That in turn would extend the

margin of safety for available escape time, taking account of the occupants' behavioural characteristics.

[276] Having regard to the particular challenges and risks presented by historic buildings as hotels and associated uses, his recommendation is that consideration be given to requiring the installation of active fire suppression systems in the conversion of historic buildings for hotel and associated uses.

Submissions

[277] The submissions for the Crown and SFRS were that the evidence supported a determination that it would have been a reasonable precaution for an active fire suppression system (a sprinkler system) to have been installed at the Hotel, and for this to have thus been activated at the time of the fire. The Crown submission in this regard was adopted on behalf of SFRS. It was submitted on behalf of Cameron House Hotel and Mr Andrew Roger that the evidence did not support such a determination.

[278] For the Crown it was submitted that while a sprinkler system may not have fully extinguished the fire it would have inhibited and slowed its spread with the consequent inhibition of the spread of smoke and fire gases. From the evidence of hotel guests and firefighters there was dense smoke in the corridors causing both breathing and visibility difficulties very shortly after the full alarm sounded. While the precise time when the deceased left their room and their movements thereafter are not known, it is a clear inference that they were unable to escape the building due to the rapid spread of smoke and fire. It was submitted that the Court is entitled to conclude that there is a real or

likely possibility that had the sprinklers been installed and worked to inhibit the extent and spread of the fire and smoke, the deceased would, like other guests, have been able safely to escape the building.

[279] For Cameron House Hotel it was submitted that a sprinkler system could not be regarded as a reasonable precaution as, by reference to the evidence led, it was not apparent whether or not the installation of a sprinkler system would have been either suitable or practicable at the Hotel. Furthermore even if it had been reasonable and practicable to have installed a sprinkler system it would not have prevented the spread of fire and smoke to the areas of the Hotel in which Mr Midgley and Mr Dyson were believed to have been.

[280] For Mr Roger it was submitted that the evidence on the possible effects of a sprinkler system was tentative and the effect of a sprinkler system on the fire could not be ascertained with any degree of precision and thus the necessary causal connection could not be established on the evidence. It was submitted that a vague suggestion that a sprinkler system would have "allowed more time" for evacuation does not amount to a "real and lively possibility" that the deaths might have been avoided.

Conclusion

[281] I have determined that it would have been a reasonable precaution for an active fire suppression system (a sprinkler system) to have been installed at the Hotel, and for this to have thus been activated at the time of the fire.

[282] I have determined that a sprinkler system would have been a precaution which could reasonably have been taken and which had it been taken might realistically have resulted in the deaths of Mr Dyson and Mr Midgley being avoided. The evidence of hotel guests and firefighters as to the impact of smoke and fire on breathing and visibility was powerful. It is a clear inference from the evidence that was the atmosphere with which Mr Midgley and Mr Dyson were confronted on leaving their room. The evidence of Group Commander Marshall was that an automatic sprinkler system would likely have had a positive effect in suppressing the fire for a period of time.

[283] Mr Drummond stated that an automatic fire suppression system would significantly slow the spread of flame and would extend the margin of safety for available escape time.

[284] Therefore on the balance of probability it is a precaution which might realistically have resulted in the deaths being avoided.

[285] Mr Drummond expressed the opinion that there is a need for other measures to control the spread of fire. There is no doubt that a sprinkler system would have been available. The issue of suitability and practicability has to be considered in the context of the purpose of such a system, which is for the safety of occupants who would often number several hundred. While the installation of a sprinkler system may have presented certain technical issues of some complexity, a degree of complexity does not render the measure impracticable. Any issues of complexity are outweighed by the potential safety benefits of a fire suppression system.

[286] Having determined that the installation of an active fire suppression system is a precaution which could reasonably have been taken and which, had it been taken might realistically have resulted in the deaths being avoided, I also consider it appropriate to recommend in terms of section 26(1)(b) that the Scottish Government should consider introducing for future conversions of historic buildings to be used as hotel accommodation a requirement to have active fire suppression systems installed. Given the potential added fire protection provided by an active fire suppression system, if such installation was said to be impossible or impractical in specific premises, it may be that such premises are simply not suitable as hotel accommodation.

The presence and impact of hidden voids

[287] Gary Love of SFRS in his Fatal Fire Investigation Report states in respect of development of the fire that it originated within the concierge cupboard on the upper ground floor. It spread within the cupboard to fully involve the contents. Once the cupboard door was opened, this enabled the well-developed fire to spread outward into the entrance foyer, reception area, and beyond. The fire continued to spread within the various wall and ceiling voids situated throughout the grade B listed main building.

[288] In his investigations subsequent to the fire he found that there were a number of substantial gaps within the walls and ceiling of the cupboard. These gaps would have enabled undetected fire to spread from the cupboard into other parts of the building. Significant voids were present within the substantial wall which housed the cupboard.

These voids would have enabled the fire to spread from the cupboard into other areas of the building undetected.

[289] Group Commander James Clark, whose role in 2017 was Fire Safety Enforcement Officer, also gave evidence about the potential impact of hidden voids and cavities. His evidence was that hidden voids and cavities can be present in buildings of the age of the Hotel due to having undergone changes in layout over the years. If a fire reaches such areas it can spread unseen throughout the building rapidly and breach compartmentation between rooms. He explained that such voids and cavities cannot be detected without an intrusive survey.

[290] The evidence of firefighters at the scene also provided striking evidence as to the rapid spread of fire within voids. Watch Commander James Armstrong and his partner, being part of one of the first fire crews to arrive at the Hotel, were instructed to enter the reception area with a view to locating and extinguishing the fire. On entering the reception area only small pockets of fire were found there with the flames in that area having been mainly extinguished by the Balloch fire crew who had entered before them. At the reception area they noticed fire in the roof space above them. A ceiling hook was used to pull down some plasterboard. Watch Commander Armstrong described then seeing every area in the void between the ceiling and the floor above was alight and that every area they could see had some degree of fire. The fire was much more developed than he had anticipated. They use a jet to extinguish as much of the fire there as they could before having to exit due to the time limit of their breathing apparatus.

[291] Crew Commander Andrew Rodger and his partner were tasked to enter the main foyer of the Hotel and start a search of the building. In carrying out that duty they reached the first floor level where they could see flames behind the skirting boards in the area above the main reception area. They used a hose reel to extinguish what they could. Crew Commander Rodger described the floor as springy being an indication that the floor was beginning to fail due to fire. After leaving the building for about five minutes to make contact with the Breathing Apparatus Officer they found that the position had deteriorated and it appeared that the wall was starting to burn away at that first floor level.

[292] Crew Commander Rodger described visibility as being very poor with smoke down to knee level. The rapid spread of dense smoke was spoken to by other firefighters. Firefighter Philip Douglas described finding a well-developed fire in the corridor at first-floor level with smoke so thick that he could not see his hand in front of his face.

[293] Watch Commander Russell Mackay gave evidence about bringing ceilings down to stop fire spreading in the void above where, as he observed, fire can spread quite easily.

[294] The speed by which smoke and fumes spread upwards through the building was a significant and consistent part of the evidence of the hotel guests. For some there was already smoke within their room upon hearing the alarm and others very soon after. The extent to which smoke was found to have spread within the corridors of the old

building thereby hindering escape from the building was a common thread. That can be explained by the existence of voids within the main building.

[295] In addition to the evidence of witnesses from SFRS and hotel guests, important evidence as to the impact of hidden voids was given by Mr Peter Drummond, an architect who has specialised in the care of historic buildings. He is an expert witness in this field and he provided a report in respect of the fatal fire at the Hotel, which he supplemented by oral evidence, both of which were not challenged and are accepted by me. His evidence provided a broader perspective of the issue of hidden voids and more generally as to the special risks presented by historic buildings.

[296] Mr Drummond explained that a historic building will have linked cavities or voids. Unless all linings are removed, it is extremely difficult to adequately stop or block these. A building such as the Hotel will, by its nature, present a risk of rapid spread once the flame breaches the wall and ceiling linings. Where there is sleeping accommodation that in turn raises the risk for occupants significantly.

[297] Mr Drummond noted that guest witness statements confirm that smoke reached the first and second floor corridors/escape routes relatively quickly and that this understandably caused a significant degree of panic for many. Some felt that they were unable safely to leave their rooms. Others did make their way out but towards the original main stair leading to reception and the seat of the fire. These individuals made their way out – with staff assistance – by means of other routes.

[298] Mr Drummond concluded that the initial fire spread was likely to be vertically into the corridor on the first floor above the concierge cupboard and, at the same time or

soon thereafter, through the reception hallway ceiling into the first floor lobby. This spread occurred within a relatively short period of time following the discovery of the fire. In Mr Drummond's opinion there are two reasons why this might have happened:

a. The spread of fire within linked cavities on the corridor side of the concierge cupboard wall. The fire could have breached the protection in and around door facings, and from there the circa 50mm cavity with timber strapping.

b. Rapid spread to the ceiling outside but adjacent to the concierge cupboard following the opening of the door, breaching the plaster lining through either (a) recessed light fittings or (b) thermally accelerated failure of aging lath and plaster linings.

[299] Whatever the principal route for the fire, it appears to have quickly breached the plaster linings. Once within the intermediate floor, there would have been numerous cavities and voids by which the fire may have spread. This includes the gap between the laths (or plasterboard) and the boarding supporting the ash pugging. The timber in this cavity would have been old and dry, presenting a ready surface for the spread of flame. The historical insertion of services – cabling and heating pipes – would create numerous small voids and routes for further penetration. Smoke would spread rapidly. This would reach the timber partitions or partition linings, and the process would repeat. That appears to Mr Drummond to be consistent with firefighter evidence and some of the guest statements regarding smoke within corridors soon after the alarm was sounded.

[300] Mr Drummond's report demonstrates the danger of rapid spread of fire via cavities and voids. That resulted in the various fire corridors within the old Hotel being heavily smoke logged only a short time after the alarm activation. As set out in the next chapter Mr Drummond in his report recommends that consideration is given to revising the guidance provided by the Scottish Government and others in respect of the special risks posed by existing premises. I have made such a recommendation including within it specific reference to the risk posed by hidden cavities and voids. While it may be they cannot be entirely eliminated, such steps as are reasonably practicable should be required to reduce that risk.

Building standards in respect of fire safety at the Hotel and more generally in hotels in Scotland, including the application of such standards to older buildings

[301] Mr Drummond identified that all historic buildings and in particular complex structures with several phases of development such as the Hotel pose potentially significant risks. They will not have been constructed to modern standards of structural fire protection and protection against spread of flames, save for a few specialist building types (typically of an industrial nature). Later phases of work, or repairs, will be to differing standards and quality, perhaps compromising previous compartmentation or fire separation measures.

[302] These may not be immediately apparent to the lay person, or even to professionals who are not specialists in that field. Even where such risks are known, there are inherent challenges in addressing them to the standards of a new building. To

plug every cavity, floor void, gap behind waste and plaster, or oversized pipe duct would be a nearly impossible undertaking in the absence of a complete stripping back of historic floors, walls, and ceiling linings.

[303] Mr Drummond considered that having regard to the complex nature of the floorplan within the hotel, it is not surprising that many of the occupants, panicking because of smoke, chose to use the routes they were familiar with in lieu of the modern fire escape. In his view particular regard has to be had to the less straightforward - and sometimes convoluted - access arrangements and layout of historic buildings when reaching a view on how occupants will exit in an emergency.

[304] Mr Drummond reported that although a copy of the building warrant for the 1985 conversion of the building had not been passed to him for review, it seemed likely to him that the property as constructed complied with the regulations in force at that time insofar as would have been considered reasonably practicable.

[305] Regulations subsequently changed. The building, as constructed, no longer complied with the Technical Standards. There was no requirement on them to do so retrospectively, for example by way of upgrading works. Mr Drummond reported that he was unable to identify any works carried out to the upper floor structure and linings which would have been warrantable.

[306] He did not know whether the recessed downlights in the reception and main hallway extended into the corridor in front of the concierge cupboard and whether, if so, they would have been of a fire resisting type. If these were later work, and were of a normal rather than fire resisting type, then he considered that they are likely to have had

an adverse effect on the fire performance of the lath and plaster ceiling. He further observed from his own experience that even using hole-cutters on aging lath and plaster ceilings can loosen the plaster from the adjacent laths, leading to potential failure of the lining.

[307] Notwithstanding the provision of an alarm system and early instigation of firefighting operations, there was a rapid spread of flames as a result of the particular constructional arrangements at the Hotel. Smoke was rapidly apparent in the upper floor corridors serving guest bedrooms, leading to panic and a measure of confusion on the part of the occupants. Some considered the corridors to be untenable. Others attempted to leave by routes which were not the most direct and, as a result, found themselves in areas of greater risk.

[308] In his opinion there is a need for other measures to control the initial flame spread in such cases in order to protect occupants. He accordingly recommends that consideration be given to revising the guidance provided by the Scottish Government and others to more fully explore the special risks which existing premises may pose through varying standards of workmanship, age, and variance from current standards.

[309] Mr Drummond recognises that the technical and regulatory issues raised are complex. His opinion is that the most appropriate way forward in this instance would be for the Scottish Government to convene an expert advisory panel involving a range of stakeholders to consider the best way forward. His opinion is that any such panel should involve those with expertise in the spread of fire and performance of materials, the assessment of fire risk in existing premises, the application of the British Standards

and other guidance to existing buildings, passive and active fire protection measures, conducting firefighting operations, and the construction of complex or multiphase historic buildings and their conversion for new uses. I consider that such a recommendation is appropriate and I have made that recommendation.

Fire risk process and implementation of identified issues

[310] Following discussions between Fiona Meek and Mark Webster-Clayton, joint managing director of Veteran Fire Safety Ltd, fire safety advice was provided to the Hotel by Veteran. Veteran is a company that carry out Fire Safety Risk Assessments.

[311] An audit was carried out by Mr Webster-Clayton at the Hotel on 13 and 14 January 2016. A fire risk assessment report was produced by Veteran and provided to the Hotel following the 2016 audit. A fire risk assessment report was produced by Veteran and provided to the hotel following the 2017 audit. Each report includes an "Action Plan" containing observations and recommendations which should be implemented in order to reduce fire risk to, or to maintain it at, a tolerable level.

[312] Part 16 of the 2016 assessment report is headed: "Other significant fire hazards that warrant consideration including process hazards that impact on general fire precautions". Within that part of the report there is listed as a hazard: "There is no current written policy in place to explaining (sic) the correct way to empty hot ash from open fires and josper ovens." Within the "*Action Plan*" section of the report, there is the following observation and recommendation which relate to the absence of a written policy in place in respect of open fires and josper ovens:

"Observation

There is no current written policy in place to explain the correct way to empty hot ash from open fires and josper ovens.

This was consistent throughout the estate.

The boat house josper oven was full of ash and had not been emptied. Staff did not know where to empty the oven.

The hotel ash bins at the rear of the building were open with lids off. The ash bins were adjacent to a skip. Ash could potentially be blown into skip causing fire.

Recommendation

Recommend a written policy is put in place so consistency is maintained throughout the estate.

For example to dispose of the ashes, they must be transferred to a metal container and wet down.

The metal container must be kept away from any combustibles until the refuse is hauled away."

[313] This is shown as having a high priority rating meaning that the hazard/deficiency identified should be addressed immediately/as soon as practicable.

[314] A subsequent audit was carried out by David Woodward, an employee of Veteran, the following year on 25 January 2017. There are two versions of the 2017 Fire Risk Assessment Report. Both again record under the same heading of "Hazards": "There is no current written policy in place to explaining (sic) the correct way to empty hot ash from open fires and josper ovens."

[315] The "Action Plan" section of the first version of the report observes that a review of the previous Fire Risk Assessment showed that a number of recommendations in the

previous report had not been addressed and it was recommended that the items identified are addressed and prioritised.

[316] That report was produced by Veteran and forwarded to Mr Andrew Roger, resort director, via Fiona Meek on 20 February 2017. Mr Roger had incorrectly assumed that a written procedure for the open fires had been prepared and he communicated that to Veteran by email via Fiona Meek. Following that email exchange, and discussion between Mr Webster-Clayton and Mr Woodward, the assessor, the report was changed by replacing the original observation and recommendation with an observation that all of the recommendations identified in the previous report have been recorded as complete. That was despite the fact that under the heading "Hazards" the report continued to state that there was no current written policy in place to explain the correct way to empty hot ash from open fires and the josper ovens.

[317] In relation to the change made in the 2017 report, the evidence of Mr Webster-Clayton was internally contradictory. At times in his evidence he claimed that it was simply an administrative error by choosing the wrong option from a drop-down menu. But he also maintained that Mr Woodward was adamant that he had not seen any written policy and therefore the comment remained within the report.

[318] If that was Mr Woodward's position, it is hard to see why Mr Webster-Clayton would have been angry with him as he said he was. It is hard to understand why the report would state that all recommendations have been recorded as complete while also recording that no written policy has been seen.

[319] The evidence of Mr Webster-Clayton was that this was done on the assurance by Mr Roger that the report was incorrect. At several points in his evidence Mr Webster-Clayton suggested the first version was a draft. However no other witness suggested that and there is nothing in the original version of the report or email correspondence to suggest that it was intended as other than the final report.

[320] Mr Woodward is the fire risk assessor with Veteran who carried out the fire risk assessment at the Hotel in January 2017. His explanation for the change in the 2017 report was also that there were two drop-down boxes and he used the wrong one. On being contacted by Mr Webster-Clayton by phone and email he confirmed that it was a mistake. His evidence was that in the course of his assessment he asked about a written policy in respect of hot ash from open fires but was never shown one. Therefore he left in the report his finding under the heading "Hazards" about the absence of a written procedure to explain the correct way to empty hot ash from open fires and josper ovens.

[321] Notwithstanding that, he was content to change the report to state that all the recommendations identified on the previous report have been recorded as complete. This inherent contradiction within the second version of the fire risk assessment report of 2017 has not been satisfactorily explained. It appears that Veteran were content to rely upon the statement by the Hotel resort director stating that matters previously reported had been completed without insisting upon sight of evidence thereof. That undermines the value of what is intended as being an independent third party assessment.

[322] It is acknowledged that a third party audit such as that carried out by Veteran is not a mandatory requirement. However the value of such an independent assessment is lost if the report arising therefrom is capable of being altered without independent verification. I have determined that alteration of the 2017 Fire Assessment Report by Veteran Fire Safety Ltd to state that all of the recommendations identified in the previous report have been recorded as complete without sight of evidence thereof is a fact relevant to the circumstances of the deaths.

The regulatory regime for fire safety at the Hotel and the enforcement thereof by the SFRS

[323] Part 3 of the Fire (Scotland) Act 2005 governs fire safety in Scotland and places duties on employers with regard to the safety of their employees and duties in relation to relevant premises for anyone that may have control to any extent. SFRS is the Enforcing Authority with responsibility for enforcing the duties contained within the Act for most relevant premises in Scotland.

[324] The Fire Safety (Scotland) Regulations 2006 provide that the statutory duty for ensuring an adequate level of fire safety within relevant premises, such as the Hotel, lies with the duty holders. It is their responsibility to assess and mitigate the fire risks to relevant persons or employees within their relevant premises.

[325] The responsibilities of SFRS include promoting fire safety, providing advice, and guidance on fire prevention and fire safety measures including means of escape and enforcing fire safety duties in relevant premises.

[326] On 22 August 2017 a SFRS Fire Safety Audit was carried out by Group Commander James Clark who at that time was a Watch Commander in the role of Fire Safety Enforcement Officer. Part of that audit involved a walk round inspection of the Hotel. In the course of that audit Group Commander Clark identified an issue in the concierge cupboard in respect of fire risk. In particular he noted combustible items on the floor along with jackets hanging in the cupboard which contained mains electrical apparatus which was a potential source of ignition. He also noted holes or gaps in the ceiling which were large enough to cause concern as to increasing the risk of fire spreading rapidly. He brought these matters to the attention of Andrew Roger, the resort director, and David McKerry, the hotel property manager, who accompanied him on the walk round inspection. He informed them forcefully that these matters had to be dealt with immediately by removing the combustibles from the cupboard.

[327] The holes/gaps were repaired within 48 hours by contractors who were on site at the time doing other work. The issue of combustibles within the cupboard was not properly addressed. Combustibles were being systematically stored within the concierge cupboard in the lead up to the fire and on the day of the fire. Mr Robinson described that kindling was kept in the cupboard in a mesh bag. Ms Rundell also referred to kindling being kept in the concierge cupboard at reception and Mr O'Malley agreed that it was fairly normal for kindling to be stored within the concierge cupboard. This became a major contributory factor in the fatal fire.

[328] Following an audit inspection Scottish Fire and Rescue issued a letter to the duty holder highlighting measures to which effect should be given to reduce the spread of

fire. In this case the letter was issued to the Hotel for the attention of the resort manager. That letter was issued dated 21 November 2017. It highlighted *inter alia* the following under the heading "Measures to reduce the spread of fire":

"6. Combustible storage should not be located within cupboards containing mains electrical installation apparatus."

[329] Receipt of this letter by Mr Roger did result in further steps to address the issue. Mr Roger issued an email to the head of the relevant department but that did not result in the issue being adequately resolved.

[330] I accepted the submission by the Crown that the level of enforcement of the statutory audit on 22 August 2017 by SFRS was adequate in itself. Nonetheless the delay of three months between the physical inspection and the issue of the outcome letter is excessive. Group Commander Clark put the delay down to workload and staffing issues. The evidence is that it would have made no practical difference in this case given that combustibles continued to be stored in the cupboard in the period of about one month between the issue of the outcome letter and the fire.

[331] However in general there is a greater possibility that issues raised verbally at the time of the audit will be lost sight of by the duty holder without a prompt written confirmation of particular improvements required. A formal letter issued by Scottish Fire and Rescue Service reinforces the requirement that highlighted measures are addressed. Therefore I recommend that SFRS reduce the time period between the fire safety audit and the issue of the written outcome report.

Improvements and changes since the fire

a. Cameron House Hotel (Loch Lomond) Limited

[332] Following the fire there was an internal investigation and review of their policies and procedures by Cameron House Hotel (Loch Lomond) Ltd. A number of recommendations were prepared for the board and they have become known as their Risk Recommendations. Andrew Roger as resort director has accountability for the delivery of these and they are reviewed every quarter with the board if there are any notable updates. Whilst the majority of the pre-2017 measures remain in place, Cameron House Hotels (Loch Lomond) Ltd have appointed a Risk and Safety Director on site who has a Health and Safety Officer and a Security and Compliance Officer in their team. The Risk Safety Director and the Resort Director now work closely together reviewing policies and procedures. They continue to seek additional input and advice from Fiona Meek as required. They have also undertaken a comprehensive review of Risk and Safety on the resort.

b. Scottish Fire and Rescue Service ("SFRS")

[333] Since the fire at the Cameron House Hotel SFRS have undertaken the following actions:

a) Fire Safety Enforcement Policy Framework for Scotland 2017 has been reviewed and replaced by Fire Safety Enforcement (Protection) Framework for Scotland 2021. The review modernised the terminology used within the document and added a section on equality and human rights. Significant

sleeping risks which have not received an audit before were also added to the list of core audits for Protection Teams to carry out.

b) An Awareness Briefing (May 2019) has been issued containing instruction for Protection Officers regarding the noting of potential for unseen smoke and fire spread within premises. This ensured Protection Officers recorded this information within the Firefighter Risk section and Part B of the Fire Safety Audit and Intelligence Form in addition to it being included in the letter issued to duty holders.

c) The above Awareness Briefing (May 2019) was disseminated and reinforced to Protection Officers via CPD events regarding the appropriate manner in which to record voids within Fire Safety Audit and Intelligence Form, including notification to operational crews and Operational Intelligence. A learning session was also provided around rapid fire spread in buildings based on building type.

d) An Awareness Briefing (May 2021) was issued. Where open fires are identified SFRS will commit to ensuring a documented procedure for cleaning the fires and disposal of ash is in place with evidence of training for the management of these fires. Where no such documented procedures or evidence of training for the management of these fires is present these will be considered as a high risk on the Fire Safety Audit and Intelligence Form. The Fire Safety Audit and Intelligence Form was also updated to prompt consideration of open fires.

e) The said Awareness Briefing (May 2021) promotes a more specific approach regarding inappropriate storage of combustibles within premises as opposed to strict reliance on an audit points scoring system. There is a requirement for a prompt response within 24 hours' notice by duty holders to ensure action has been completed.

f) Presentation to hoteliers in Glasgow covering general fire safety and incorporating issues including the potential for unseen smoke and fire spread with recommendation for compartmentation surveys, benefits of carrying out a head count as a matter of urgency, the need for good housekeeping, and the dangers associated with open fires including the disposal of ash;

g) TV and Radio media campaign aimed at hotel residents to promote awareness of what to do in the event of a fire alarm, including knowing your nearest and available escape routes;

h) A new 5-year training programme for Protection officers has been implemented to ensure all new officers are trained to the level identified in the NFCC National Fire Chiefs Council Competency Framework (CF). This will be a SCQF Scottish Credit and Qualifications Framework Level 8 which aligns to the equivalency set out within the NFCC Competency Framework.

Submissions for Ms Jane Midgley

[334] I have considered the submissions for Ms Midgley which were annexed to the Crown written submission, albeit she is not a formal Participant in this Inquiry. Her

comments in respect of voids and cavities are largely reflected in this determination. Other points, such as in respect of lath and plaster wall coverings, the presence of any fire-resistant material, and low-level emergency lighting were not matters explored in evidence to such an extent that this Determination can make any specific finding on these points. Nonetheless these points can be expected to be part of the broader consideration by the expert working group exploring the risks posed by all such buildings used as hotel premises which has been recommended in this Determination.

[335] Ms Midgley supports the recommendations made by Peter Drummond regarding installation of fire suppression systems and improved guidance to raise awareness in duty holders in historic buildings regarding fire safety and risk assessment and those recommendations are made in this Determination.

[336] Ms Midgley makes a number of points about the evidence relating to the roll call which she describes as "shambolic". In her view it was wrong to move the guests to the Boat House until the roll call had been established; provision for welfare and comfort items should have been available at the assembly point with specific arrangements for vulnerable guests. Ms Midgley considers that there is still a lot of time unaccounted for in the period from the alarm until it was identified that Mr Midgley and Mr Dyson were unaccounted for.

I have set out the evidence in respect of the evacuation and roll call in some detail in the appropriate chapter of this determination and have reached the conclusion that the root cause of the delay in the roll call was the human error in the guest list being left behind

by the night manager after actually having it in his hand and that was the primary cause of the delay in completing a roll call.

[337] Ms Midgley suggests that once it was established that a small number of rooms were unaccounted for, this information could have allowed SFRS to have directed resources accordingly. However I consider the accuracy of that information would not have been clear and it could have caused attention to be directed to the wrong area.

[338] I did not consider that the evidence supported specific recommendations in respect of emergency procedures beyond the recommendations addressed to owners or operators of hotels or similar sleeping accommodation in terms of section 26(1)(b) of the Act which are made. Nonetheless it is to be expected that such issues will be considered by owners or operators of hotels within those recommendations.

[339] Ms Midgley suggests a number of recommendations relating to SFRS and Police Scotland. I do not consider there was any defect in the system of working of either organisation or any other facts in relation to fire and police service operations in response to the fire which are relevant to the circumstances of the death. Ms Midgley notes the system whereby a more senior fire officer takes command of an incident on arrival and suggest that requires to be reviewed. The evidence indicated that this did not happen automatically and it was for the more senior officer to decide whether to take charge having been briefed. There is no evidence suggesting that operating in that way impacted adversely police and fire responses to the fire. It is also noted that SFRS have carried out a review and implemented various actions in consequence of the Cameron House fire.

[340] I have made a recommendation regarding delay by SFRS in issuing correspondence to duty holders highlighting areas for improvement or notification of deficiencies following a fire audit.

Conclusion

[341] The immediate cause of the fatal fire at the Hotel was the placing of hot ash within the concierge cupboard at the reception area of the Hotel, which allowed a fire to develop within said cupboard and then spread to other parts of the Hotel, exposing both deceased to the effects of smoke and fire gases.

[342] Precautions which could reasonably have been taken which might realistically have resulted in the deaths or the accident resulting in the deaths being avoided have been identified. There were a number of defects in systems of working which contributed to the accident resulting in the deaths and also a number of other facts which are relevant to the circumstances of the deaths. Arising from the Inquiry are a number of recommendations as set out in this Determination.

[343] The Crown and the Participants in their submissions offered condolences to the families of Mr Midgley and Mr Dyson. I wish to conclude by expressing the deepest sympathies and condolences of the Court to both families.

APPENDIX ONE

Witnesses to the Inquiry

Hotel Guests

AndrewLogan

Alan Pilkington

Hannah Munns

Paul Dear

Lorna McGregor

Pauline Booth

Chloe Marchbank

Scottish Fire and Rescue Service

Russell Mackay, Watch Manager, Scottish Fire and Rescue Service (Retired)

James Armstrong, Crew Manager, Scottish Fire and Rescue Service

Graham Atwell, Watch Manager, Scottish Fire and Rescue Service (Retired)

Andrew Rodger, Crew Manager, Scottish Fire and Rescue Service

David Proctor, Area Commander, Scottish Fire and Rescue Service (Retired)

Grant McDonald Fire Fighter, Scottish Fire and Rescue Service (Retired)

Paul Blackwood, Group Commander, Scottish Fire and Rescue Service (Retired)

James Musset, Fire Fighter, Scottish Fire and Rescue Service

Philip Douglas, Fire Fighter, Scottish Fire and Rescue Service

Joseph Langford, Fire Fighter, Scottish Fire and Rescue Service

Paul Stewart, Assistant Chief Officer, Scottish Fire and Rescue Service

Mark Duffy, Area Commander, Scottish Fire and Rescue Service

Gary Marshall, Group Commander, Scottish Fire and Rescue Service

James Clark, T/Group Commander, Scottish Fire and Rescue Service

Police Service of Scotland

Allan Orr, Inspector (Retired), Police Scotland

Steven Prentice, Constable, Police Scotland

Cameron House Hotel Employees

Darren Robinson, Night Manager

Anne Rundell, Night Manager

Christopher O'Malley, Night Porter

James Brown, Director of Golf Courses and Estates

Craig Paton, General Manager

Sebastian Pinn, Deputy General Manager

David McKerry, Property Director

Alan Grimes, Head Concierge

Andrew Rodger, Resort Director

Village Hotels Ltd

Fiona Meek, Risk and Safety Manager

Veteran Fire Safety Ltd

Mark Webster-Clayton, Joint Managing Director

David Woodward, Fire Risk Assessor

Expert and Opinion Witnesses

Gary Love, Watch Manager, Scottish Fire and Rescue Service (Retired)

Dr Julie McAdam, Forensic Pathologist, Head of Forensic Pathology Service, University of Glasgow

Richard Vallance, Forensic Scientist, Scottish Police Authority Forensic Services,

Mike Wisekal, Senior Investigator, Jensen Hughes

Peter Drummond, Architect, Peter Drummond Architect Ltd