Manchester Arena Inquiry

Day 68

March 1, 2021

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Monday, 1 March 2021

(10.00 am)

(Delay in proceedings)

(10.07 am)

MR GREANEY: Sir, good morning. I'm sorry that we're starting 7 minutes late, I do know that you are very keen that we should start promptly at 10, but it was necessary that I should spend some time with this morning's witnesses. It's my fault and you have my apology.

The first witness today is Brigadier Timothy Hodgetts. May I begin by making plain that in the course of his evidence this morning he will be dealing in detail with the treatment of blast injuries, including the use of tourniquets. Whilst his evidence will not be graphic, it is plainly capable in my view of being distressing and so those effected by the arena attack should carefully consider whether they wish to view and hear this evidence.

Having given that warning, could I ask that the brigadier be sworn, please.

BRIGADIER TIMOTHY HODGETTS (sworn)

Questions from MR GREANEY

MR GREANEY: Would you begin, please, by telling us your full name?

A. Timothy John Hodgetts.

Q. Brigadier, your purpose in giving evidence today is to explain the work of a charity called citizenAID; is that correct?

A. That's correct.

Q. And are you the chair of trustees of that charity?

A. I am, since its inception.

Q. Before we get to that, we should deal with your qualifications and experience. I'm at paragraph 2 of your first witness statement, although of course this material will be most familiar to you.

Are you a registered medical practitioner?

A. I am.

Q. In other words, a medical doctor?

A. I am, with a qualification in BBS.

Q. Do you hold fellowships of the Royal College of Physicians of London?

A. Yes.

Q. The Royal College of Surgeons of Edinburgh?

A. Yes.

Q. The Royal College of Emergency Medicine?

A. Yes.

Q. The Faculty of Pre-hospital Care?

A. Yes.

Q. And the Chartered Management Institute?

A. Yes.

Q. Were you appointed a consultant in emergency medicine in 1995?

A. Yes.

Q. And have you been an honorary university professor since 1998?

A. Yes.

Q. With a current appointment at City University of London?

A. Yes.

Q. Were you made an officer of the Order of St John in 1999?

A. Yes.

Q. A Commander of the British Empire in 2009?

A. Yes.

Q. And in 2018 were you appointed the honorary surgeon to Her Majesty the Queen?

A. Yes.

Q. In 1983 were you commissioned in the army?

A. I was.

Q. As both the chairman and I have indicated, do you currently serve at the senior rank of brigadier?

A. I do.

Q. What current official appointments within the army do you hold, please?

A. I am the senior health adviser to the army and the head

of the Army Medical Services and that's also linked to being a commissioner at the Royal Hospital Chelsea.

Q. Are you also the Surgeon General Elect?

A. I am.

Q. What does that mean, please?

A. It means that from 21 May this year, I will be the Surgeon General.

Q. The Surgeon General being?

A. Surgeon General is the senior serving doctor within the armed forces.

Q. Do your previous roles in the military include being the defence consultant adviser in emergency medicine?

A. Yes, I held that post from 1997 to 2008.

Q. The defence professor of emergency medicine?

A. Yes.

Q. And medical director of the defence medical services?

A. Yes.

Q. And lest we should think that you've spent your service in this country in hospital, you have served, have you not, on operations in Northern Ireland?

A. Yes.

Q. In Kosovo?

A. Yes.

Q. In Iraq?

A. Yes, four tours.

Q. And in Afghanistan?
A. Yes, three tours.
Q. During those operational deployments, have you dealt with quite literally hundreds of casualties suffering blast and ballistic injury?
A. I have.
Q. Does that include as both an emergency physician and a helicopter retrieval doctor?
A. It does.
Q. Just so we can understand those terms -- helicopter retrieval doctor might perhaps speak for itself, so you would be within a helicopter going to a scene?
A. Flying forward to the point of wounding to pick up the seriously injured at the point of wounding and bringing them back to hospital.
Q. And the distinction between that and emergency physician?
A. Emergency physician is at the front end of the field hospital running the resuscitation.
Q. And indeed on six of your deployments, were you the medical director of a field hospital?
A. I was.
Q. In parallel with those operational deployments, have you been responsible for developing many concepts, curricula, manuals and clinical guidelines that relate

to first aid, pre-hospital emergency care, hospital-based resuscitation, and major incident management?
A. I have, since the early 1990s.
Q. Have you published widely, both books and papers, on pre-hospital and emergency care and the emergency treatment of combat injuries?
A. I have.
Q. What is the major incident medical management and support course and what part have you played in that?
A. I was one of the original authors of that particular programme. It is a programme for doctors, nurses and paramedics, in what to do at the scene of a multi-casualty incident. The trigger to that was after I had been involved in a bombing of a hospital in Northern Ireland in 1991. I was working at the hospital, 2 November 1991, and I wasn't actually in the room when the bomb went off but I was close by. It was an IRA bomb targeting the doctors, nurses and workers at the hospital. I acted as the medical commander at that particular incident and it was really quite an inflection point for me and I reflected on it deeply on it afterwards and I wrote about it in an academic journal. I thought we did well but we could have done better if there was some kind of system that we could

apply at the scene. There was no such system internationally, so we invented the major management and support programme which trains the medical professionals at the scene and it has become an international standard and the standard within NATO since then.
Q. And that's often known as the MIMMS system?
A. It is.
Q. Did you develop and manage for 13 years, from 1997, the system of major trauma governance in the military?
A. I did.
Q. Did that ensure learning from every soldier's serious injury or death?
A. It did.
Q. The purpose of that being to drive continuous improvement in patient outcomes?
A. Patient outcomes and patient protection, be that personal, system protection or vehicle protection.
Q. In terms of what that process of major trauma governance has demonstrated, what would you say?
A. Well, personally I would say it was the most important initiative in driving continuous change because it gave us the data to show what we were doing was either working or not working. It was a system that I took from Australia because they had a regional trauma system in the 1990s which the UK did not. I implemented it in

a UK hospital in 1997 and showed year-on-year for 3 years that our outcomes were continually getting better. I took that system to Kosovo in 1999 and for the first time we were then able to demonstrate that our military outcomes in the field were as good as NHS outcomes and then we used it from the start of the Iraq and the Afghan campaigns from 2003 onwards to generate month-on-month improvement, and we got a strategic drift in the outcomes of our military patients. We were able to get better outcomes in the field than we could get back at home in the UK because we were so aggressive with our governance, our weekly telephone conferences of all of the deployed hospitals, sending somebody to every military post-mortem, ensuring we learnt the maximum from every single death, putting it on a single registry so that we could continue to improve.
Q. And this maybe goes without saying, but the serious injuries and deaths that you were considering, recording and indeed learning from related to or commonly related to ballistic and/or blast injuries?
A. Yes. In fact we showed that between 2003 and 2012, 70% of the injuries were in relation to blast and every year, 2003 to 2012, although the injury severity got worse, the outcomes got better.
Q. As part of that, did you introduce and measure the

impact of a tourniquet for every soldier engaged in combat operations from 2005?
A. I did. We introduced the concept of bringing the tourniquet back in 2005 when we changed our paradigm from ABC, airway, breathing, circulation, to CABC, catastrophic haemorrhage, airway, breathing, circulation, and we introduced a tourniquet for every soldier from 2006 and, yes, we tracked the impact of that very carefully.
Q. Having tracked the impact of that, were you able to demonstrate that the use of a tourniquet or the availability to a soldier of a tourniquet saved lives?
A. Yes. So in the year up to 2007, we had 70 patients who had 107 tourniquets applied. Their survival was 87%. And there was very minor complications as a result of that; 1.5% identified with transient nerve compression symptoms. When the Americans published their series in 2011 of 499 patients with over 800 tourniquets applied to those patients, they had the same survival, 87%, and the same complication rate of about 1.5% of transient nerve compression.
But in both groups there was no case when a tourniquet was applied there was any unnecessary following amputation.
Q. We're going to come on, are we not, to look at

tourniquets, but the message is that in the event of an explosion where blast injuries are sustained, the use of a tourniquet is or may be absolutely critical?
A. It's critical and also the time at which it is applied is critical because in that larger American series of the 499 patients, they also identified that a higher survival up to 96% was when the tourniquet was applied before shock had ensued, in other words before the patient had lost so much blood that they were classified as in serious shock.
The survival fell down to 4% if the patient was substantially shocked at the time the tourniquet was applied, in other words they had already lost a critical amount of their blood volume.
Q. So we are jumping ahead, which is my fault, something I do often, but that's helpful for you to indicate. That's what I wanted to ask you about your background and experience and I'm sure I'll be excused for framing what I next say as a comment rather than a question, but in those circumstances, you are well qualified, to say the least, to express the views and give the evidence you're about to give.
SIR JOHN SAUNDERS: If I may say so, it sounds like hugely impressive work that you've done.
A. Thank you.

MR GREANEY: Does the Queen Elizabeth Hospital in Birmingham have some relevance to what you're about to tell us?
A. Yes, the Queen Elizabeth in Birmingham has been the receiving hospital for all soldiers returning from operations since 2001 and hosts the Royal Centre for Defence Medicine.
SIR JOHN SAUNDERS: Is it actually the QE or a branch of it somewhere else?
A. No, it is the QE.
SIR JOHN SAUNDERS: The QE building?
A. Yes. Originally it was on a split site with the Selly Oak Hospital being the acute site, but a part of the same trust. In 2010, everything moved onto a single site about -- they're about a mile apart.
SIR JOHN SAUNDERS: Yes. Thank you.
MR GREANEY: Do you either work at or work closely with those at the Queen Elizabeth Hospital?
A. I had previously been a consultant within that trust and I continue to work closely with individuals at the hospital, yes.
Q. As the inquiry knows and indeed as you know, 2015 saw a significant rise in the number of terrorist attacks within Europe.
A. Yes.
Q. And indeed, within that year, in January 2015, the

Charlie Hebdo attack occurred and, later that year in the November, the Bataclan and associated attacks took place.
A. Yes.
Q. In the latter part of 2015, did you and senior colleagues in Birmingham become concerned about a particular issue?
A. We did. What we became concerned about is that we could see terrorism marching across Europe, there were instances, as you say, in Turkey, Germany, France, Belgium, and we believed that it would be inevitable that something would come back to mainland UK because we had experience before of terrorism. Indeed, we were aware that the Met police commissioner had said it was when, not if, an event was going to happen in the UK.
So we reflected on whether or not there was anything available to adequately prepare the public if they were unusually but unfortunately caught up in such an incident and we believed there was nothing that integrated all of the necessary information in terms of the safety information for yourselves and the wider public at the scene, how to communicate from the scene and at the scene, how to sort out the priorities of patients if there are multiple patients, and then how to treat them in a systematic way. We did not believe

anything existed and yet we did believe that we had that information from our experience and our track record of developing curricula.

So we took it upon ourselves —— we were not tasked, we saw it as a moral duty —— to get this information out to the public.

Q. So you've just made the point, but let's be absolutely clear about it: no one told you to do this?

A. No.

Q. This is something you and your colleagues decided was necessary and you took it upon yourselves to do?

A. Yes.

Q. The way in which you put it in your witness statement —— I'm at paragraph 4 at the bottom of page 2 —— is this:

"As clinicians deeply experienced in the emergency management of blast and ballistic injury, and as experienced educators and innovators of training and first aid pre—hospital care, we could not identify any public information or training system that would adequately prepare the public to react and save lives when faced with multiple serious casualties from a deliberate attack."

A. That's correct.

Q. "Our clinical experience from contemporary conflicts had confirmed that rapid treatment in the first 10 to

15 minutes following combat—type injury improved the probability of survival and had contributed to a documented cohort of unexpected survivors."

A. That's right. The survival requires every link of the chain to be effective, which is why you require that aggressive governance of the whole chain. But it starts in the first few minutes. If you haven't got the care within that platinum 10 minutes, particularly to stop the catastrophic bleeding or to open an obstructed airway, then there will be potentially avoidable deaths.

Q. You use in your statement the term "unexpected survivors"; what does that term mean in this context, please?

A. That relates to international models, mathematical models which are able to predict on an individual and a systems base whether you have more than a 50% probability of survival or not. If you have less than a 50% probability of survival and you survive, then you fall into an unexpected survivor category.

If particularly you get down the lower end of the scale, perhaps less than 5% or less than 1% mathematical probability and you are surviving, then there is something quite disruptive within your system. And that's what we were identifying. We were identifying individuals with very high injury severity scores and

yet they were still surviving. In fact, we identified people with maximal injury severity scores, who by all calculations should have died but they were surviving.

Q. You've used the term rapid treatment. Being realistic about it, at what point must such treatment be administered?

A. You talk in the first few minutes after injury and it's why for soldiers we've pushed the understanding and the capability, the equipment far forward so you can look after whoever is next to you who is injured, so whether that soldier is next to you in a trench, in a vehicle, on a patrol, you rely on your buddy to actually be able to step in in the first couple of minutes after injury or the first few minutes, that platinum 10 minutes, and be able to make a difference.

Q. You describe in your statement that being the rationale for self—aid and buddy aid.

A. Yes. In some instances you still have enough gumption to be able to treat yourself. I could recall a case of an individual soldier who had lost three limbs but was still conscious and was able to use his tourniquet with his one remaining arm to apply to one of his injured limbs before his mates arrived rapidly to apply tourniquets to the other limbs. So there is an element of self—aid as well as buddy aid.

Q. From what you've said to us already, this is something which is taught and taught extensively to soldiers in the British Army?

A. It's mandatory annual training for all soldiers within the army, but also before they deploy they will get refresher training and practical training to put it into the context of where they're deploying.

Q. Is that training known as battlefield casualty drills or BCD?

A. It is.

Q. Since when has that system been taught to soldiers?

A. I designed that system in 1998. It was called battlefield first aid at that particular time and it was re—badged as battlefield casualty drills just before the start of the Iraq War in 2003. It contains a simple system, control then ACT, of how to manage the incident. So control the setting and assess, communicate, triage, sort the patients into priorities for treatment, and then follow a very simple set of predetermined drills because if you follow the system, you will do the right things in the right order and have the maximum chance to save life.

Q. So this is very important, is it not, to what we're going to be discussing in terms of the general public?

A. Yes.

Q. So assess, communicate, triage, ACT?
A. Yes.
Q. Since 1998 there has been this understanding in the military and there has existed battlefield casualty drills of which you were the author. And that was, as we've understood it from what you've said so far, something which was proven to save lives?
A. It has been proven in the contemporary conflicts. We have made major improvements to it over time so it is now in iteration 10, last published in 2018.
Q. So in late 2015, when your group in Birmingham were concerned about the significant increase in terrorism around Europe and were positing that this was bound to happen in the UK, were hearing Dame Cressida Dick in July 2016 saying exactly that, what was your line of thinking given your experience of BCD and how it worked?
A. Our line of thinking was that we had disruptive outcomes because we had pushed the understanding and the equipment forward to individual soldiers on the ground. So the analogy is that if we push that understanding and equipment potentially forward to the public then we can get the same benefits in the public setting as the military setting.
This is something that has happened psychically in the last couple of hundred years: medicine advances

in war and then, in the peacetime setting, those benefits spread into the wider civilian healthcare community. So this was really an extension of that to ensure that we were taking those benefits from the military understanding and ensuring that the public had the maximum benefit.
Q. Did citizenAID develop directly out of that thinking?
A. Yes.
Q. We'll just deal with some of the basics in relation to citizenAID and then we'll deal with the important evidence you have to give about what citizenAID communicates to the public.
Is citizenAID a registered charity in England and Wales?
A. It is.
Q. Before establishing its own independence, did it function as a charitable fund within the Queen Elizabeth Hospital Charity?
A. It did.
Q. Does it have a governing board of seven trustees of whom you're the chair?
A. Yes.
Q. And a network of ambassadors?
A. Yes.
Q. And has funding been through a combination of charitable

grants, donations from royal colleges, the British Medical Association, the Fore Trust and the Wesleyan Foundation?
A. It has.
Q. Together with donations from industry and the sale of products through the charity's shop?
A. Yes.
Q. I'm now at paragraph 6 of your witness statement. What is the principal objective of citizenAID?
A. It's about enhancing public resilience. So it's about enabling, empowering the public to do the right things in the right order to save lives in the unusual but not impossible event of being caught up in a deliberate attack. When we first launched the charity, we were thinking about shooting, stabbing and bombing. But in version 2 of the products we extended that to vehicle attack and acid attack because of what we were seeing within the community.
Q. As you express in your statement:
"The principal objective was to provide knowledge and understanding of how a member of the public can keep safe in a range of deliberate attack situations and, when safe to do so, to prioritise and treat the seriously injured."
A. That's right.

Q. In terms of that objective, namely the prioritisation and the treatment of the seriously injured, what was the connection between that objective and the availability of medical equipment and/or training?
A. What we recognised was that if equipment is present, of course use it. Use the equipment for the purpose that it is designed. If equipment is not present, it's okay to improvise. There are many skills, including the arrest of severe bleeding, that can be improvised.
Q. And to put it in simple terms, is citizenAID designed to empower the public to save lives in the critical minutes before the emergency services are able to attend?
A. It is.
Q. In your statement you state that:
"This is a recognition of the fact that there may be an extended barrier time to patient contact during a terrorist incident."
A. That's right. Dr Christina Hernon, who was present at the Boston marathon bombing, called that the disaster gap, so the time from the incident happening before the emergency services can actually make contact with the patients and the only people who are able to actually intervene at that time are the people who are trapped within the incident who need to be able to look after themselves and others.

Q. Does the system that citizenAID has devised prioritise addressing the most commonly avoidable causes of death from combat−type injuries?
A. It does, and battlefield experience is that the most commonly avoidable cause of death from combat−type injuries is external bleeding and specifically external bleeding from limbs.
Q. So the system is about or principally about ensuring that the public have an understanding of how to treat such injuries?
A. It is about that, but it is not just about that. This is where we differ from the American "Stop the Bleed" campaign. The Americans introduced their "Stop the Bleed" campaign from around the same time, around 2016, but all that talks about is the arrest of haemorrhage, it doesn't integrate the national scene safety messaging, it doesn't integrate the communications, it doesn't triage, and it doesn't have any intervention other than arrest of haemorrhage when there may be other issues that can be amenable to treatment by the public until the emergency services are available.
Q. So the system wasn't just about saying to a member of the public, "Here, you can identify this serious injury resulting from an explosion; this is how you treat it", namely by the application of a tourniquet? It was about

that but it was also about dealing with a situation in which, for example, someone injured in an explosion wasn't breathing, what might you do to help them in that situation?
A. Yes.
Q. So a more holistic approach?
A. Yes.
SIR JOHN SAUNDERS: And the reason for the American view is perhaps because they think if you get one message across you're doing well, trying to get more than one is impossible? You don't agree with that?
A. I don't agree with that and indeed we've been able to achieve that mixed approach with soldiers. If we can train soldiers, we can train the public.
MR GREANEY: Perhaps it isn't just about training, but as we're going to see from the app that has been produced in due course, it's about producing a method by which they can, in a highly pressured situation, work out what to do?
A. It is, but we would strongly encourage that if people are going to use the app, they familiarise themselves with it and not try and just download it and use it on the day, which we have seen in some incidents, such as the Las Ramblas vehicle attack in Barcelona, we were spotting that the app was being downloaded during the

incident, which may have given some benefit, but I think would have given greater benefit if people had prepared themselves in advance.
Q. And members of the public, as you will appreciate, will be watching these proceedings, some on a 10−minute delay on YouTube, others may become aware of it subsequently, but I know that an important message that you want to get across and which I have no doubt the inquiry will want to support is that people should download your app, which is available at Google Play or the Apple App Store?
A. Yes, it's a free resource. Please do avail yourself of it.
Q. And all one needs to do is to go to Google Play or the App Store, type in citizenAID, and your app is freely available?
A. Yes. There's no need to register, there's no personal information exchanged, you can just download the app on to your phone.
SIR JOHN SAUNDERS: And then read it.
A. Absolutely.
MR GREANEY: And as we're going to see, one can just work through it and see how it operates?
A. Yes. But there are plenty of supporting materials on the website, there are cartoon explainer videos.

There's a simulated scene of a bombing that people can watch, although there is a caution in watching that simulated scene of a bombing because it could be a little distressing.
Q. I'm going to come on to ask you about the video, which is an extraordinary piece of footage which I know the chairman has viewed and you're right to express caution, but one of the things that I'm going to be doing is to encourage members of the public to view that video, which does communicate many of the ideas that citizenAID wishes to get across, does it not?
A. Yes.
Q. Let's return to the structure of your witness statement. What you are saying to us, as we've understood it, is that the explicit intent of the authors of citizenAID was to use their military first aid know−how with the proven impact to improve the outcomes of seriously injured soldiers to the benefit of the general public, should they suffer comparable injuries from blast or ballistics?
A. Correct.
Q. When was citizenAID established?
A. We did a soft launch supported by the National Counter−terrorism Security Office during the Counter−terrorism Awareness Week in November 2016. We

did a hard launch on 4 January, again supported by the head of National Counter−terrorism Security Office, but through the BBC, and that received substantial public understanding because we had 1 million hits on the website in a single day and we were the trending number 1 app internationally of all apps.

As a formal charity standing alone, it was incorporated, I believe, on 24 November 2017.

SIR JOHN SAUNDERS: So the hard launch was January 2017?

A. 4 January 2017.

MR GREANEY: Let's just be clear about these dates. You inform us in your statement that citizenAID was established in November of 2016.

A. Correct.

Q. And that was designed to coincide with National Counter−terrorism Awareness Week?

A. Yes.

Q. The establishment was possible because of charitable funding which was made available?

A. Yes.

Q. Which was used to create a website that we'll discuss in due course?

A. Yes.

Q. Explanatory cartoon videos?

A. Yes.

Q. A paper pocket guide?

A. Yes.

Q. And a free app for both iPhones and Android phones?

A. Yes.

Q. And before all of that was done there had been close consultation in the development of all of those things with the NaCTSO, the National Counter−terrorism Security Office?

A. Yes.

Q. Because there was a desire to reflect the national messaging?

A. We believed that was essential.

Q. The national messaging being, as the inquiry knows, "Run, Hide, Tell"?

A. That's right.

Q. So what you were seeking to achieve, I think, was consistency between what you were devising and publishing and what was already in existence at a national level?

A. Yes. What we were seeking support for was "Run, hide, tell and, when safe to do so, treat". So to ensure that when people are hiding or trapped within a room waiting to be supported by the emergency services, then they could get on and be empowered to treat.

Q. The hard launch, as the chairman mentioned a moment ago,

was on 4 January 2017 −−

A. Yes.

Q. −− through an extensive BBC media campaign?

A. Yes.

Q. And with about 1 million hits on the website in the very first day of launch?

A. Correct.

Q. I think I've mentioned already, in case I haven't, the website being citizenAID.org?

A. Yes.

Q. And to say the least did, that indicate there was a high level of public interest in what you were seeking to achieve?

A. It did. It also indicated a high degree of international interest.

Q. I believe you say that because there were a high number of early downloads of the app in the United States of America?

A. Yes, and that did concern me for two reasons, that the national message in the UK is "Run, Hide, Tell". In the US it's "Run, Hide, Fight", different culture. But also our emergency number, 999, was on our app, and what I was concerned about is that people might download in America and think that this must be a new number for a terrorist incident and dial the wrong number. So

within 2 weeks we actually created an American version of the app which was free to download in the US, which was adjusted to "Run, Hide, Fight" and with the appropriate emergency service number in it.

Q. We'll look at the app in due course with the assistance of Mr Suter and his iPhone, but let's just deal first of all with what it deals with, what it addresses in summary.

The app deals with a number of potential events, does it not?

A. It does.

Q. One of those events being an explosion?

A. Yes.

Q. For an explosion what advice does the app give?

A. The advice for an explosion is it takes you directly to the first page of Control then Act. And indeed, it is the same information that we are giving to somebody who might be exposed to a vehicle attack. So a vehicle attack and explosion actually follow the same logic: Control then Act.

Q. So when you say it takes you to that page, you literally you press "explosion" on the app?

A. That's right, and the first page of the Control then Act series opens up.

Q. And ACT, let's remind ourselves, is: A the assessment of

hazards and the number of injured?
A. Correct.
Q. C, communication with the emergency services?
A. Yes.
Q. And I think as we're going to see that uses the mnemonic SLIDE?
A. Yes.
Q. And triage, namely the identification of the most seriously injured with a view to treating those persons first?
A. Yes.
Q. Is that approach exactly the same logic that's found in battlefield casualty drills?
A. It is the same logic but it has been contextualised for that civilian setting.
Q. As we've understood already, soldiers have used that aide—memoire in conflict and emergency settings for over 20 years now?
A. Correct.
Q. And it is tried and tested?
A. Yes.
Q. In other words, to put it very simply, that approach works?
A. Yes.
Q. I mentioned that as part of the C of ACT, communication

with the emergency services, the mnemonic SLIDE is used. What does SLIDE stand for in this context?
A. S is situation: what's going on? L, location, as accurate as you can be because clearly the emergency services will respond more effectively the more accurate the location. I, the injured numbers and severity, but it is okay for it to be an estimate, it does not have to be accurate, just accurate enough to get the right resources rolling towards the scene. D is the dangers that you can see. E is the emergency services present and required.
SIR JOHN SAUNDERS: We've heard about what the emergency services do is use METHANE, which stands for —— are you able to do it off the top of your head?
A. I am because I invented it.
SIR JOHN SAUNDERS: Oh right!
A. M is my name or call sign and major incident standby or declared. E is exact location. T, type of incident. H, hazards. A, access and egress. N, number and severity of casualties. E, emergency services present and required.
SIR JOHN SAUNDERS: So that's very similar. Is there any particular reason for using a different one?
A. Yes. Originally I'd put METHANE into the citizenAID system but in our consultation period I consulted ——

together with Professor Sir Keith Porter, we visited the chief executive of the West Midlands Ambulance Service, Anthony Marsh, who I understand is currently the portfolio owner of EPRR, so a very experienced individual. His concern was that we should be able to discriminate a message from the public versus a message from the emergency services. So was there anything else that we could do other than METHANE? And no skin off our nose, we just made it even simpler. So I think we get effectively the same information but in an even simpler format for the public.
SIR JOHN SAUNDERS: You'll understand we're dealing with a plethora of mnemonics in this particular hearing, so one extra doesn't matter too much. That was good to hear the reason for it, thank you.
MR GREANEY: As you've said, you were the inventor of the METHANE message?
A. Yes. So that was part of the original MIMMS course in the 1990s. The reason I came up with METHANE was I heard the message at the time, which the police were using, was CHALET, which was casualties, hazards, access, location, emergency services, type of incident, which was all the right information but in completely the wrong order. It was not a logical order to be giving information on a radio message. So we

re—arranged CHALET to create METHANE.
Q. That was authored in 1995?
A. Yes.
Q. And, as the inquiry knows, continues to be in use today in the current Joint Emergency Services Interoperability Principles, JESIP?
A. Yes. Effectively it took 20 years for METHANE to be adopted into the standards for the UK, so I hope that SLIDE will not take quite as long as that to be accepted.
Q. And SLIDE is a simplification of the METHANE message for the reasons you have given.
We were dealing with the app. Is it the position that the app prompts subtly different information needs under the SLIDE headings depending on the situation that's being dealt with?
A. It does.
Q. So that the information sought might be different depending on whether it was an explosion or an acid attack or a knife attack?
A. Yes, or indeed if you are communicating that you have an unattended item or a suspicious item.
Q. Now, triage, next, which forms an important part of ACT. Triage is what?
A. Triage is the process of sorting casualties into

priorities for treatment. So if you're on your own and you have two casualties to deal with, then you have to decide which casualty to deal with first. In effect, you're looking for the most seriously injured to deal with first.

Q. In your statement you express it in these terms:

"The simple variant within citizenAID is based upon this military triage sieve."

A. Yes. So the triage sieve originated within the MIMMS programme. The military adopted it within battlefield casualty drills and we have refined it to a degree because pure triage involves no treatment at all, it is just about prioritisation. What we have identified in the military or combat setting is you can't wait for the treatment people to come along behind because there are some really time-critical injuries that need to be treated as you find them. So if within triage you identify catastrophic haemorrhage from a limb then put the tourniquet on there and then before moving on to the next casualty to triage. And if you identify somebody who has a reduced level of response and therefore, particularly if they're lying on their back, they might obstruct their airway, their tongue might fall back into their airway and they obstruct their airway, then flip them on to their side into the recovery position before

you move on to the next casualty to triage, so you've done the immediate life-saving intervention without waiting for someone else to come along behind you to do that.

Q. As you have mentioned already, the treatment of casualties in citizenAID is focused on stopping bleeding but is not confined to stopping bleeding?

A. That's right, and within triage you end up with two priority 1 situations. One is stopping that severe bleeding and the other is the individual who may have a potential airway obstruction and that's about putting them into the recovery position. Those are the ones that come out with the highest priority.

Q. We'll see the app probably after our morning break. How does the app seek to achieve a situation in which the member of the public knows how to ensure that occurs? A rather clumsy question but I hope you understand what I'm driving at.

A. The important thing for the public is they don't actually have to think because the decisions are predetermined and it's the same for soldiers. If you follow the system, you will do the right things in the right order, you just need to follow the system.

Q. Quite literally, you just need to assess what is in front of you on the app and press the button or press

the area of the screen that best reflects what you're seeing?

A. Correct.

SIR JOHN SAUNDERS: But as you've already indicated, quite difficult often to do that within the emergency situation, to be using the app at the same time?

A. Of course it can be difficult. It's why actually we'd got the paper pocket guide, because the paper pocket guide is a concertina -- and I do have one here if you've not seen that. On one side of the concertina it is how to manage the incident and on the flip side it's how to manage the incident, and you move along it panel by panel. You could drop that down on the floor when you're kneeling down to the patient or even just drop it across the patient and then you would have both hands available to deal with the procedures while not necessarily worrying about flipping through a phone.

SIR JOHN SAUNDERS: Perhaps a simple way of saying it, from my point of view, is the triage you're talking about at the scene is triaging for the purposes of doing what you can to treat yourself, whereas triage within a medical concept, whether at a hospital or when medics on the scene, tends to be triaging for other people to do the treatment but giving the priorities?

A. If you were injured, we'd be encouraging you to use the

system to treat yourself. If you're not injured or you only have a minor injury and you feel you are able to help others, then you're using the system to help others.

SIR JOHN SAUNDERS: Yes.

MR GREANEY: The way in which it is expressed in your statement is:

"There is a linear logic in the app and the pocket guide where the clinical importance of these conditions is predetermined and the user must follow through to conclusion for each casualty."

A. Yes. That's where the assurance is in the system that the clinical experts have predetermined that order.

Q. Where equipment is available, what does the app encourage?

A. To use equipment if you have it available, so to use dressings or commercial tourniquets if you have them available by all means. If you don't, it's okay to improvise and even if you do have equipment, you might run out because that equipment is finite and there may be more casualties than there is equipment to treat.

Q. Is the pocket guide that you've referred to readily available?

A. Yes, through the charity website.

Q. I said after the break, but we haven't been going for

quite an hour yet and I think we will try and look at the app now. Sorry, I didn't give Mr Suter quite the level of warning he needed. I know it's going to take a minute to switch over the systems.

So we are there looking at the ——

SIR JOHN SAUNDERS: Okay, it's on the big screens, is it? Have you got it? You can see it? Okay, thank you.

MR GREANEY: It did come on the smaller screens earlier. That's what taking the time.

SIR JOHN SAUNDERS: It's now come on the smaller screens, thank you.

MR GREANEY: If we therefore go to the homepage, Mr Suter. Are we there looking at the various situations that the app is designed to assist with?

A. That's correct.

Q. We've spoken about the pocket guide as well. The app and the pocket guide are materially identical, are they not, in format and in what they are designed to achieve?

A. Except within the pocket guide there's only one version of SLIDE.

Q. I see. So:

"Knife attacker, active shooter, vehicle attack, explosion, acid burns, unattended item, suspicious item, treatment, prepare and learn."

The part of it that I'm going to ask that we look at

is explosion.

SIR JOHN SAUNDERS: I'm not going to ask to look at it, but active shooter. It sounds a bit odd to me, rather than saying gunshot wounds.

A. Yes, and we're always open, sir, to refinements, so thank you for that feedback. We will immediately take that. It is very much an emergency service term and perhaps an Americanised term.

SIR JOHN SAUNDERS: Right. Let's go to what you wanted to go to.

MR GREANEY: We can all look at active shooter in due course, but it includes important advice, for example, about not using one's telephone to make a call in the event of such a situation.

A. If you go to knife attack or active shooter, the next screen is about ——

SIR JOHN SAUNDERS: I'm really sorry to have diverted. I can look at it on my own.

A. It's about turning your phone to silent because you are into the "Run, Hide, Tell" territory when you're in active shooter and knife attack. So it's a different logic for managing the incident, as it were, but once you get on to patient treatment that is a common logic, whatever the cause.

SIR JOHN SAUNDERS: Thank you.

MR GREANEY: We will just look at active shooter because we're very keen that the public watching this should understand the utility of this app.

Mr Suter, could you press on active shooter? We're then seeing the screen that you have told us about, "Switch phone to silent".

A. Yes.

Q. No doubt it's for the obvious reason that you don't want to receive a call when you are hiding from someone who's intent upon shooting you.

Next, please. We can see the various options.

A. The important element with the active shooter or the knife attacker is that you've understood in advance that you have to run, hide, tell. We don't want people to have to look at the phone, look at the pocket guide, to know that they have to run, hide, tell. But while preparing yourself, if you, for example, go into hide, there is additional information that sits behind that to prepare yourself. Also it draws to the attention of the public the 55 system, which is becoming more increasingly known but still is not well—known that, where if you are unable to speak because you're hiding from a terrorist, or even in a case of domestic abuse, you might be hiding and you don't want to be heard, when you dial 999 and say nothing, you'll be put forward to

an automated system where will ask you to press 55.

SIR JOHN SAUNDERS: What's apparent from what we're seeing is there's a great deal more information here than just how to do your best to treat people who are injured.

A. Yes.

MR GREANEY: Let's go back one page and we'll see the very point the chairman is making. We can see option 3 is "How to treat".

A. Yes.

Q. If we press on that, we can see various scenarios are there identified. And if we were to click on any one of them, it would give advice on what to do?

A. It will and this is the same advice you would get if you came through vehicle attack or explosion.

Q. So we won't go to that at this stage, but we're seeing already the way in which the app works?

A. Yes.

Q. Could we go back to the homepage, Mr Suter, and then click into explosion.

So we have this screen you told us about already, Control then ACT, and advice is given. Then we have a button at the bottom, "Assess the scene".

A. Yes. The Control page, there's a real safety element here. First of all, it's your personal safety, but the 1, 2, 3 of safety that we have within MIMMS is yourself,

the scene and the casualties. So there's elements of scene safety here too. If there was an incident outside and vehicles were moving around, how do you control those so they don't injure patients who might be on the ground? And how do you free casualties from danger and put them in a safe place to wait while awaiting the emergency services?

SIR JOHN SAUNDERS: Of those I am not sure I would instantly understand 3 of the Control:

"Only control access if safe."

A. So safe for you. That's your personal safety.

SIR JOHN SAUNDERS: But it means letting people in or?

A. So if you were outside and you've dialled 999, then there's going to be a lot of vehicles that are going to be arriving rather quickly and there might be casualties who are in the road. Think of the Boston bombing with lots of casualties lying around in the street. You've called the emergency services in, you don't want secondary casualties from people arriving at haste and not realising there are casualties in the way.

SIR JOHN SAUNDERS: Okay, thank you.

MR GREANEY: Mr Suter, can I just check that we are broadcasting this image on YouTube? We are, thank you very much.

Before we go further and assess the scene, I'm sure

you can understand the point the chairman was investigating earlier. This is obviously a wonderful app, but one has to think about the situation of a member of the public who is placed in a truly extraordinary situation of having to respond to an emergency in the sense of an explosion. One can also understand that a soldier who is trained annually in these techniques will understand, if not instinctively, readily what to do. How does one ensure that a member of the public, even one with this app on the telephone, has that level of assurance or confidence?

A. A member of the public can only do their best, and the app is there to try and get the best out of that individual. If that individual has taken the time to work through it and mentally rehearse it then they'll probably perform better. If that individual perhaps has looked at some of the videos that are online, they will do even better. If that individual has been on some of the training that is available from citizenAID, then they will do even better.

If you open the app for the first time at the time of the incident, you will do your best, but you may not perform as well as if you'd had the chance to prepare yourself.

Q. So the message, certainly as I've understood it, is

download the app and ensure that you are familiar with it at the time that you do that?

A. Yes.

Q. And perhaps go back to it from time to time?

A. Absolutely.

Q. And watch the videos?

A. Yes.

Q. Mr Suter, we were working through this. The next page I would like to go to, please, is "Assess the scene".

Could you describe that page to us, please?

A. First of all, it's about assessing for dangers which might change, they might emerge, or as you move around the scene, particularly at the scene of a bombing, you might identify an unattended or suspicious item that represents a secondary device and therefore you can go to the page for unattended item or suspicious item, which really will be telling you to move away and report it.

Q. The bottom button on the page, "Communicate". We'll go there next, please. There we see SLIDE. So this is the concept of the member of the public communicating with the emergency services and giving the information that the emergency services require in the order in which it'll be most helpful to them?

A. It does, and if you were to press the yellow

999 button -- I do not recommend that, please, because it will actually link you to -- it'll ask if you want to call 999, you'll say yes, and you actually call the emergency services.

SIR JOHN SAUNDERS: We could see if it works, couldn't we?

A. Well, you could. I would recommend being in flight mode if you're going to be practising that particular function.

MR GREANEY: So then we have communicated and the next thing in accordance with ACT that we should do is triage?

A. Yes.

Q. So that's the bottom button on the page. This really is a page that one needs to be familiar with before being in the midst of an attack?

A. It is. But what it's just reminding you is that if you're at the top of the page and you do just have one casualty or you've been given the responsibility to look after one individual, then you can go directly to the treatment page. But if there are more than one casualties then you do need to sort out who you're going to treat first and, as I said earlier, it identifies two categories that are priority 1, which are the two categories that the public can make a specific difference in, even with no equipment or with improvised equipment, while waiting for the emergency services.

Q. So if we work down: "Begin, 1, 2, 3, triage". What does the 1, 2, 3, mean in that context?
A. The triage priorities, so priority 1, priority 2, priority 3, and they represent the larger coloured squares down the right-hand margin of the page.
Q. So "Single or last casualty", this idea that one just has one person to deal with. That's the person you're going to treat, so we would press on "Go" to go to that. Otherwise if there's more than one casualty, work down the page:
"Multiple casualties. Severe bleeding. Yes. Pack and press the wound and/or use a limb tourniquet."
And then if there is not severe bleeding, other options are there provided.
A. Yes.
SIR JOHN SAUNDERS: And the logic? You have told us that severe bleeding and if there are any signs of life but unconsciousness use the recovery position, just as a matter of interest, why do you start one from one end and the other from the other end?
A. Because what's been demonstrated to kill you really quickly with combat-type injuries is the rapid loss of blood. So that's what we want you to get on with and then the walking -- you can very quickly say, "Go and sit over there", because people who are walking, you

immediately take them out of the equation. Then identify those who are talking, which means that they are alert or responsive to voice on their response scale, so they can wait, they are not priority 1 at that point, so you're left then with people who are either sitting or lying and are effectively unresponsive and they therefore have a potential airway issue that you need to protect. It's all something that can happen very, very quickly.
MR GREANEY: We see:
"Severe bleeding. If yes, pack and press the wound and/or use a limb tourniquet."
What does packing and pressing the wound involve and when and why would one do that?
A. Tourniquets are only appropriate for limb injuries. If you have an injury that is bleeding that is not on a limb, then your only option is to pack and press. If you have an injury on a limb then you can try packing and pressing first because that might be sufficient, you may not require a tourniquet. If you do not rapidly gain control of significant bleeding which is on a limb by packing and pressure then you progress to the tourniquet, or, as you'll see when we get to the tourniquet page, if the limb is clearly severely mangled or has been amputated, then you move directly to

a tourniquet because packing and pressing is just going to be too difficult to achieve.
Q. So the term packing and pressing, pressing may be obvious but not everyone will necessarily understand what the packing part of that is. Would you explain that, please?
A. Yes. You will see it later on the bleeding page. Packing means you have to put something into the wound to fill that wound cavity. Then you apply pressure over that so you get what we would call a tamponade effect: you get pressure against the wound edges, within the wound bowl. Simply placing a dressing over the top of a significant wound is not going to stop the bleeding; you have to get the pressure inside the wound.
Q. Once we have worked through this page, we can see "Go" at the top right, which takes us to a series of further options. We won't work through each of those, but we will work through severe bleeding, please.
This is the page which is perhaps of greatest relevance to the inquiry. Could you talk us through this page, please?
A. As we have already identified, if you see a limb that is amputated or mangled, then you go directly to placing a tourniquet on that, and if you need to be prompted how to put that tourniquet on, then it takes you to that

page, which we can follow.
If it is not a mangled or amputated limb, then you're going to try packing and pressing first. A very superficial wound is just going to need dressing and pressure over the wound. But a penetrating wound is going to need pressure into the wound. If it has a narrow entry then packing with gauze if you have it, so if you have medical equipment, use it, if you don't have medical equipment then a piece of clean cloth or clothing could be pushed into the wound with your finger and use your finger.
For a slightly bigger wound, then you may be applying pressure with one, two, three, knuckles, and a very large wound may require your fist.
Q. We're told, "Use equipment but it's okay to improvise".
A. Yes. So the icons there on the left-hand side are showing gauze or a trauma bandage, but you could use, as shown there, a tie, a sock, a scarf, T-shirt, or some kind of sanitary product, a clean sanitary dressing or a nappy with an absorbent pad is something that you could improvise with.
Q. And indeed in the video that we have spoken about, there are descriptions of nappies being used to pack a wound. There's then a requirement to maintain the pressure and elevate the limb and questioning about whether bleeding

is thereafter controlled. And by a number of routes we may be taken to the tourniquet page. So could we go to the "Go" in the middle top?

"Tourniquet. For limb bleeds only. Place just above bleeding and not over a joint."

Could you explain that page to us, please?

A. Yes. First of all, there is one indication for a tourniquet: it is life-threatening limb bleeding that cannot be controlled by other means. So we've identified that you may have tried packing and pressing, but if it's a mangled limb or an amputated limb then you are going to need a tourniquet to control that.

Q. Can I ask you to pause for one moment so we can ensure we understand something. The person that we're concerned with is a member of the public who almost certainly will not have formal medical training, who may not have even any first aid training. How is that person to make the critical assessment you've just described, which is a condition for a tourniquet, of concluding that the person they're dealing with is in a life-threatening situation?

A. Right. Firstly, has the limb been amputated? Is the limb mangled? If the answer is yes, then a tourniquet above the level of the injury. Otherwise if you're not sure, you're going to be trying packing and pressing

first. If it's clear that the bleeding is continuing, even though you are packing and pressing, then that is life-threatening bleeding and you then would proceed to a tourniquet.

Q. Sorry, I interrupted you. Would you carry on to explain this page to us, please.

A. This talks you through how to improvise a tourniquet. If you had a commercial tourniquet then of course you can use it. But if you don't have a commercial tourniquet, you can improvise. So you need a strip of material. That could be a gentleman's tie, a lady's scarf, particularly those thin non-stretchy scarves, if you try improvising with those, they work very well, or a triangular bandage and specifically a calico bandage that doesn't stretch.

You can use any piece of firm material that's lying around, a piece of wood, a piece of metal, a piece of cutlery.

SIR JOHN SAUNDERS: Okay, just let me stop for a moment because this is something which has obviously been considered. I have seen the video so I do perhaps understand. The most immediate tourniquet that most people have no knowledge at all, like me, would think of would be to use a belt and that's probably one of the most common items that would be present. I know in the

video you don't say don't use it, you say the problem is you have to keep tightening it.

A. You'll find the belt a little bit further down the page. After item 4 it says a belt pulled tight can work but we would prefer you use a windlass-type tourniquet. That is likely to be more effective than -- and easier to continue to apply the pressure -- than a belt, which someone's going to have to stay there and continue to pull with even and hard pressure indefinitely until help arrives.

SIR JOHN SAUNDERS: Okay. Forgive me for not going down the page, I should have done.

MR GREANEY: Not at all, sir. This is an important issue.

A. And may I just interject. I have used a belt before to improvise a tourniquet. It's a long time ago, 1986, at the scene of a road traffic accident, where a young man had lost his arm above the elbow and I used his belt to improvise a tourniquet until the emergency services arrived and they took 30 to 45 minutes to arrive because it was at night on a country road, and that individual did survive the injury.

MR GREANEY: Indeed, there is quite a remarkable end to that story, is there not, brigadier? That person went on to win medals at the Paralympics.

A. He did.

Q. Let's just work through this page, which is an important one for reasons which everyone in this room is aware. Just explain what the process is, please, for the application of a tourniquet?

A. What you need, you need a band of material above the level of the injury, and then you need to be able to tighten that band of material only as tight as is necessary to stop the bleeding, so you need to create what we call a windlass and the way we do that is to tie some kind of rod in a knot and then twist that rod and for the rod you can use any piece of material that's to hand or indeed what the charity has designed, a little plastic key called the Tourni-Key. The reason we designed that is to have something really cheap and effective which can secure the rod once it has been twisted. Because otherwise someone is going to have to stay with the patient and hold that rod in place. It's absolutely plausible that if you have limited people that can do the treatment, you want to be able to move on and have safely secured it.

SIR JOHN SAUNDERS: And when looking at the video again, you're talking about improvising, it uses in the video a piece of wood --

A. Yes.

SIR JOHN SAUNDERS: -- and actually perhaps that part is the

one where you're least likely to have something available at the scene to allow you to do that.
A. Yes. You have to have the mental agility to think broadly. You can probably get away with a pen. It might not be strong enough to do the windlass, but if that's all you've got, then that's what you would try.
MR GREANEY: And I think in the video a screwdriver is also used?
A. Yes.
Q. So it's really just a question of making the best of what is available at the scene if there is no formal medical equipment available?
A. And feeling empowered that it is okay to try and improvise.
Q. So one gets the item into the knot and twists?
A. Yes. Sometimes one tourniquet will not be enough and the data that we mentioned earlier, the UK and the American data, where you have many more tourniquets than patients, it may be because more than one limb was injured and required a tourniquet each, but it might be that a second tourniquet was placed above the first. And particularly for high leg wounds where there's a lot of muscle bulk, the one band may not be enough. So if it's still bleeding, place a second tourniquet immediately above the first.

Q. How do I know when or whether I should apply a second tourniquet? How do I know when to stop twisting the item within the knot?
A. It's visual. You are putting a tourniquet on because there's bleeding that you haven't been able to control by other means. You tighten it until that bleeding stops. If you cannot get the bleeding to stop with a single tourniquet, you place a second tourniquet, and even if there were some bleeding that continued to a minor degree after the second tourniquet, that's pretty much as good as you can do, but it is likely that one or two tourniquets is going to stop that bleeding.
We're talking about a very simple system here: there is a pipe with blood in it that just needs to be compressed closed through the application of that circular pressure.
Q. In terms of what a person needs to achieve that result, the material is likely to be readily available. Many people in this hearing room are wearing a tie, for example, or maybe wearing a scarf and other items maybe to hand. What might not be, as the chairman has identified, so readily to hand is the item that goes into the knot and which is used to apply the mechanical pressure?
A. Yes.

Q. Along the way of one of the answers you gave you mentioned that citizenAID, the charity, has devised something called the Tourni-Key?
A. That's right.
Q. How readily available is a Tourni-Key?
A. The Tourni-Key is available through the charity shop.
Q. Would I have to drive to Birmingham to --
A. No, it's all online.
Q. And have you brought with you an example of a Tourni-Key?
A. I have.
Q. I'm going to be guided by the chairman. It's often thought that demonstrations in court are not a good idea and may go wrong, but I think you are in a position, are you not, to demonstrate what you have been telling us about?
A. If that's permissible.
SIR JOHN SAUNDERS: I just hope it's not going to be distressing to anybody, but everyone is aware of what's coming. Yes, do.
A. I'm going to use a very simple model that was prepared by the court just as I arrived.
SIR JOHN SAUNDERS: That's just to blame us if it goes wrong!
A. It's really simple when you look at it. So our idea

is that you can practice this as home, you do not need any sophisticated equipment to practice a tourniquet, but you should never be practising on each other. That's a cardinal rule: do not practice on somebody who is alive. The only indication for a tourniquet is life-threatening limb bleeding that cannot be controlled by other means, so that's the only time you put it on a living person.
You could improvise a model with a couple of magazines rolled up inside a rolled-up towel. You might want to shove it down a pair of jeans. It is something as simple as that that you can make at home. I think we have here a scarf wrapped around -- it feels like some magazines here.
Q. It's a bottle.
A. So within the package, there are two principal components, which is the Tourni-Key itself.
SIR JOHN SAUNDERS: Do you want to stand up to do this?
A. If that's okay. There are two principal components, which is the key and the triangular bandage, and the triangular bandage just needs to be roughly folded into a broad band. That goes round the limb just above the level of the injury. We do include, it is not essential to use, but it is present, something called an anti-pinch card and I'll come back to that in a moment.

The tourniquet itself is then tied in. Then you twist until the bleeding stops and then you secure, and with this device there is a quick secure, just hook it over, and then what we call a hard lock, where you pass it underneath and back over the top. That's less likely to become dislodged, particularly when you start to move the patient.

You saw that from opening the packet to applying that didn't take very long at all. There is a little bit of mythology around improvised or semi-improvised tourniquets that they take too long to apply, and I have just proven that to be false. In fact we have done a study and we have published the study where we compare the application of the Tourni-Key with the most commonly applied commercial tourniquet, which is the one the military use, which is called the Combat Application Tourniquet. We found in 100 people, 50 of whom were already trained and 50 of whom were untrained, who were Jamaican Defence Force, that with 10 minutes of familiarisation of both devices to the Combat Application Tourniquet, an average of 41 seconds to apply the Tourni-Key, an average of 38 seconds from taking it out of your pocket, out of the packet and on to the patient with effective control. What does that mean? It's the same and it dispels the mythology that

an improvised or semi-improvised tourniquet cannot be applied fast enough in the field.

Q. Just before we take the break, I'm going to ask Mr Suter if it's possible to return to the app. We don't, I think, unless you feel it would be helpful, brigadier, need to click any further, but the tourniquet page provides instruction and then at the bottom the question is posed:

"Responding? Yes or no."

And further guidance and instruction is given depending upon which of those options the user takes.

A. Correct.

Q. I am going to ask in just one moment the chairman to take a break, and just so you know, when we return I am going to have some further questions about the tourniquet. I'm going to ask you to deal with some further myths which have existed in relation to the use of such devices, I am going to ask you also to help us also with when the Tourni-Key was introduced, and indeed with when the app was introduced, so that is what is to come.

SIR JOHN SAUNDERS: Among the myths, no doubt, I hope you'll be dealing with a myth that I believe, that if you put a tourniquet on, you have to release it from time to time, but you can deal with that as part of that.

This is what will be considered a completely facile point, but as you'll see, Mr Suter using the app, the light goes off so you have to keep tapping it, which in an emergency situation -- I know it's a function of phones that they operate that way. Is there any way of making the app in such a way --

A. Again we'll take that away, but that is how that individual has set their phone up, how many seconds before their own phone goes to sleep. That's for Mr Suter. Mine doesn't go off that quickly.

SIR JOHN SAUNDERS: I do understand the point. If you're in an area that is dark and you're trying to use the app, it will go off periodically however you set your phone up.

A. That's a very good point and we'll certainly look into that. Remember there is the pocket guide as well.

SIR JOHN SAUNDERS: Quarter of an hour break, please. 11.45. Thank you very much.

(11.30 am)

(A short break)

(11.45 am)

MR GREANEY: Just before we deal with the issues that I indicated before the break we would address, I just want you to help with one particular scenario and whether this contraindicates the use of a tourniquet.

Obviously you will have encountered a situation in which someone has sustained life-threatening injury through the use of an explosive device and that explosive device has contained shrapnel. Where a piece of shrapnel remains or may remain in a limb, is that a reason why one shouldn't use a tourniquet?

A. No. You put a tourniquet above the level of where there is life-threatening limb bleeding that cannot be controlled by other means. It might be that a piece of shrapnel is preventing you from pressing into a wound and adequately controlling the bleeding from that wound. So I would say it's actually quite the converse, that packing and pressing might be very difficult if a large piece of shrapnel were present, whereas placing a tourniquet above it would be able to control that haemorrhage.

Q. Thank you. I hope that answer is helpful to those who were particularly concerned with it. I can see that it was.

The recommendation for using a tourniquet, as we all now understand, is central to the advice in citizenAID, is it not?

A. Yes.

Q. In your statement, and I'm at paragraph 15, you observe that:

"That is one aspect that has separated citizenAID until recently from the mainstream first aid advice of the voluntary aid societies."
A. That's correct.
Q. First of all, what do you mean by "it has separated it from the mainstream first aid advice"?
A. So what I would say is until the turn of this century, after the Second World War, the prevailing advice became: do not use a tourniquet because it might produce harm. Therefore tourniquets effectively became taboo within first aid practice. But what we determined from the literature of the Vietnam war and beyond was that there was a substantial cohort of injured soldiers who were dying from isolated limb injury as a result of catastrophic haemorrhage. In other words, if they had had a tourniquet, those individuals would have survived.
From a military perspective, we needed to change that narrative, which is why we started, in 2005, 2006, to change that narrative and provide the tourniquets for individual soldiers. As I've already identified, we now have the compelling evidence that that was the right thing to do because we have saved lives without there being significant complications and specifically without there being unnecessary amputations, which was the reason in the previous narrative for not using

a tourniquet.
Part of the statement was "until recently" because we have been working strategically with St John's Ambulance and they are now teaching the use of tourniquets and indeed they have taken the citizenAID pocket guide and white labelled it with a St John cover and they have taken the tourniquet for distribution to individual first-aiders.
Q. So the question that I have no doubt some, perhaps many, will be interested in knowing the answer to is: since when have other mainstream first aid organisations adopted the citizenAID type approach?
A. It's only recently. It's only within the last 6 to 12 months that we've made that strategic breakthrough.
Q. So we're talking about, obviously, a substantial period after the arena attack?
A. Yes.
Q. At the time of the arena attack, to what extent -- it's my word, you'll probably agree with it -- did the myth about the use of tourniquets prevail?
A. Within the civilian community, the prevailing narrative at the time of the arena attack would have been: don't use tourniquets in first aid because they may cause harm. The military had changed that in 2006, but it had not been easy in the military and indeed I'd had

substantial internal resistance within our own organisation, specifically from orthopaedic surgeons, and that resistance played out in the pages of the academic literature. But we were still able to make that change and then prove that it had been the right thing to do.
SIR JOHN SAUNDERS: From an academic point of view, is it still contentious or would you say within the academic community generally accepted in your view?
A. In my view, the debate is over and anybody who persists --
SIR JOHN SAUNDERS: Whenever somebody says that, they say it because they believe they must be right. Is there a body of opinion who still says you are wrong?
A. Yes, but they're not looking at the evidence. The evidence is now compelling. We've got the contemporary evidence.
SIR JOHN SAUNDERS: I'm not suggesting you're wrong in any way, believe me. I just needed to know whether there is acceptable or -- from reputable academics within this area who are saying, "We still don't accept what you are saying".
A. I think that would have been acceptable before we introduced it to the military and then tracked the outcomes and have been able to prove the very high

survival and very low complication rate with no unnecessary amputations. Before that, we just didn't know and therefore we had to accept that some people may oppose it.
SIR JOHN SAUNDERS: Right, thank you.
MR GREANEY: I suppose a way of looking at it might be that, particularly these days, one can find a person who holds an opinion about almost anything, including some remarkable opinions. The question is whether it remains the position that there is a responsible body of opinion that tourniquets are a bad thing or whether the evidence which is now available and has been for some time demonstrates that there is no such body of responsible opinion.
A. I would state there is no body of responsible opinion any more, now that we have the evidence that we do.
Q. And from what point in time did the evidence crystallise sufficient that that was the position?
A. The series that we published of 70 patients in the UK was 2007. The series of American patients was 2011. We also published, in Philosophical Transactions of the Royal Society -- I'm trying to remember the exact year. But it was after 2011, which was the unexpected survivors and that analysis too. So from 2007, we have had successive published evidence that continues to

corroborate that position.
SIR JOHN SAUNDERS: Okay. But it's only in the recent 6 to 12 months, because these things always take time to be accepted, that it's been generally accepted among the civilian population?
A. Certainly within St John in terms of taking forward that change in their policy.
SIR JOHN SAUNDERS: Okay, thank you.
MR GREANEY: Just on this point, although we don't need to deal with it in any detail, were you and one of the colleagues you have told us about, Professor Sir Keith Porter, invited to make a submission to the Kerslake Review?
A. Yes.
Q. Was the point that you've just made a point that you addressed in the letter that you wrote to Lord Kerslake on 22 November 2017?
A. I have not got that in front of me. Can I just be ——
Q. I've got it, so you will be able to confirm. Let's put it on the screen for you. {INQ000199/1}.
The point emerges at a number of points, others may ask you about that. {INQ000199/2}. The final paragraph.
We saw from the first page, it's dated 22 November 2017. The authors of the letter are you and

Professor Sir Keith Porter. Am I right he's one of those with whom you've worked closely on this issue?
A. Yes, and he's one of the trustees of citizenAID.
Q. You have published papers together with him and others, have you not, on this topic?
A. Yes.
Q. One of those being a paper called "Enhancing National Resilience: a citizenAID Initiative" published in 2017 in the journal Trauma; is that right?
A. That's correct.
Q. It's {INQ040225/1}.
Back to the point that I was exploring with you. This is your letter in 2017 to Lord Kerslake:
"Injuries from blast and ballistics are unusual in UK civilian practice. The immediate interventions to save lives will place a priority on stopping external bleeding. Just dressing wounds is inadequate; wounds need to be packed and pressure applied. Where this does not quickly slow bleeding from limbs, or there is a limb amputation, a tourniquet is needed."
A. Correct.
Q. "First aid in these circumstances must recognise this paradigm. The prevailing narrative that a tourniquet will cause harm if applied for the wrong reason needs to be reset to recognise that a tourniquet applied for the

right reason will save life. Without this acceptance, and without the empowerment in the hands of the public, it is predictable that explosive incidents may result in avoidable deaths."
So that was, to put it in my terms, you writing to Lord Kerslake and saying people need to get over this myth?
A. Correct.
Q. So it is that in your statement, paragraph 15, the way in which you put is this:
"The military's published experience in the UK and USA from recent conflicts is indisputable in demonstrating how tourniquets have saved lives."
A. Yes, I believe that.
Q. "The citizenAID position is that tourniquets are for life-threatening limb bleeding that cannot be controlled by other means."
A. Correct.
Q. "In this context, a tourniquet can only be of benefit. The alternative is that the patient would die."
A. Correct.
Q. That was the first myth that I wanted to deal with. The second myth or potential myth takes us back to a question that was posed by the chairman just before the break, namely the sense that may exist within the

public or sections of it that a tourniquet has to involve the application of pressure followed by release followed by the application of pressure.
A. That is something that has been taught in the past, but there's no logic because the reason you're applying it is for life-threatening bleeding that cannot be controlled. So why would you take it off?
SIR JOHN SAUNDERS: I thought it was because part of the limb may die off which otherwise would not.
A. Which is the logic that has been given in the past. But it is not logical because you're only applying it to control life-threatening limb bleeding. So effectively when a tourniquet goes on for the right reason, it stays on until that patient gets to hospital.
SIR JOHN SAUNDERS: So that means, perhaps, that although it may cause some damage to the limb in the nervous system by putting on a tourniquet, if you didn't use it and keep it on, someone would die?
A. You are potentially sacrificing a limb to save a life. But you are applying the tourniquet at the most distal part of the injured limb that's possible, so you're applying it just above the injured area.
SIR JOHN SAUNDERS: Thank you.
MR GREANEY: So the message, your message, is the tourniquet is applied, pressure is applied until bleeding stops or

is very significantly diminished to a point that isn't life-threatening, and the tourniquet then remains on until that patient arrives at hospital?
A. Correct.
Q. I'm going to move on to ask you about the video in a moment, but first just to try and establish a chronology or develop the chronology you told us about earlier. The hard launch of citizenAID was in the January of 2017.
A. Yes.
Q. 4 January. First of all, at what stage did citizenAID publish the app and/or the pocket guide?
A. When we did the soft launch on 23 November 2016, we advertised, and there was a countdown clock on the website for when the app would come out, which was effectively New Year of 2017. And it was available New Year of 2017 but not a lot of people were watching the website at that point. It wasn't until the BBC made it visible that everybody knew the app was there and the pocket guide was available at the same time.
Q. So this really feeds back to something you told us about earlier, that on 4 January 2017, there were many, many hits, 1 million hits, on the website, and many people were downloading the app at that stage?
A. That's correct.

Q. Has the app remained the same since then or has it evolved over time?
A. No, we came out with a version 2 of the app in 2018, which was to take account of some of the strategic context changes, so we'd seen a pattern of vehicle attacks and a pattern of acid attacks throughout 2017, so we decided we needed to ensure that advice was there too and we would intend to refresh and update if any other emerging threats become apparent.
Q. I think, but you must correct me if I'm wrong, that it must be the position that the version we've been looking at is the current version published in 2018?
A. Yes.
Q. So what I'm going to ask you to do, once you've left here today, I have no reason to suspect it will make it necessary for you to return, is if you could supply the inquiry, please, with a copy of the version that was in force, as it were, from the beginning of 2017?
A. Yes. I'm not sure if we'll be able to do it electronically, but we'll certainly be able to provide you the pocket guide.
SIR JOHN SAUNDERS: That will be fine. The essential thing is the guidance about tourniquets was presumably exactly the same when you first brought it out?
A. Yes.

SIR JOHN SAUNDERS: Even though it may not have been generally accepted in the way it is now?
A. Yes.
MR GREANEY: The guidance must have been the same with perhaps one qualification: was the Tourni-Key referred to in the initial iteration?
A. No, because that had not been launched at that point; it was just about improvised or commercial.
Q. And that leads on to the next question: when was the Tourni-Key introduced?
A. So late 2017 is when we had the Tourni-Key on its own, and 2018 is when we introduced the Tourni-Key Plus, which is what was demonstrated today, which also includes a triangular bandage in the packaging. In other words if you didn't have the material, the material is provided for you.
Q. Are you able to say, if you can't now, take this away, when in 2017 the Tourni-Key was introduced?
A. I can't give you that exact date, but I can find that exact date.
Q. Thank you very much, that would be helpful.
Just before we turn to the video, anybody who visits your website, which the inquiry legal team would invite everybody to do, will see one of the things that is available in the shop is something called a grab bag?

A. Yes.
Q. What is the grab bag, please?
A. So the grab bag contains four identical cells of equipment and a stretcher. So within the cell of equipment are two Tourni-Keys -- Tourni-Key Pluses --
Q. In each cell there are two Tourni-Keys?
A. Two Tourni-Key Pluses with the triangular bandage. A trauma dressing, so that's an absorbtive pad on an elastic bandage, and two packs of gauze in order to pack the wound, together with trauma shears to be able to cut the clothing away in order to get at the wound, and a shortened version of the treatment.
The shortened version of the treatment is around the management of bleeding and the amount of the airway, the two priority 1 issues that I've identified, and a missed(?) card, an icon-based picture-based tick-it-with-the pen-that's-provided, what have you found and what treatment have you given, so that you have something that you can hand over to the emergency services as treatment that I have done and it is a record of what has been done.
Q. Are you able to say, again you may need to take this away, when it was that grab bags first became available?
A. This is new equipment that is available now through the shop. So it is only in the last month that we've been

able to put together the final equipment offerings.
Q. And I think you've said that the grab bag also contains a stretcher?
A. Correct.
Q. We can all find it out from the website. Are you able to give us an indication of the cost of a Tourni-Key Plus and the cost of a grab bag?
A. So a Tourni-Key Plus, I believe, is going for £7.50. An individual pouch, which is something that's designed for a security guard or a steward, I think that's down as £53. I don't have the other prices in my head I'm afraid.
Q. Mr Suter is about to --
SIR JOHN SAUNDERS: A grab bag presumably is not intended for the average member of the public?
A. No.
SIR JOHN SAUNDERS: It's more for someone who is organising an event where something might go wrong and they then have a built-in first aid --
A. That's correct and we've also created some boxes to be mounted on a wall, one that can be mounted inside and one that is weatherproof to be mounted outside.
MR GREANEY: I'm very grateful to Mr Suter, as is usually the case. The Tourni-Key Plus, £7.50. I'm not identifying everything that is available on the website:

a disposable emergency stretcher, £17.99; the bleeding control patch, £58.33; the grab bag, £241.67; and the box to go on the wall, namely a bleeding control station, £412.50.
A. And the box to go on the wall inside has seven treatment kits, all with the same level of equipment as previously described and a stretcher.
Q. One of the other resources made available by citizenAID is, as you've said a number of times, a video recording. Was it in early 2017 that the Faculty of Pre-hospital Care at the Royal College of Surgeons of Edinburgh sponsored the production of that video?
A. That's right. The Faculty of Pre-hospital Care is the primus inter pares for pre-hospital emergency care standards across the UK. so although it's the Edinburgh college, it is setting standards across the UK.
Q. I'm going to mention just a small number of details about the video before encouraging people to watch it. This is a moment at which people might want to step away from their screen or turn down the volume.
In terms of the details of the video, does it deal with a suicide bombing?
A. Yes.
Q. Was that staged to have occurred on a station concourse?
A. Yes.

Q. With the viewer led through how to manage the incident itself?
A. Yes.
Q. And to treat multiple casualties through the eyes of a number of people present?
A. Yes.
Q. And it's dealing with a situation before the emergency services attended the scene --
A. Correct.
Q. -- although we see a handover to emergency services? We see it through the eyes of a transport manager who is present?
A. Yes.
Q. And a security guard?
A. Yes.
Q. And other bystanders?
A. Yes.
Q. Anyone that is considering viewing it should bear in mind that the content is graphic in the extreme, is it not?
A. It is.
Q. But no doubt that's because there are important messages that need to be got across?
A. Correct.
Q. It shows those responding to the explosion using the

citizenAID app?
A. Yes.
Q. And it shows the treatment of injuries?
A. It does.
Q. Including very graphically the use of a tourniquet on injured limbs?
A. Yes.
Q. It lasts, I think, for just over 6 minutes?
A. I think it's just over 7 minutes, yes.
Q. So it's not a very substantial investment of anyone's time, but anyone that watches that video should come away with a clear understanding of how to apply tourniquets; do you agree?
A. Yes.
Q. And I have no doubt that you would want to take this opportunity to invite the public to view that video along with downloading your app?
A. Yes, thank you.
Q. Was the video placed on the citizenAID website, which is open source, about 2 weeks before the bombing at the Manchester Arena?
A. Yes, it was at least 2 weeks. I have tried to identify the exact date, but it was April, so it's over 3 weeks.
Q. And sadly, as anyone listening to the way in which I've described it will realise, it was to be prescient

because it shared many of the features of what happened at the arena. I'll give the website entry for it: it's citizenAID.org/explosion.

One of the issues that the chairman has been highlighting and that I asked you about directly was how this information about dealing with injuries is to be communicated to the public, which is what citizenAID is about, is it not?

A. Yes.

Q. Has citizenAID identified that schools, colleges and universities are important audiences?

A. Yes, very important audiences.

Q. Why is that?

A. Because, firstly, they are the people who are out and about. Young people are out and about on the street. We owe it to them to prepare them so that they can be prepared and not scared, but also a key objective of citizenAID is to have a critical mass of the general public who feel empowered. So the young population is an important target audience.

Q. And perhaps it might also be added that young people are highly likely to be proficient in the use of their mobile telephones?

A. Yes.

Q. As a result, to deal with primary schools first of all,

have specific materials been developed for primary schools that convey the message of "Run, Hide, Tell and, when safe to do so, Treat"?

A. Yes.

Q. Albeit in an abstract and non-threatening way?

A. Yes.

Q. Obviously you don't want to scare the life out of children by teaching them these lessons.

A. No.

Q. For key stage 1, is a large format book available entitled "Moggy's Coming"?

A. It is.

Q. Telling the story of a cat on the loose in a school of mice?

A. Yes.

Q. For key stage 2 children, is a series of story cards called "Lion on the Loose" available?

A. It is, and we are also providing that as a book too.

Q. And that involves, in order to communicate these important lessons, a circus lion entering a school?

A. Yes.

Q. Were those materials trialled with 500 teachers in Birmingham in 2017?

A. They were.

Q. Again, take this away if needs be, but are you able to

recall over what period in 2017 that happened?

A. So that was from March 2017 and it was within their annual safeguarding training that happened to be delivered over a series of sessions, just because of the number of individuals involved.

Q. Did the materials gain universally positive support from the teachers who had utilised them?

A. They did and they were both primary and secondary schoolteachers who were present.

Q. To deal with secondary schools and colleges, has citizenAID delivered presentations to teach practical first aid skills for serious injuries?

A. Yes.

Q. I think that that included an invitation to address students of a sixth form college in Stockport in June 2017, shortly after the arena attack?

A. That's correct.

Q. Have universities run student-led open day demonstrations?

A. Yes.

Q. Organised conferences?

A. Yes.

Q. Formed clubs?

A. Yes.

Q. Received lectures and distributed white label versions

of the pocket guide?

A. Yes.

Q. No doubt you have it in mind when we are dealing with primary schools and secondary schools that this is something which is capable of being made mandatory as part of the syllabus?

A. First aid now is on the syllabus for schools. I think it's mandatory now for secondary schools, although I know that other first aid agencies are providing basic first aid training within primary schools. So there absolutely is the opportunity now, which wasn't there before -- and this came in in 2020 -- to put first aid on the syllabus.

Q. So there is the opportunity to generate a generation now with familiarity, not just generally with first aid, but also in the principles that citizenAID is trying to embed?

A. Yes.

Q. Has citizenAID received three awards?

A. Yes.

Q. Namely the West Midlands Area Health Scientific Network Innovation Award?

A. Yes.

Q. The National Counter-terrorism Project Award?

A. Yes.

Q. And the National Business Resilience Award?
A. Yes.
Q. Has citizenAID, as you put it in your statement, further propagated its messages —— paragraph 20 —— and delivered familiarisation through key stakeholder conferences in Birmingham?
A. Yes.
Q. In Glasgow, supported by Police Scotland?
A. Yes.
Q. Has it had involvement in two multi—agency counter—terrorism exercises ——
A. Yes.
Q. —— in Birmingham shopping centres?
A. Yes.
Q. Has it displayed at trade exhibitions and medical conferences?
A. Yes.
Q. Have keynote national and international lectures been delivered by you and other trustees?
A. Yes.
Q. By the publication of journal articles?
A. Yes.
Q. And by appearances on daytime television in the United Kingdom and Australia?
A. Yes.

Q. By radio and newspaper interviews?
A. Yes.
Q. And by family open day events both within the police, Ministry of Defence and industry?
A. Yes.
Q. Has it developed a level 2 qualification accredited by Qualsafe?
A. Yes.
Q. To whom is that qualification available?
A. It's open to the whole public. The entry criteria are simply that you're over the age of 14, but in terms of a focused target, it would be most appropriate to those organisations that have a duty of care or feel a duty of care towards the public, so perhaps retail organisations, security organisations, stewards of mass gathering events. That I would say is a subset to whom it would particularly appeal, but it is open to the public aged 14 and over.
Q. In terms of television and television appearances, one of the matters that you draw attention to in your statement is something said by the This Morning presenter, Phillip Schofield, a very well—known television personality. What did he have to say about your app and when did he say it?
A. On the day after the Westminster Bridge attack, unbeknown to us, he got his phone out on this morning television, went to the app and said, "Why didn't I know about this app? Everybody should have this app on their phone", and then proceeded to flick through it and talk about it, which produced a substantial spike in interest on the website.
Q. At paragraph 22 of your first statement and your main statement, you say:
"CitizenAID is a small charity with a big message."
What is that message?
A. The message is that we're here to build public resilience, to give people information that will keep them safe, keep others safe, and allow them to do the right things in the right order to save lives in the unlikely but not impossible event of being caught up in a deliberate attack.
Q. And it poses, I think, the question, "Are you prepared? Because you can save lives in that situation".
A. Yes.
Q. And does it remain the objective of citizenAID to generate a critical mass of the population who can, when caught up in a multi—casualty event, act both safely and efficiently to save lives whilst they wait for the support of the emergency services?
A. Yes. And linked to that is a change in public culture.

What we've seen over the last 20 to 30 years is a change in public culture in relation to basic life support and the use of the defibrillator. Now, if somebody collapses in the street or a supermarket with a heart attack, and their heart stops, there will be enough people around who know how to do basic life support and there will be enough people around who know where the automated defibrillator is and are comfortable using that in order to save life. But we do not yet have an equivalent critical mass of people who will feel comfortable in being able to intervene when there is serious injury.
Q. I suppose ultimately one of the things that needs to be understood is that the systems that you are encouraging the public to understand and apply are systems that have been tried and tested in the most challenging of circumstances?
A. Yes.
MR GREANEY: Brigadier, thank you very much indeed for answering my questions. I have completed them at least at this stage. There are others who wish to ask you questions and first of all I'm going to invite ——
SIR JOHN SAUNDERS: Do you mind if I just ask?
MR GREANEY: No sir, of course not.
SIR JOHN SAUNDERS: I'm going to ask three things and

they're very much off the top of my head, so, please, no one take these as something we're thinking of doing or intending to do.

First of all, we know from the fact that the government has put out now the consultation for the Protect duty, of course that is to do with stopping explosions happening. But it may be, and I'm only say that, that consideration could be given to actually having something as part of that duty which requires people working within crowded places to have some sort of training in the sort of things you're talking about. If that were to be the case, is that something you would be able to cooperate with?

A. Very much so. It's why we've partnered with Qualsafe, as the country's largest provider of accredited first aid training, because they have a thousand training centres. So if there was something that's necessary at scale, it's potentially deliverable.

SIR JOHN SAUNDERS: I make this clear for other people: this is only a thing I'm raising at this stage as a remote possibility, because I know that there are some people who are concerned that anything said which might add or alter the Protect duty might stop it coming into existence and I have no intention of that happening.

The second thing is this: I think it's right to say

that a number of police officers who were involved at the initial stages of this have indicated that they wish they had more training to do with this sort of thing. Are you in collaboration with police forces? No doubt you are available to them to help if need be.

A. So not directly in support, but very willing, of course, to discuss. We have had -- as I said, we've done family days at police events. We've had peripheral contact with the police but would be very pleased to engage with the police.

SIR JOHN SAUNDERS: Thirdly, this -- and this is not said in any way to suggest that what you are doing is other than what appears to be other than completely wonderful work and hopefully life-saving work: if I were someone to whom it's being suggested that if I went out of an evening, I should be taking with me a tourniquet key, a Tourni-Key, something I could use as a tourniquet, I might personally be saying, well, I think I'll stay at home if that's a risk that I'm running. And of course, in a way, that's what terrorists want to happen, to disrupt our way of life. Is there a risk of that or not, and if there is a risk, how do you cope with it when you're doing your presentations to young people and things like that?

A. I would say the first thing is about being mentally

prepared and then also having that back-up as your app or pocket guide, because you can improvise. You can still save life with improvised equipment so it's not necessary to go everywhere all the time with equipment. You might consider having something in your car. You might certainly consider having it in your place of work, particularly if it's a place of work that employs a good number of people, and certainly mass gathering arenas would be very well suited to be thinking about the equipment that they have available for the public to use when they are there rather than the public having to bring the equipment with them.

SIR JOHN SAUNDERS: Okay, thank you very much.

Those are my questions.

MR GREANEY: Thank you very much indeed, sir.

NWAS had submitted a Rule 10 request, but they have most helpfully indicated that their issues have been covered during my questioning. So I'll turn, first of all, please, to Mr Atkinson who is leading on behalf of the families in relation to the brigadier.

MR ATKINSON: Sir, I hope you can hear me as well as see me today.

A. I can, yes.

SIR JOHN SAUNDERS: You're not actually synchronised, but we can see and hear you, Mr Atkinson.

Questions from MR ATKINSON

MR ATKINSON: I think synchronisation on top is a step too far for me, sir, I apologise.

Brigadier, I want to ask you for a little more help in two areas, and the first is in relation to mnemonics or METHANE more particularly, which I find easier to say. This was something that you first invented with a view to achieving what?

A. So METHANE was part of the original MIMMS course. In fact, in version 1 it was ETHANE. So it wasn't until our second edition in 2002 that we actually put the M in front of ETHANE to make METHANE, although we'd been teaching it for a couple of years before version 2 came out.

So it was about giving the same information that the police were already giving at that time from the scene of an incident but in a more logical order. So CHALET became ETHANE which became METHANE. That particular message was taken up by the UK military in the Iraq conflict as the principal messaging system for a multiple casualty event. But it wasn't until 2012 that it became fully incorporated as the message for all emergency services within the UK, within the joint emergency services interoperability procedures.

Q. So the value it has, is this right, is in ensuring that

someone in a pressured situation conveys the essential things that they need to communicate in the right order and doesn't miss one out?
A. Yes, absolutely, and in a consistent order, and that consistency is important for the receiver as well because the receiver is expecting that information. And if that information isn't forthcoming, they would then know what to ask for and prompt the individual for.
Q. Its value in terms of interoperability, presumably, being that if it's a recognised format of information, it is very easy to share it between emergency services, who will equally understand if they're missing one of the elements?
A. Yes.
Q. So is this right: it is important for that reason, and recognised to be important, that the METHANE message is one that is communicated clearly and early and shared?
A. Yes.
Q. That's all I need to ask you about that.
Can I turn to my second area, and this really is building on what I think you described in an article you wrote back in 2006, in the Emergency Medical Journal, as to the pivotal role of external haemorrhage control in managing ballistic casualties. Is that the learning that you've been telling us about that was very much

underlined by the figures and the results you were getting from 2007 onwards in terms of the importance of very quick and very efficiently dealing with external bleeding from bomb-related injuries?
A. Yes. I think you're referring to the article about ABC to CABC and changing the trauma paradigm. Up to that point, up to 2005/2006, the civilian narrative for treating all medical emergencies, including trauma emergencies, was ABC, airway, breathing, circulation. But it just didn't fit with what was killing people avoidably in a military situation, and I would say that from the contemporary perspective, but also the historical perspective, because when we looked back at the Vietnam data, it was saying the same thing: the wound data and the munitions effectiveness team data from 25 years before that was saying that the commonest cause of avoidable death on the battlefield is external bleeding and specifically external bleeding from limbs.
We decided that we have to change, we have to fly in the face of convention, and be bold and put catastrophic haemorrhage ahead of the airway because that's the first thing you see as you approach the serious combat injured who might have a traumatic amputation or obvious external haemorrhage from a ballistic injury, and that's what you need to treat first. As I say, it did fly

in the face of convention, but it has been proven to be the right thing to do.
Q. Sir, for your note, I don't seek to take the brigadier to it, that 2006 article is {INQ040223/1}.
In terms of a chronology, by 2007 you were obtaining real data that was showing that the move to a wider use of tourniquets in the immediate response to external haemorrhage in a ballistic context, you were getting real data in 2007 to show that was right?
A. Yes, that's correct.
Q. And in the US --
A. The US gave similar data in parallel, but a little bit later, the 2011 series. The phrase that's been referred to in terms of unexpected survivors, that was a cohort from 2006 to 2008, and within those 2 years we identified 75 unexpected survivors, so mathematically people who should have died who did not die, including people with very, very high injury scores or maximal injury scores, who by all of the modelling -- there was no reason they should have been alive. So that's corroborative data too.
Q. If I can take you to the document you submitted to the Kerslake Inquiry with Sir Keith Porter, and that is {INQ000199/1}.
We can see halfway down the page, the third

paragraph down, you explain what citizenAID is designed to achieve in terms of taking lessons learned from a military context to those situations which, sadly, because of the spread of terrorism, are not limited to a military context.
A. Yes.
Q. If we go to the bottom of that page, please, we can see the last paragraph there:
"CitizenAID strongly endorses the appropriate use of tourniquets in first aid. The published evidence, both UK and US, overwhelmingly demonstrates the value of tourniquets in combat-style injury where limb bleeding cannot be controlled by other means."
Pausing there, the UK and US published evidence, including your publication in 2007, and the US material thereafter?
A. Yes.
Q. "Despite this, there remains a historical scepticism in the use of tourniquets that undermines the acceptance of this life-saving technique in this specific circumstance."
Was that a historical scepticism among the public or was that scepticism prevalent also in other areas, for example amongst emergency responders?
A. Yes, very much, it was a scepticism within the medical

community just as much as it was within the public.
Q. If we move on to the second page {INQ000199/2} of that, Mr Lopez, we can see that the first new paragraph there begins:
"Medicine advances in war and these advances have consistently been transferred to the benefit of the wider community in peace."
Something that you have touched on already:
"Recent conflicts in Iraq and Afghanistan are no different and there has been widespread transfer of military medical practices into both the pre-hospital and hospital components of the UK trauma system."
And just pausing there, pre-hospital, would that include paramedics by way of example?
A. Yes.
Q. And clearly hospital referring to once someone has arrived there. And you go on:
"However, there remains a recognised therapeutic vacuum."
Is that a reference to what I think you've also described as the disaster gap?
A. Absolutely.
Q. The period of time before anyone with medical training is on scene?
A. Yes, absolutely.

Q. "Responding healthcare providers may be held back when the security of the incident is uncertain. As avoidable death from bleeding (on military evidence from comparable injuries) can occur in a matter of minutes, the opportunity to save life rests with those who are part of the incident. This is the public."
And you go on to explain why it is therefore that citizenAID is seeking to talk to the public in the ways that you have told us about this morning.
A. Yes, that's correct.
Q. Just to unpick those various points as may help the chair in relation to the issues that he has to consider, you have identified a number of ways in which citizenAID is trying to educate the public, for example the deployment of Moggy in relation to key stage 1 students, unleashing the lion in relation to key stage 2, and moving up through universities and so on thereafter. But do we also understand that there certainly has historically been a need for such education in relation to first-aiders, for example St John's Ambulance, but that kind of body of first-aiders?
A. Yes, absolutely. As I mentioned earlier, the extraordinary outcomes are only possible when every link of the chain has been enabled and empowered. So we cannot allow any of those links to be less informed than

others.
Q. So given that St John's Ambulance have adopted training in relation to tourniquets within the last 6 to 12 months -- and if you can't help on this you must say, brigadier -- would you have expected, generally speaking, those in a comparable position, first-aiders not to have been trained in tourniquets back in 2017, which is obviously when we're mainly concerned?
A. I think in 2017 that narrative was still prevailing, that tourniquets were dangerous, and in many instances if people had been trained on commercial courses, they would not necessarily have been introduced to a tourniquet. Some might, but it would not have been guaranteed.
Q. Even if they had received training in relation to tourniquets, they may equally have received the message from training and from colleagues that tourniquets were a bad idea rather than a good one because of that being a prevalent view at the time?
A. Definitely. There were still mixed messages in 2017.
Q. Would that, in terms of those who may be filling that disaster gap in that immediate period when there was an emergency, who may be, for example, police personnel who are near to the scene and therefore there very quickly -- and again if you can't help, you must say

so -- would you have expected them to have had any training in relation to the use of tourniquets back in 2017?
A. I wouldn't have expected necessarily an average police officer to have had that training, but I would have expected, if they were specialist police officers, such as tactical firearms, they would likely have received that training by 2017.
Q. And taking each of those in turn, certainly is it your view, if it's not already the case, that first-aiders of a St John's Ambulance type should now all receive training in the use of tourniquets in appropriate circumstances?
A. Yes, because the evidence is strong enough in order to make that a generally accepted intervention for saving life.
Q. And equally, emergency responders who are not paramedics but who may nevertheless be confronted with such a situation?
A. Yes, absolutely. We train soldiers, so anybody who is going to be put in a situation where they have to provide first aid to the public, certainly from an official perspective, it would make sense that they have that life-saving skill.
Q. (Inaudible: distorted) with the Ambulance Service

paramedics, the same question in relation to them, and again if you can't say, you must say so. Are you able to help us as to whether you would have expected them to have been trained in the use of tourniquets by 2017, given that it was a decade after your first very clear data about the importance of their use?

A. Yes, I would have expected the Ambulance Service -- and I think the issue with the Ambulance Service is there may be some variation from one service to another, but overall I would have expected them to have understood and have the equipment to use in terms of a tourniquet and perhaps also as well a topical haemostatic, which is an activated bandage impregnated with a material which, when pressed into a wound, actually helps to control haemorrhage.

Q. Finally in relation to the Ambulance Service, a slightly different topic, which is in relation to the triage sieve that you have helped us about. Clearly we all have experience, if we've been unfortunate to find ourselves in A&E, to have seen triage of that type in action, the identification of who needs treatment first and second or third in a queue. Do we understand from what you've said this morning that that approach may not be the right approach in this kind of situation where you have ballistic injuries?

A. Just to qualify, are you saying the triage sieve might be inappropriate in ballistic injuries? Was that your question?

Q. It's to understand whether it is not enough to identify who someone else should treat first, second or third, but with an additional element, where there are ballistic injuries, of: who do I need to treat before I move on to triage someone else?

A. Right. I'm not sure I'm quite getting your question, but let me try and give you an answer and see if that's satisfactory.

CitizenAID is a very simple system of triage for use by the public. When the emergency services arrive, they will have a more sophisticated version of the triage sieve, which requires you to, if they're using the very latest version, to do an assessment of the level of response, to count the respiratory rate, to count the pulse rate.

To be able to do that requires more training and more understanding, so it's appropriate that it is sitting with the more professional group to do that, that higher level of assessment. And triage is dynamic, it doesn't just happen once. If somebody's condition changes then you need to re-triage them and what you'll find at the scene of a multiple casualty incident is you

may have to be serially triaging people to pick up, first of all, those who might respond to treatment and also those who are deteriorating and whose priority may change.

Q. Thank you. Building on that from the point of view of a paramedic as opposed to a member of the public, is your experience and your assessment in relation to a situation where there are ballistic casualties that matters such as "Do I need to apply a tourniquet to this person?", or, "Do I need to put them into a position where their airway is not obstructed?", is something that needs to be done immediately by that paramedic rather than them triaging everybody and then either themselves or someone else coming back to the person they started with?

A. Right. Understood. So as I said earlier in evidence, triage as a purist is about going round sorting everybody into priorities while others then come along behind to do the treatment. But as a pragmatist, what we've realised in the military is you don't know how long it's going to take before somebody else comes along behind you to do that treatment. So we have built into the triage a system critical and very simple interventions that do not take a lot of time and do not disrupt unduly your ability to keep going and triaging

your patients. So if you came across that catastrophic limb haemorrhage then you should be treating it before then moving on to your next patient to triage. If you come across a patient who's lying on their back unconscious, you should flip them into the recovery position so their airway is open and stays open, otherwise it could be an avoidable death before the treatment resource comes along behind you.

SIR JOHN SAUNDERS: Clearly, how you triage may be very much fact dependent on what is going on and what is known to the person. I'm slightly worried about this being applied to the individual facts of this case, which you're not aware of.

A. The triage system, whatever service is in operation within the military or within the responding ambulance service in Manchester, it will be the triage system they use for a train crash, a plane crash, a multiple incident car crash, a terrorist bomb. It will be the same system. They may have paediatric versions -- we in the military have paediatric versions for triage as well as adult versions -- and there are also chemical triage versions for those specific incidents. But in general terms, it is a generic approach, an all-hazard approach which is agnostic of the cause of the incident.

SIR JOHN SAUNDERS: Okay. Sorry, Mr Atkinson.
MR ATKINSON: My final question, moving on again, is in relation to the kit. You've been taken through the items that are available from citizenAID that will help people deal with these kind of terrible situations. Is it your view that venues that clearly, given the state of terrorism, may be at risk should have such kit and have staff who know how to use it?
A. Yes, it is. And if I can just do a little illustration. In 1995, again going back a little while, I was the senior medical officer for Wembley Stadium, the old Wembley Stadium, just something I did as an extra duty at weekends. I wrote their major incident plan and within their major incident plan I said they did need equipment, but that equipment needed to be in multiple locations because I was learning from the incident I'd had in Northern Ireland where the hospital had been blown up, that if your emergency department intensive care operating theatres were destroyed, where is your kit?
So in a stadium, if you have only placed your equipment in one place and that happens to become part of the incident and the equipment is no longer accessible or has been damaged, then how do you then move on? Therefore within a stadium you should be

thinking of having equipment in more than one place so that it is accessible and hasn't been damaged by the incident itself.
MR ATKINSON: Thank you, brigadier. That's very helpful.
Sir, those are all my questions. Thank you very much.
MR GREANEY: Thank you very much. I ought to have said before Mr Atkinson started that I'm very grateful to counsel for the families cooperating with me and speaking to me over the course of last week to ensure that this witness's evidence remains within proper limits. I can see that Mr Weatherby has appeared on the screen. I was going to invite questions from him if he has any.
Questions from MR WEATHERBY
MR WEATHERBY: Thank you very much. Just two very small points. It won't take me more than a couple of minutes.
Can you help me? For good reason you've stressed the importance of the application of tourniquets within what you describe as the platinum 10 to 15 minutes, and we all understand why from the excellent work that you've been doing. It may be a matter of common sense, in which case I apologise in advance, but you're not indicating that the use of a tourniquet will only save life if used within that period, you're indicating that

it's got a higher success rate the sooner it's used; is that fair?
A. Yes, that's absolutely fair and that's borne out in the American evidence where the average survival is the same as ours, 87%, but was as high as 96% when the tourniquet was applied before shock, so before a critical amount of blood had been lost, but was as low as 4% if applied late when that critical amount of blood had been lost.
Q. And late will depend on a number of different factors.
Would I be right in saying that the efficacy of a tourniquet will be a function of the seriousness and type of the injury, how efficiently the tourniquet is applied and how quickly?
A. Yes. The actual anatomical location of the injury and the rate of blood loss are going to be determinants.
Q. Yes. Thank you. Just finally, is there any relevance to other issues such as, for example, swelling? If a limb is swollen, it might be more difficult to apply a tourniquet but ——
A. I am not quite sure what you might be getting at there, but I cannot see why that would be a specific issue.
Q. That's very helpful indeed. Thank you very much, brigadier. That's all the questions I have.
MR GREANEY: Sir, Mr Cooper does have questions on behalf of the families that he represents and he's just appeared

on our screens.
Questions from MR COOPER
MR COOPER: I'm very grateful, Mr Greaney, and Brigadier Hodgetts. I won't detain you too long as you've dealt with a lot of the questions that I was going to ask you with other counsel.
Can you help me with this as far as tourniquets are concerned? Is there any particular paediatric application for the application of tourniquets we should be aware of? Obviously we've heard you describing them, we assume, the application of them, on adults and indeed upon service people in combat. And you've referred in your answers to muscle bulk and that sort of thing as being important things to take into account. You know the matters we're dealing with in this inquiry, I won't go into them, but it's a general question: is there any form of paediatric assessment that needs to be undertaken with the application of tourniquets, maybe not just paediatrics, simply young people and teenagers?
A. With an injured limb with life—threatening haemorrhage, the age is not the factor. If the limb is injured and you are losing blood, then you need a tourniquet. The issue will arise that some commercial tourniquets may not be designed to go on very narrow limbs. So you may struggle with some of the commercial tourniquets, not

all of them, but struggle with some of the commercial tourniquets. Ultimately, if you were to take your tie or the triangular bandage and even tie it round the narrowest limb and be able to create a windlass, you can get a tourniquet effect. You might find yourself with a very narrow limb and if a commercial tourniquet didn't fit, you might have to improvise but the principles would be the same: use a windlass to tighten until the bleeding stops.

Q. Thank you. Another question. In terms of how long one can leave a tourniquet on for, if you can just dispel those myths or misunderstandings here. There was a view that perhaps only 1 minute, for instance, might be appropriate. You've given us very helpful evidence on the basis of keep it on until the individual gets to hospital. Can you just clarify that as to whether the tourniquet should be removed swiftly or simply or, however long it takes, keep it on until they get to hospital?

A. If it is applied, a life-threatening bleeding that cannot be controlled by other means, if you release it, you're going to get bleeding again, so you're putting the patient at risk. Therefore it goes on and it stays on if it's applied for that reason that you can't control bleeding by other means.

Q. Common sense really, I suppose, is a lot of what you're saying in many respects.

I want to ask you a little again, not about the detail of the tragedy we're dealing with, but the generalities, about the removal of people and the manner of their removal if they are bleeding heavily and indeed have catastrophic bleeding. You have dealt with, for instance, the provision of stretchers.

Is there a particular method of removing people on a stretcher from a scene which minimises the risk to their life?

SIR JOHN SAUNDERS: Is this someone who has a tourniquet on or is it generally?

MR COOPER: Generally, first, sir, and then perhaps with a tourniquet, but first generally.

A. I think this is quite a broad scope question and the answer is that it depends. If somebody's life is at immediate risk and they need to be moved to a place of safety, so if they're in a place that is hazardous to them, then you are just going to move them by whatever means you can because to leave them where they are is more dangerous than moving them.

If they're not in a position where their life is immediately threatened, then you may consider that you want to do a controlled move of that patient because you

might consider that other injuries that they have could be made more painful or even exacerbated by an uncontrolled move. So it depends on the tactical situation. If there's fire, if you have to move them away from fire, then you're just going to grab them and drag them away from fire. But as I say, if there isn't a requirement to immediately move them, then you may wait for the more specialist equipment that allows you to move somebody more comfortably and more safely.

Q. Thank you. Is that advice or that evidence that you give the same whether or not a person has a tourniquet applied?

A. Absolutely. But what is important to recognise is that if you have something like a tourniquet in place, or a tube down into the airway to support breathing, once you start moving a patient, things can become dislodged, so you have to have them as secure as possible and monitor them as you move them or immediately after that move to make sure that nothing has been dislodged.

Q. Thank you. One of the -- and it's the only reference I'm taking you to and it was in the executive summary, it's, please, {INQ040223/1}, it's the article you co-wrote back in 2006. I just want to take you, please, to the latter column, which begins:

"Is this discussion relevant to UK civilian

practice?"

You say:

"The attacks of July 2005 in London and the resulting clinical experiences described illustrate how blast and ballistic injury are a reality for today's National Health Service. The rescue of patients from a scene where an explosive or other threat is present or possible [you go on to clarify that] has clear parallels with care under fire and tactical field care."

You wrote that along with your colleagues, didn't you, in 2006?

A. Yes.

Q. And indeed, in your evidence today, you highlighted the fact that the tourniquet was brought, I think you said, if my note's correct, back for every soldier in 2006?

A. Correct.

Q. So would you say that perhaps in emergency service and civilian life, their understanding and use of the tourniquet is perhaps lagging behind the warnings you were given, if warnings is the word, in 2006?

A. As I've identified earlier in evidence, medicine advances in war and it advances at huge pace because of the casualty imperative. 2006 was a really intense period once we got into Helmand Province and what we saw in the next few years after that was month on month

changes, bringing in new equipment, bringing in new organisation, bringing in new processes and practices and guidelines, and very aggressive governance in order to save as many lives as we could in the operational setting.

And yes, we have been translating those practices into civilian care, be it in the NHS or charity air ambulances. But yes, it does take time for those elements to filter through. Indeed, in 2009, the Healthcare Commission visited the hospital deployed in Afghanistan, and this is the precursor of the Care Quality Commission that many will be familiar with that goes to hospitals and primary care services to assess their quality. And what they reported was that the care in the operational setting was exemplary and they had never before used that descriptor of an ambulance service or an acute hospital. They said that there was much that the NHS could learn from the military in relation to trauma services.

We have seen it very much as our role to help spread that understanding into the NHS, whether it is just through our clinicians being embedded in the NHS across the country, both as regulars and reservists, by writing papers, by teaching on courses, by going to conferences, et cetera, and presenting our work. So we do try very

hard to spread the learning.

Indeed, in 2018 the NHS published major incident guidelines, which were very much based on the military's guidelines that we'd been using since 2004 that were officially published in 2009 as clinical guidelines for operations, so they used the same format and it was the combined civilian/military team in Birmingham who wrote those guidelines because that team is exquisitely experienced in blast and gunshot injuries. They've been receiving the most seriously injured coming back from operations since the start of the Afghan and Iraq conflicts, so from 2002 onwards, so it was absolutely right that they were the people that write the guidelines for the NHS.

Yes, it may be that the civilian services haven't moved at exactly the pace of the military, but the military was moving at a rapid pace because of the casualty imperative. They were dealing with these casualties every single day, so we had to do something. It's not been the case in the civilian setting.

Q. Again, if I can press you, and this is by no means a criticism, you will understand, of you, whose evidence has been, quite frankly, commendable, if I may say so. Can I put it to you generally, given that the military were thoroughly aware of this, as you put it, in 2004,

and you comment on 2006 as well, and given the amount of terrorist atrocities we've had, certainly up until 2018, when you say the National Health Service adopted all this, would you accept the suggestion that the National Health Service, Fire and the police had enough notice of the atrocities that were being caused to civilians with those terrorist atrocities between 2004 and 2018 to have acted far quicker in catching up with the military?

A. I would say the evidence was there, but as we've discussed, changing the prevailing culture has been a challenge. It was a challenge in the military to change that culture and we're going through the same arguments we went through in the military to get the civilian services to agree with the same approach, particularly in the use of tourniquets.

Q. I'll finish, because I won't overstay my welcome on these questions, but overcoming culture seems to have taken a decade to get, for instance, the National Health Service and the police and the Fire Service —— it's taken a decade to overturn culture so that they can activate some of the impressive steps that the military have taken. Is that your evidence?

A. Yes, and it does take time. If we look at major trauma centres, so you may be familiar that there's a network of major trauma centres around the country, the

messaging around the requirement for major trauma centres was very strong in 1988 when we invited the Americans —— or the Royal College of Surgeons of England invited Professor Donald Trunkey to come and review the requirement for major trauma centres in the UK. There was a strong message in 1988 that we should have regionalised major trauma centres, but they weren't introduced until 2012. And it's taken a series of reports to actually make that happen.

SIR JOHN SAUNDERS: We need to be balanced about this. So as I understand it, it's not —— in 2004, no doubt your evidence was entirely correct and your conclusions were entirely correct as has been proved. The difficulty has been getting other people to accept that your conclusions would be right in a civilian setting?

A. Yes.

SIR JOHN SAUNDERS: Which is what's taken the time. I just want to distinguish that, if it's right, from someone saying: well, we know you're right, but we're not going to get on with doing anything about it.

A. Yes. It's exactly the same in the United States. They actually talk about the portrait of contradictions, or they did in 2016, talk about a portrait of contradictions, where they recognised the substantial changes in their military trauma system and their

outcomes, but recognised that 4,000 people in the US a year were dying of trauma and how do we get that military know—how into the civilian system. They actually set up something called the Hartford Consensus, which was specifically endorsed at presidential level, about how to get that military know—how into the civilian trauma system.

SIR JOHN SAUNDERS: Mr Cooper.

MR COOPER: Thank you, sir.

Only one question. It's more of a suggestion to assist. The chair, perfectly properly, raised with you the issue concerning the app and the light going off, as it were, on the telephone. You'll remember that passage of evidence. Is there any way, for instance, the app can be applied so that it is audio, for instance the information being given out in an audio way rather than a visual way? For instance, if a scene is —— the visibility is obscured and at times in the matter we're dealing with there was a degree of obscurity in the early aftermath, is there any way your app can give instructions orally rather than visually?

A. I think everything is possible and that's a very reasonable observation to make, particularly perhaps for people who are visually challenged, but it will come down to cost in terms of development of another version

and we are a small and modestly funded charity. I am very happy to progress down that route if people feel benevolent towards that particular cause.

MR COOPER: Thank you so much.

Thank you, sir, those are all my questions.

MR GREANEY: Subject to any questions that you have, sir, that concludes the evidence of the brigadier.

SIR JOHN SAUNDERS: I'm extremely grateful. You've obviously done fantastic work in the past and you're doing so in the present, so thank you very much for all you're doing and thank you for telling us about it.

2.05.

(1.06 pm)

(The lunch adjournment)

(2.05 pm)

MS CARTWRIGHT: Good afternoon, sir. The witness for this afternoon is Ms Gillespie. For good reason she is joining us via a live link and I was going to ask her to turn her camera on, but she's already done that.

MS MARGARET GILLESPIE (sworn)

Questions from MS CARTWRIGHT

MS CARTWRIGHT: Good afternoon, Ms Gillespie. As you will appreciate, it's more difficult to ask questions and to answer them by this means, so we'll all just have to bear with each other.

I'm going to begin by asking you to tell us your full name, please.

A. Margaret Josephine Gillespie, but I'm known as Jo.

Q. Thank you. I think it is right that in 2017 were you Head of Resilience for the north of England in the Resilience and Emergencies Division of the Department for Communities and Local Government?

A. Yes.

Q. I've referred to it as the Department for Communities and Local Government. After the attack and in January of 2018, did that department become known as the Ministry for Housing, Communities and Local Government?

A. It did, yes.

Q. But for the purposes of this afternoon, I'm going to refer to it as the DCLG.

A. Yes. I may alternate between the two, but I understand it to be DCLG at the time of the attack.

Q. Thank you. What I'm going to now do is identify and identify for the benefit of others the seven topics I'm going to address with you over the course of the next hour or so.

First, your career, background and current role. Second, the role of the Resilience Emergencies Division. Third, the staffing and resources within RED. Fourthly, the resilience advisers within RED's attendance at

exercises, including Winchester Accord. Fifthly, the Resilience Emergencies Department's role in the government policy document "Planning for Marauding Terrorist Firearms Attacks" and any further advice. Sixthly, RED's role in the updated 2018 government policy document, "Planning for Marauding Terrorist Firearms Attacks". And finally, RED's immediate emergency response work and the role of the government liaison officer.

A. Yes.

Q. Having set out our path of travel for the next hour or so, I think it's right that you have provided a witness statement following on from a request from the inquiry dated 23 October of last year?

A. Yes.

Q. And are the contents of that statement true to the best of your knowledge and belief?

A. They are. There have been some updates to it since I presented the statement. I've identified a typographical error and the name of my directorate has changed since then.

Q. Let's first deal with the typographical error. I think you identified that to me before we commenced. I think at paragraph 5, you took up the post in RED, is that correct, in January of 2015?

A. Yes, I was made a permanent Head of Resilience at that time.
Q. And then the other update you wanted to provide for the inquiry?
A. Throughout my evidence, I've referred to RED, Resilience and Emergencies Division. My directorate is now called the Resilience and Recovery Directorate. We have increased in size in the time period. But for the purposes of the evidence, it was RED and it was a division. I'm happy to provide additional information to the inquiry just to explain that if that would be helpful.
Q. Perhaps as we move along, if it becomes relevant, you could deal with it at that stage rather than at the outset.
A. Thank you.
Q. Could I then deal with the first topic, please. Can you give a brief high-level overview of your career, background and current role, please?
A. Yes. I have been in the Civil Service since 1987. I joined the Resilience and Emergencies Division in 2011 as a resilience adviser. As we have said, in 2015 I became head of resilience for the north of England. In November 2019, I became temporarily promoted to deputy director in resilience and emergencies, leading

on the recovery from the floods of 2019, which primarily affected South Yorkshire. I became a permanent deputy director in September 2020. I lead on the policy, strategy and resilience work, which is the longer term and more strategic view of our role in resilience and the role of LRFs in resilience as well.
Q. Thank you. Could we then move to the second area, please. Could you, first of all, describe what the Resilience Emergencies Division is, please, and its role?
A. Yes. Our role is very much to link the local response and the local responders to national government, to be that conduit of information to and from Central Government. And also to support Local Resilience Forums in their planning for emergencies and, in the event of an emergency happening, we also provide a government liaison function as well, again linking national and Central Government with the local response arrangements, and sort of with local responders.
Q. Just breaking that down, please, in terms of RED's role for planning with the Local Resilience Forum, could you just explain practically what it actually does, please?
A. Thank you, yes. We have as part of RED -- and I will call it RED -- resilience advisers, and these are members of DCLG or MHCLG staff who work directly with

the local resilience forums to support those forums in their planning in helping to share practice between LRFs and also to share government guidance and to help LRFs work and develop their plans based on a new and revised government guidance.

We also provide support and act as a critical friend to LRFs. We're able to answer questions from them, but also ask them questions about their arrangements and their planning.

We act on behalf of wider government departments as being that link into the Local Resilience Forum, so for example you've referenced the -- I will call it the MTFA guidance. We were able to sort of support LRFs in how they interpreted that, how they worked, and we facilitated workshops, for example. So it's very much that conduit, that link between Central Government and the local response community via the LRFs. We work very much with the LRFs rather than the individual responders.
Q. You've said on a number of occasions that the role of the RED, the Resilience and Emergencies Division, is to support the Local Resilience Forum.
A. Yes.
Q. Does any aspect of -- the role of RED, is it to give assurance that what's being done is correct or in

accordance with policy? Is there an assurance role?
A. No, we do not have an assurance role. You will have noted, I think, from some of the documents, the emergency preparedness chapter, which gives the assurance functions within LRFs and there is no permanent assurance body for LRFs, so we do not act as assurance for LRFs or for their plans.
Q. So when you have described that the Resilience and Emergencies Division support, you've already told us that they can attend at -- the advisers can attend at the meetings of the Local Resilience Forum. But how practically do the resilience advisers support the Local Resilience Forum?
A. Again, by being part of the discussions and the arrangements. The planning that's done via the resilience forum, the category 1 and 2 responders -- I believe you've had evidence on the differentiation. For the category 1 responders, there is a duty to plan and a duty to assess risk. For example, there is guidance on how to assess risk and our resilience advisers would support -- if there were questions from the LRFs about how should something be interpreted or additional support that we needed from a government department -- for example if there was new guidance on flooding, there's a facilitation role there that we're

able to bring the lead department to each of the LRFs, we're able to ask and answer questions as well, so it is able to —— you know, if an LRF had a particular question around a particular subject, my team of resilience advisers at the time could act as support in answering that question or, if it was beyond the information we had, we're able to facilitate the lead government department to come to the LRF as well.

I'm not sure if the inquiry has heard of the lead government department principle. I don't know if that has come up.

Q. Perhaps if you explain that principle now, please.

A. For a number of policy areas, including terrorism, there is a lead department. For terrorism, that's the Home Office, as you'll probably have heard. For flooding, that would be DEFRA. If it was to do with energy, that would be... Again across Whitehall, each department has a lead role. For example, with DCLG as was, we are the lead department for recovery from flooding, so we're able to act as —— my resilience adviser colleagues are able to act as that ability to bring Whitehall departments to the LRFs and to support the LRFs in accessing information as well. Because when there's new and emerging risks, a lot of the information will be held centrally within government and we are able

to make sure that gets shared effectively to help the local planners and local responders write their plans, develop their plans.

Q. Thank you. Perhaps then if we look at some guidance that explains that in a simple format, please.

Mr Lopez, please could you display {INQ018892/153}.

A. I understand this is the non—statutory emergency response and recovery that we're looking at.

Q. It is. Ms Gillespie, you've provided with your witness statement "Emergency Response and Recovery: Non—statutory Guidance Accompanying the Civil Contingencies Act of 2004". This was the relevant guidance that was in place from October of 2013?

A. Yes.

Q. If we look at page 157, we can see set out there the DCLG, as it was. If we could perhaps expand, please. {INQ018892/153} to start with, please, Mr Lopez.

We can see there within the 2013 guidance, it sets out that:

"The Department [as it was then known] for Communities and Local Government's Resilience and Emergencies Division is responsible for providing the government liaison function on resilience issues below the national level, formerly provided through government offices in the regions, working with local resilience

forums to build resilience, emergency preparedness and to support the response to an emergency."

A. That was correct, yes.

Q. And is there any significance by reference to the closure of government offices in the regions?

A. Prior to 2011, there were regional resilience teams based in each of the nine government offices for the English regions. On the closure of the government office network, the resilience function moved into DCLG as it was as part of —— and that became the Resilience and Emergencies Division, RED.

So the closure of the government offices, they consolidated the teams into a single team. That team was also —— worked across England and I just want to say that t DCLG we support the English LRFs —— so that the Resilience and Emergencies Division had four offices in Leeds, Birmingham, Bristol and London, supporting the 38 LRFs across England.

Q. Thank you. You've told us already about the role that RED has in terms of planning. But can you then perhaps give a little bit more detail now to the support that you provide or RED provides to LRFs for response to an emergency, please?

A. Thank you. When an emergency occurs, and that can be a range of different events, and obviously we've had

COVID for the past year, the resilience advisers become what is called a government liaison officer. Now, I will separate the response into the malicious threats and the hazards. When it comes to hazards, which are things like flooding, then the government liaison officer is the primary means by which the local response is linked back into Central Government —— you'll have heard of COBR —— so far as that function of situational awareness into Central Government.

In a situation —— when it comes to the threat side, we become part of what's called a government liaison team and the lead department, as I have mentioned, is Home Office, and they would have that primary lead. The role of my team and the government liaison officer at that stage is really working with partners around the consequence management: what are the consequences of the threat and what are the actions needed to provide support in the aftermath and support with the consequences? And that's the role we played in the events of May 2017.

Q. Mr Lopez, if we could turn over the page, please, {INQ018892/154}. Paragraph 9.1.2. Is it right that it sets out within that 2013 guidance what you've effectively just told us around the role of the Resilience Emergencies Division in an emergency but also

the deployment of a government liaison officer in an incident?
A. Yes, it does.
Q. Which I will touch upon very briefly in topic 7.
Could I ask you at this stage —— sorry, you broke up there.
A. Apologies, I think I might have cut across you. I said it does summarise our role.
Q. Could I, by using this guidance, seek your assistance with one other matter, please?
Mr Lopez, could we please display paragraph 5.6.9, which is at page 107 of the guidance {INQ018892/107}.
If we could expand the "Identifying and learning lessons".
Within the October 2013 guidance, Ms Gillespie, it sets out that:
"The collation of lessons identified from the recovery phase of emergencies and exercises should be the same as those used for the response phase. National lessons identified can be fed via DCLG RED or the LGD to the Civil Contingencies Secretariat in the Cabinet Office for collation and coordination of any subsequent actions by the relevant government departments. Local lessons identified can be collated for consideration and action by Local Resilience

Forums."
Could you just explain practically what that means in terms of RED's role arising from learning from exercises, please?
A. Yes. In terms of the first bullet point, national lessons, that is around the lessons associated with departments and with how government responds to an incident or an emergency or the recovery phase as well. So if there were comments on say the recovery from floods and an LRF wanted to feed comments back on how my department has led the recovery and wants a consideration given to changes in policy or procedure, that's what it means by the national lessons, and RED, the advisers, we can feed that into the Central Government process.
The second bullet point is very much around those local lessons and what the local responders have identified as a lesson. And the embedding and the learning of those lessons is very much to be taken forward at that Local Resilience Forum level as the responsibility of the local partners.
Q. We will perhaps come to deal with that in a little bit more when we deal with the role of the specific resilience adviser in the Winchester Accord exercise, which you deal with in your statement.

A. Yes.
Q. I'm looking at paragraph 11 of your witness statement, where you give us a little bit more detail about RED's advisory and planning work. You set out that:
"The risks on which we advise are very wide—ranging, including serious disruptions to utilities and communications supply chains, floods and other severe weather, terrorist attacks, and major transport and urban accidents."
Pausing there, the chairman specifically is interested in this inquiry in terrorist attacks. Can you give us detail as to how RED assists in the terms of the planning work in respect of terrorist attacks, please?
A. In terms of risk assessment or the response and planning for?
Q. Well, at this stage in respect of the planning work, please.
A. Obviously, the planning work is very much dependent on the assessment of risk. I will deal with that first. We're able to support LRFs in looking at the risk assessment based on national guidance and documentation, which is provided by Cabinet Office. So they are the lead department there.
So it's very much supporting the LRF, identifying

their own risk picture for their local area, and obviously the planning is led by the local responders. Where there is additional guidance or support needed from Central Government, we're able to act again as that conduit to work with departments.
The preparation for the threat side of things is a more restrictive environment than for the hazards or the non—malicious threats, so quite often that might be led through the counter—terrorism security advisers, the CTSAs, or the counter—terrorism units as well. In a number of LRFs, when the assessment of risk is to do with a malicious threat, that can sometimes be done within a more closed group with a higher security consideration.
My resilience adviser colleagues, we are involved in that, but the threat side is a more specialist area, I would say, than the non—malicious hazards.
SIR JOHN SAUNDERS: I just wonder if you could help me in practical terms. We know that the threat level was severe throughout this period, so when you say it depends on the assessment of risk, we know it's severe. Then you say you support the LRFs by looking at risk assessment. How do you do that? In practical terms, what are you doing?
A. So in terms of information available to the local

resilience forums, there is a national risk assessment at that point. It's now called the national security risk assessment. And that's a classified document, I don't think I'm going beyond anything you have already heard. That was available for LRFs to consider, the types of threats that might be available. You have as part of the evidence bundle the National Risk Register for 2015, which is the public−facing version of the more classified document. In that, threats are mentioned.

That gives the LRF an overview of the types of threats that they might want to consider. The counter−terrorism security advisers and the regional counter−terrorism units are able to provide more nuanced, more detail to the LRF planners around their specific area. So again, there is information available from Central Government that my Resilience and Emergencies Division can help the LRF access and see, but that is supplemented by that local support by the counter−terrorism networks.

SIR JOHN SAUNDERS: Okay. As far as I understand at the moment, what we've heard is that the risk assessment, which will be give to places where large numbers of people gather together, is −− at that particular time the risk assessment of a terrorist attack was severe, that meant that an attack was likely.

A. Yes. That was the −− sorry.

SIR JOHN SAUNDERS: Does it go beyond that, your advice?

A. It goes into more detail of assessing whether it's severe or critical. That is the ... I believe it's JTAC. That's the view of what is the current threat picture for the country so that an attack is imminent or is possible. But behind that for the individual risk assessment by each LRF there's a lot more detail given in the documents I have mentioned and the Cabinet Office also provide for local resilience forums at that time what was called Local Risk Management Guidance, which was specific guidance to LRFs about how to assess risk and how to include that in their Community Risk Register as well, which is a duty under the Civil Contingencies Act, to prepare.

So there was additional guidance available to LRFs in addition to that national overview of what is the current threat level.

SIR JOHN SAUNDERS: Thank you.

MS CARTWRIGHT: Still on your paragraph 11, you set out in the witness statement that:

"In terms of the risks [as you have just told us] many are captured on the National Risk Register, an analysis on the nature, likelihood and potential impact of civil emergency risks, maintained by the

Cabinet Office. In each local resilience area, a Local Resilience Forum is also required by the Civil Contingencies Act of 2004 to maintain a Community Risk Register, which assesses the nature, likelihood and potential impact of civil emergency risks, which may affect their local area."

A. Yes.

Q. So you have just touched upon the Community Risk Register that needs to be in place locally by the LRF. But can you then assist practically as to how your resilience advisers in RED are supporting the LRFs in terms of the completion and updating of Community Risk Registers, please?

A. Yes. Each LRF will generally have what's called a risk assessment working group, in which they will take forward the preparation of their Community Risk Register. I've already mentioned some guidance that that was produced and if I go back to sort of 2015, in particular, along with the national risk assessment and the document called the Local Risk Management Guidance, as RED we facilitated workshops with all of the LRFs to discuss the risk documentation, to support LRFs in developing their Community Risk Registers, to bring key government departments to these workshops so they can explain any changes in risk.

So the Local Risk Management Guidance also sets out a mechanism and methodology by which LRFs can undertake a risk assessment as well. It's quite a detailed process and I believe you do have a copy of one of the Community Risk Registers from Manchester as part of the evidence. What it tended −− what it did is you look at the individual risk, you look at the impact and the likelihood as a matrix, and I think if you look in the National Risk Register of 2015, you will see a matrix that is {INQ019168/1}.

On {INQ019168/12−13} of that, you will see two matrices, one for terrorist and malicious threats, one for other risks. LRFs −− that is the publicly −− it's a public version of what LRFs will do for each of the risks. They'll produce a matrix.

SIR JOHN SAUNDERS: Is there anything wrong with having that document up?

MS CARTWRIGHT: I was just going to ask.

{INQ019168/12}.

A. On pages 12 and 13, you will see a matrix per page.

Q. I don't know whether the document is being displayed.

(Pause)

A. It's not quite what I was −− it's on page 12. I don't know if you can access page 12.

SIR JOHN SAUNDERS: We are looking at page 12.

MS CARTWRIGHT: Perhaps I could use a different document, Ms Gillespie, which perhaps gives a practical way that resilience advisers were looking at the Community Risk Register.

Mr Lopez, could you please display {INQ012442/2}. Ms Gillespie, just to identify, these are the minutes of the Resilience Development Group of the Greater Manchester Resilience Forum from 2 November of 2016. They are minutes that you have provided as part of your evidence.

A. Yes.

Q. We can see on page 2 one of the items that was being discussed at that meeting was the Greater Manchester Community Risk Register review.

A. Yes.

Q. We'll just identify at this stage —— we can see there's a TG that is dealing with an action here by reference to the Community Risk Register. Tim Goodstone (sic), as we know from the first page, which I won't ask to be displayed, was the resilience adviser from the DCLG present at that resilience meeting.

A. Yes.

Q. Is that correct?

A. Yes.

Q. And perhaps ——

A. Tim Godson his name was.

Q. And we can see that by way of a practical application of what the resilience advisers did, within that meeting from 2 November 2016, we can see that there was a proposed leads and timescales risk assessment template for the GM Community Risk Register review.

A. Yes.

Q. And it sets out that:

"A discussion took place regarding the statutory duty to undertake risk assessments on a Greater Manchester footprint. The national approach taken by some agencies was noted and Mr Godson agreed to raise this at the forthcoming risk workshops."

Then a little further down for action we can see:

"TG to raise the issues around the national approach taken by some agencies in leading some risk assessments at the forthcoming risk workshops."

So using this as a practical input of a resilience adviser looking at a GM Community Risk Register review, could you just explain what that summary suggests was being done by the resilience adviser, please?

A. Yes, I will do. I'm not entirely certain which risk Mr Godson was feeding back on, so this is a generic comment, in that it could be that an agency or department, and I'll just use my own —— for example,

DCLG, we are the lead department for earthquakes. So if there was a generic risk assessment done for the whole country on earthquakes and Greater Manchester felt that this was not appropriate and wanted a more location—specific risk assessment and support for Greater Manchester, that would be fed back into, for example, DCLG to say: is there more information you can give for Greater Manchester as a single location rather than a generic risk assessment for the whole country.

So that's the type of conversation that we had. If there was a new and emerging risk, for example a risk came through around volcanos following the Icelandic eruption some years back, which disrupted air travel, then our resilience advisers would be the means by which that more detailed national information could be brought to the local resilience forums so they could interpret it for purposes of the Community Risk Register for that area because there are certain things that will be of higher risk in some areas compared to others, flooding would be an example as well.

It's going back to that point of the conduit of information, that linking of Central Government into the Local Resilience Forum and taking questions back from the Local Resilience Forum into Central Government.

Q. Could I ask, Ms Gillespie, in terms of a more specific

example that this inquiry is considering, in terms of specific venues that fall within a Community Risk Register, such as crowded places, and you'll be aware that plainly this inquiry is looking at the Manchester Arena, do the resilience advisers have a specific role with looking at risk assessments for individual venues that are being looked at as part of the risk register?

A. No, we don't. That's very much a local planning option as well.

Q. Thank you.

Perhaps if I then can summarise the next aspect of your evidence. It's right, isn't it, that routinely the government department, as it was, does not fund the local resilience forums?

A. No, we did not fund at that time.

Q. That RED or the government department at the time is not (inaudible: distorted) tasked with emergency planning or relief duties under the Civil Contingencies Act?

A. No, we are not.

Q. And you have provided then, again, another document which was the Cabinet Office's guidance, which essentially summarises the extent of RED's advisory and planning function, and please, Mr Lopez, if we could display on the screen {INQ019372/1}.

If we could then move, please, to {INQ019372/13}. This is guidance that was in place in March 2012. We see at paragraph 13.27, Ms Gillespie, that the Cabinet Office guidance confirms that:

"The Resilience and Emergencies Division helps responders identify for themselves the risks they face, mitigate those risks, and manage the impact of risks that materialise, including through liaison with Central Government departments."

A. Yes.

Q. Is that correct?

A. That's correct.

Q. And within your witness statement, you then directly quote from the next paragraph, paragraph 13.28, which sets out what the Resilience and Emergencies Division will do, which are the following bullet points:

"Act as a critical friend, question rationales, suggest alternatives, share good practice and support local planning activities."

A. Yes.

SIR JOHN SAUNDERS: Is acting as a critical friend a term of art in government?

A. It is not uncommon in government to be used. It is quite frequently used.

SIR JOHN SAUNDERS: Right. Thank you.

MS CARTWRIGHT: The second bullet point:

"To provide a support mechanism helping local partners develop an appropriate response capability, brokering advance mutual aid agreements between areas."

A. Yes.

Q. Thirdly:

"To make links between local responders and the lead government departments."

A. Yes.

Q. "Supporting cross-boundary strategies, protocols and procedures whilst ensuring a close fit with both the needs of government in a national emergency and the needs of the local responders."

A. Yes.

Q. "Support local and national exercising. Helping to ensure lessons learnt are effectively shared across the relevant partnership."

A. Yes.

Q. We'll come back to that last bullet point shortly.

Could I then move, please, to the third area that I wish to deal with you this afternoon, Ms Gillespie. If you could offer assistance to the inquiry in respect of the staffing and resources at the relevant time within the Resilience and Emergencies Division. I'm at your paragraph 14 now.

A. Yes.

Q. You've already told us about resilience advisers. You set out there that:

"RED undertakes these duties..."

And those are the duties we've just looked at in the Cabinet Office guidance:

"... primarily through a team of resilience advisers led by a Head of Resilience."

A. Yes.

Q. And pausing there, at the relevant time you were that Head of Resilience for the north of England?

A. I was, yes.

Q. And you say this:

"Resilience advisers form a relationship with the Local Resilience Forum or a number of local resilience forums, attend relevant meetings, form good working relationships, and undertake the duties outlines in the Cabinet Office guidance", which we have looked a together.

A. Yes.

Q. And then you give us some information as to the officers of RED at the relevant time. You say this:

"In addition, resilience advisers may specialise in particular types of risk, known as resilience policy areas, such as flooding or terrorist attacks, and they

likewise advise local areas and feed into Central Government's plans on how to deal with particular risks within the relevant resilience policy areas."

A. That's correct.

Q. Pausing there, were any resilience advisers that were supporting Greater Manchester Resilience Forum specialists in terrorism?

A. Not to my knowledge as far as I recollect, no. The colleague who had the lead in that area, I believe, was part of the office in Birmingham.

Q. Is that individual Tim Godson?

A. No, Tim worked in the north, in my team, in the north of England. The colleague who led on working with Home Office, I believe, was -- my understanding as far as I recollect was somebody called Nick White and he was based in the Birmingham office. I am aware, and I know we will cover Winchester Accord, that when Tim was planning to attend the exercise, he did ask for advice from Nick on anything he needed to know prior to the exercise.

Q. So how would it be then that a Local Resilience Forum might get specific specialist advice from a resilience adviser with a speciality in terrorism, please?

A. If an LRF did ask for advice in a particular area which that particular team member wasn't a lead policy team

member —— the individual could ask another member of RED who was that lead to come to any LRF meeting to provide advice to that LRF or to answer any questions, you know, that were raised by the LRF. So while the team was a national team, and basically supported all the LRFs across England —— Mr Godson led on flooding, for example, so he was able to provide advice to the LRFs across England around flooding and links into DEFRA.

And the role of that policy lead was resilience adviser was very much working with the lead government department, so they were able to support the lead government's department planning for the particular policy area.

I've mentioned Nick and he would probably have worked with the Home Office, as far as I remember, to help the Home Office develop policy areas as well as working with LRFs as well.

Q. So at the relevant time, prior to the attack, we can see in a number of the minutes you've provided there's a number of the meetings where the attendee resilience adviser is Mr Godson.

A. Yes.

Q. And could you assist as to what period of time Mr Godson was the resilience adviser to Greater Manchester Resilience Forum, please?

A. I believe it would largely have been 2015 and 2016. I'm not quite certain when he started. I believe he moved from DCLG to DEFRA at the end of 2016, so you'll see he handed over to another resilience adviser. That's to the best of my recollection.

Q. To that extent, would the usual practice be that you'd have a specific resilience adviser that would attend the meetings of the same Local Resilience Forum?

A. Yes. I had a small team at the time, about five people, and each particular resilience adviser had specific LRFs with which they worked. However, the whole team was able to provide that support. For example, if somebody was on leave, another resilience adviser could attend the meeting, but the primary relationship was with a named individual and between two and three LRFs.

Q. So then when Mr Godson left, who was the resilience adviser that was in the main dealing with the Greater Manchester Resilience Forum?

A. It was Emma McDonough as then, she is now Emma Feeney.

Q. Did she have any specific specialism with terrorism?

A. I don't believe so, no. I don't recollect.

Q. Thank you.

You indicated in your witness statement that resilience advisers are under the supervision of one of a number of grade 6 heads of resilience.

A. Yes.

Q. I think that was the role you were practising in at the time.

A. It was, yes.

Q. To what extent would you know what was going on in that Local Resilience Forum?

A. I would hold regular team meetings. I would hold a weekly team meeting and I would expect —— and part of that was feedback from each of the LRFs so that the resilience advisers were able to share information, share key priorities from the LRFs as well, and with the resilience advisers generally having a relationship with more than one LRF they themselves were able to compare and contrast the LRFs as well. And also on a national basis as well, because we were a national team, we were able to share the information across all 38 LRFs within England as well. We had regular team meetings for the whole division and regular catch—ups. We also had a mechanism by sort of capturing key information about an LRF. So you've seen in my witness statement the ability to deploy in the event of an emergency happens, so we had a basic set of information that would allow any resilience adviser to know the key —— the chair, the secretariat, the out—of—hours details for any particular LRF, so they were able to be effectively —— to

effectively represent government at any LRF meeting or at any SCG because out of hours, it wasn't necessarily the resilience adviser for that LRF who would attend the SCG.

Q. Could you then, just dealing with the staffing and resources —— you also tell us about RED reserves, could you explain what they are, please?

A. Yes. RED reserves were members of staff within the department. When an emergency happens, and I'll refer to flooding at this point, it gets —— there's a lot of work to be done by a lot of people and it goes beyond the capacity of RED. So at that time we were able to call on additional staff from within the department to support any response activity and to bring people in from the wider department and that had been extensively used, for example, in response to the flooding in late 2015.

Q. Thank you. You go in your witness statement to produce various minutes from Greater Manchester Resilience Forum meetings but also meetings of the Resilience Development Group at which the resilience advisers were present. I'm not going to take you through the minutes of each of those documents, but could you just explain the purpose in providing these minutes as to why they were included in your witness statement, please?

A. It's to show the engagement that we had with Greater Manchester Resilience Forum and to show that our attendance —— we prioritise obviously attendance at the GMRF, the executive level meeting, I describe it as, but also we attended the working group meetings as well. We didn't always attend the other subgroup meetings, which I believe you've heard of, particularly from Ms Roby. That would be more on a case—by—case basis if our specific engagement was requested. So we were able to provide support at both the executive level, the strategic level, but also at the working level as well because most of the development of plans and the sort of operational tactical questions happen at that —— it's called the RDG in Greater Manchester.

Q. Thank you. Could I then briefly use just one of those sets of minutes before moving on to the next area, please, area 4. One of the sets of minutes you have provided was from one of those Resilience Development Group meetings. Could I just take you to the 12 May 2016 minutes for that meeting just to try and understand again how the resilience advisers would work.

Mr Lopez, please could you display {INQ012468/1}.

We can see there, these are the minutes from the 12 May 2016 Resilience Development Group, and we see TG there, Tim Godson, from DCLG.

Could we move, then, please, to {INQ012468/6}?

Under item 5, we've got the Greater Manchester Resilience Forum work programme updates. We can see that part of what was being discussed was that work programme and we can see TG:

"TG questioned the green RAG rating for the use of Resilience Direct as a tool in integrated/planning preparedness and response because GMP do not fully use the system because of their reservations about the security. A national fire user group has met to discuss increased use of Resilience Direct."

So pausing there, would it be right to say that Mr Godson has obviously reviewed a work programme and seen that that suggested Resilience Direct being used and identified that that wasn't the case within the Greater Manchester Resilience Forum at that time?

A. From reading the minutes, yes, that's my interpretation as well.

Q. Can I ask, going back to some of the evidence you've given about the role of RED being the critical friend or to support and encourage, we've heard some little evidence about what Resilience Direct was or could be in terms of the tool. So using this as an example, when a Local Resilience Forum wasn't using one of the government tools of Resilience Direct, would this be

a scenario where you would expect the resilience advisers to be encouraging that Local Resilience Forum to implement and adopt a government system to equip and assist interoperability between blue light services?

A. Very much so, and Resilience Direct was a platform that was specifically developed to allow the sharing of information. So again what I have seen in the minutes here would very much reflect the expected role of a resilience adviser: it was to question —— it goes back to the question of critical friend in that obviously it's been rated as green whereas not all the partners are using it. So I think what I see there is a resilience adviser doing what I'd expect them to do.

Q. Again, in terms of trying to understand how practically then the resilience advisers would be operating in a resilience forum, would it ever be the role of a resilience adviser to say, "You must and should implement Resilience Direct"?

A. We wouldn't —— we don't have a command and control role in that sense. In this —— if —— hypothetically, if there was a new system that just wasn't being used at all by a particular partner, we would talk to that partner, talk to the secretariat of the Local Resilience Forum just to find out why. We would then say: why, is there a particular reason? If there was a reason, there

was a question around in this case, for example, security, we would go back to the department whose system or guidance it was and ask the question. So it would be persuasional influencing rather than: you must.

Because the duty —— you know, there could be a reason why a partner has chosen not to follow guidance or use a system, but we'd want to speak —— we'd question why and if there was a —— if we had significant concerns and there was just —— it was —— we could talk to the lead departments and —— say, the Home Office if it was the police or DEFRA if it was the Environment Agency. You know, is there a reason why? In that sense —— but we don't command and control the local partners.

Q. Could I move now, please, Ms Gillespie, to topic 4, the RED resilience advisers' attendance at exercises, including Winchester Accord. I'm at your paragraph 18 now and you say this:

"As part of our advisory and planning work, we undertake some event—based work, for example advising local responders on security risks associated with major events such as general elections, and we may also coordinate different agencies involved for preparing for such events, such as facilitating meetings between members of local resilience forums and government departments. RED resilience advisers also attend

exercises, for example a RED resilience adviser attended Winchester Accord and provided advice on the interpretation of national guidance."
A. Yes.
Q. So pausing there, was it Mr Godson that attended the Winchester Accord exercise?
A. It was, yes.
Q. And then can you explain, please, what his role would have been as part of that Winchester Accord exercise?
A. My understanding about Winchester Accord is that it was actually in two parts. It wasn't actually an exercise that was developed by the resilience forum itself, I believe, and I understand from other evidence, it was organised by the police and the military. So the part of the exercise Mr Godson took part in was the activation and set-up of the SCC, the strategic coordination centre, and setting up the SCG, the strategic coordination group, to do -- so he took part in that aspect of the exercise. We didn't take part in the live play aspect of Winchester Accord. Does that answer or do you want me to go further on Tim's role?
Q. Could you just explain why it was Mr Godson then was having a role in the setting-up of the SCC and the SCG, please?
A. As you'll see from the existing guidance and the

national concept of operations, we attend any SCG as a government liaison officer or part of a government liaison team. So Mr Godson would have attended in that basis as in effect exercising the role of government liaison officer. Now, I have spoken to Mr Godson about the exercise and it was testing the sort of IT and systems within the SCC and could we activate our own IT. Were we called to the SCG, et cetera? So it wasn't -- it was a part of the exercise, but it wasn't part of the live play aspect of the exercise.
Q. In terms of then the debrief, the multi-agency debrief arising out of Winchester Accord, would Mr Godson have had a role in terms of taking forward any of the actions or learning from that exercise?
A. Not unless the actions were directed at a particular government department. And from my understanding, there wasn't any particular government department in the SCC element of the exercise. I will not -- I'm not able to comment on the live play aspect.
So in that sense if there was a particular action around something in Central Government maybe you need to consider, yes, but otherwise the actions are for the local responders to take forward.
MS CARTWRIGHT: Sir, is there anything else you want to deal with?

SIR JOHN SAUNDERS: Yes.
One interpretation of the evidence I have already heard, and it may be the only possible interpretation, is that Winchester Accord was a disaster and there were a lot of things which needed to be learnt out of that. One of the problems appears to be that the Local Resilience Forum has no part in making sure that people put right what has gone wrong in an exercise. Is that right?
A. I would say no, not that -- that is not my general experience, sir. I can expand if that would help.
SIR JOHN SAUNDERS: Well, they certainly don't -- they can't tell people what to do, can they? They don't seem to have any powers of compulsion.
A. I think if I take a step back from Winchester Accord, because I think that's a particularly unique exercise, so I will take a step back. I would expect, for every LRF that takes part in an exercise, that there will be a tracker for the lessons from that exercise and that those lessons will be followed through the system to see have those been actioned. I wouldn't necessarily expect them to be discussed at every executive LRF meeting, I would expect them to be looked at a working group and operational level group and only come back to the more senior meeting if there was an issue that needed to be

addressed or there needed to be basically a change of plans that needed to be then agreed with the LRF.
So while there's no power to compel, there is -- the CCA does have that duty on responders to plan, to assess risk, et cetera, but it is by cooperation that you fulfil that duty. So I don't think it's that -- that in itself I don't think stops any lessons being identified and then being learned.
I think if I then move back to Winchester Accord, I don't believe, and from looking at the minutes, I don't think the live play element of the exercise came to GMRF, but that's my understanding from the minutes; I myself was not at the meetings. So I think there's a particular -- Winchester Accord is -- does not fit with my normal experience of LRFs and exercises and lessons.
SIR JOHN SAUNDERS: There was a tracker, we know that, and there were discussions about it periodically, but the fact of the matter is it doesn't seem that the necessary steps were taken and there doesn't appear to be anyone who can say, "You have got to take them", and make sure they are taken. If not, why don't local resilience forums have that power?
A. I would expect that to be the Local Resilience Forum, around an exercise, that that would keep -- that there

would be sufficient —— that... In normal —— in other exercises I have seen and understand resilience forums will have said, "Action needs to be taken". But as you say, there is no power to compel a particular partner within the forum to do something by another partner. There are mechanisms by which my team could become involved. If there was a dispute between partners, we could seek to see how we can move things forward, how we can resolve that dispute and I could engage other departments to help resolve that issue.

So I do fully accept your point that there isn't that power to compel, but I also expect that at that senior level, the partnership should work together and if there are critical issues that need to be resolved, I would expect that to be resolved at the LRF if that's appropriate.

SIR JOHN SAUNDERS: Should the LRF have the power to compel?

A. Sorry, sir?

SIR JOHN SAUNDERS: Should the LRF have the power to compel action to be taken if it's not being done in a timely manner?

A. It's difficult for me to answer that question, but I don't think it's necessary. I think there is sufficient seniority (?) and cooperation that ——

SIR JOHN SAUNDERS: Okay. My interpretation of the evidence

of Winchester Accord is that there were things which had gone wrong, which the tracker picked up had gone wrong, which had not been put right by the following May. If that is right, and obviously I will need to examine the evidence and hear submissions, but if that were not the position —— if that were to be the position, why isn't it necessary for someone to have the power to make sure that the individual agency involved actually got on and did it?

A. I believe that that collaborative power sits with the LRF. I think the specific issue with Winchester Accord is the LRF was not aware of some of the actions that needed to be taken, but I'm not —— because I wasn't at the exercise and wasn't part of the live play, I find it a little bit difficult to comment in detail.

SIR JOHN SAUNDERS: I understand that. Okay. But I'm going to carry on asking the questions and you'll just tell me you can't answer them. So if the LRF were not aware of some of the problems, why not? And shouldn't they have been aware of them?

A. Again, this is my personal opinion. I think ... Certainly the multi—agency aspect of the exercise did identify an issue with the setting—up of the SCC, et cetera, and that action was taken. In terms of the live play aspect, I don't know why the action wasn't

taken and I don't know why... I think the way the exercise was created did —— it was created away from the LRF, I think, was one of the challenges. Again, I can't necessarily comment in detail on GMRF in terms of exact exercise learning, but I'm aware that they also planned for a major flooding exercise the year before, maybe the same year, and lessons were taken through from that and there was a tracker.

So I can't comment on the specific actions from the live play because they didn't come to the resilience forum.

SIR JOHN SAUNDERS: Right. So theoretically does RED have any power to make someone do something if they're not doing it?

A. We don't have the legislative power, but we have —— we will do a lot of work to talk to the individual agencies and, if needs be, also talk to the sponsor departments of a particular sort of partner of the LRF. Now, I'm speaking hypothetically here, there's no criticism applied here at all. If, for example, in planning for floods there was a concern raised about the Environment Agency or about the Met Office and that couldn't be resolved locally, it couldn't be resolved by discussion between partners, then I would speak to DEFRA, I would speak to a more senior management within

the Met Office, I would speak to my colleagues in Cabinet Office who have that civil contingencies overarching role.

So in that sense one has the persuasive element coming through. I don't necessarily think —— it would very much change that relationship with the resilience adviser, no longer acting as a critical friend, it would change that dynamic and I think that persuasion, that influencing, that working with the departments, I think is very, very effective.

SIR JOHN SAUNDERS: So he would remain critical but perhaps not in a friendly way if it was changed?

A. I think that's a very good way of summarising it.

SIR JOHN SAUNDERS: And do you think the friendly critic works better than the person who says, "You are not doing what you need to do, get on and do it"?

A. Each of the partner agencies in LRF does have its own regulatory —— and some have an inspection regime as well, so that is in place if concerns were raised. So in that sense, I think, again, that support, challenge and collaborative support and challenge, I think, does work.

SIR JOHN SAUNDERS: Okay. I'm sorry for asking those questions, you're not responsible for the policy, but you're the person who's here to justify it, so thank you

very much for that.
MS CARTWRIGHT: Just as a final question just before we finish topic 4. I'm not going to ask for it to be displayed on the screen again, but when we looked at the Cabinet Office guidance, {INQ019372/13}, and paragraph 13.28, you'll recall that the last bullet point was in terms of what the Resilience and Emergency Divisions will do was to support local and national exercising, helping to ensure lessons learnt are effectively shared across the relevant partnership.
A. Yes.
Q. So in a sense of now a concrete example of Winchester Accord, which was an exercise where the resilience adviser was involved, are you able to assist us as to how practically, using Winchester Accord, the Resilience and Emergencies Division helped to ensure lessons learnt were effectively shared across the relevant partnership by reference to Winchester Accord, please?
A. I spoke to Mr Godson about his engagement in Winchester Accord and his recollection of the lesson he identified was the need to make sure that the SCG recognised the role that my division played in terms of the consequence management side and our need to be part of the -- part of any SCG as well. So looking at the

lessons of Winchester Accord that I've seen for the multi-agency partnership, most of them did sit with the local partners -- in fact all of them did. So again, with that it was around making sure the SCG activation procedures were adequately updated in the aftermath of the exercise as well, as I understand it.
MS CARTWRIGHT: Sir, we've been going a little over an hour. I don't know whether the stenographer would welcome a short break before we deal with the last three topics areas or whether he's content... We're going to continue.
Ms Gillespie, I'm moving now to topic 5, which is closely linked to topic 6 as well, which is the role of RED in government policy document planning for marauding terrorist firearms attacks and further advice for local resilience forums. I'm now at your paragraph 19.
You tell us in your witness statement, as we're already aware, the policy regarding marauding terrorist firearms attacks sits with the Home Office and in 2013, a guidance document entitled "Planning for a Marauding Terrorist Firearms attack: Further Advice for Local Resilience Forums" was published and this guidance was developed by the Office for Security and Counter-terrorism in the Home Office, the Cabinet Office, DCLG and the Department of Health,

alongside national police, ambulance, fire and rescue and LRF partners. The lead department on the guidance was OSCT, the Office for Security and Counter-terrorism.
You confirmed that the department of which your team sat, the Department for Communities and Local Government, shared the guidance with the Local Resilience Forum community.
A. Yes.
Q. And just for completeness, why was it important that the RED division shared that guidance, please?
A. Again, because it was guidance for local resilience forums, we have that primary relationship with the local resilience forums, so we're the conduit with which the guidance can be shared, and in looking through some of our records we also hosted workshops as well to help LRFs sort of consider the guidance and bringing together LRFs with the OSCT, et cetera.
And I think if I could clarify one point as well. As far as I recollect, at that point, fire policy also sat within DCLG. It transferred in 2016 to the Home Office. So obviously there was a direct link with fire services from another part of DCLG, it wasn't RED.
Q. Thank you. But in terms of then, in July of 2013, when this guidance was published, you say this, in your paragraph 20:

"The guidance set out the particular challenges that a high-impact fast-moving attack of this kind could raise for responders that sat on a Local Resilience Forum, particularly category 1 responders. It provided practical advice to ensure that generic response and recovery plans were geared to help manage this kind of incident. In particular, it identified five key aims. Firstly, to gain access to relevant information to ensure understanding of the threat and how national strategy translates at local level. Secondly, to ensure clear understanding of the joint emergency services response. Thirdly, to engage with your local police force to identify vulnerabilities specific to your region to develop an understanding of what an attack may look like in your area to inform planning. Fourthly, to review existing major incident response plans against the national risk planning assumptions and other relevant documents to see whether they are current and suitable for an MTFA incident. And fifthly, to develop corporate and community resilience as far as possible."
A. Yes.
Q. Then perhaps if we, please, look at that guidance just to see the clarity of the advice that was being given to local resilience forums in respect of MTFAs, please.
Mr Lopez, it's {INQ031148/1}.

This is the document, isn't it, Ms Gillespie?
A. Yes. I believe it is.
Q. Thank you. If we then turn, please, to {INQ031148/3}. It's right, isn't it, that the guidance to Local Resilience Forums provided clear guidance as to how to structure their planning for MTFAs, would you agree?
A. Yes, it does.
Q. In terms of —— if we look at the bullet points under 2(a), it indicated that local planners should therefore be aware of the joint operating principles (JOPs).
A. Yes.
Q. That there should be clear identification and declaration of an MTFA.
A. Yes.
Q. "Consideration of mobilisation of specialist emergency service responders. Assessment and management of risk at the scene. Tactics for managing casualties in areas that cannot yet be declared completely safe. Tactics for managing other hazards such as smoke and fire."
A. Yes.
Q. I'm not going to take you through all of that, but would your assessment of that July 2013 guidance be that it was clearly identifying for Local Resilience Forums and particularly category 1 responders the care and consideration that they needed to give specifically to

an MTFA?
A. Yes.
Q. I think we can see at (b), there is also —— that guidance to local resilience forums also made clear that the issue as to access to warm zones was being highlighted in that guidance.
A. Yes.
Q. But also highlighting that the initial stage of an MTFA is likely to be fast—moving and constantly changing with the majority of casualties occurring in the first —— and an indication of timing.
A. Yes.
Q. And that the operational response is aimed at ensuring decisions are made quickly on the ground at the lowest appointed level.
A. Yes.
Q. And over the page, please ——
SIR JOHN SAUNDERS: Before you leave that, is there —— have we gone over the page now? Thank you.
Is there a section, I'm asking you this, for the tactics for managing casualties in areas that cannot yet be declared completely safe?
MS CARTWRIGHT: I have not specifically seen it in this document, sir.
A. I don't think it was in that document, sir. I think

that's much more operational detail than you'd have. This is more of an overview document.
SIR JOHN SAUNDERS: If we can see the whole of that paragraph. Can you go back up the document, please, to what governs the bullet points:
"This document sets out how the emergency services should respond to identified tasks and priorities such as those listed below. Identification and declaration of an MTFA. Mobilisation. Assessment and management of risk. Tactics for managing casualties in areas ..."
Does it in fact do that, this document?
A. No, because it references the joint operating principles, I believe that's the reference to which ——
SIR JOHN SAUNDERS: "This document" means JOPs, does it?
A. I believe so. That's my interpretation of that paragraph.
SIR JOHN SAUNDERS: Sometimes I just need to understand it's not referring to the particular document we've got on the screen.
A. No.
SIR JOHN SAUNDERS: But it is a reference to JOPs?
A. As far as I recollect, that level of detail was not shared with LRFs —— as an LRF.
SIR JOHN SAUNDERS: So if I replaced "this" with "JOPs" then even if I couldn't get confused by it?

A. I believe so, but I myself have not seen JOPs, I have to say.
MS CARTWRIGHT: Sir, you'll see plainly this guidance was from July 2013, so JOPs 3 would not have been the effective JOPs at that time.
SIR JOHN SAUNDERS: It would have been JOPs 2?
MS CARTWRIGHT: It may still have been JOPs 1. I'm not entirely clear.
SIR JOHN SAUNDERS: But a JOPs document?
MS CARTWRIGHT: Yes.
And over the page, Mr Lopez. {INQ031148/4}. Again, there's clarification within this document that:
"Due to the dynamic nature of the attack and urgency of the response, decisions will need to be made rapidly and before the setting—up of the strategic coordination group."
A. Yes.
Q. Thank you.
Ms Gillespie, can I move now to item 6, please, because you have set out within your statement the change in guidance that took place in 2018. We're now at your paragraph 21, please. Can we deal with the sixth issue, the role of RED in updating the policy document "Planning for Marauding Terrorist Firearms Attacks" that was the updated guidance provided to local

resilience forums in 2018. Could you assist as to how the guidance was updated, please, from what have we've looked at a moment ago to the 2018 guidance?
A. I am not aware of our engagement in the updating of the guidance. Again, our role would have been to share the guidance with LRFs and to facilitate that sharing with LRFs.
On looking at the guidance, I think the guidance has been updated to take account of some of the learning from 2017 from the various events, ie particular terrorist events, during that year and it did highlight that it may take -- the SCG may be set up, in effect, after the incident itself has concluded.
Q. Can we then display, please, Mr Lopez, briefly, that updated guidance that post-dates the arena attack. {INQ018929/1}, please.
Ms Gillespie, can you help me then with just this paragraph under the "Please note the following" a little bit further down? We can see it records:
"This document is not being issued due to any increase in threat level from this kind of attack or any specific intelligence. It is provided as an update to the original guidance provided in July 2013 and to reflect the national risk assessment, which now includes malicious attacks at official -sensitive."

Could you just explain what that means, please?
A. It means that it's a slightly lower security classification, so it's more easily accessed, the national risk assessment. As far as I recollect, it was actually shared via Resilience Direct and that is up to an official -sensitive classification. So it increased the amount of information available to national resilience forums at a more easily accessible security level.
Q. I think we can see in the bullet point below what you essentially tell us in your witness statement, that:
"This guidance [was] not asking Local Resilience Forums to develop separate bespoke plans to respond to this kind of attack, instead it [was] strongly encouraging planners to work together to consider how existing contingency and security plans can be adapted or strengthened to address the specific challenges of this type of incident."
A. Yes.
Q. Thank you.
A. I think the guidance very much reflected the speed with which such incidents occur and the challenge that that would provide, to make sure that planners -- to look at existing plans and to see what needs to be done and how best they can work together to strengthen the plans.

Q. Thank you.
SIR JOHN SAUNDERS: Not necessarily criticising you, but it's a bit a statement of the obvious, isn't it, that?
A. One would expect that to underpin all planning, but I think it's very much around recognising with the lens of what is an MTFA in that very, very fast-moving, very dynamic attack, and to really look at the plans through that lens. So it is stating what they should be doing anyway but with that specific focus.
SIR JOHN SAUNDERS: Thank you.
MS CARTWRIGHT: Your paragraph 22 now, Ms Gillespie. You say this:
"The revised guidance set out six key issues.
"Firstly, threat. Gain access to relevant information to ensure understanding of the national risk and how to apply that information locally.
"Secondly, local planning. To engage with your local police force to identify vulnerabilities specific to your region, developing an understanding of what an attack may look like in your area to inform your planning.
"Thirdly, review existing major incident response plans against the relevant planning assumptions to ascertain whether they are current and suitable for an MTFA incident.

"Fourthly, to develop corporate and community resilience as far as possible.
"Fifthly, by way of response and recovery, ensure a clear understanding between the emergency services and non-blue light LRF partners.
"Sixth, understand the role of Local Resilience Forum partners during an MTFA."
A. Yes.
Q. Finally on topic 6, you say that:
"If an LRF required any assistance in interpreting or implementing the MTFA guidance, then RED could facilitate contact with the relevant government department, usually OSCT. In many cases the local police service would have a pre-existing working relationship with the Home Office and contact could be made directly."
A. Yes. I think that goes back to my point that on the threat side, there are very strong links with the counter-terrorism security advisers with the regional counter-terrorism units, et cetera, to deliver where there were established relationships as well as the contact we could help facilitate through the Home Office.
Q. One final topic to deal with, Ms Gillespie, and then Mr Atkinson has some questions, and so I wonder if in

fact now would be an appropriate time to take a short break to give the stenographer a break, but also Ms Gillespie, to deal with my final topic, and then Mr Atkinson's questions.

SIR JOHN SAUNDERS: Right. We'll have a break until 3.40. Currently, on our clocks, it's 3.23, so just so you have some idea, Ms Gillespie.

MS CARTWRIGHT: Thank you, sir.

(3.23 pm)

(A short break)

(3.40 pm)

MS CARTWRIGHT: Ms Gillespie, can you see and hear me?

A. I can indeed.

Q. The final topic from me, please, which is the Resilience and Emergency Division's role with emergency response work. I'm at paragraph 24 of your witness statement. You tell us that:

"When an emergency occurs, the basic role of RED is to provide liaison between local responders and Central Government."

And:

"This is achieved largely through RED's participation on the strategic coordination group."

A. Yes, that is correct.

Q. "The SCG is made up of members of the Local Resilience

Forum who have particular duties under the Civil Contingencies Act and is convened when an emergency occurs in order to coordinate the local response."

A. That's correct.

Q. You explain in that scenario within an SCG a RED employee will attend as a government liaison officer, so a GLO?

A. That's correct.

Q. And you have indicated that the role of the government liaison officer on behalf of RED at an SCG is to obtain updates on the situation on the ground, provide information from Central Government as well as advice to the SCG, and identify whether the SCG or any of its members are overstretched, need additional resources, and relay requests for assistance for the SCG or any of its members to relevant partners in local or Central Government via RED?

A. That's correct, yes.

Q. You have indicated that generally that will include the lead government department and in more serious emergencies they may also include other government departments and COBR?

A. Yes, that's correct.

Q. Thank you. Perhaps just to use the emergency response plan that you've provided to your witness statement,

just to identify this in a pictorial form, please. Mr Lopez, please could you display on the screen {INQ031147/1}.

You provided the emergency response plan guidance. This is the guidance that was effective from February of 2015, version 3.2; is that correct?

A. That's correct.

Q. Mr Lopez, if we turn to {INQ031147/7}, please. If you could expand on the diagram, please.

Does that figure 3 effectively display what the role of the GLO and RED is at the strategic coordinating group?

A. It does, yes.

Q. You also tell us in your witness statement that an updated version of the DCLG emergency response plan was issued after the attack in June of 2017, and you describe that as version 3.4. Just pausing there for a moment, was there a version 3.3?

A. Not that I can find. What I believe is the case is that we updated and version 3.4 is the finalised and agreed version; we never issued a version 3.3.

Q. Why was the -- what was the change between the emergency response plan that was effective at the time of the attack and the changes that were brought in in June 2017, please?

A. On consideration of the two documents, I -- obviously in paragraph 15, I mention that fire policy was still part of DCLG at that stage and the updated plan 17 removes the reference to the fire policy colleagues. But apart from that, it's broadly similar. Our role in terms of an SCG does not change between the two documents.

Q. Thank you.

Then finally in your witness statement, you deal with the specifics of what happened on the night of the attack in terms of the role of RED and the government liaison officer. You tell us this at paragraph 28:

"On the night of the arena attack, in accordance with protocol, a RED resilience adviser, Mr Graham Scott, was deployed to Greater Manchester Police Headquarters to perform the role of the government liaison officer.

"Mr Scott arrived at Greater Manchester Police on 23 May at 02.30 am and he acted as the single point of contact between the local response partners and structures and Central Government."

A. Yes.

Q. "He attended the first strategic coordination group meeting held at 04.15 am on 23 May 2017."

A. Yes, that's correct.

Q. And:

He used the information gathered from that SCG to brief ministers and senior government officials."
A. That's correct.
Q. Then:
"Subsequent SCG meetings were attended by RED resilience advisers, Ms Christine Gough and Ms Julie Dawber."
A. Yes.
Q. You say this:
"In a terrorist incident, the department's role is to act as a GLO and provide advice on the management of consequences. As part of that consequence management, RED established a dedicated team to support the recovery efforts and worked with Manchester authorities and government departments to provide recovery support."
A. That's correct.
MS CARTWRIGHT: Thank you. Those complete my questions, sir, unless you have any specific questions.
SIR JOHN SAUNDERS: Yes. I want to talk about, please, the response on the night.
A. Yes, sir.
SIR JOHN SAUNDERS: So the person who went, the RED resilience adviser, is he someone who lives in the Manchester area?
A. He is, yes, sir. If I just explain, if you read our

emergency response plan, in terms of our 24/7 cover we operate a duty system with a duty Head of Resilience and two duty officers with two dedicated phone numbers. By chance, I was the duty Head of Resilience on the night of the attack. In our emergency response plan, out of hours, if an SCG is called, it's expected that it will be covered by the duty team, by the two duty officers and myself. Mr Scott lives locally and he proactively contacted me to say he was able to deploy if that would help. I obviously took Mr Scott up on his offer to deploy and he went there in person on the night. Had we not had somebody locally, then we would have tried to cover any multi-agency meetings remotely via our duty team.
Just to clarify, Ms Dawber had been a member of staff in DCLG, but she again volunteered to support. She worked for DfE at the time, as a clarification.
SIR JOHN SAUNDERS: Okay. You were the first person to be notified?
A. I wasn't notified. I heard the news via the media and I proactively contacted somebody within the Association of Greater Manchester Authorities' Civil Resilience Unit to establish what was happening because I had heard it on the media.
SIR JOHN SAUNDERS: Should you have been notified?

A. We should be notified if an SCG has been established. In terms of how quickly we should be notified, I think that's the question. And yes, I would expect to be notified at a certain point.
SIR JOHN SAUNDERS: Well, at some point, that doesn't really help, does it, when and how quickly should you be notified?
A. In terms of something as serious as that, I'd expect to be notified quickly as soon as arrangements are in place to set up a multi-agency response. Given the events -- sorry, if I could just sort of clarify what I've said there.
Recognising the significant nature of what happened and the fact that that immediate response had been there by the emergency services, I would expect to be notified by somebody maybe within the AGMA team or if an SCG has been called, a cascade mechanism to say, "We're calling an SCG, we need you there".
I heard probably the news about 11.15/11.30, I think. I heard there had been an incident. At that point it hadn't been declared as a terrorist attack, so I couldn't say at what point it was definitely known it was a terrorist attack, but I proactively contacted the Civil Resilience Unit. That probably doesn't answer your question as well as you'd like.

SIR JOHN SAUNDERS: No. Whose job is it to notify you?
A. If an event has happened, it slightly depends on the event. In something like -- where there's a -- if it's a response to something that has happened, each LRF will have its own activation arrangements and with Greater Manchester I would expect to be told probably by the Civil Resilience Unit. It may be the police in some circumstances. But I would probably expect it to be the Civil Resilience Unit in Manchester and that they would call our duty numbers.
SIR JOHN SAUNDERS: Could I find it in writing anywhere as to who has the job of notifying you?
A. It should be in the --
SIR JOHN SAUNDERS: Is there a policy or protocol?
A. It should be in the generic response plan for Greater Manchester.
SIR JOHN SAUNDERS: Okay. Would you mind checking for us who should do it?
A. My understanding from the most recent plan is it's a cascade mechanism and it is AGMA who tell us. That's my understanding of having read the most recent iteration, but I will double check that, sir.
SIR JOHN SAUNDERS: Would I be right in saying that an SCG meeting should be held at the first possible opportunity?

A. Yes, that is correct.
SIR JOHN SAUNDERS: This one didn't take place until 4.15 in the morning. That seems quite a long time after 10.31.
A. I have spoken to Mr Scott, who obviously did deploy on the night. There were Gold huddles happening around Force HQ and when Mr Scott deployed we understood an SCG was planned imminently and that seems to have got delayed and delayed, so it was probably established later than I anticipated because I understood one was almost as soon as Graham got there.
I think the most recent guidance on the MTFA guidance does recognise that an SCG may be formed after the event has happened. In terms of ——
SIR JOHN SAUNDERS: (Overspeaking) after the event has happened, wouldn't it? It's not going to be formed before the MTFA. I'm sorry to be facile about it. But nevertheless it should happen, shouldn't it, as soon as it has happened?
A. It should happen soon, yes. As soon as practicable.
SIR JOHN SAUNDERS: You're meant to be the link with Central Government, aren't you?
A. In terms of a terrorist event, we are supporting the Home Office, they are the primary lead department. That's the one difference between a terrorist response

and non—threat response in that we —— my team leads on that consequence management side. The Home Office lead in terms of the ... I would expect the Home Office would be that lead department. So in terms of the terrorist threat, because of the sensitive nature of a lot of the information that is being considered and being discussed, I wouldn't necessarily expect us to be the primary lead in a terrorist event.
SIR JOHN SAUNDERS: Well, in fact Central Government, through CT Police, got to know in London a great deal quicker than you did, which you'd expect to be the case, would you?
A. I would expect that to be the case, yes. I would expect the police to have those direct links in with the Home Office.
SIR JOHN SAUNDERS: And they were the people who actually brief, as I understand it, ministers in the COBR meeting?
A. Yes. That's as I would expect because again, because of the nature of the incident, it's a much more intelligence —led/police—led operation. So even the —— as I understand it, you know, the COBR meetings would be more intelligence—led. My ministers did not attend the first COBR meetings; we were involved in the consequence management and the recovery side.

SIR JOHN SAUNDERS: As a result of a RED member going to the police headquarters, what actually, if anything, did he instigate? This is not a criticism, I'd just quite like to know what his role was and what he was doing there.
A. In terms of his role, his role —— one of the very practical things we had to do was helping set up the COBR meeting and locating and finding the contact details for the Mayor of Greater Manchester. Also during the evening and going into the following morning, we provided advice to the Greater Manchester authorities around sort of support via the Victims of Terrorism Unit, which was being established in the Home Office. And it was working closely particularly with the local authority side, City of Manchester, and the AGMA team as well to really look at and to move into —— to get ready for that next stage of that support to the victims or to families, support to the recovery efforts as well, because recognising we don't have that role in the Pursue or the police—led element. So it was really establishing those links and getting ready for those next stages as well.
The other thing as well is that within our department we had the Faith Integration Team making sure they're ready to work with the local authorities and the local teams to support communities because obviously

there was quite a lot of community concern. I think during the evening, I can't quite recollect, there was an issue with a fire at a mosque in Oldham as well, and again providing information on that and making sure that the department is ready to support in that broader departmental sense as well.
SIR JOHN SAUNDERS: Okay, thank you.
MS CARTWRIGHT: Ms Gillespie, just to finish off using the plan to deal with the matters that the chairman's just dealt with, Mr Lopez, could we briefly have on the screen again, please, {INQ031147/6} of that document.
Ms Gillespie, at paragraph 1.10 we can see under "Strategic Coordinating Groups" it says:
"When an incident occurs or is likely to occur, DCLG will be notified a strategic coordination group will meet at a certain time."
1.11:
"SCGs are made up of members of the Local Resilience Forum who meet in an emergency, often via teleconference and at short notice to share information quickly and make strategic decisions about how to respond. Through RED, DCLG represents the whole of Whitehall, passing information to and from the local level to Central Government so partners have one contact instead of several."

Was that the position at the time of the attack?
A. It was, yes.
Q. And then perhaps just to underline what you said about the nature of the incident, Mr Lopez, if we can move forward to {INQ031147/8}, please.
Under "Lead Government Department", it says at 1.18:
"Most emergencies in the United Kingdom are handled at a local level by the emergency services and by the appropriate local authority or authorities, with no direct involvement by Central Government. However, where the scale or complexity of an incident is such that some degree of Central Government coordination or support becomes necessary, a designated lead government department or, where appropriate, a devolved administration department will be made responsible for the overall management of the Central Government response to the incident."
A. Yes.
Q. And we can see that from paragraph 1.19, it sets out the terrorism always starts at this level, level 2, with the Home Office in the lead?
A. Yes.
Q. Is that what you have just explained to the chairman?
A. Yes, it is, and at paragraph 1.13 on page 6, you'll notice again reference to the government liaison team

and our role as consequence management rather than sort of the ...
Q. Thank you. But certainly the emergency response plan in effect at the time did envisage that your department would be notified of the strategic coordination group when it was going to meet but also there may be a need for teleconferences at short notice?
A. Yes.
Q. Thank you.
A. On the evening, just to confirm, we did establish close working relationships with the Civil Resilience Unit and I have a number of email exchanges with them where they also provided us with up-to-date information and Mr Scott deployed with them and sat down sort of close to them.
MS CARTWRIGHT: Thank you.
That completes my questions unless there's any further clarification.
Ms Gillespie, you're now going to be questioned by Mr Atkinson on behalf of one of the core participants on behalf of the families. He is not in the room, so it may be even more difficult than it has been between the two of us. I'm sure everyone will be understanding. I can see Mr Atkinson is now on the screen.

Questions from MR ATKINSON
MR ATKINSON: Thank you, Ms Cartwright.
Ms Gillespie, can you hear me?
A. I can indeed.
Q. Excellent. I had five topics. You'll be pleased to know that the chair has just dealt with one of them, so I have just four areas that I need your help with, and I'm grateful to you, sir, for that.
Just in terms of what the role of an LRF is in an emergency context, I wonder, Mr Lopez, if we could have {INQ019372/1}, please.
Could we try going to page 10 of the document {INQ019372/10}. This document, produced by the Cabinet Office, deals with emergency responses and identifies the various organisations that will or may have a role to play in a response to an emergency of any number of types.
We can see that, towards the bottom of what is on our screen, paragraph 13.18 deals with the role of a Local Resilience Forum because it's right to say, is it not, that it is recognised that LRFs do have a role to play, both in responding to an emergency but also in terms of preparation for the event of an emergency?
A. If I could just sort of -- the LRF itself doesn't respond; the partner agencies respond via things like

the SCG, but the LRF, certainly as a partnership, is -- that preparation, that planning is their critical role.
Q. One sees that spelt out, does one not, in paragraph 13.18, that Local Resilience Forums are not legal entities and that duties rest with the responders?
A. Yes.
Q. "This does not mean that a forum and its members are powerless to intervene to develop its members' performance."
So that's preparation for rather than an immediate response to an emergency?
A. Could you just repeat the question, sir? My apologies.
Q. Not at all. You're absolutely right. It's the responder agencies themselves, the first responders, who have the responsibility to responding to an emergency but LRFs have an important role in relation to their collective preparation for such an eventuality?
A. Yes, yes.
Q. And we see, as we go on three lines down in that paragraph:
"A forum's strength rests in the cooperative and teamworking nature of the relationships between organisations and the trust that the members have built between them. Collectively, forums can give leadership and bring considerable peer pressure and support to

bear."
A. Yes.
Q. In terms of going back to some of the questions you were asked by the chair a little earlier today, in terms the role an LRF can have, is it through, firstly, bringing the agencies together so that they can talk about their plans for particular kinds of events and also putting pressure on them through that collective responsibility, that collective discussion, to get things done?
A. I think in order to have an effective plan for any emergency, it's rarely that it's a single-agency plan. There will be a single-agency element to a plan, but if we think about things like flooding, for example, it's important that the local authorities, the emergency services, military colleagues, all have a shared understanding of what plan is needed to respond to a particular incident.

I think the critical function the LRF provides is that ability to cooperate in multi-agency planning and building on those single-agency plans to develop that multi-agency plan.
Q. Because to take flooding as an example, you would expect each of those agencies that you've just mentioned to have its own plan in place for dealing with floods?
A. I would indeed, yes.

Q. What is critically important is that each of the agencies that is going to have to play a part in responding to a flood knows what the other agencies' plans are and that those plans work together rather than contradicting each other?
A. Yes, I would agree with that.
Q. And that's where the LRF should come in?
A. It should do and actually sort of to create those multi-agency plans and to work together to ensure those plans are in place and are also tested and exercised as well.
Q. But that can only work if the various organisations that form up the LRF are actually cooperating with each other?
A. Yes.
Q. So in effect, if they don't share, there's a limit to what the LRF can actually do to make them share?
A. Yes. That's true, yes.
Q. And taking into account the role of your unit and the RED, there's a limit to what they can do to make one of the component parts of an LRF share?
A. There are, you will notice in the document you've raised -- if there is significant and serious concern about sharing information, there are legal powers available to both category 1 responders and ministers if

there is -- for example, if sharing does not happen. That is referenced in the document at {INQ019372/1}, I believe.
Q. Is that something of a last resort to go to such measures? If the whole idea of an LRF is for it to be collaborative and cooperative, then surely the aim will always be to try to bring people to cooperate rather than start threatening --
A. Oh, definitely, and I have not in my experience come across a time when that has even been suggested. That cooperation, that collaboration, that persuasion, that peer influence, and even again as I have mentioned earlier in my evidence, if needs be, the departments could speak to core members of LRFs to suggest if change is needed. So it is very much the last resort.
Q. Against that background, let me look at the now four areas that I need your help with. The first of those is in relation to the assessment of risk. If, Mr Lopez, we can take that document down, thank you very much, and go to {INQ018892/14}.

As we can see from the heading, this is "The Principles of Effective Response and Recovery". We can see, the fourth bullet point down, that it identifies as the first of those principles:

"Anticipation. Ongoing risk identification and

analysis is essential to the anticipation and management of the direct, indirect and interdependent consequences of emergencies."
A. Yes.
Q. So a crucial role, would you agree, for LRFs is to --
A. Yes.
Q. -- through its members, anticipate things that could go wrong and how collectively they are to be dealt with?
A. Yes, I would agree.
Q. And as a starting point to that process, as you made clear at the beginning of your evidence, is the assessment of risk, identification of risks, and then moving on from there, how do we deal with them?
A. Yes.
Q. Is that process designed to be informed by the National Risk Register?
A. In part, it is part of the suite of documentation and information available to LRFs to help them assess risk.
Q. So clearly, would one source of information be -- in the context that we are obviously concerned with of counter-terrorism, one source of information will be what the national assessment of risk is by reference to what the risk level is?
A. It is. The risk level is a dynamic thing that changes depending on the immediate circumstance. In terms of

the introduction of the Community Risk Registers and the risk registers for LRFs, that's more dependent on the documentation that I have referenced in my previous evidence. But the current threat assessment is in the back of everybody's mind about the dynamic nature of the changing threat levels.

Q. To take an example from the National Risk Register in that regard, Mr Lopez, we can move on to another document, please. This one will be {INQ019168/42}.

This is the 2015 National Risk Register, to help you, Ms Gillespie.

A. Yes.

Q. If we could highlight the blue heading, we can see that this is a section of that document that identifies -- that addresses terrorist attacks on crowded places, which, as you'll understand, is an area that we are interested in.

A. Yes.

Q. And what this document does is to explain what that risk is and then addresses ways that that is being addressed by UK Government. We can see over on the right it goes on to talk about other agencies and other parts of the planning for the risk of a terrorist attack on crowded places --

A. Yes.

Q. -- and explaining what the risk is.

A. Yes.

Q. Certainly in terms of the comparable Greater Manchester risk register there was no comparable section in the document that we looked at with Mr Argyle from the GMRF that dealt with this topic.

A. Yes.

Q. He suggested that there may be a separate closed document that did so, but really my question for you, from the point of view of your constituency, is: should that have been something that the RED adviser working with Manchester should have identified if they hadn't seen it?

A. If I could just go back to an early part of the evidence I presented. I would need to check the document in detail and I'm happy to provide it to the inquiry. As part of the risk assessment process, LRFs were provided with guidance called the Local Risk Management Guidance, and that guidance -- I think it was an official-sensitive document. That guidance gave advice to LRFs on how threat should be assessed and how the information available from the Central Government risk documentation could be used.

So there was specific guidance given to LRFs about how to assess threat, and as I recall the particular

document -- and I'm happy to check this -- it did say that in the public-facing version of the Community Risk Register that threat should be covered by referring to the National Risk Register.

Now, I am aware in a number of LRFs that the assessment of threat was done by a more closed group. Now, I cannot recall exactly what the arrangements were in Greater Manchester, I would have to say I'd be surprised if they didn't consider threat because I am aware that, you know, they had a robust -- seemed to have a robust risk assessment process. So again, I wouldn't -- if it wasn't in a public-facing document, it would not surprise me if somebody referred to the National Risk Register. So I'm very happy to check the exact guidance given to LRFs around assessments of threat if that would help.

Q. But certainly, going back to my question, which is no criticism of what you've just said, which was very helpful, would you expect one of your advisers to be raising -- if they had not seen in the risk register the risk assessment by an LRF and evidence of them having dealt with this topic, would you expect that person maybe going to the LRF and saying, "Sorry, where is it? I haven't seen it"?

A. Yes, I'd expect them to raise there's been no assessment

of threats.

Q. And if it hadn't been done, what then?

A. If it hadn't been done, we would first raise it with the chair of the LRF and say, "The risk assessment process -- there hasn't been an assessment of threat, could just check what your process is?" If they refused -- which I would -- I have never come across this, I just want to caveat that I have not had any experience that this has ever happened -- if the chair then said, "We're not going to consider threat", I would then sort of discuss with my colleagues in the Cabinet Office, who are the owners of the national risk information, and we would discuss how we would sort of encourage and discuss, persuade, ie to consider the threat picture.

But my experience of LRFs is that consideration of threat was something that they were very, very alive to as well. So I am -- again, I can't comment about the information you've seen from Greater Manchester, but I am not aware of that gap being identified to me at any point.

Q. Moving on, in terms of joint planning and in terms of the various component parts of an LRF cooperating together to address a particular area that they need to have joint planning for, such as the response to

a terrorist incident, in your experience is one of the difficulties potentially with that that LRFs have a very wide range of work to cover?
A. They do have a wide range of risks to cover, but I think one of the things that we do consider in the resilience world are those common consequences and there are individual, obviously, response plans at particular risks, but in terms of that multi-agency environment it is -- you know, sadly the common consequence of something like an air crash could result in a mass fatality situation or a mass casualty situation, the same way a criminal act such as terrorism would. So there's work to be done in that common consequence planning, but for the very specific risk planning, yes, there is quite a wide range of risks against which LRFs are planning.
Q. So just as an illustration of that, if we could have {INQ012422/3}. This is the contents page from the Greater Manchester Resilience Forum strategy. I'm not going to ask you about the details of strategy, Ms Gillespie, because that wouldn't be at all fair. But what it does is to identify a series of areas which are set out in that strategy that it was the plan for the GMRF to cover.
A. Yes.

Q. One can see the wide range of different areas that it was expected they would be spending time on from 2015 onwards.
A. Yes.
Q. Really, the question I ask is whether there is a risk that when an LRF has so many areas to cover that plans that they would assume that each agency would have in place, and indeed did have in place, they wouldn't get round to really looking at those to see if they did join up or not.
A. I think the resilience strategy very much builds on all the work that's done below that. I think if I -- I'm struggling to look at the... Is there any possibility to expand the screen a little bit? It's the colour contrast is the problem.
Again, looking at the strategy, a lot of that is around a wider societal resilience as well, which I think is something that GM particularly looked at. Could I just check the point that -- your question again, sir?
Q. Of course.
SIR JOHN SAUNDERS: It was quite a long one with subclauses, I think.
MR ATKINSON: I'm afraid, Ms Gillespie, I'm notorious for those, so I'll try and break it down. The question is

whether the wide range of topics that that an LRF might consider, this list being an example, whether that range of topics meant that other things would just not have the time?
A. I think that's where we need to look at the LRF executive meeting and those working group meetings as well. I think what we're looking at here is the overall resilience strategy and that is about -- and that is just from looking at -- and this is my personal view, by the way -- it is looking at that resilience in the context of a real whole society, a whole city type resilience, the building -- that is built from those individual plans, which are largely dealt with at that working group level and the groups below that.
I would agree with you in the sense that there are a lot of risks that an LRF needs to be aware of. The national risk assessment process, of which the National Risk Register is an element and I referred previously to those two matrices that are in the National Risk Register, there's the likelihood versus impact and that allows a prioritisation of those risks as well so that -- that is reviewed on a regular -- part of the CCA does state it does need to be done regularly. Each LRF's risk is reviewed on a regular basis to check that the prioritisation is there.

Again also, I would also look at that prioritisation but also have a register of exercises and plans to update on what needs to be updated or tested in the event of additional and new developing information. So yes, there's a wide range of risks but there's also prioritisation to a mechanism to which the LRF can prioritise its work.
Q. Again, just by way of example, if one looked, and I'm not going to take you through them all now for obvious reasons, but if one looked through the minutes, particularly of the GMRF from the period from 2015, one can see each of these topics talked about, pages of minutes devoted to them. By way of example, MTFAs are hardly mentioned at all. I think in fact there is one reference to a video in that period of time.
Clearly, each of the components had a plan for that, but no discussion in the minutes of those various plans. Is that because they were just trusting them to get on with it or was that because they had too much else to do or can you not help?
A. Again, I can't comment directly on every GMRF meeting, so again I would expect that something like MTFA, where the guidance was produced in 2013, the plans would be developed on that basis and that would be done at the working level. I would expect the executive meeting to

be aware of new plans, if plans have been updated significantly, and to sign off those changes and also to give agreement if there was a new and developing risk to say: we need to go away and look at this risk, are our generic plans suitable for this risk or do we need a risk-specific plan? Because not every risk needs a specific plan as well. So I'd expect that iterative process that some will come to resilience forum on a routine basis, but the bulk of the work to do, the actual planning, should be done at the working group level.

Q. Moving on from that document, but staying with MTFAs, I wonder if we could go back to the 2013 Government document in relation to those, which is {INQ031148/1}. If we could enlarge the bottom half of the page, please, Mr Lopez.

This document makes the point on its very first page, with the second indented paragraph:

"We are not asking LRFs to develop separate bespoke plans to respond to this kind of attack."

That's a marauding terrorist firearms attack:

"Instead, we strongly encourage planners to work together to consider how existing generic plans might be adapted or improved to address the specific challenges of this type of emergency. A flexible response will

enable you to manage a wide range of incidents, including smaller scale attacks such as an active shooter."

Was the role of what this was seeking to do really to encourage people to look at the plans they already had rather than to start again?

A. That's my understanding, to build on those existing response plans and, again, with something like -- obviously, the Home Office are the lead department here so for the detail of the policy behind this I would point to the Home Office, but again with the LRF, that multi-agency partnership, it's to really look at your plans with the lens of this guidance and does anything need to be changed or updated.

Q. If one goes to {INQ031148/3} to illustrate that, and I won't take long over this, but again if we could enlarge the middle part of the page, please. There it is spelt out, and repeated in its later incarnation, that:

"Local planners should therefore be aware of the joint operating principles, the JOPs. This document sets out [which we've established through the chair is referring to the JOPs] how the emergency services should respond to identify tasks and priorities such as."

So if an LRF was looking for help as to the things

that perhaps it ought to in particular be thinking about when there was a consideration of an MTFA, there are a series of bullet points that highlight important points for them?

A. Yes.

Q. So there should have been a stage for any LRF on receipt of this when they were, for example, considering the assessment and management of risk at the scene and the mobilisation of specialist emergency service responders, that kind of thing, they should have --

A. Yes.

Q. And that would have required them, would it, the LRF, to look or rather to invite its members to effectively bring along their plans so that they could together make sure that they were consistent one with another?

A. Yes, I'd expect that to be the case.

Q. And given that the threat that this is to deal with, the threat from an MTFA, is an evolving threat and we know that Government guidance evolved over time, would you expect this to be something that an LRF ought to be doing on a fairly regular basis to ensure that the plans were joined up?

A. It's harder to define regular, but yes, I would expect all plans to be looked at on a rolling basis to make sure they are up to date and are, you know -- reflect

the risk picture and current guidance.

Q. Presumably one catalyst for such a review would be if there had been a training exercise where a lack of joined-upness, if that's a word, had been identified?

A. I would expect so, yes.

Q. Which takes me on, you'll be pleased to know, to my final topic, and the learning from training exercises. Do we understand that there is, as you see it, a potential difference between the amount of time that an executive level of an LRF will spend on that compared to its subgroups and the time they may spend on it?

A. Very much so. I would expect a very detailed consideration of the lessons and I would separate identified and learned as two separate topics. I would expect the subgroups to look at the detail, to have the tracker, to have the detail, and then to again bring any core issues that need a resolution at executive level to come to the executive meeting. If a plan needs to be updated or changed on the basis of those lessons, that would come to the executive group as well. But the bulk of the work I would expect to be done at the subgroup level, going through each of the lessons.

Q. And there's a real onus, is there not, on the participants in those training exercises that are clearly represented on an LRF for themselves to identify

things they thought had gone wrong?
A. Yes.
Q. To share them at subgroup level and to identify those things that need to be talked about at executive level?
A. Very much so. It's important to articulate the reasons why a participant felt something, not just to put a comment that it didn't work. It's to really explain what the situation was and what did or did not work from that business point of view.
You can sometimes get conflicting views from an exercise, you know, but I would expect the participants to say: we tested this element of the plan, this did or did not work, this is the action that is required.
Q. So very briefly, and finally, can we just look at an example of that. {INQ012471/5}.
What I hope you're about to be shown is the minutes of the RDG meeting for the GMRF from July of 2016.
A. Yes.
Q. We can see that right at the bottom of our screen, if we could move down to that bit, Mr Lopez, please.
A. That's the part under "Any other business"?
Q. That's it. We can see that Winchester Accord did come up.
A. It did.
Q. "The debrief report for the counter–terrorism exercise

at the Trafford Centre was circulated. It seems that the recommendations are mainly around the understanding of plans and IT issues."
And a series of actions including that a report was GMRF in September for approval.
A. Mm–hm.
Q. And if we then go to the GMRF for September, which is {INQ012412/5}, we can see, the lower half of the page, that the Winchester Accord debrief report did go to the next executive level where there was suggestion of the SCC, the strategic coordination centre, which was the topic that Mr Godson had expressed ––
A. Yes.
Q. –– had been part of the testing of ––
A. Yes.
Q. –– on the part of Winchester Accord that he was involved in.
A. That's correct.
Q. But in terms of a lack of understanding in relation to plans, which was what the RDG minutes are suggesting, no real detail there in relation to that?
A. No, and as I say, with Winchester Accord, as I mentioned earlier, it was in those two parts. So my understanding is, and from talking to Mr Godson, that what came both to the RDG and GMRF was that element of the SCC

activation rather than the live play element. So again, you'll see here that the procedures for setting up the SCC, that's to be taken forward at that working group level. And I understand –– again –– I'm just double–checking –– the minutes that we're looking at here came after the previous RDG minutes, didn't they –– so again this then remitted the work on the SCC to that working group to take forward that additional work.
Q. So if, to use the chair's description, Winchester Accord in terms of the other aspect of it, the live part of it, had been a bit of a disaster, but that being a part that Mr Godson had not been involved with ––
A. Yes.
Q. –– on the face of these documents, that part of it doesn't appear to have been raised either at RDG or at executive GMRF level?
A. From the information I've seen, I have not seen that live play element raised at either RDG or the GMRF level.
Q. And to the extent that those problems from the live aspect had been in relation to a joint operation between the services, there really was an onus on them to have flagged that up, wasn't there?
A. Yes, I would say so. I think with the live play, because the very operational nature of the live play ––

it is ... And again I honestly don't know because, as I say, I didn't take part, at what point does that get escalated? But yes as you say, if there were significant issues raised from Winchester Accord, the live play, it would have been helpful to raise at the resilience forum.
Q. An LRF can deal with interoperability issues, but only if they're told about them?
A. Yes.
MR ATKINSON: Thank you very much indeed, Ms Gillespie, for your patience with me.
Sir, those are my questions, thank you.
MS CARTWRIGHT: Sir, we've had a request from Mr Cooper that he be permitted 5 minutes to ask questions. There's no Rule 10 request, but the indication is he would like 5 minutes.
SIR JOHN SAUNDERS: Five minutes it is.
Questions from MR COOPER
MR COOPER: It came out of a question –– in fact I'm only asking for 2 minutes, so let me get straight to it.
Do I understand, Ms Gillespie, you were responsible for communications with bereaved families immediately after this atrocity, that is on Monday the 22nd and Tuesday the 23rd? Did I understand you to give evidence this afternoon to that effect?

A. No, I wasn't involved with communication with the bereaved families.
Q. I must have misheard your evidence this afternoon when you said one of your colleagues -- when the learned chair asked you what he was actually doing when he was trying to --
A. Oh yes, we provided details of the Greater Manchester Mayor for COBR, but we also provided details to the Civil Resilience Unit around support to victims, the Victims of Terrorism Unit sort of set up, so no, I didn't have direct contact with the families.
Q. That's what I heard, so any questions to you about the adequacy or inadequacy of communications with bereaved families in the direct aftermath of this atrocity should not be directed to you?
A. No, no, not to me. My sympathies are with the families.
MR COOPER: Of course, and I'm not suggesting that in any way is not the case.
Thank you, sir, that was quicker than 5 minutes and didn't even have a question in it.
MS CARTWRIGHT: Sir, unless you have any further questions.
SIR JOHN SAUNDERS: I have one.
We've recently seen a document and we've seen it, I think, now several times, where I misunderstood the "this" not to refer to the JOPs advice but to refer to

that document. I was interested in looking at the area which dealt with treatment of casualties who were in an area where it wasn't safe to work. We've looked at JOPs and JOPs does deal with the issue of treating casualties or what to do about casualties who are being treated in the warm zone. But it is silent as to what to do when casualties are being treated in the hot zone. That's how I understand the evidence at the moment. And of course in this particular case we were dealing with casualties being treated in the hot zone.
On the face of it, there is a lacuna in JOPs. Would you expect that to have been picked up by the resilience board when they're discussing it as a lacuna?
A. If a member of the LRF -- and I suspect in this situation it might be the Ambulance Service who potentially would be the ones who would have to treat casualties. If they had significant concerns about a piece of guidance, I would expect them to take it up through their own reporting lines into things like the NHS or into Department of Health and Social Care. They may raise it as "and we have asked this question" around the treatment of casualties in the hot zone. But this is me being hypothetical.
If they had had a resolution or had not had -- if there was a question to be asked or something to report

back, I suspect that -- I would expect then they may bring that back to the resilience forum and say, "Oh, by the way we've asked questions around treatment in the hot zone, this was the outcome". But I think I would -- and again my personal view -- I would expect those initial conversations to be had within that health chain rather than expect the multi-agency partners -- then I would expect them to potentially share understanding with the other emergency service partners if they did --
SIR JOHN SAUNDERS: Could I stop you for a moment? I think actually it is multi-agency.
A. Yes.
SIR JOHN SAUNDERS: Because the reality is: whoever arrives first before the --
A. Yes.
SIR JOHN SAUNDERS: -- armed officers may well be doing their best to help casualties in the hot zone.
A. Yes.
SIR JOHN SAUNDERS: So it would be ideally for the resilience committee because it actually goes right across, so would you --
A. I think --
SIR JOHN SAUNDERS: -- expect it to pick up on this lacuna?
A. Yes, I would, if -- again, and I use the (inaudible) as an example. I would expect that if that gap had been

identified that the question would be asked and the solution or -- be brought back to multi-agency discussion. Whether that was at the GMRF or whether that was the more operational group, that could be argued either way, what's the most appropriate level at which to discuss this very operational and tactical detail, but the plans then to be updated to take account of that at a multi-agency level.
SIR JOHN SAUNDERS: You say "if it was picked up".
A. Yes.
SIR JOHN SAUNDERS: Bearing in mind that the resilience forum is there to discuss plans to deal with things like this on a cross-agency basis, would you expect it to have been picked up? It doesn't seem that you couldn't imagine the situation where people are being treated in the hot zone and not --
A. I just have my area of expertise, I have to say, and I feel a little unable to comment because I am aware that there's a hazard area response team within the ambulance service, et cetera, but I don't have sufficient knowledge to be able to answer you effectively, sir.
SIR JOHN SAUNDERS: Okay, thank you.
MS CARTWRIGHT: That then would conclude Ms Gillespie's evidence.

SIR JOHN SAUNDERS: Thank you very much for your evidence, which is -- I'm very grateful for. I think you win the prize for the best quality of video evidence in that we heard you clearly and saw you clearly and your lips moved with the sound as well. I think yours is quite the best we've seen so far, so thank you for that.
A. Thank you.
SIR JOHN SAUNDERS: And that's it for today?
MS CARTWRIGHT: It is, sir. Tomorrow we have three Greater Manchester Fire and Rescue Service witnesses. We start with Mr Alan Topping, then we have Andrew Simister and Neil Helmrich. We're due to commence the evidence tomorrow at 9.30, so could I ask, please, that we adjourn until tomorrow at 9.30?
SIR JOHN SAUNDERS: Right, thank you very much.
(4.40 pm)
(The inquiry adjourned until 9.30 am on Tuesday, 2 March 2021)

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