

OPUS2

Manchester Arena Inquiry

Day 68

March 1, 2021

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Phone: +44 (0)20 3008 5900

Email: transcripts@opus2.com

Website: <https://www.opus2.com>

Monday, 1 March 2021

1
2 (10.00 am)
3 (Delay in proceedings)
4 (10.07 am)
5 MR GREANEY: Sir, good morning. I'm sorry that we're
6 starting 7 minutes late, I do know that you are very
7 keen that we should start promptly at 10, but it was
8 necessary that I should spend some time with this
9 morning's witnesses. It's my fault and you have my
10 apology.
11 The first witness today is Brigadier
12 Timothy Hodgetts. May I begin by making plain that
13 in the course of his evidence this morning he will be
14 dealing in detail with the treatment of blast injuries,
15 including the use of tourniquets. Whilst his evidence
16 will not be graphic, it is plainly capable in my view of
17 being distressing and so those effected by the arena
18 attack should carefully consider whether they wish to
19 view and hear this evidence.
20 Having given that warning, could I ask that the
21 brigadier be sworn, please.
22 BRIGADIER TIMOTHY HODGETTS (sworn)
23 Questions from MR GREANEY
24 MR GREANEY: Would you begin, please, by telling us your
25 full name?

1

1 A. Timothy John Hodgetts.
2 Q. Brigadier, your purpose in giving evidence today is to
3 explain the work of a charity called citizenAID; is that
4 correct?
5 A. That's correct.
6 Q. And are you the chair of trustees of that charity?
7 A. I am, since its inception.
8 Q. Before we get to that, we should deal with your
9 qualifications and experience. I'm at paragraph 2 of
10 your first witness statement, although of course this
11 material will be most familiar to you.
12 Are you a registered medical practitioner?
13 A. I am.
14 Q. In other words, a medical doctor?
15 A. I am, with a qualification in BBS.
16 Q. Do you hold fellowships of the Royal College of
17 Physicians of London?
18 A. Yes.
19 Q. The Royal College of Surgeons of Edinburgh?
20 A. Yes.
21 Q. The Royal College of Emergency Medicine?
22 A. Yes.
23 Q. The Faculty of Pre-hospital Care?
24 A. Yes.
25 Q. And the Chartered Management Institute?

2

1 A. Yes.
2 Q. Were you appointed a consultant in emergency medicine in
3 1995?
4 A. Yes.
5 Q. And have you been an honorary university professor since
6 1998?
7 A. Yes.
8 Q. With a current appointment at City University of London?
9 A. Yes.
10 Q. Were you made an officer of the Order of St John in
11 1999?
12 A. Yes.
13 Q. A Commander of the British Empire in 2009?
14 A. Yes.
15 Q. And in 2018 were you appointed the honorary surgeon to
16 Her Majesty the Queen?
17 A. Yes.
18 Q. In 1983 were you commissioned in the army?
19 A. I was.
20 Q. As both the chairman and I have indicated, do you
21 currently serve at the senior rank of brigadier?
22 A. I do.
23 Q. What current official appointments within the army
24 do you hold, please?
25 A. I am the senior health adviser to the army and the head

3

1 of the Army Medical Services and that's also linked to
2 being a commissioner at the Royal Hospital Chelsea.
3 Q. Are you also the Surgeon General Elect?
4 A. I am.
5 Q. What does that mean, please?
6 A. It means that from 21 May this year, I will be the
7 Surgeon General.
8 Q. The Surgeon General being?
9 A. Surgeon General is the senior serving doctor within the
10 armed forces.
11 Q. Do your previous roles in the military include being the
12 defence consultant adviser in emergency medicine?
13 A. Yes, I held that post from 1997 to 2008.
14 Q. The defence professor of emergency medicine?
15 A. Yes.
16 Q. And medical director of the defence medical services?
17 A. Yes.
18 Q. And lest we should think that you've spent your service
19 in this country in hospital, you have served, have you
20 not, on operations in Northern Ireland?
21 A. Yes.
22 Q. In Kosovo?
23 A. Yes.
24 Q. In Iraq?
25 A. Yes, four tours.

4

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

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

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

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1 a UK hospital in 1997 and showed year-on-year for
 2 3 years that our outcomes were continually getting
 3 better. I took that system to Kosovo in 1999 and for
 4 the first time we were then able to demonstrate that our
 5 military outcomes in the field were as good as NHS
 6 outcomes and then we used it from the start of the Iraq
 7 and the Afghan campaigns from 2003 onwards to generate
 8 month-on-month improvement, and we got a strategic drift
 9 in the outcomes of our military patients. We were able
 10 to get better outcomes in the field than we could get
 11 back at home in the UK because we were so aggressive
 12 with our governance, our weekly telephone conferences of
 13 all of the deployed hospitals, sending somebody to every
 14 military post-mortem, ensuring we learnt the maximum
 15 from every single death, putting it on a single registry
 16 so that we could continue to improve.
 17 Q. And this maybe goes without saying, but the serious
 18 injuries and deaths that you were considering, recording
 19 and indeed learning from related to or commonly related
 20 to ballistic and/or blast injuries?
 21 A. Yes. In fact we showed that between 2003 and 2012, 70%
 22 of the injuries were in relation to blast and every
 23 year, 2003 to 2012, although the injury severity got
 24 worse, the outcomes got better.
 25 Q. As part of that, did you introduce and measure the

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1 impact of a tourniquet for every soldier engaged in
 2 combat operations from 2005?
 3 A. I did. We introduced the concept of bringing the
 4 tourniquet back in 2005 when we changed our paradigm
 5 from ABC, airway, breathing, circulation, to CABC,
 6 catastrophic haemorrhage, airway, breathing,
 7 circulation, and we introduced a tourniquet for every
 8 soldier from 2006 and, yes, we tracked the impact of
 9 that very carefully.
 10 Q. Having tracked the impact of that, were you able to
 11 demonstrate that the use of a tourniquet or the
 12 availability to a soldier of a tourniquet saved lives?
 13 A. Yes. So in the year up to 2007, we had 70 patients who
 14 had 107 tourniquets applied. Their survival was 87%.
 15 And there was very minor complications as a result of
 16 that; 1.5% identified with transient nerve compression
 17 symptoms. When the Americans published their series in
 18 2011 of 499 patients with over 800 tourniquets applied
 19 to those patients, they had the same survival, 87%, and
 20 the same complication rate of about 1.5% of transient
 21 nerve compression.
 22 But in both groups there was no case when
 23 a tourniquet was applied there was any unnecessary
 24 following amputation.
 25 Q. We're going to come on, are we not, to look at

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

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

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

1 anything existed and yet we did believe that we had that
 2 information from our experience and our track record of
 3 developing curricula .
 4 So we took it upon ourselves -- we were not tasked,
 5 we saw it as a moral duty -- to get this information out
 6 to the public .
 7 Q. So you've just made the point, but let's be absolutely
 8 clear about it: no one told you to do this?
 9 A. No.
 10 Q. This is something you and your colleagues decided was
 11 necessary and you took it upon yourselves to do?
 12 A. Yes.
 13 Q. The way in which you put it in your witness statement --
 14 I'm at paragraph 4 at the bottom of page 2 -- is this:
 15 "As clinicians deeply experienced in the emergency
 16 management of blast and ballistic injury, and as
 17 experienced educators and innovators of training and
 18 first aid pre-hospital care, we could not identify any
 19 public information or training system that would
 20 adequately prepare the public to react and save lives
 21 when faced with multiple serious casualties from
 22 a deliberate attack."
 23 A. That's correct.
 24 Q. "Our clinical experience from contemporary conflicts had
 25 confirmed that rapid treatment in the first 10 to

1 15 minutes following combat-type injury improved the
 2 probability of survival and had contributed to
 3 a documented cohort of unexpected survivors."
 4 A. That's right. The survival requires every link of the
 5 chain to be effective, which is why you require that
 6 aggressive governance of the whole chain. But it starts
 7 in the first few minutes. If you haven't got the care
 8 within that platinum 10 minutes, particularly to stop
 9 the catastrophic bleeding or to open an obstructed
 10 airway, then there will be potentially avoidable deaths.
 11 Q. You use in your statement the term "unexpected
 12 survivors"; what does that term mean in this context,
 13 please?
 14 A. That relates to international models, mathematical
 15 models which are able to predict on an individual and a
 16 systems base whether you have more than a 50%
 17 probability of survival or not. If you have less than
 18 a 50% probability of survival and you survive, then you
 19 fall into an unexpected survivor category.
 20 If particularly you get down the lower end of the
 21 scale, perhaps less than 5% or less than 1% mathematical
 22 probability and you are surviving, then there is
 23 something quite disruptive within your system. And
 24 that's what we were identifying. We were identifying
 25 individuals with very high injury severity scores and

1 yet they were still surviving. In fact, we identified
 2 people with maximal injury severity scores, who by all
 3 calculations should have died but they were surviving.
 4 Q. You've used the term rapid treatment. Being realistic
 5 about it, at what point must such treatment be
 6 administered?
 7 A. You talk in the first few minutes after injury and it's
 8 why for soldiers we've pushed the understanding and the
 9 capability, the equipment far forward so you can look
 10 after whoever is next to you who is injured, so whether
 11 that soldier is next to you in a trench, in a vehicle,
 12 on a patrol, you rely on your buddy to actually be able
 13 to step in in the first couple of minutes after injury
 14 or the first few minutes, that platinum 10 minutes, and
 15 be able to make a difference.
 16 Q. You describe in your statement that being the rationale
 17 for self-aid and buddy aid.
 18 A. Yes. In some instances you still have enough gumption
 19 to be able to treat yourself. I could recall a case of
 20 an individual soldier who had lost three limbs but was
 21 still conscious and was able to use his tourniquet with
 22 his one remaining arm to apply to one of his injured
 23 limbs before his mates arrived rapidly to apply
 24 tourniquets to the other limbs. So there is an element
 25 of self-aid as well as buddy aid.

1 Q. From what you've said to us already, this is something
 2 which is taught and taught extensively to soldiers in
 3 the British Army?
 4 A. It's mandatory annual training for all soldiers within
 5 the army, but also before they deploy they will get
 6 refresher training and practical training to put it into
 7 the context of where they're deploying.
 8 Q. Is that training known as battlefield casualty drills or
 9 BCD?
 10 A. It is.
 11 Q. Since when has that system been taught to soldiers?
 12 A. I designed that system in 1998. It was called
 13 battlefield first aid at that particular time and it was
 14 re-badged as battlefield casualty drills just before the
 15 start of the Iraq War in 2003. It contains a simple
 16 system, control then ACT, of how to manage the incident.
 17 So control the setting and assess, communicate, triage,
 18 sort the patients into priorities for treatment, and
 19 then follow a very simple set of predetermined drills
 20 because if you follow the system, you will do the right
 21 things in the right order and have the maximum chance to
 22 save life.
 23 Q. So this is very important, is it not, to what we're
 24 going to be discussing in terms of the general public?
 25 A. Yes.

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

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

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

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

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

21

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

22

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

23

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

24

1 did a hard launch on 4 January, again supported by the
 2 head of National Counter-terrorism Security Office, but
 3 through the BBC, and that received substantial public
 4 understanding because we had 1 million hits on the
 5 website in a single day and we were the trending
 6 number 1 app internationally of all apps.
 7 As a formal charity standing alone, it was
 8 incorporated, I believe, on 24 November 2017.
 9 SIR JOHN SAUNDERS: So the hard launch was January 2017?
 10 A. 4 January 2017.
 11 MR GREANEY: Let's just be clear about these dates. You
 12 inform us in your statement that citizenAID was
 13 established in November of 2016.
 14 A. Correct.
 15 Q. And that was designed to coincide with National
 16 Counter-terrorism Awareness Week?
 17 A. Yes.
 18 Q. The establishment was possible because of charitable
 19 funding which was made available?
 20 A. Yes.
 21 Q. Which was used to create a website that we'll discuss in
 22 due course?
 23 A. Yes.
 24 Q. Explanatory cartoon videos?
 25 A. Yes.

25

1 Q. A paper pocket guide?
 2 A. Yes.
 3 Q. And a free app for both iPhones and Android phones?
 4 A. Yes.
 5 Q. And before all of that was done there had been close
 6 consultation in the development of all of those things
 7 with the NaCTSO, the National Counter-terrorism Security
 8 Office?
 9 A. Yes.
 10 Q. Because there was a desire to reflect the national
 11 messaging?
 12 A. We believed that was essential.
 13 Q. The national messaging being, as the inquiry knows,
 14 "Run, Hide, Tell"?
 15 A. That's right.
 16 Q. So what you were seeking to achieve, I think, was
 17 consistency between what you were devising and
 18 publishing and what was already in existence at
 19 a national level?
 20 A. Yes. What we were seeking support for was "Run, hide,
 21 tell and, when safe to do so, treat". So to ensure that
 22 when people are hiding or trapped within a room waiting
 23 to be supported by the emergency services, then they
 24 could get on and be empowered to treat.
 25 Q. The hard launch, as the chairman mentioned a moment ago,

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1 was on 4 January 2017 --
 2 A. Yes.
 3 Q. -- through an extensive BBC media campaign?
 4 A. Yes.
 5 Q. And with about 1 million hits on the website in the very
 6 first day of launch?
 7 A. Correct.
 8 Q. I think I've mentioned already, in case I haven't, the
 9 website being citizenAID.org?
 10 A. Yes.
 11 Q. And to say the least did, that indicate there was a high
 12 level of public interest in what you were seeking to
 13 achieve?
 14 A. It did. It also indicated a high degree of
 15 international interest.
 16 Q. I believe you say that because there were a high number
 17 of early downloads of the app in the United States of
 18 America?
 19 A. Yes, and that did concern me for two reasons, that the
 20 national message in the UK is "Run, Hide, Tell". In the
 21 US it's "Run, Hide, Fight", different culture. But also
 22 our emergency number, 999, was on our app, and what
 23 I was concerned about is that people might download in
 24 America and think that this must be a new number for
 25 a terrorist incident and dial the wrong number. So

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1 within 2 weeks we actually created an American version
 2 of the app which was free to download in the US, which
 3 was adjusted to "Run, Hide, Fight" and with the
 4 appropriate emergency service number in it.
 5 Q. We'll look at the app in due course with the assistance
 6 of Mr Suter and his iPhone, but let's just deal first of
 7 all with what it deals with, what it addresses in
 8 summary.
 9 The app deals with a number of potential events,
 10 does it not?
 11 A. It does.
 12 Q. One of those events being an explosion?
 13 A. Yes.
 14 Q. For an explosion what advice does the app give?
 15 A. The advice for an explosion is it takes you directly to
 16 the first page of Control then Act. And indeed, it is
 17 the same information that we are giving to somebody who
 18 might be exposed to a vehicle attack. So a vehicle
 19 attack and explosion actually follow the same logic:
 20 Control then Act.
 21 Q. So when you say it takes you to that page, you literally
 22 you press "explosion" on the app?
 23 A. That's right, and the first page of the Control then Act
 24 series opens up.
 25 Q. And ACT, let's remind ourselves, is: A the assessment of

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1 hazards and the number of injured?
 2 A. Correct.
 3 Q. C, communication with the emergency services?
 4 A. Yes.
 5 Q. And I think as we're going to see that uses the mnemonic
 6 SLIDE?
 7 A. Yes.
 8 Q. And triage, namely the identification of the most
 9 seriously injured with a view to treating those persons
 10 first?
 11 A. Yes.
 12 Q. Is that approach exactly the same logic that's found in
 13 battlefield casualty drills?
 14 A. It is the same logic but it has been contextualised for
 15 that civilian setting.
 16 Q. As we've understood already, soldiers have used that
 17 aide-memoire in conflict and emergency settings for over
 18 20 years now?
 19 A. Correct.
 20 Q. And it is tried and tested?
 21 A. Yes.
 22 Q. In other words, to put it very simply, that approach
 23 works?
 24 A. Yes.
 25 Q. I mentioned that as part of the C of ACT, communication

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

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

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

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

6 Q. In your statement you express it in these terms:
 7 "The simple variant within citizenAID is based upon
 8 this military triage sieve."

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

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

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

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

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

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

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

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

3 A. Correct.

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

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

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

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

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

5 SIR JOHN SAUNDERS: Yes.

6 MR GREANEY: The way in which it is expressed in your
 7 statement is:
 8 "There is a linear logic in the app and the pocket
 9 guide where the clinical importance of these conditions
 10 is predetermined and the user must follow through to
 11 conclusion for each casualty."

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

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

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

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

24 A. Yes, through the charity website.

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

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1 quite an hour yet and I think we will try and look at
 2 the app now. Sorry, I didn't give Mr Suter quite the
 3 level of warning he needed. I know it's going to take
 4 a minute to switch over the systems.
 5 So we are there looking at the ---
 6 SIR JOHN SAUNDERS: Okay, it's on the big screens, is it?
 7 Have you got it? You can see it? Okay, thank you.
 8 MR GREANEY: It did come on the smaller screens earlier.
 9 That's what taking the time.
 10 SIR JOHN SAUNDERS: It's now come on the smaller screens,
 11 thank you.
 12 MR GREANEY: If we therefore go to the homepage, Mr Suter.
 13 Are we there looking at the various situations that the
 14 app is designed to assist with?
 15 A. That's correct.
 16 Q. We've spoken about the pocket guide as well. The app
 17 and the pocket guide are materially identical, are they
 18 not, in format and in what they are designed to achieve?
 19 A. Except within the pocket guide there's only one version
 20 of SLIDE.
 21 Q. I see. So:
 22 "Knife attacker, active shooter, vehicle attack,
 23 explosion, acid burns, unattended item, suspicious item,
 24 treatment, prepare and learn."
 25 The part of it that I'm going to ask that we look at

1 is explosion.
 2 SIR JOHN SAUNDERS: I'm not going to ask to look at it, but
 3 active shooter. It sounds a bit odd to me, rather than
 4 saying gunshot wounds.
 5 A. Yes, and we're always open, sir, to refinements, so
 6 thank you for that feedback. We will immediately take
 7 that. It is very much an emergency service term and
 8 perhaps an Americanised term.
 9 SIR JOHN SAUNDERS: Right. Let's go to what you wanted to
 10 go to.
 11 MR GREANEY: We can all look at active shooter in due
 12 course, but it includes important advice, for example,
 13 about not using one's telephone to make a call in the
 14 event of such a situation.
 15 A. If you go to knife attack or active shooter, the next
 16 screen is about ---
 17 SIR JOHN SAUNDERS: I'm really sorry to have diverted.
 18 I can look at it on my own.
 19 A. It's about turning your phone to silent because you are
 20 into the "Run, Hide, Tell" territory when you're in
 21 active shooter and knife attack. So it's a different
 22 logic for managing the incident, as it were, but once
 23 you get on to patient treatment that is a common logic,
 24 whatever the cause.
 25 SIR JOHN SAUNDERS: Thank you.

1 MR GREANEY: We will just look at active shooter because
 2 we're very keen that the public watching this should
 3 understand the utility of this app.
 4 Mr Suter, could you press on active shooter? We're
 5 then seeing the screen that you have told us about,
 6 "Switch phone to silent".
 7 A. Yes.
 8 Q. No doubt it's for the obvious reason that you don't want
 9 to receive a call when you are hiding from someone who's
 10 intent upon shooting you.
 11 Next, please. We can see the various options.
 12 A. The important element with the active shooter or the
 13 knife attacker is that you've understood in advance that
 14 you have to run, hide, tell. We don't want people to
 15 have to look at the phone, look at the pocket guide, to
 16 know that they have to run, hide, tell. But while
 17 preparing yourself, if you, for example, go into hide,
 18 there is additional information that sits behind that to
 19 prepare yourself. Also it draws to the attention of the
 20 public the 55 system, which is becoming more
 21 increasingly known but still is not well-known that,
 22 where if you are unable to speak because you're hiding
 23 from a terrorist, or even in a case of domestic abuse,
 24 you might be hiding and you don't want to be heard, when
 25 you dial 999 and say nothing, you'll be put forward to

1 an automated system where will ask you to press 55.
 2 SIR JOHN SAUNDERS: What's apparent from what we're seeing
 3 is there's a great deal more information here than just
 4 how to do your best to treat people who are injured.
 5 A. Yes.
 6 MR GREANEY: Let's go back one page and we'll see the very
 7 point the chairman is making. We can see option 3 is
 8 "How to treat".
 9 A. Yes.
 10 Q. If we press on that, we can see various scenarios are
 11 there identified. And if we were to click on any one of
 12 them, it would give advice on what to do?
 13 A. It will and this is the same advice you would get if you
 14 came through vehicle attack or explosion.
 15 Q. So we won't go to that at this stage, but we're seeing
 16 already the way in which the app works?
 17 A. Yes.
 18 Q. Could we go back to the homepage, Mr Suter, and then
 19 click into explosion.
 20 So we have this screen you told us about already,
 21 Control then ACT, and advice is given. Then we have
 22 a button at the bottom, "Assess the scene".
 23 A. Yes. The Control page, there's a real safety element
 24 here. First of all, it's your personal safety, but the
 25 1, 2, 3 of safety that we have within MIMMS is yourself,

1 the scene and the casualties. So there's elements of
 2 scene safety here too. If there was an incident outside
 3 and vehicles were moving around, how do you control
 4 those so they don't injure patients who might be on the
 5 ground? And how do you free casualties from danger and
 6 put them in a safe place to wait while awaiting the
 7 emergency services?
 8 SIR JOHN SAUNDERS: Of those I am not sure I would instantly
 9 understand 3 of the Control:
 10 "Only control access if safe."
 11 A. So safe for you. That's your personal safety.
 12 SIR JOHN SAUNDERS: But it means letting people in or?
 13 A. So if you were outside and you've dialled 999, then
 14 there's going to be a lot of vehicles that are going to
 15 be arriving rather quickly and there might be casualties
 16 who are in the road. Think of the Boston bombing with
 17 lots of casualties lying around in the street. You've
 18 called the emergency services in, you don't want
 19 secondary casualties from people arriving at haste and
 20 not realising there are casualties in the way.
 21 SIR JOHN SAUNDERS: Okay, thank you.
 22 MR GREANEY: Mr Suter, can I just check that we are
 23 broadcasting this image on YouTube? We are, thank you
 24 very much.
 25 Before we go further and assess the scene, I'm sure

1 you can understand the point the chairman was
 2 investigating earlier. This is obviously a wonderful
 3 app, but one has to think about the situation of
 4 a member of the public who is placed in a truly
 5 extraordinary situation of having to respond to an
 6 emergency in the sense of an explosion. One can also
 7 understand that a soldier who is trained annually in
 8 these techniques will understand, if not instinctively,
 9 readily what to do. How does one ensure that a member
 10 of the public, even one with this app on the telephone,
 11 has that level of assurance or confidence?
 12 A. A member of the public can only do their best, and the
 13 app is there to try and get the best out of that
 14 individual. If that individual has taken the time to
 15 work through it and mentally rehearse it then they'll
 16 probably perform better. If that individual perhaps has
 17 looked at some of the videos that are online, they will
 18 do even better. If that individual has been on some of
 19 the training that is available from citizenAID, then
 20 they will do even better.
 21 If you open the app for the first time at the time
 22 of the incident, you will do your best, but you may not
 23 perform as well as if you'd had the chance to prepare
 24 yourself.
 25 Q. So the message, certainly as I've understood it, is

1 download the app and ensure that you are familiar with
 2 it at the time that you do that?
 3 A. Yes.
 4 Q. And perhaps go back to it from time to time?
 5 A. Absolutely.
 6 Q. And watch the videos?
 7 A. Yes.
 8 Q. Mr Suter, we were working through this. The next page
 9 I would like to go to, please, is "Assess the scene".
 10 Could you describe that page to us, please?
 11 A. First of all, it's about assessing for dangers which
 12 might change, they might emerge, or as you move around
 13 the scene, particularly at the scene of a bombing, you
 14 might identify an unattended or suspicious item that
 15 represents a secondary device and therefore you can go
 16 to the page for unattended item or suspicious item,
 17 which really will be telling you to move away and report
 18 it.
 19 Q. The bottom button on the page, "Communicate". We'll go
 20 there next, please. There we see SLIDE. So this is the
 21 concept of the member of the public communicating with
 22 the emergency services and giving the information that
 23 the emergency services require in the order in which
 24 it'll be most helpful to them?
 25 A. It does, and if you were to press the yellow

1 999 button -- I do not recommend that, please, because
 2 it will actually link you to -- it'll ask if you want to
 3 call 999, you'll say yes, and you actually call the
 4 emergency services.
 5 SIR JOHN SAUNDERS: We could see if it works, couldn't we?
 6 A. Well, you could. I would recommend being in flight mode
 7 if you're going to be practising that particular
 8 function.
 9 MR GREANEY: So then we have communicated and the next thing
 10 in accordance with ACT that we should do is triage?
 11 A. Yes.
 12 Q. So that's the bottom button on the page. This really is
 13 a page that one needs to be familiar with before being
 14 in the midst of an attack?
 15 A. It is. But what it's just reminding you is that if
 16 you're at the top of the page and you do just have one
 17 casualty or you've been given the responsibility to look
 18 after one individual, then you can go directly to the
 19 treatment page. But if there are more than one
 20 casualties then you do need to sort out who you're going
 21 to treat first and, as I said earlier, it identifies two
 22 categories that are priority 1, which are the two
 23 categories that the public can make a specific
 24 difference in, even with no equipment or with improvised
 25 equipment, while waiting for the emergency services.

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

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

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

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

1 is thereafter controlled. And by a number of routes we
 2 may be taken to the tourniquet page. So could we go to
 3 the "Go" in the middle top?
 4 "Tourniquet. For limb bleeds only. Place just
 5 above bleeding and not over a joint."
 6 Could you explain that page to us, please?
 7 A. Yes. First of all, there is one indication for
 8 a tourniquet: it is life-threatening limb bleeding that
 9 cannot be controlled by other means. So we've
 10 identified that you may have tried packing and pressing,
 11 but if it's a mangled limb or an amputated limb then
 12 you are going to need a tourniquet to control that.
 13 Q. Can I ask you to pause for one moment so we can ensure
 14 we understand something. The person that we're
 15 concerned with is a member of the public who almost
 16 certainly will not have formal medical training, who may
 17 not have even any first aid training. How is that
 18 person to make the critical assessment you've just
 19 described, which is a condition for a tourniquet, of
 20 concluding that the person they're dealing with is in
 21 a life-threatening situation?
 22 A. Right. Firstly, has the limb been amputated? Is the
 23 limb mangled? If the answer is yes, then a tourniquet
 24 above the level of the injury. Otherwise if you're not
 25 sure, you're going to be trying packing and pressing

1 first. If it's clear that the bleeding is continuing,
 2 even though you are packing and pressing, then that is
 3 life-threatening bleeding and you then would proceed to
 4 a tourniquet.
 5 Q. Sorry, I interrupted you. Would you carry on to explain
 6 this page to us, please.
 7 A. This talks you through how to improvise a tourniquet.
 8 If you had a commercial tourniquet then of course you
 9 can use it. But if you don't have a commercial
 10 tourniquet, you can improvise. So you need a strip of
 11 material. That could be a gentleman's tie, a lady's
 12 scarf, particularly those thin non-stretchy scarves, if
 13 you try improvising with those, they work very well, or
 14 a triangular bandage and specifically a calico bandage
 15 that doesn't stretch.
 16 You can use any piece of firm material that's lying
 17 around, a piece of wood, a piece of metal, a piece of
 18 cutlery.
 19 SIR JOHN SAUNDERS: Okay, just let me stop for a moment
 20 because this is something which has obviously been
 21 considered. I have seen the video so I do perhaps
 22 understand. The most immediate tourniquet that most
 23 people have no knowledge at all, like me, would think of
 24 would be to use a belt and that's probably one of the
 25 most common items that would be present. I know in the

1 video you don't say don't use it, you say the problem is
 2 you have to keep tightening it.
 3 A. You'll find the belt a little bit further down the page.
 4 After item 4 it says a belt pulled tight can work but we
 5 would prefer you use a windlass-type tourniquet.
 6 That is likely to be more effective than -- and easier
 7 to continue to apply the pressure -- than a belt, which
 8 someone's going to have to stay there and continue to
 9 pull with even and hard pressure indefinitely until help
 10 arrives.
 11 SIR JOHN SAUNDERS: Okay. Forgive me for not going down the
 12 page, I should have done.
 13 MR GREANEY: Not at all, sir. This is an important issue.
 14 A. And may I just interject. I have used a belt before to
 15 improvise a tourniquet. It's a long time ago, 1986,
 16 at the scene of a road traffic accident, where a young
 17 man had lost his arm above the elbow and I used his belt
 18 to improvise a tourniquet until the emergency services
 19 arrived and they took 30 to 45 minutes to arrive because
 20 it was at night on a country road, and that individual
 21 did survive the injury.
 22 MR GREANEY: Indeed, there is quite a remarkable end to that
 23 story, is there not, brigadier? That person went on to
 24 win medals at the Paralympics.
 25 A. He did.

1 Q. Let's just work through this page, which is an important
 2 one for reasons which everyone in this room is aware.
 3 Just explain what the process is, please, for the
 4 application of a tourniquet?
 5 A. What you need, you need a band of material above the
 6 level of the injury, and then you need to be able to
 7 tighten that band of material only as tight as is
 8 necessary to stop the bleeding, so you need to create
 9 what we call a windlass and the way we do that is to tie
 10 some kind of rod in a knot and then twist that rod and
 11 for the rod you can use any piece of material that's to
 12 hand or indeed what the charity has designed, a little
 13 plastic key called the Tourni-Key. The reason we
 14 designed that is to have something really cheap and
 15 effective which can secure the rod once it has been
 16 twisted. Because otherwise someone is going to have to
 17 stay with the patient and hold that rod in place. It's
 18 absolutely plausible that if you have limited people
 19 that can do the treatment, you want to be able to move
 20 on and have safely secured it.
 21 SIR JOHN SAUNDERS: And when looking at the video again,
 22 you're talking about improvising, it uses in the video
 23 a piece of wood --
 24 A. Yes.
 25 SIR JOHN SAUNDERS: -- and actually perhaps that part is the

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

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

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

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

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1 The tourniquet itself is then tied in. Then you
 2 twist until the bleeding stops and then you secure, and
 3 with this device there is a quick secure, just hook it
 4 over, and then what we call a hard lock, where you pass
 5 it underneath and back over the top. That's less likely
 6 to become dislodged, particularly when you start to move
 7 the patient.
 8 You saw that from opening the packet to applying
 9 that didn't take very long at all. There is a little
 10 bit of mythology around improvised or semi-improvised
 11 tourniquets that they take too long to apply, and I have
 12 just proven that to be false. In fact we have done a
 13 study and we have published the study where we compare
 14 the application of the Tourni—Key with the most commonly
 15 applied commercial tourniquet, which is the one the
 16 military use, which is called the Combat Application
 17 Tourniquet. We found in 100 people, 50 of whom were
 18 already trained and 50 of whom were untrained, who were
 19 Jamaican Defence Force, that with 10 minutes of
 20 familiarisation of both devices to the Combat
 21 Application Tourniquet, an average of 41 seconds to
 22 apply the Tourni—Key, an average of 38 seconds from
 23 taking it out of your pocket, out of the packet and on
 24 to the patient with effective control. What does that
 25 mean? It's the same and it dispels the mythology that

1 an improvised or semi-improvised tourniquet cannot be
 2 applied fast enough in the field.
 3 Q. Just before we take the break, I'm going to ask Mr Suter
 4 if it's possible to return to the app. We don't,
 5 I think, unless you feel it would be helpful, brigadier,
 6 need to click any further, but the tourniquet page
 7 provides instruction and then at the bottom the question
 8 is posed:
 9 "Responding? Yes or no."
 10 And further guidance and instruction is given
 11 depending upon which of those options the user takes.
 12 A. Correct.
 13 Q. I am going to ask in just one moment the chairman to
 14 take a break, and just so you know, when we return I am
 15 going to have some further questions about the
 16 tourniquet. I'm going to ask you to deal with some
 17 further myths which have existed in relation to the use
 18 of such devices, I am going to ask you also to help us
 19 also with when the Tourni—Key was introduced, and indeed
 20 with when the app was introduced, so that is what is to
 21 come.
 22 SIR JOHN SAUNDERS: Among the myths, no doubt, I hope you'll
 23 be dealing with a myth that I believe, that if you put
 24 a tourniquet on, you have to release it from time to
 25 time, but you can deal with that as part of that.

1 This is what will be considered a completely facile
 2 point, but as you'll see, Mr Suter using the app, the
 3 light goes off so you have to keep tapping it, which in
 4 an emergency situation — I know it's a function of
 5 phones that they operate that way. Is there any way of
 6 making the app in such a way —
 7 A. Again we'll take that away, but that is how that
 8 individual has set their phone up, how many seconds
 9 before their own phone goes to sleep. That's for
 10 Mr Suter. Mine doesn't go off that quickly.
 11 SIR JOHN SAUNDERS: I do understand the point. If you're in
 12 an area that is dark and you're trying to use the app,
 13 it will go off periodically however you set your phone
 14 up.
 15 A. That's a very good point and we'll certainly look into
 16 that. Remember there is the pocket guide as well.
 17 SIR JOHN SAUNDERS: Quarter of an hour break, please.
 18 11.45. Thank you very much.
 19 (11.30 am)
 20 (A short break)
 21 (11.45 am)
 22 MR GREANEY: Just before we deal with the issues that
 23 I indicated before the break we would address, I just
 24 want you to help with one particular scenario and
 25 whether this contraindicates the use of a tourniquet.

1 Obviously you will have encountered a situation in
 2 which someone has sustained life-threatening injury
 3 through the use of an explosive device and that
 4 explosive device has contained shrapnel. Where a piece
 5 of shrapnel remains or may remain in a limb, is that
 6 a reason why one shouldn't use a tourniquet?
 7 A. No. You put a tourniquet above the level of where there
 8 is life-threatening limb bleeding that cannot be
 9 controlled by other means. It might be that a piece of
 10 shrapnel is preventing you from pressing into a wound
 11 and adequately controlling the bleeding from that wound.
 12 So I would say it's actually quite the converse, that
 13 packing and pressing might be very difficult if a large
 14 piece of shrapnel were present, whereas placing
 15 a tourniquet above it would be able to control that
 16 haemorrhage.
 17 Q. Thank you. I hope that answer is helpful to those who
 18 were particularly concerned with it. I can see that it
 19 was.
 20 The recommendation for using a tourniquet, as we all
 21 now understand, is central to the advice in citizenAID,
 22 is it not?
 23 A. Yes.
 24 Q. In your statement, and I'm at paragraph 15, you observe
 25 that:

1 "That is one aspect that has separated citizenAID
 2 until recently from the mainstream first aid advice of
 3 the voluntary aid societies."

4 A. That's correct.

5 Q. First of all, what do you mean by "it has separated it
 6 from the mainstream first aid advice"?

7 A. So what I would say is until the turn of this century,
 8 after the Second World War, the prevailing advice
 9 became: do not use a tourniquet because it might produce
 10 harm. Therefore tourniquets effectively became taboo
 11 within first aid practice. But what we determined from
 12 the literature of the Vietnam war and beyond was that
 13 there was a substantial cohort of injured soldiers who
 14 were dying from isolated limb injury as a result of
 15 catastrophic haemorrhage. In other words, if they had
 16 had a tourniquet, those individuals would have survived.

17 From a military perspective, we needed to change
 18 that narrative, which is why we started, in 2005, 2006,
 19 to change that narrative and provide the tourniquets for
 20 individual soldiers. As I've already identified, we now
 21 have the compelling evidence that that was the right
 22 thing to do because we have saved lives without there
 23 being significant complications and specifically without
 24 there being unnecessary amputations, which was the
 25 reason in the previous narrative for not using

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1 a tourniquet.

2 Part of the statement was "until recently" because
 3 we have been working strategically with St John's
 4 Ambulance and they are now teaching the use of
 5 tourniquets and indeed they have taken the citizenAID
 6 pocket guide and white labelled it with a St John cover
 7 and they have taken the tourniquet for distribution to
 8 individual first aiders.

9 Q. So the question that I have no doubt some, perhaps many,
 10 will be interested in knowing the answer to is: since
 11 when have other mainstream first aid organisations
 12 adopted the citizenAID type approach?

13 A. It's only recently. It's only within the last 6 to
 14 12 months that we've made that strategic breakthrough.

15 Q. So we're talking about, obviously, a substantial period
 16 after the arena attack?

17 A. Yes.

18 Q. At the time of the arena attack, to what extent -- it's
 19 my word, you'll probably agree with it -- did the myth
 20 about the use of tourniquets prevail?

21 A. Within the civilian community, the prevailing narrative
 22 at the time of the arena attack would have been: don't
 23 use tourniquets in first aid because they may cause
 24 harm. The military had changed that in 2006, but it had
 25 not been easy in the military and indeed I'd had

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1 substantial internal resistance within our own
 2 organisation, specifically from orthopaedic surgeons,
 3 and that resistance played out in the pages of the
 4 academic literature. But we were still able to make
 5 that change and then prove that it had been the right
 6 thing to do.

7 SIR JOHN SAUNDERS: From an academic point of view, is it
 8 still contentious or would you say within the academic
 9 community generally accepted in your view?

10 A. In my view, the debate is over and anybody who
 11 persists --

12 SIR JOHN SAUNDERS: Whenever somebody says that, they say it
 13 because they believe they must be right. Is there
 14 a body of opinion who still says you are wrong?

15 A. Yes, but they're not looking at the evidence. The
 16 evidence is now compelling. We've got the contemporary
 17 evidence.

18 SIR JOHN SAUNDERS: I'm not suggesting you're wrong in any
 19 way, believe me. I just needed to know whether there is
 20 acceptable or -- from reputable academics within this
 21 area who are saying, "We still don't accept what you are
 22 saying".

23 A. I think that would have been acceptable before we
 24 introduced it to the military and then tracked the
 25 outcomes and have been able to prove the very high

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1 survival and very low complication rate with no
 2 unnecessary amputations. Before that, we just didn't
 3 know and therefore we had to accept that some people may
 4 oppose it.

5 SIR JOHN SAUNDERS: Right, thank you.

6 MR GREANEY: I suppose a way of looking at it might be that,
 7 particularly these days, one can find a person who holds
 8 an opinion about almost anything, including some
 9 remarkable opinions. The question is whether it remains
 10 the position that there is a responsible body of opinion
 11 that tourniquets are a bad thing or whether the evidence
 12 which is now available and has been for some time
 13 demonstrates that there is no such body of responsible
 14 opinion.

15 A. I would state there is no body of responsible opinion
 16 any more, now that we have the evidence that we do.

17 Q. And from what point in time did the evidence crystallise
 18 sufficient that that was the position?

19 A. The series that we published of 70 patients in the UK
 20 was 2007. The series of American patients was 2011. We
 21 also published, in Philosophical Transactions of the
 22 Royal Society -- I'm trying to remember the exact year.
 23 But it was after 2011, which was the unexpected
 24 survivors and that analysis too. So from 2007, we have
 25 had successive published evidence that continues to

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1 corroborate that position.
 2 SIR JOHN SAUNDERS: Okay. But it's only in the recent 6 to
 3 12 months, because these things always take time to be
 4 accepted, that it's been generally accepted among the
 5 civilian population?
 6 A. Certainly within St John in terms of taking forward that
 7 change in their policy.
 8 SIR JOHN SAUNDERS: Okay, thank you.
 9 MR GREANEY: Just on this point, although we don't need to
 10 deal with it in any detail, were you and one of the
 11 colleagues you have told us about, Professor
 12 Sir Keith Porter, invited to make a submission to the
 13 Kerslake Review?
 14 A. Yes.
 15 Q. Was the point that you've just made a point that you
 16 addressed in the letter that you wrote to Lord Kerslake
 17 on 22 November 2017?
 18 A. I have not got that in front of me. Can I just be --
 19 Q. I've got it, so you will be able to confirm. Let's put
 20 it on the screen for you. {INQ000199/1}.
 21 The point emerges at a number of points, others may
 22 ask you about that. {INQ000199/2}. The final
 23 paragraph.
 24 We saw from the first page, it's dated
 25 22 November 2017. The authors of the letter are you and

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

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

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

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

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

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

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

1 able to put together the final equipment offerings.
 2 Q. And I think you've said that the grab bag also contains
 3 a stretcher?
 4 A. Correct.
 5 Q. We can all find it out from the website. Are you able
 6 to give us an indication of the cost of a Tourni—Key
 7 Plus and the cost of a grab bag?
 8 A. So a Tourni—Key Plus, I believe, is going for £7.50. An
 9 individual pouch, which is something that's designed for
 10 a security guard or a steward, I think that's down as
 11 £53. I don't have the other prices in my head I'm
 12 afraid.
 13 Q. Mr Suter is about to --
 14 SIR JOHN SAUNDERS: A grab bag presumably is not intended
 15 for the average member of the public?
 16 A. No.
 17 SIR JOHN SAUNDERS: It's more for someone who is organising
 18 an event where something might go wrong and they then
 19 have a built—in first aid --
 20 A. That's correct and we've also created some boxes to be
 21 mounted on a wall, one that can be mounted inside and
 22 one that is weatherproof to be mounted outside.
 23 MR GREANEY: I'm very grateful to Mr Suter, as is usually
 24 the case. The Tourni—Key Plus, £7.50. I'm not
 25 identifying everything that is available on the website:

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

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1 Q. With the viewer led through how to manage the incident
 2 itself ?
 3 A. Yes.
 4 Q. And to treat multiple casualties through the eyes of
 5 a number of people present?
 6 A. Yes.
 7 Q. And it's dealing with a situation before the emergency
 8 services attended the scene --
 9 A. Correct.
 10 Q. -- although we see a handover to emergency services?
 11 We see it through the eyes of a transport manager
 12 who is present?
 13 A. Yes.
 14 Q. And a security guard?
 15 A. Yes.
 16 Q. And other bystanders?
 17 A. Yes.
 18 Q. Anyone that is considering viewing it should bear in
 19 mind that the content is graphic in the extreme, is it
 20 not?
 21 A. It is.
 22 Q. But no doubt that's because there are important messages
 23 that need to be got across?
 24 A. Correct.
 25 Q. It shows those responding to the explosion using the

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

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1 because it shared many of the features of what happened
 2 at the arena. I'll give the website entry for it: it's
 3 citizenAID.org/explosion.
 4 One of the issues that the chairman has been
 5 highlighting and that I asked you about directly was how
 6 this information about dealing with injuries is to be
 7 communicated to the public, which is what citizenAID is
 8 about, is it not?
 9 A. Yes.
 10 Q. Has citizenAID identified that schools, colleges and
 11 universities are important audiences?
 12 A. Yes, very important audiences.
 13 Q. Why is that?
 14 A. Because, firstly, they are the people who are out and
 15 about. Young people are out and about on the street.
 16 We owe it to them to prepare them so that they can be
 17 prepared and not scared, but also a key objective of
 18 citizenAID is to have a critical mass of the general
 19 public who feel empowered. So the young population is
 20 an important target audience.
 21 Q. And perhaps it might also be added that young people are
 22 highly likely to be proficient in the use of their
 23 mobile telephones?
 24 A. Yes.
 25 Q. As a result, to deal with primary schools first of all,

1 have specific materials been developed for primary
 2 schools that convey the message of "Run, Hide, Tell and,
 3 when safe to do so, Treat"?
 4 A. Yes.
 5 Q. Albeit in an abstract and non-threatening way?
 6 A. Yes.
 7 Q. Obviously you don't want to scare the life out of
 8 children by teaching them these lessons.
 9 A. No.
 10 Q. For key stage 1, is a large format book available
 11 entitled "Moggy's Coming"?
 12 A. It is.
 13 Q. Telling the story of a cat on the loose in a school of
 14 mice?
 15 A. Yes.
 16 Q. For key stage 2 children, is a series of story cards
 17 called "Lion on the Loose" available?
 18 A. It is, and we are also providing that as a book too.
 19 Q. And that involves, in order to communicate these
 20 important lessons, a circus lion entering a school?
 21 A. Yes.
 22 Q. Were those materials trialled with 500 teachers in
 23 Birmingham in 2017?
 24 A. They were.
 25 Q. Again, take this away if needs be, but are you able to

1 recall over what period in 2017 that happened?
 2 A. So that was from March 2017 and it was within their
 3 annual safeguarding training that happened to be
 4 delivered over a series of sessions, just because of the
 5 number of individuals involved.
 6 Q. Did the materials gain universally positive support from
 7 the teachers who had utilised them?
 8 A. They did and they were both primary and secondary
 9 schoolteachers who were present.
 10 Q. To deal with secondary schools and colleges, has
 11 citizenAID delivered presentations to teach practical
 12 first aid skills for serious injuries?
 13 A. Yes.
 14 Q. I think that that included an invitation to address
 15 students of a sixth form college in Stockport in
 16 June 2017, shortly after the arena attack?
 17 A. That's correct.
 18 Q. Have universities run student-led open day
 19 demonstrations?
 20 A. Yes.
 21 Q. Organised conferences?
 22 A. Yes.
 23 Q. Formed clubs?
 24 A. Yes.
 25 Q. Received lectures and distributed white label versions

1 of the pocket guide?
 2 A. Yes.
 3 Q. No doubt you have it in mind when we are dealing with
 4 primary schools and secondary schools that this is
 5 something which is capable of being made mandatory as
 6 part of the syllabus?
 7 A. First aid now is on the syllabus for schools. I think
 8 it's mandatory now for secondary schools, although
 9 I know that other first aid agencies are providing basic
 10 first aid training within primary schools. So there
 11 absolutely is the opportunity now, which wasn't there
 12 before — and this came in in 2020 — to put first aid
 13 on the syllabus.
 14 Q. So there is the opportunity to generate a generation now
 15 with familiarity, not just generally with first aid, but
 16 also in the principles that citizenAID is trying to
 17 embed?
 18 A. Yes.
 19 Q. Has citizenAID received three awards?
 20 A. Yes.
 21 Q. Namely the West Midlands Area Health Scientific Network
 22 Innovation Award?
 23 A. Yes.
 24 Q. The National Counter-terrorism Project Award?
 25 A. Yes.

1 Q. And the National Business Resilience Award?
 2 A. Yes.
 3 Q. Has citizenAID, as you put it in your statement, further
 4 propagated its messages -- paragraph 20 -- and delivered
 5 familiarisation through key stakeholder conferences in
 6 Birmingham?
 7 A. Yes.
 8 Q. In Glasgow, supported by Police Scotland?
 9 A. Yes.
 10 Q. Has it had involvement in two multi-agency
 11 counter-terrorism exercises --
 12 A. Yes.
 13 Q. -- in Birmingham shopping centres?
 14 A. Yes.
 15 Q. Has it displayed at trade exhibitions and medical
 16 conferences?
 17 A. Yes.
 18 Q. Have keynote national and international lectures been
 19 delivered by you and other trustees?
 20 A. Yes.
 21 Q. By the publication of journal articles?
 22 A. Yes.
 23 Q. And by appearances on daytime television in the
 24 United Kingdom and Australia?
 25 A. Yes.

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1 Q. By radio and newspaper interviews?
 2 A. Yes.
 3 Q. And by family open day events both within the police,
 4 Ministry of Defence and industry?
 5 A. Yes.
 6 Q. Has it developed a level 2 qualification accredited by
 7 Quasafe?
 8 A. Yes.
 9 Q. To whom is that qualification available?
 10 A. It's open to the whole public. The entry criteria are
 11 simply that you're over the age of 14, but in terms of
 12 a focused target, it would be most appropriate to those
 13 organisations that have a duty of care or feel a duty of
 14 care towards the public, so perhaps retail
 15 organisations, security organisations, stewards of mass
 16 gathering events. That I would say is a subset to whom
 17 it would particularly appeal, but it is open to the
 18 public aged 14 and over.
 19 Q. In terms of television and television appearances, one
 20 of the matters that you draw attention to in your
 21 statement is something said by the This Morning
 22 presenter, Phillip Schofield, a very well-known
 23 television personality. What did he have to say about
 24 your app and when did he say it?
 25 A. On the day after the Westminster Bridge attack,

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1 unbeknown to us, he got his phone out on this morning
 2 television, went to the app and said, "Why didn't I know
 3 about this app? Everybody should have this app on their
 4 phone", and then proceeded to flick through it and talk
 5 about it, which produced a substantial spike in interest
 6 on the website.
 7 Q. At paragraph 22 of your first statement and your main
 8 statement, you say:
 9 "CitizenAID is a small charity with a big message."
 10 What is that message?
 11 A. The message is that we're here to build public
 12 resilience, to give people information that will keep
 13 them safe, keep others safe, and allow them to do the
 14 right things in the right order to save lives in the
 15 unlikely but not impossible event of being caught up in
 16 a deliberate attack.
 17 Q. And it poses, I think, the question, "Are you prepared?
 18 Because you can save lives in that situation".
 19 A. Yes.
 20 Q. And does it remain the objective of citizenAID to
 21 generate a critical mass of the population who can, when
 22 caught up in a multi-casualty event, act both safely and
 23 efficiently to save lives whilst they wait for the
 24 support of the emergency services?
 25 A. Yes. And linked to that is a change in public culture.

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

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1 they're very much off the top of my head, so, please,
 2 no one take these as something we're thinking of doing
 3 or intending to do.
 4 First of all, we know from the fact that the
 5 government has put out now the consultation for the
 6 Protect duty, of course that is to do with stopping
 7 explosions happening. But it may be, and I'm only say
 8 that, that consideration could be given to actually
 9 having something as part of that duty which requires
 10 people working within crowded places to have some sort
 11 of training in the sort of things you're talking about.
 12 If that were to be the case, is that something you would
 13 be able to cooperate with?
 14 A. Very much so. It's why we've partnered with Quallsafe,
 15 as the country's largest provider of accredited first
 16 aid training, because they have a thousand training
 17 centres. So if there was something that's necessary at
 18 scale, it's potentially deliverable.
 19 SIR JOHN SAUNDERS: I make this clear for other people: this
 20 is only a thing I'm raising at this stage as a remote
 21 possibility, because I know that there are some people
 22 who are concerned that anything said which might add or
 23 alter the Protect duty might stop it coming into
 24 existence and I have no intention of that happening.
 25 The second thing is this: I think it's right to say

1 that a number of police officers who were involved
 2 at the initial stages of this have indicated that they
 3 wish they had more training to do with this sort of
 4 thing. Are you in collaboration with police forces? No
 5 doubt you are available to them to help if need be.
 6 A. So not directly in support, but very willing, of course,
 7 to discuss. We have had — as I said, we've done family
 8 days at police events. We've had peripheral contact
 9 with the police but would be very pleased to engage with
 10 the police.
 11 SIR JOHN SAUNDERS: Thirdly, this — and this is not said in
 12 any way to suggest that what you are doing is other than
 13 what appears to be other than completely wonderful work
 14 and hopefully life-saving work: if I were someone to
 15 whom it's being suggested that if I went out of an
 16 evening, I should be taking with me a tourniquet key,
 17 a Tourni-Key, something I could use as a tourniquet,
 18 I might personally be saying, well, I think I'll stay at
 19 home if that's a risk that I'm running. And of course,
 20 in a way, that's what terrorists want to happen, to
 21 disrupt our way of life. Is there a risk of that or
 22 not, and if there is a risk, how do you cope with it
 23 when you're doing your presentations to young people and
 24 things like that?
 25 A. I would say the first thing is about being mentally

1 prepared and then also having that back-up as your app
 2 or pocket guide, because you can improvise. You can
 3 still save life with improvised equipment so it's not
 4 necessary to go everywhere all the time with equipment.
 5 You might consider having something in your car. You
 6 might certainly consider having it in your place of
 7 work, particularly if it's a place of work that employs
 8 a good number of people, and certainly mass gathering
 9 arenas would be very well suited to be thinking about
 10 the equipment that they have available for the public to
 11 use when they are there rather than the public having to
 12 bring the equipment with them.
 13 SIR JOHN SAUNDERS: Okay, thank you very much.
 14 Those are my questions.
 15 MR GREANEY: Thank you very much indeed, sir.
 16 NWAS had submitted a Rule 10 request, but they have
 17 most helpfully indicated that their issues have been
 18 covered during my questioning. So I'll turn, first of
 19 all, please, to Mr Atkinson who is leading on behalf of
 20 the families in relation to the brigadier.
 21 MR ATKINSON: Sir, I hope you can hear me as well as see me
 22 today.
 23 A. I can, yes.
 24 SIR JOHN SAUNDERS: You're not actually synchronised, but
 25 we can see and hear you, Mr Atkinson.

1 Questions from MR ATKINSON
 2 MR ATKINSON: I think synchronisation on top is a step too
 3 far for me, sir, I apologise.
 4 Brigadier, I want to ask you for a little more help
 5 in two areas, and the first is in relation to mnemonics
 6 or METHANE more particularly, which I find easier to
 7 say. This was something that you first invented with
 8 a view to achieving what?
 9 A. So METHANE was part of the original MIMMS course. In
 10 fact, in version 1 it was ETHANE. So it wasn't until
 11 our second edition in 2002 that we actually put the M in
 12 front of ETHANE to make METHANE, although we'd been
 13 teaching it for a couple of years before version 2 came
 14 out.
 15 So it was about giving the same information that the
 16 police were already giving at that time from the scene
 17 of an incident but in a more logical order. So CHALET
 18 became ETHANE which became METHANE. That particular
 19 message was taken up by the UK military in the Iraq
 20 conflict as the principal messaging system for
 21 a multiple casualty event. But it wasn't until 2012
 22 that it became fully incorporated as the message for all
 23 emergency services within the UK, within the joint
 24 emergency services interoperability procedures.
 25 Q. So the value it has, is this right, is in ensuring that

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

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

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

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

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

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

1 others.
 2 Q. So given that St John's Ambulance have adopted training
 3 in relation to tourniquets within the last 6 to
 4 12 months -- and if you can't help on this you must say,
 5 brigadier -- would you have expected, generally
 6 speaking, those in a comparable position, first-aiders
 7 not to have been trained in tourniquets back in 2017,
 8 which is obviously when we're mainly concerned?
 9 A. I think in 2017 that narrative was still prevailing,
 10 that tourniquets were dangerous, and in many instances
 11 if people had been trained on commercial courses, they
 12 would not necessarily have been introduced to
 13 a tourniquet. Some might, but it would not have been
 14 guaranteed.
 15 Q. Even if they had received training in relation to
 16 tourniquets, they may equally have received the message
 17 from training and from colleagues that tourniquets were
 18 a bad idea rather than a good one because of that being
 19 a prevalent view at the time?
 20 A. Definitely. There were still mixed messages in 2017.
 21 Q. Would that, in terms of those who may be filling that
 22 disaster gap in that immediate period when there was an
 23 emergency, who may be, for example, police personnel who
 24 are near to the scene and therefore there very
 25 quickly -- and again if you can't help, you must say

1 so -- would you have expected them to have had any
 2 training in relation to the use of tourniquets back in
 3 2017?
 4 A. I wouldn't have expected necessarily an average police
 5 officer to have had that training, but I would have
 6 expected, if they were specialist police officers, such
 7 as tactical firearms, they would likely have received
 8 that training by 2017.
 9 Q. And taking each of those in turn, certainly is it your
 10 view, if it's not already the case, that first-aiders of
 11 a St John's Ambulance type should now all receive
 12 training in the use of tourniquets in appropriate
 13 circumstances?
 14 A. Yes, because the evidence is strong enough in order to
 15 make that a generally accepted intervention for saving
 16 life.
 17 Q. And equally, emergency responders who are not paramedics
 18 but who may nevertheless be confronted with such
 19 a situation?
 20 A. Yes, absolutely. We train soldiers, so anybody who is
 21 going to be put in a situation where they have to
 22 provide first aid to the public, certainly from an
 23 official perspective, it would make sense that they have
 24 that life-saving skill.
 25 Q. (Inaudible: distorted) with the Ambulance Service

1 paramedics, the same question in relation to them, and
 2 again if you can't say, you must say so. Are you able
 3 to help us as to whether you would have expected them to
 4 have been trained in the use of tourniquets by 2017,
 5 given that it was a decade after your first very clear
 6 data about the importance of their use?
 7 A. Yes, I would have expected the Ambulance Service -- and
 8 I think the issue with the Ambulance Service is there
 9 may be some variation from one service to another, but
 10 overall I would have expected them to have understood
 11 and have the equipment to use in terms of a tourniquet
 12 and perhaps also as well a topical haemostatic, which is
 13 an activated bandage impregnated with a material which,
 14 when pressed into a wound, actually helps to control
 15 haemorrhage.
 16 Q. Finally in relation to the Ambulance Service, a slightly
 17 different topic, which is in relation to the triage
 18 sieve that you have helped us about. Clearly we all
 19 have experience, if we've been unfortunate to find
 20 ourselves in A&E, to have seen triage of that type in
 21 action, the identification of who needs treatment first
 22 and second or third in a queue. Do we understand from
 23 what you've said this morning that that approach may not
 24 be the right approach in this kind of situation where
 25 you have ballistic injuries?

1 A. Just to qualify, are you saying the triage sieve might
 2 be inappropriate in ballistic injuries? Was that your
 3 question?
 4 Q. It's to understand whether it is not enough to identify
 5 who someone else should treat first, second or third,
 6 but with an additional element, where there are
 7 ballistic injuries, of: who do I need to treat before
 8 I move on to triage someone else?
 9 A. Right. I'm not sure I'm quite getting your question,
 10 but let me try and give you an answer and see if that's
 11 satisfactory.
 12 CitizenAID is a very simple system of triage for use
 13 by the public. When the emergency services arrive, they
 14 will have a more sophisticated version of the triage
 15 sieve, which requires you to, if they're using the very
 16 latest version, to do an assessment of the level of
 17 response, to count the respiratory rate, to count the
 18 pulse rate.
 19 To be able to do that requires more training and
 20 more understanding, so it's appropriate that it is
 21 sitting with the more professional group to do that,
 22 that higher level of assessment. And triage is dynamic,
 23 it doesn't just happen once. If somebody's condition
 24 changes then you need to re-triage them and what you'll
 25 find at the scene of a multiple casualty incident is you

1 may have to be serially triaging people to pick up,
 2 first of all, those who might respond to treatment and
 3 also those who are deteriorating and whose priority may
 4 change.
 5 Q. Thank you. Building on that from the point of view of
 6 a paramedic as opposed to a member of the public, is
 7 your experience and your assessment in relation to
 8 a situation where there are ballistic casualties that
 9 matters such as "Do I need to apply a tourniquet to this
 10 person?", or, "Do I need to put them into a position
 11 where their airway is not obstructed?", is something
 12 that needs to be done immediately by that paramedic
 13 rather than them triaging everybody and then either
 14 themselves or someone else coming back to the person
 15 they started with?
 16 A. Right. Understood. So as I said earlier in evidence,
 17 triage as a purist is about going round sorting
 18 everybody into priorities while others then come along
 19 behind to do the treatment. But as a pragmatist, what
 20 we've realised in the military is you don't know how
 21 long it's going to take before somebody else comes along
 22 behind you to do that treatment. So we have built into
 23 the triage a system critical and very simple
 24 interventions that do not take a lot of time and do not
 25 disrupt unduly your ability to keep going and triaging

1 your patients. So if you came across that catastrophic
 2 limb haemorrhage then you should be treating it before
 3 then moving on to your next patient to triage. If you
 4 come across a patient who's lying on their back
 5 unconscious, you should flip them into the recovery
 6 position so their airway is open and stays open,
 7 otherwise it could be an avoidable death before the
 8 treatment resource comes along behind you.
 9 SIR JOHN SAUNDERS: Clearly, how you triage may be very much
 10 fact dependent on what is going on and what is known to
 11 the person. I'm slightly worried about this being
 12 applied to the individual facts of this case, which
 13 you're not aware of.
 14 A. The triage system, whatever service is in operation
 15 within the military or within the responding
 16 ambulance service in Manchester, it will be the triage
 17 system they use for a train crash, a plane crash,
 18 a multiple incident car crash, a terrorist bomb. It
 19 will be the same system. They may have paediatric
 20 versions -- we in the military have paediatric versions
 21 for triage as well as adult versions -- and there are
 22 also chemical triage versions for those specific
 23 incidents. But in general terms, it is a generic
 24 approach, an all-hazard approach which is agnostic of
 25 the cause of the incident.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 Q. Thank you. One of the -- and it's the only reference
 21 I'm taking you to and it was in the executive summary,
 22 it's, please, {INQ040223/1}, it's the article you
 23 co-wrote back in 2006. I just want to take you, please,
 24 to the latter column, which begins:
 25 "Is this discussion relevant to UK civilian

1 practice?"

2 You say:

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

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

12 A. Yes.

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

16 A. Correct.

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

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

1 changes, bringing in new equipment, bringing in new
 2 organisation, bringing in new processes and practices
 3 and guidelines, and very aggressive governance in order
 4 to save as many lives as we could in the operational
 5 setting.
 6 And yes, we have been translating those practices
 7 into civilian care, be it in the NHS or charity air
 8 ambulances. But yes, it does take time for those
 9 elements to filter through. Indeed, in 2009, the
 10 Healthcare Commission visited the hospital deployed in
 11 Afghanistan, and this is the precursor of the Care
 12 Quality Commission that many will be familiar with that
 13 goes to hospitals and primary care services to assess
 14 their quality. And what they reported was that the care
 15 in the operational setting was exemplary and they had
 16 never before used that descriptor of an ambulance
 17 service or an acute hospital. They said that there was
 18 much that the NHS could learn from the military
 19 in relation to trauma services.
 20 We have seen it very much as our role to help spread
 21 that understanding into the NHS, whether it is just
 22 through our clinicians being embedded in the NHS across
 23 the country, both as regulars and reservists, by writing
 24 papers, by teaching on courses, by going to conferences,
 25 et cetera, and presenting our work. So we do try very

1 hard to spread the learning.
 2 Indeed, in 2018 the NHS published major incident
 3 guidelines, which were very much based on the military's
 4 guidelines that we'd been using since 2004 that were
 5 officially published in 2009 as clinical guidelines for
 6 operations, so they used the same format and it was the
 7 combined civilian/military team in Birmingham who wrote
 8 those guidelines because that team is exquisitely
 9 experienced in blast and gunshot injuries. They've been
 10 receiving the most seriously injured coming back from
 11 operations since the start of the Afghan and Iraq
 12 conflicts, so from 2002 onwards, so it was absolutely
 13 right that they were the people that write the
 14 guidelines for the NHS.
 15 Yes, it may be that the civilian services haven't
 16 moved at exactly the pace of the military, but the
 17 military was moving at a rapid pace because of the
 18 casualty imperative. They were dealing with these
 19 casualties every single day, so we had to do something.
 20 It's not been the case in the civilian setting.
 21 Q. Again, if I can press you, and this is by no means
 22 a criticism, you will understand, of you, whose evidence
 23 has been, quite frankly, commendable, if I may say so.
 24 Can I put it to you generally, given that the military
 25 were thoroughly aware of this, as you put it, in 2004,

1 and you comment on 2006 as well, and given the amount of
 2 terrorist atrocities we've had, certainly up until 2018,
 3 when you say the National Health Service adopted all
 4 this, would you accept the suggestion that the National
 5 Health Service, Fire and the police had enough notice of
 6 the atrocities that were being caused to civilians with
 7 those terrorist atrocities between 2004 and 2018 to have
 8 acted far quicker in catching up with the military?
 9 A. I would say the evidence was there, but as we've
 10 discussed, changing the prevailing culture has been
 11 a challenge. It was a challenge in the military to
 12 change that culture and we're going through the same
 13 arguments we went through in the military to get the
 14 civilian services to agree with the same approach,
 15 particularly in the use of tourniquets.
 16 Q. I'll finish, because I won't overstay my welcome on
 17 these questions, but overcoming culture seems to have
 18 taken a decade to get, for instance, the National Health
 19 Service and the police and the Fire Service — it's
 20 taken a decade to overturn culture so that they can
 21 activate some of the impressive steps that the military
 22 have taken. Is that your evidence?
 23 A. Yes, and it does take time. If we look at major trauma
 24 centres, so you may be familiar that there's a network
 25 of major trauma centres around the country, the

1 messaging around the requirement for major trauma
 2 centres was very strong in 1988 when we invited the
 3 Americans — or the Royal College of Surgeons of England
 4 invited Professor Donald Trunkey to come and review the
 5 requirement for major trauma centres in the UK. There
 6 was a strong message in 1988 that we should have
 7 regionalised major trauma centres, but they weren't
 8 introduced until 2012. And it's taken a series of
 9 reports to actually make that happen.
 10 SIR JOHN SAUNDERS: We need to be balanced about this. So
 11 as I understand it, it's not — in 2004, no doubt your
 12 evidence was entirely correct and your conclusions were
 13 entirely correct as has been proved. The difficulty has
 14 been getting other people to accept that your
 15 conclusions would be right in a civilian setting?
 16 A. Yes.
 17 SIR JOHN SAUNDERS: Which is what's taken the time. I just
 18 want to distinguish that, if it's right, from someone
 19 saying: well, we know you're right, but we're not going
 20 to get on with doing anything about it.
 21 A. Yes. It's exactly the same in the United States. They
 22 actually talk about the portrait of contradictions, or
 23 they did in 2016, talk about a portrait of
 24 contradictions, where they recognised the substantial
 25 changes in their military trauma system and their

1 outcomes, but recognised that 4,000 people in the US
 2 a year were dying of trauma and how do we get that
 3 military know—how into the civilian system. They
 4 actually set up something called the Hartford Consensus,
 5 which was specifically endorsed at presidential level,
 6 about how to get that military know—how into the
 7 civilian trauma system.
 8 SIR JOHN SAUNDERS: Mr Cooper.
 9 MR COOPER: Thank you, sir.
 10 Only one question. It's more of a suggestion to
 11 assist. The chair, perfectly properly, raised with you
 12 the issue concerning the app and the light going off, as
 13 it were, on the telephone. You'll remember that passage
 14 of evidence. Is there any way, for instance, the app
 15 can be applied so that it is audio, for instance the
 16 information being given out in an audio way rather than
 17 a visual way? For instance, if a scene is — the
 18 visibility is obscured and at times in the matter we're
 19 dealing with there was a degree of obscurity in the
 20 early aftermath, is there any way your app can give
 21 instructions orally rather than visually?
 22 A. I think everything is possible and that's a very
 23 reasonable observation to make, particularly perhaps for
 24 people who are visually challenged, but it will come
 25 down to cost in terms of development of another version

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1 and we are a small and modestly funded charity. I am
 2 very happy to progress down that route if people feel
 3 benevolent towards that particular cause.
 4 MR COOPER: Thank you so much.
 5 Thank you, sir, those are all my questions.
 6 MR GREANEY: Subject to any questions that you have, sir,
 7 that concludes the evidence of the brigadier.
 8 SIR JOHN SAUNDERS: I'm extremely grateful. You've
 9 obviously done fantastic work in the past and you're
 10 doing so in the present, so thank you very much for all
 11 you're doing and thank you for telling us about it.
 12 2.05.
 13 (1.06 pm)
 14 (The lunch adjournment)
 15 (2.05 pm)
 16 MS CARTWRIGHT: Good afternoon, sir. The witness for this
 17 afternoon is Ms Gillespie. For good reason she is
 18 joining us via a live link and I was going to ask her to
 19 turn her camera on, but she's already done that.
 20 MS MARGARET GILLESPIE (sworn)
 21 Questions from MS CARTWRIGHT
 22 MS CARTWRIGHT: Good afternoon, Ms Gillespie. As you will
 23 appreciate, it's more difficult to ask questions and to
 24 answer them by this means, so we'll all just have to
 25 bear with each other.

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1 I'm going to begin by asking you to tell us your
 2 full name, please.
 3 A. Margaret Josephine Gillespie, but I'm known as Jo.
 4 Q. Thank you. I think it is right that in 2017 were you
 5 Head of Resilience for the north of England in the
 6 Resilience and Emergencies Division of the Department
 7 for Communities and Local Government?
 8 A. Yes.
 9 Q. I've referred to it as the Department for Communities
 10 and Local Government. After the attack and in January
 11 of 2018, did that department become known as the
 12 Ministry for Housing, Communities and Local Government?
 13 A. It did, yes.
 14 Q. But for the purposes of this afternoon, I'm going to
 15 refer to it as the DCLG.
 16 A. Yes. I may alternate between the two, but I understand
 17 it to be DCLG at the time of the attack.
 18 Q. Thank you. What I'm going to now do is identify and
 19 identify for the benefit of others the seven topics I'm
 20 going to address with you over the course of the next
 21 hour or so.
 22 First, your career, background and current role.
 23 Second, the role of the Resilience Emergencies Division.
 24 Third, the staffing and resources within RED. Fourthly,
 25 the resilience advisers within RED's attendance at

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1 exercises, including Winchester Accord. Fifthly, the
 2 Resilience Emergencies Department's role in the
 3 government policy document "Planning for Marauding
 4 Terrorist Firearms Attacks" and any further advice.
 5 Sixthly, RED's role in the updated 2018 government
 6 policy document, "Planning for Marauding Terrorist
 7 Firearms Attacks". And finally, RED's immediate
 8 emergency response work and the role of the government
 9 liaison officer.
 10 A. Yes.
 11 Q. Having set out our path of travel for the next hour or
 12 so, I think it's right that you have provided a witness
 13 statement following on from a request from the inquiry
 14 dated 23 October of last year?
 15 A. Yes.
 16 Q. And are the contents of that statement true to the best
 17 of your knowledge and belief?
 18 A. They are. There have been some updates to it since
 19 I presented the statement. I've identified
 20 a typographical error and the name of my directorate has
 21 changed since then.
 22 Q. Let's first deal with the typographical error. I think
 23 you identified that to me before we commenced. I think
 24 at paragraph 5, you took up the post in RED, is that
 25 correct, in January of 2015?

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

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

1 the local resilience forums to support those forums in
 2 their planning in helping to share practice between LRFs
 3 and also to share government guidance and to help LRFs
 4 work and develop their plans based on a new and revised
 5 government guidance.
 6 We also provide support and act as a critical friend
 7 to LRFs. We're able to answer questions from them, but
 8 also ask them questions about their arrangements and
 9 their planning.
 10 We act on behalf of wider government departments as
 11 being that link into the Local Resilience Forum, so for
 12 example you've referenced the -- I will call it the MTFA
 13 guidance. We were able to sort of support LRFs in how
 14 they interpreted that, how they worked, and we
 15 facilitated workshops, for example. So it's very much
 16 that conduit, that link between Central Government and
 17 the local response community via the LRFs. We work very
 18 much with the LRFs rather than the individual
 19 responders.
 20 Q. You've said on a number of occasions that the role of
 21 the RED, the Resilience and Emergencies Division, is to
 22 support the Local Resilience Forum.
 23 A. Yes.
 24 Q. Does any aspect of -- the role of RED, is it to give
 25 assurance that what's being done is correct or in

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

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

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

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

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

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

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

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

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

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

14 A. Yes.

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

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

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

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

3 A. That was correct, yes.

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

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

12 So the closure of the government offices, they
13 consolidated the teams into a single team. That team
14 was also -- worked across England and I just want to say
15 that t DCLG we support the English LRFs -- so that the
16 Resilience and Emergencies Division had four offices in
17 Leeds, Birmingham, Bristol and London, supporting the
18 38 LRFs across England.

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

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

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

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

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

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

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

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

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

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1 resilience forums, there is a national risk assessment
 2 at that point. It's now called the national security
 3 risk assessment. And that's a classified document,
 4 I don't think I'm going beyond anything you have already
 5 heard. That was available for LRFs to consider, the
 6 types of threats that might be available. You have as
 7 part of the evidence bundle the National Risk Register
 8 for 2015, which is the public-facing version of the more
 9 classified document. In that, threats are mentioned.
 10 That gives the LRF an overview of the types of
 11 threats that they might want to consider. The
 12 counter-terrorism security advisers and the regional
 13 counter-terrorism units are able to provide more
 14 nuanced, more detail to the LRF planners around their
 15 specific area. So again, there is information available
 16 from Central Government that my Resilience and
 17 Emergencies Division can help the LRF access and see,
 18 but that is supplemented by that local support by the
 19 counter-terrorism networks.
 20 SIR JOHN SAUNDERS: Okay. As far as I understand at the
 21 moment, what we've heard is that the risk assessment,
 22 which will be give to places where large numbers of
 23 people gather together, is -- at that particular time
 24 the risk assessment of a terrorist attack was severe,
 25 that meant that an attack was likely.

1 A. Yes. That was the -- sorry.
 2 SIR JOHN SAUNDERS: Does it go beyond that, your advice?
 3 A. It goes into more detail of assessing whether it's
 4 severe or critical. That is the... I believe it's
 5 JTAC. That's the view of what is the current threat
 6 picture for the country so that an attack is imminent or
 7 is possible. But behind that for the individual risk
 8 assessment by each LRF there's a lot more detail given
 9 in the documents I have mentioned and the Cabinet Office
 10 also provide for local resilience forums at that time
 11 what was called Local Risk Management Guidance, which
 12 was specific guidance to LRFs about how to assess risk
 13 and how to include that in their Community Risk Register
 14 as well, which is a duty under the Civil Contingencies
 15 Act, to prepare.
 16 So there was additional guidance available to LRFs
 17 in addition to that national overview of what is the
 18 current threat level.
 19 SIR JOHN SAUNDERS: Thank you.
 20 MS CARTWRIGHT: Still on your paragraph 11, you set out
 21 in the witness statement that:
 22 "In terms of the risks [as you have just told us]
 23 many are captured on the National Risk Register,
 24 an analysis on the nature, likelihood and potential
 25 impact of civil emergency risks, maintained by the

1 Cabinet Office. In each local resilience area, a Local
 2 Resilience Forum is also required by the Civil
 3 Contingencies Act of 2004 to maintain a Community Risk
 4 Register, which assesses the nature, likelihood and
 5 potential impact of civil emergency risks, which may
 6 affect their local area."
 7 A. Yes.
 8 Q. So you have just touched upon the Community Risk
 9 Register that needs to be in place locally by the LRF.
 10 But can you then assist practically as to how your
 11 resilience advisers in RED are supporting the LRFs in
 12 terms of the completion and updating of Community Risk
 13 Registers, please?
 14 A. Yes. Each LRF will generally have what's called a risk
 15 assessment working group, in which they will take
 16 forward the preparation of their Community Risk
 17 Register. I've already mentioned some guidance that
 18 that was produced and if I go back to sort of 2015, in
 19 particular, along with the national risk assessment and
 20 the document called the Local Risk Management Guidance,
 21 as RED we facilitated workshops with all of the LRFs to
 22 discuss the risk documentation, to support LRFs in
 23 developing their Community Risk Registers, to bring key
 24 government departments to these workshops so they can
 25 explain any changes in risk.

1 So the Local Risk Management Guidance also sets out
 2 a mechanism and methodology by which LRFs can undertake
 3 a risk assessment as well. It's quite a detailed
 4 process and I believe you do have a copy of one of the
 5 Community Risk Registers from Manchester as part of the
 6 evidence. What it tended -- what it did is you look
 7 at the individual risk, you look at the impact and the
 8 likelihood as a matrix, and I think if you look in the
 9 National Risk Register of 2015, you will see a matrix
 10 that is {INQ019168/1}.
 11 On {INQ019168/12-13} of that, you will see two
 12 matrices, one for terrorist and malicious threats, one
 13 for other risks. LRFs -- that is the publicly -- it's
 14 a public version of what LRFs will do for each of the
 15 risks. They'll produce a matrix.
 16 SIR JOHN SAUNDERS: Is there anything wrong with having that
 17 document up?
 18 MS CARTWRIGHT: I was just going to ask.
 19 {INQ019168/12}.
 20 A. On pages 12 and 13, you will see a matrix per page.
 21 Q. I don't know whether the document is being displayed.
 22 (Pause)
 23 A. It's not quite what I was -- it's on page 12. I don't
 24 know if you can access page 12.
 25 SIR JOHN SAUNDERS: We are looking at page 12.

1 MS CARTWRIGHT: Perhaps I could use a different document,
 2 Ms Gillespie, which perhaps gives a practical way that
 3 resilience advisers were looking at the Community Risk
 4 Register.
 5 Mr Lopez, could you please display {INQ012442/2}.
 6 Ms Gillespie, just to identify, these are the minutes of
 7 the Resilience Development Group of the
 8 Greater Manchester Resilience Forum from 2 November of
 9 2016. They are minutes that you have provided as part
 10 of your evidence.
 11 A. Yes.
 12 Q. We can see on page 2 one of the items that was being
 13 discussed at that meeting was the Greater Manchester
 14 Community Risk Register review.
 15 A. Yes.
 16 Q. We'll just identify at this stage -- we can see there's
 17 a TG that is dealing with an action here by reference to
 18 the Community Risk Register. Tim Goodstone (sic), as we
 19 know from the first page, which I won't ask to be
 20 displayed, was the resilience adviser from the DCLG
 21 present at that resilience meeting.
 22 A. Yes.
 23 Q. Is that correct?
 24 A. Yes.
 25 Q. And perhaps --

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1 A. Tim Godson his name was.
 2 Q. And we can see that by way of a practical application of
 3 what the resilience advisers did, within that meeting
 4 from 2 November 2016, we can see that there was
 5 a proposed leads and timescales risk assessment template
 6 for the GM Community Risk Register review.
 7 A. Yes.
 8 Q. And it sets out that:
 9 "A discussion took place regarding the statutory
 10 duty to undertake risk assessments on
 11 a Greater Manchester footprint. The national approach
 12 taken by some agencies was noted and Mr Godson agreed to
 13 raise this at the forthcoming risk workshops."
 14 Then a little further down for action we can see:
 15 "TG to raise the issues around the national approach
 16 taken by some agencies in leading some risk assessments
 17 at the forthcoming risk workshops."
 18 So using this as a practical input of a resilience
 19 adviser looking at a GM Community Risk Register review,
 20 could you just explain what that summary suggests was
 21 being done by the resilience adviser, please?
 22 A. Yes, I will do. I'm not entirely certain which risk
 23 Mr Godson was feeding back on, so this is a generic
 24 comment, in that it could be that an agency or
 25 department, and I'll just use my own -- for example,

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1 DCLG, we are the lead department for earthquakes. So if
 2 there was a generic risk assessment done for the whole
 3 country on earthquakes and Greater Manchester felt that
 4 this was not appropriate and wanted a more
 5 location-specific risk assessment and support for
 6 Greater Manchester, that would be fed back into, for
 7 example, DCLG to say: is there more information you can
 8 give for Greater Manchester as a single location rather
 9 than a generic risk assessment for the whole country.
 10 So that's the type of conversation that we had. If
 11 there was a new and emerging risk, for example a risk
 12 came through around volcanos following the Icelandic
 13 eruption some years back, which disrupted air travel,
 14 then our resilience advisers would be the means by which
 15 that more detailed national information could be brought
 16 to the local resilience forums so they could interpret
 17 it for purposes of the Community Risk Register for that
 18 area because there are certain things that will be of
 19 higher risk in some areas compared to others, flooding
 20 would be an example as well.
 21 It's going back to that point of the conduit of
 22 information, that linking of Central Government into the
 23 Local Resilience Forum and taking questions back from
 24 the Local Resilience Forum into Central Government.
 25 Q. Could I ask, Ms Gillespie, in terms of a more specific

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1 example that this inquiry is considering, in terms of
 2 specific venues that fall within a Community Risk
 3 Register, such as crowded places, and you'll be aware
 4 that plainly this inquiry is looking at the
 5 Manchester Arena, do the resilience advisers have
 6 a specific role with looking at risk assessments for
 7 individual venues that are being looked at as part of
 8 the risk register?
 9 A. No, we don't. That's very much a local planning option
 10 as well.
 11 Q. Thank you.
 12 Perhaps if I then can summarise the next aspect of
 13 your evidence. It's right, isn't it, that routinely the
 14 government department, as it was, does not fund the
 15 local resilience forums?
 16 A. No, we did not fund at that time.
 17 Q. That RED or the government department at the time is not
 18 (inaudible: distorted) tasked with emergency planning or
 19 relief duties under the Civil Contingencies Act?
 20 A. No, we are not.
 21 Q. And you have provided then, again, another document
 22 which was the Cabinet Office's guidance, which
 23 essentially summarises the extent of RED's advisory and
 24 planning function, and please, Mr Lopez, if we could
 25 display on the screen {INQ019372/1}.

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1 If we could then move, please, to {INQ019372/13}.

2 This is guidance that was in place in March 2012. We

3 see at paragraph 13.27, Ms Gillespie, that the

4 Cabinet Office guidance confirms that:

5 "The Resilience and Emergencies Division helps

6 responders identify for themselves the risks they face,

7 mitigate those risks, and manage the impact of risks

8 that materialise, including through liaison with Central

9 Government departments."

10 A. Yes.

11 Q. Is that correct?

12 A. That's correct.

13 Q. And within your witness statement, you then directly

14 quote from the next paragraph, paragraph 13.28, which

15 sets out what the Resilience and Emergencies Division

16 will do, which are the following bullet points:

17 "Act as a critical friend, question rationales,

18 suggest alternatives, share good practice and support

19 local planning activities."

20 A. Yes.

21 SIR JOHN SAUNDERS: Is acting as a critical friend a term of

22 art in government?

23 A. It is not uncommon in government to be used. It is

24 quite frequently used.

25 SIR JOHN SAUNDERS: Right. Thank you.

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1 MS CARTWRIGHT: The second bullet point:

2 "To provide a support mechanism helping local

3 partners develop an appropriate response capability,

4 brokering advance mutual aid agreements between areas."

5 A. Yes.

6 Q. Thirdly:

7 "To make links between local responders and the lead

8 government departments."

9 A. Yes.

10 Q. "Supporting cross—boundary strategies, protocols and

11 procedures whilst ensuring a close fit with both the

12 needs of government in a national emergency and the

13 needs of the local responders."

14 A. Yes.

15 Q. "Support local and national exercising. Helping to

16 ensure lessons learnt are effectively shared across the

17 relevant partnership."

18 A. Yes.

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

20 Could I then move, please, to the third area that

21 I wish to deal with you this afternoon, Ms Gillespie.

22 If you could offer assistance to the inquiry in respect

23 of the staffing and resources at the relevant time

24 within the Resilience and Emergencies Division. I'm at

25 your paragraph 14 now.

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1 A. Yes.

2 Q. You've already told us about resilience advisers. You

3 set out there that:

4 "RED undertakes these duties..."

5 And those are the duties we've just looked at in the

6 Cabinet Office guidance:

7 "... primarily through a team of resilience advisers

8 led by a Head of Resilience."

9 A. Yes.

10 Q. And pausing there, at the relevant time you were that

11 Head of Resilience for the north of England?

12 A. I was, yes.

13 Q. And you say this:

14 "Resilience advisers form a relationship with the

15 Local Resilience Forum or a number of local resilience

16 forums, attend relevant meetings, form good working

17 relationships, and undertake the duties outlined in the

18 Cabinet Office guidance", which we have looked a

19 together.

20 A. Yes.

21 Q. And then you give us some information as to the officers

22 of RED at the relevant time. You say this:

23 "In addition, resilience advisers may specialise in

24 particular types of risk, known as resilience policy

25 areas, such as flooding or terrorist attacks, and they

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1 likewise advise local areas and feed into Central

2 Government's plans on how to deal with particular risks

3 within the relevant resilience policy areas."

4 A. That's correct.

5 Q. Pausing there, were any resilience advisers that were

6 supporting Greater Manchester Resilience Forum

7 specialists in terrorism?

8 A. Not to my knowledge as far as I recollect, no. The

9 colleague who had the lead in that area, I believe, was

10 part of the office in Birmingham.

11 Q. Is that individual Tim Godson?

12 A. No, Tim worked in the north, in my team, in the north of

13 England. The colleague who led on working with

14 Home Office, I believe, was — my understanding as far

15 as I recollect was somebody called Nick White and he was

16 based in the Birmingham office. I am aware, and I know

17 we will cover Winchester Accord, that when Tim was

18 planning to attend the exercise, he did ask for advice

19 from Nick on anything he needed to know prior to the

20 exercise.

21 Q. So how would it be then that a Local Resilience Forum

22 might get specific specialist advice from a resilience

23 adviser with a speciality in terrorism, please?

24 A. If an LRF did ask for advice in a particular area which

25 that particular team member wasn't a lead policy team

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

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

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

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

22 A. Yes.

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

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

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

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

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

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

20 Q. Did she have any specific specialism with terrorism?

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

22 Q. Thank you.

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

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1 A. Yes.

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

4 A. It was, yes.

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

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

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

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

8 A. Yes. RED reserves were members of staff within the
 9 department. When an emergency happens, and I'll refer
 10 to flooding at this point, it gets — there's a lot of
 11 work to be done by a lot of people and it goes beyond
 12 the capacity of RED. So at that time we were able to
 13 call on additional staff from within the department to
 14 support any response activity and to bring people in
 15 from the wider department and that had been extensively
 16 used, for example, in response to the flooding in late
 17 2015.

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

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

15 Q. Thank you. Could I then briefly use just one of those
 16 sets of minutes before moving on to the next area,
 17 please, area 4. One of the sets of minutes you have
 18 provided was from one of those Resilience Development
 19 Group meetings. Could I just take you to the
 20 12 May 2016 minutes for that meeting just to try and
 21 understand again how the resilience advisers would work.
 22 Mr Lopez, please could you display {INQ012468/1}.

23 We can see there, these are the minutes from the
 24 12 May 2016 Resilience Development Group, and we see TG
 25 there, Tim Godson, from DCLG.

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

2 Under item 5, we've got the Greater Manchester
 3 Resilience Forum work programme updates. We can see
 4 that part of what was being discussed was that work
 5 programme and we can see TG:
 6 "TG questioned the green RAG rating for the use of
 7 Resilience Direct as a tool in integrated/planning
 8 preparedness and response because GMP do not fully use
 9 the system because of their reservations about the
 10 security. A national fire user group has met to discuss
 11 increased use of Resilience Direct."
 12 So pausing there, would it be right to say that
 13 Mr Godson has obviously reviewed a work programme and
 14 seen that that suggested Resilience Direct being used
 15 and identified that that wasn't the case within the
 16 Greater Manchester Resilience Forum at that time?

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

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

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

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

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

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

1 was a question around in this case, for example,
 2 security, we would go back to the department whose
 3 system or guidance it was and ask the question. So it
 4 would be persuasional influencing rather than: you must.
 5 Because the duty -- you know, there could be
 6 a reason why a partner has chosen not to follow guidance
 7 or use a system, but we'd want to speak -- we'd question
 8 why and if there was a -- if we had significant concerns
 9 and there was just -- it was -- we could talk to the
 10 lead departments and -- say, the Home Office if it was
 11 the police or DEFRA if it was the Environment Agency.
 12 You know, is there a reason why? In that sense -- but
 13 we don't command and control the local partners.

14 Q. Could I move now, please, Ms Gillespie, to topic 4, the
 15 RED resilience advisers' attendance at exercises,
 16 including Winchester Accord. I'm at your paragraph 18
 17 now and you say this:
 18 "As part of our advisory and planning work, we
 19 undertake some event-based work, for example advising
 20 local responders on security risks associated with major
 21 events such as general elections, and we may also
 22 coordinate different agencies involved for preparing for
 23 such events, such as facilitating meetings between
 24 members of local resilience forums and government
 25 departments. RED resilience advisers also attend

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

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

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

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

1 would be sufficient — that... In normal — in other
 2 exercises I have seen and understand resilience forums
 3 will have said, "Action needs to be taken". But as you
 4 say, there is no power to compel a particular partner
 5 within the forum to do something by another partner.
 6 There are mechanisms by which my team could become
 7 involved. If there was a dispute between partners, we
 8 could seek to see how we can move things forward, how
 9 we can resolve that dispute and I could engage other
 10 departments to help resolve that issue.
 11 So I do fully accept your point that there isn't
 12 that power to compel, but I also expect that at that
 13 senior level, the partnership should work together and
 14 if there are critical issues that need to be resolved,
 15 I would expect that to be resolved at the LRF if that's
 16 appropriate.
 17 SIR JOHN SAUNDERS: Should the LRF have the power to compel?
 18 A. Sorry, sir?
 19 SIR JOHN SAUNDERS: Should the LRF have the power to compel
 20 action to be taken if it's not being done in a timely
 21 manner?
 22 A. It's difficult for me to answer that question, but
 23 I don't think it's necessary. I think there is
 24 sufficient seniority (?) and cooperation that —
 25 SIR JOHN SAUNDERS: Okay. My interpretation of the evidence

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1 of Winchester Accord is that there were things which had
 2 gone wrong, which the tracker picked up had gone wrong,
 3 which had not been put right by the following May. If
 4 that is right, and obviously I will need to examine the
 5 evidence and hear submissions, but if that were not the
 6 position — if that were to be the position, why isn't
 7 it necessary for someone to have the power to make sure
 8 that the individual agency involved actually got on and
 9 did it?
 10 A. I believe that that collaborative power sits with the
 11 LRF. I think the specific issue with Winchester Accord
 12 is the LRF was not aware of some of the actions that
 13 needed to be taken, but I'm not — because I wasn't
 14 at the exercise and wasn't part of the live play, I find
 15 it a little bit difficult to comment in detail.
 16 SIR JOHN SAUNDERS: I understand that. Okay. But I'm going
 17 to carry on asking the questions and you'll just tell me
 18 you can't answer them. So if the LRF were not aware of
 19 some of the problems, why not? And shouldn't they have
 20 been aware of them?
 21 A. Again, this is my personal opinion. I think ...
 22 Certainly the multi-agency aspect of the exercise did
 23 identify an issue with the setting-up of the SCC,
 24 et cetera, and that action was taken. In terms of the
 25 live play aspect, I don't know why the action wasn't

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1 taken and I don't know why... I think the way the
 2 exercise was created did — it was created away from the
 3 LRF, I think, was one of the challenges. Again, I can't
 4 necessarily comment in detail on GMRF in terms of exact
 5 exercise learning, but I'm aware that they also planned
 6 for a major flooding exercise the year before, maybe the
 7 same year, and lessons were taken through from that and
 8 there was a tracker.
 9 So I can't comment on the specific actions from the
 10 live play because they didn't come to the resilience
 11 forum.
 12 SIR JOHN SAUNDERS: Right. So theoretically does RED have
 13 any power to make someone do something if they're not
 14 doing it?
 15 A. We don't have the legislative power, but we have —
 16 we will do a lot of work to talk to the individual
 17 agencies and, if needs be, also talk to the sponsor
 18 departments of a particular sort of partner of the LRF.
 19 Now, I'm speaking hypothetically here, there's no
 20 criticism applied here at all. If, for example, in
 21 planning for floods there was a concern raised about the
 22 Environment Agency or about the Met Office and that
 23 couldn't be resolved locally, it couldn't be resolved by
 24 discussion between partners, then I would speak to
 25 DEFRA, I would speak to a more senior management within

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1 the Met Office, I would speak to my colleagues in
 2 Cabinet Office who have that civil contingencies
 3 overarching role.
 4 So in that sense one has the persuasive element
 5 coming through. I don't necessarily think — it would
 6 very much change that relationship with the resilience
 7 adviser, no longer acting as a critical friend, it would
 8 change that dynamic and I think that persuasion, that
 9 influencing, that working with the departments, I think
 10 is very, very effective.
 11 SIR JOHN SAUNDERS: So he would remain critical but perhaps
 12 not in a friendly way if it was changed?
 13 A. I think that's a very good way of summarising it.
 14 SIR JOHN SAUNDERS: And do you think the friendly critic
 15 works better than the person who says, "You are not
 16 doing what you need to do, get on and do it"?
 17 A. Each of the partner agencies in LRF does have its own
 18 regulatory — and some have an inspection regime as
 19 well, so that is in place if concerns were raised. So
 20 in that sense, I think, again, that support, challenge
 21 and collaborative support and challenge, I think, does
 22 work.
 23 SIR JOHN SAUNDERS: Okay. I'm sorry for asking those
 24 questions, you're not responsible for the policy, but
 25 you're the person who's here to justify it, so thank you

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

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

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

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

1 This is the document, isn't it, Ms Gillespie?
 2 A. Yes. I believe it is.
 3 Q. Thank you. If we then turn, please, to {INQ031148/3}.
 4 It's right, isn't it, that the guidance to Local
 5 Resilience Forums provided clear guidance as to how to
 6 structure their planning for MTFAs, would you agree?
 7 A. Yes, it does.
 8 Q. In terms of -- if we look at the bullet points under
 9 2(a), it indicated that local planners should therefore
 10 be aware of the joint operating principles (JOPs).
 11 A. Yes.
 12 Q. That there should be clear identification and
 13 declaration of an MTFA.
 14 A. Yes.
 15 Q. "Consideration of mobilisation of specialist emergency
 16 service responders. Assessment and management of risk
 17 at the scene. Tactics for managing casualties in areas
 18 that cannot yet be declared completely safe. Tactics
 19 for managing other hazards such as smoke and fire."
 20 A. Yes.
 21 Q. I'm not going to take you through all of that, but would
 22 your assessment of that July 2013 guidance be that it
 23 was clearly identifying for Local Resilience Forums and
 24 particularly category 1 responders the care and
 25 consideration that they needed to give specifically to

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

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

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

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

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

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

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

1 fact now would be an appropriate time to take a short
 2 break to give the stenographer a break, but also
 3 Ms Gillespie, to deal with my final topic, and then
 4 Mr Atkinson's questions.
 5 SIR JOHN SAUNDERS: Right. We'll have a break until 3.40.
 6 Currently, on our clocks, it's 3.23, so just so you have
 7 some idea, Ms Gillespie.
 8 MS CARTWRIGHT: Thank you, sir.
 9 (3.23 pm)
 10 (A short break)
 11 (3.40 pm)
 12 MS CARTWRIGHT: Ms Gillespie, can you see and hear me?
 13 A. I can indeed.
 14 Q. The final topic from me, please, which is the Resilience
 15 and Emergency Division's role with emergency response
 16 work. I'm at paragraph 24 of your witness statement.
 17 You tell us that:
 18 "When an emergency occurs, the basic role of RED is
 19 to provide liaison between local responders and Central
 20 Government."
 21 And:
 22 "This is achieved largely through RED's
 23 participation on the strategic coordination group."
 24 A. Yes, that is correct.
 25 Q. "The SCG is made up of members of the Local Resilience

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1 Forum who have particular duties under the Civil
 2 Contingencies Act and is convened when an emergency
 3 occurs in order to coordinate the local response."
 4 A. That's correct.
 5 Q. You explain in that scenario within an SCG a RED
 6 employee will attend as a government liaison officer, so
 7 a GLO?
 8 A. That's correct.
 9 Q. And you have indicated that the role of the government
 10 liaison officer on behalf of RED at an SCG is to obtain
 11 updates on the situation on the ground, provide
 12 information from Central Government as well as advice to
 13 the SCG, and identify whether the SCG or any of its
 14 members are overstretched, need additional resources,
 15 and relay requests for assistance for the SCG or any of
 16 its members to relevant partners in local or Central
 17 Government via RED?
 18 A. That's correct, yes.
 19 Q. You have indicated that generally that will include the
 20 lead government department and in more serious
 21 emergencies they may also include other government
 22 departments and COBR?
 23 A. Yes, that's correct.
 24 Q. Thank you. Perhaps just to use the emergency response
 25 plan that you've provided to your witness statement,

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1 just to identify this in a pictorial form, please.
 2 Mr Lopez, please could you display on the screen
 3 {INQ031147/1}.
 4 You provided the emergency response plan guidance.
 5 This is the guidance that was effective from February of
 6 2015, version 3.2; is that correct?
 7 A. That's correct.
 8 Q. Mr Lopez, if we turn to {INQ031147/7}, please. If you
 9 could expand on the diagram, please.
 10 Does that figure 3 effectively display what the role
 11 of the GLO and RED is at the strategic coordinating
 12 group?
 13 A. It does, yes.
 14 Q. You also tell us in your witness statement that an
 15 updated version of the DCLG emergency response plan was
 16 issued after the attack in June of 2017, and you
 17 describe that as version 3.4. Just pausing there for
 18 a moment, was there a version 3.3?
 19 A. Not that I can find. What I believe is the case is that
 20 we updated and version 3.4 is the finalised and agreed
 21 version; we never issued a version 3.3.
 22 Q. Why was the -- what was the change between the emergency
 23 response plan that was effective at the time of the
 24 attack and the changes that were brought in in
 25 June 2017, please?

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1 A. On consideration of the two documents, I -- obviously in
 2 paragraph 15, I mention that fire policy was still part
 3 of DCLG at that stage and the updated plan 17 removes
 4 the reference to the fire policy colleagues. But apart
 5 from that, it's broadly similar. Our role in terms of
 6 an SCG does not change between the two documents.
 7 Q. Thank you.
 8 Then finally in your witness statement, you deal
 9 with the specifics of what happened on the night of the
 10 attack in terms of the role of RED and the government
 11 liaison officer. You tell us this at paragraph 28:
 12 "On the night of the arena attack, in accordance
 13 with protocol, a RED resilience adviser,
 14 Mr Graham Scott, was deployed to Greater Manchester
 15 Police Headquarters to perform the role of the
 16 government liaison officer.
 17 "Mr Scott arrived at Greater Manchester Police on
 18 23 May at 02.30 am and he acted as the single point of
 19 contact between the local response partners and
 20 structures and Central Government."
 21 A. Yes.
 22 Q. "He attended the first strategic coordination group
 23 meeting held at 04.15 am on 23 May 2017."
 24 A. Yes, that's correct.
 25 Q. And:

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1 He used the information gathered from that SCG to
 2 brief ministers and senior government officials.”
 3 A. That’s correct.
 4 Q. Then:
 5 “Subsequent SCG meetings were attended by RED
 6 resilience advisers, Ms Christine Gough and
 7 Ms Julie Dawber.”
 8 A. Yes.
 9 Q. You say this:
 10 “In a terrorist incident, the department’s role is
 11 to act as a GLO and provide advice on the management of
 12 consequences. As part of that consequence management,
 13 RED established a dedicated team to support the recovery
 14 efforts and worked with Manchester authorities and
 15 government departments to provide recovery support.”
 16 A. That’s correct.
 17 MS CARTWRIGHT: Thank you. Those complete my questions,
 18 sir, unless you have any specific questions.
 19 SIR JOHN SAUNDERS: Yes. I want to talk about, please, the
 20 response on the night.
 21 A. Yes, sir.
 22 SIR JOHN SAUNDERS: So the person who went, the RED
 23 resilience adviser, is he someone who lives in the
 24 Manchester area?
 25 A. He is, yes, sir. If I just explain, if you read our

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

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

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

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1 A. Yes, that is correct.
 2 SIR JOHN SAUNDERS: This one didn't take place until 4.15
 3 in the morning. That seems quite a long time after
 4 10.31.
 5 A. I have spoken to Mr Scott, who obviously did deploy on
 6 the night. There were Gold huddles happening around
 7 Force HQ and when Mr Scott deployed we understood an SCG
 8 was planned imminently and that seems to have got
 9 delayed and delayed, so it was probably established
 10 later than I anticipated because I understood one was
 11 almost as soon as Graham got there.
 12 I think the most recent guidance on the MTFA
 13 guidance does recognise that an SCG may be formed after
 14 the event has happened. In terms of --
 15 SIR JOHN SAUNDERS: (Overspeaking) after the event has
 16 happened, wouldn't it? It's not going to be formed
 17 before the MTFA. I'm sorry to be facile about it. But
 18 nevertheless it should happen, shouldn't it, as soon as
 19 it has happened?
 20 A. It should happen soon, yes. As soon as practicable.
 21 SIR JOHN SAUNDERS: You're meant to be the link with Central
 22 Government, aren't you?
 23 A. In terms of a terrorist event, we are supporting the
 24 Home Office, they are the primary lead department.
 25 That's the one difference between a terrorist response

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

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

1 there was quite a lot of community concern. I think
 2 during the evening, I can't quite recollect, there was
 3 an issue with a fire at a mosque in Oldham as well, and
 4 again providing information on that and making sure that
 5 the department is ready to support in that broader
 6 departmental sense as well.
 7 SIR JOHN SAUNDERS: Okay, thank you.
 8 MS CARTWRIGHT: Ms Gillespie, just to finish off using the
 9 plan to deal with the matters that the chairman's just
 10 dealt with, Mr Lopez, could we briefly have on the
 11 screen again, please, {INQ031147/6} of that document.
 12 Ms Gillespie, at paragraph 1.10 we can see under
 13 "Strategic Coordinating Groups" it says:
 14 "When an incident occurs or is likely to occur, DCLG
 15 will be notified a strategic coordination group will
 16 meet at a certain time."
 17 1.11:
 18 "SCGs are made up of members of the Local Resilience
 19 Forum who meet in an emergency, often via teleconference
 20 and at short notice to share information quickly and
 21 make strategic decisions about how to respond. Through
 22 RED, DCLG represents the whole of Whitehall, passing
 23 information to and from the local level to Central
 24 Government so partners have one contact instead of
 25 several."

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

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1 and our role as consequence management rather than sort
 2 of the ...
 3 Q. Thank you. But certainly the emergency response plan in
 4 effect at the time did envisage that your department
 5 would be notified of the strategic coordination group
 6 when it was going to meet but also there may be a need
 7 for teleconferences at short notice?
 8 A. Yes.
 9 Q. Thank you.
 10 A. On the evening, just to confirm, we did establish close
 11 working relationships with the Civil Resilience Unit and
 12 I have a number of email exchanges with them where they
 13 also provided us with up-to-date information and
 14 Mr Scott deployed with them and sat down sort of close
 15 to them.
 16 MS CARTWRIGHT: Thank you.
 17 That completes my questions unless there's any
 18 further clarification .
 19 Ms Gillespie, you're now going to be questioned by
 20 Mr Atkinson on behalf of one of the core participants on
 21 behalf of the families. He is not in the room, so it
 22 may be even more difficult than it has been between the
 23 two of us. I'm sure everyone will be understanding.
 24 I can see Mr Atkinson is now on the screen.
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1 Questions from MR ATKINSON
 2 MR ATKINSON: Thank you, Ms Cartwright.
 3 Ms Gillespie, can you hear me?
 4 A. I can indeed.
 5 Q. Excellent. I had five topics. You'll be pleased to
 6 know that the chair has just dealt with one of them, so
 7 I have just four areas that I need your help with, and
 8 I'm grateful to you, sir, for that.
 9 Just in terms of what the role of an LRF is in an
 10 emergency context, I wonder, Mr Lopez, if we could have
 11 {INQ019372/1}, please.
 12 Could we try going to page 10 of the document
 13 {INQ019372/10}. This document, produced by the
 14 Cabinet Office, deals with emergency responses and
 15 identifies the various organisations that will or may
 16 have a role to play in a response to an emergency of any
 17 number of types.
 18 We can see that, towards the bottom of what is on
 19 our screen, paragraph 13.18 deals with the role of
 20 a Local Resilience Forum because it's right to say, is
 21 it not, that it is recognised that LRFs do have a role
 22 to play, both in responding to an emergency but also in
 23 terms of preparation for the event of an emergency?
 24 A. If I could just sort of -- the LRF itself doesn't
 25 respond; the partner agencies respond via things like

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

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1 bear.”
 2 A. Yes.
 3 Q. In terms of going back to some of the questions you were
 4 asked by the chair a little earlier today, in terms the
 5 role an LRF can have, is it through, firstly, bringing
 6 the agencies together so that they can talk about their
 7 plans for particular kinds of events and also putting
 8 pressure on them through that collective responsibility,
 9 that collective discussion, to get things done?
 10 A. I think in order to have an effective plan for any
 11 emergency, it's rarely that it's a single-agency plan.
 12 There will be a single-agency element to a plan, but
 13 if we think about things like flooding, for example,
 14 it's important that the local authorities, the emergency
 15 services, military colleagues, all have a shared
 16 understanding of what plan is needed to respond to
 17 a particular incident.
 18 I think the critical function the LRF provides
 19 is that ability to cooperate in multi-agency planning
 20 and building on those single-agency plans to develop
 21 that multi-agency plan.
 22 Q. Because to take flooding as an example, you would expect
 23 each of those agencies that you've just mentioned to
 24 have its own plan in place for dealing with floods?
 25 A. I would indeed, yes.

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

1 there is — for example, if sharing does not happen.
 2 That is referenced in the document at {INQ019372/1},
 3 I believe.
 4 Q. Is that something of a last resort to go to such
 5 measures? If the whole idea of an LRF is for it to be
 6 collaborative and cooperative, then surely the aim will
 7 always be to try to bring people to cooperate rather
 8 than start threatening —
 9 A. Oh, definitely, and I have not in my experience come
 10 across a time when that has even been suggested. That
 11 cooperation, that collaboration, that persuasion, that
 12 peer influence, and even again as I have mentioned
 13 earlier in my evidence, if needs be, the departments
 14 could speak to core members of LRFs to suggest if change
 15 is needed. So it is very much the last resort.
 16 Q. Against that background, let me look at the now four
 17 areas that I need your help with. The first of those is
 18 in relation to the assessment of risk. If, Mr Lopez,
 19 we can take that document down, thank you very much, and
 20 go to {INQ018892/14}.
 21 As we can see from the heading, this is "The
 22 Principles of Effective Response and Recovery". We can
 23 see, the fourth bullet point down, that it identifies as
 24 the first of those principles:
 25 "Anticipation. Ongoing risk identification and

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

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

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

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

12 A. Yes.

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

18 A. Yes.

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

25 A. Yes.

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1 Q. -- and explaining what the risk is.

2 A. Yes.

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

7 A. Yes.

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

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

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

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

5 Now, I am aware in a number of LRFs that the
6 assessment of threat was done by a more closed group.

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

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

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

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1 of threats.

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

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

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

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

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

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

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

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

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

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

17 This document makes the point on its very first
 18 page, with the second indented paragraph:
 19 "We are not asking LRFs to develop separate bespoke
 20 plans to respond to this kind of attack."

21 That's a marauding terrorist firearms attack:
 22 "Instead, we strongly encourage planners to work
 23 together to consider how existing generic plans might be
 24 adapted or improved to address the specific challenges
 25 of this type of emergency. A flexible response will

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

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

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

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

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

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

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

5 A. Yes.

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

11 A. Yes.

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

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

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

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

1 the risk picture and current guidance.

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

5 A. I would expect so, yes.

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

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

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

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

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

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

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1 it is ... And again I honestly don't know because, as
 2 I say, I didn't take part, at what point does that get
 3 escalated? But yes as you say, if there were
 4 significant issues raised from Winchester Accord, the
 5 live play, it would have been helpful to raise at the
 6 resilience forum.
 7 Q. An LRF can deal with interoperability issues, but only
 8 if they're told about them?
 9 A. Yes.
 10 MR ATKINSON: Thank you very much indeed, Ms Gillespie, for
 11 your patience with me.
 12 Sir, those are my questions, thank you.
 13 MS CARTWRIGHT: Sir, we've had a request from Mr Cooper that
 14 he be permitted 5 minutes to ask questions. There's no
 15 Rule 10 request, but the indication is he would like
 16 5 minutes.
 17 SIR JOHN SAUNDERS: Five minutes it is.
 18 Questions from MR COOPER
 19 MR COOPER: It came out of a question — in fact I'm only
 20 asking for 2 minutes, so let me get straight to it.
 21 Do I understand, Ms Gillespie, you were responsible
 22 for communications with bereaved families immediately
 23 after this atrocity, that is on Monday the 22nd and
 24 Tuesday the 23rd? Did I understand you to give evidence
 25 this afternoon to that effect?

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

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

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

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

1 SIR JOHN SAUNDERS: Thank you very much for your evidence,
 2 which is — I'm very grateful for. I think you win the
 3 prize for the best quality of video evidence in that we
 4 heard you clearly and saw you clearly and your lips
 5 moved with the sound as well. I think yours is quite
 6 the best we've seen so far, so thank you for that.

7 A. Thank you.

8 SIR JOHN SAUNDERS: And that's it for today?

9 MS CARTWRIGHT: It is, sir. Tomorrow we have three
 10 Greater Manchester Fire and Rescue Service witnesses.
 11 We start with Mr Alan Topping, then we have Andrew
 12 Simister and Neil Helmrich. We're due to commence the
 13 evidence tomorrow at 9.30, so could I ask, please, that
 14 we adjourn until tomorrow at 9.30?

15 SIR JOHN SAUNDERS: Right, thank you very much.
 16 (4.40 pm)

17 (The inquiry adjourned until 9.30 am
 18 on Tuesday, 2 March 2021)

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