

OPUS2

Manchester Arena Inquiry

Day 82

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Thursday, 25 March 2021

(10.00 am)

SIR JOHN SAUNDERS: Good morning. Ms Cartwright.

MS CARTWRIGHT: The gentleman in the witness box is

Dr Edward Tunn. Could I ask him now to be sworn,

please, sir.

DR EDWARD TUNN (sworn)

Questions from MS CARTWRIGHT

MS CARTWRIGHT: Could you please tell the court your full name?

A. Edward James Tunn.

Q. Dr Tunn (inaudible: distorted) at the time you had provided answers by way of an account to Greater Manchester Police. I think in your witness statement you identify that being provided in April, but you have been provided with that also in your pack. Is it correct that that earlier account of your involvement on the night was dated 6 February 2018?

A. I have it here, so I'll just check.

Q. If you look on the last page of that document, it records the date and time completed, 6 February 2018.

A. Yes.

Q. Are the contents of that document true to the best of your knowledge and belief as well?

A. Yes.

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Q. Dr Tunn, in starting, I just want to identify both for your benefit but also the benefit of those watching, as we'll deal with shortly, you attended the scene on the night, but we are not going to identify any of the deceased by name, nor are we going to provide any details of individual casualties that would enable them to be identified. So I make that clear at this stage.

A. Thank you.

Q. And I would ask that none of those asking questions today ask questions so as to identify any of those casualties.

Having set that out, could you first of all ask you to give us details of your qualifications? We can see from the witness statement you provided that you were at the relevant time a consultant rheumatologist, so could you first of all deal with your role as a consultant rheumatologist and your qualifications for that role, please?

A. Standard UK training, so an MBChB, the medical degree, Glasgow, 1978. The standard post-grad physician's Membership of the Royal College of Physicians, which later gets converted to a fellowship, but essentially MRCP, some 3 years after qualification, which is the standard general medicine postgraduate qualification.

Q. Thank you.

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A. Thereafter, there's then specialty training within one's chosen specialty, which in my case is rheumatology, which follows the standard UK pattern and is externally controlled by, for example, the College of Physicians.

Q. Thank you. In May 2017, it's correct, isn't it, that your primary role was as a consultant rheumatology at the Royal Liverpool and Broad Green University Hospital's NHS trust?

A. Yes, that was my primary role. Effectively, I had a standard consultant contract with the hospital. For the first, roughly... From 1990, for roughly the first 10 years that was purely rheumatology. Then from 2001 onwards, I was gradually seconded in part, for part of the time, but within the same overall envelope, to a number of other roles, which changed as the years evolved.

Q. I want to now deal with two of those other roles if you can assist us, please. It's correct, isn't it, that in May 2017 you were also the associate medical director for North West Ambulance Service?

A. Yes.

Q. And additionally to that, you were the medical adviser for the National Ambulance Resilience Unit?

A. Yes.

Q. So dealing with the second of your roles, that of the

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associate medical director, you tell us in your witness statement that you had held that position from 2006 until October of 2018.

A. Yes. So I first joined the ambulance services in 2001, which was the then Mersey Regional Ambulance Service, and that was as medical director of the small ambulance service as it was at the time, Cheshire and Mersey, as we now know it.

In 2006, there was a national reorganisation of the ambulance services into larger units, which became the North West Ambulance Service, and at that time I then moved -- stayed within the Ambulance Service and became one of the associate medical directors in that new larger organisation.

Q. Thank you. Can you please just give us some idea, bearing in mind the different hats and roles you have, as to how much of your time being an associate medical director for NWAS would take.

A. Roughly, 2 days a week. It'd be a very, very rough estimate. The job plan is reviewed every year by peer appraisers and agreed with essentially the executives. It's changed over the years. I think initially, at the start, around 2001, it might have been as much as 3 days a week. Roughly 50%, 40%, I think, to start with, but by the time we came to 2017, which would be the relevant

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1 time, I think it was 2 days per week.
 2 Q. You describe in the account you provided to the police
 3 in February 2018 that the associate medical director
 4 role is mainly a senior management office role, but with
 5 operational capability and regular participation in
 6 operational emergency ambulance jobs as the desk job
 7 permits?
 8 A. Yes. So there is no requirement in the job to be
 9 operational, in the job. So doctors are used in the
 10 Ambulance Service to help to develop the profession and
 11 the service. When the paramedic profession and the
 12 technician colleagues are developing into new areas,
 13 such as urgent care to help take the pressure off
 14 emergency departments, as a straightforward example,
 15 there are new ways of working. So it's to help, to
 16 facilitate and develop those new ways of working. So
 17 it's mainly doing that from behind the scenes. Hence
 18 the desk job reference.
 19 Personally, I elected to get pretty close to the
 20 front line in order to be able to understand the
 21 granularity of the systems that we were expecting to
 22 develop. So there's a bit of being well-informed about
 23 the nature of the challenge and also the notion of
 24 visible leadership. So if we're going to ask the
 25 profession, our colleagues in the Ambulance Service, to

1 undertake new roles, to be visible to them in leading
 2 that development, so hence the involvement in emergency
 3 care as the day job permitted and also at night, from
 4 home, for example.
 5 Q. Thank you. So perhaps then, would it be fair to say
 6 that being an associate medical director does not
 7 require you to take on duties operationally?
 8 A. Absolutely.
 9 Q. But you took on that responsibility or chose to?
 10 A. Exactly. As a rough idea, sometimes other duties
 11 permitting, it might be four 999 responses in a day,
 12 sometimes it might be one in a fortnight, just depending
 13 on the... because we are used to go to a selection of
 14 the more serious incidents or the larger incidents where
 15 assistance might be of use.
 16 Q. I'm going to ask you in a minute about those operational
 17 teams that you work within. Before doing so, could you
 18 first of all identify at the relevant time who was the
 19 medical director for North West Ambulance Service,
 20 please?
 21 A. That's changed a number of times in the nature of the
 22 business, but I think I'm pretty sure it was
 23 David Ratcliffe, my colleague.
 24 Q. In describing what your role was in terms of the office
 25 role, could you just give us a bit more of an

1 understanding as to what that actually practically meant
 2 you did by way of development of policies or
 3 implementation of training for front line personnel?
 4 A. So within the --- I think we had, it changed from time to
 5 time, but between four and five associate medical
 6 directors and so the workload was divided up into
 7 natural groups. Some were dealing with things like air
 8 ambulance and the like, which was not me. I was dealing
 9 mainly with urgent care, so looking at ways of arranging
 10 for patients in the community to have their needs met
 11 without having necessarily to present at ED, so in other
 12 words trying to take the pressure off emergency
 13 departments. And a separate role, an additional role in
 14 2017, was working with the clinical commissioning group,
 15 to work with them to develop the urgent care system so
 16 that we had services that we could divert patients to
 17 appropriately.
 18 Q. Could I ask, as part of your role as the associate
 19 medical director, would you have had any role in the
 20 development of North West Ambulance Service's major
 21 incident response plan?
 22 A. Indirectly. I mean, yes, the medical directorate, which
 23 would comprise the medical director, the associate
 24 medical directors, the most senior paramedics, the
 25 consultant paramedics, would be a collective that would

1 do the work, the clinical work. That would then be
 2 presented to boards for formal sign-off. So it would be
 3 more --- the majority of the major incident plan is
 4 logistics, which is not core clinical. So we would
 5 be --- it would be for information and to check that
 6 there were no clinical issues in that major incident
 7 plan, but there are others who are within the
 8 Ambulance Service who are technically more qualified to
 9 deal with the logistics.
 10 Q. Can I ask you, were you involved pre the attack
 11 in May 2017 at all with the development of the triage
 12 sieve or triage sort process in a major incident?
 13 A. So prior to 2017... Prior to 2017, I was not involved
 14 in the development. One of my training elements was the
 15 standard... One of the standard courses for management
 16 of a major incident is the so-called MIMMS, major
 17 incident management medical, and in the early --- the
 18 first decade of working with the Ambulance Service,
 19 I undertook that course and then became an instructor
 20 in that, so I was familiar with it and I was
 21 an instructor in it but not a developer of it.
 22 Q. Thank you. I think you also identify in your witness
 23 statement that you're also currently one of the
 24 authoring faculty for a new European pre-hospital trauma
 25 course?

1 A. Yes. That's been somewhat delayed in its launch by
 2 COVID but it's just on the point of being delivered and
 3 it's underwritten by the Royal College of Surgeons, for
 4 example, so it's a large national faculty that's trying
 5 to refine existing courses and trying to develop one
 6 that takes on the latest learning.

7 Q. Thank you. What I'm going to ask you to do now, please,
 8 is just describe those operational roles that you had
 9 with North West Ambulance Service as of the time of the
 10 incident of May 2017, please. You've already
 11 identified, I think, the AIT team, the Ambulance
 12 Intervention Team. Could you describe what your role
 13 was as part of the Ambulance Intervention Team, please?

14 A. The real answer is no significant involvement with that
 15 team. It was -- I was trained in AIT. Like the
 16 discussions we had earlier, there was no requirement for
 17 one of the associate medical directors to be trained to
 18 that standard because the AIT team are our core clinical
 19 staff in the ambulance who have volunteered to undertake
 20 the additional training to work in those particular
 21 environments.

22 I chose to undertake the training because, from
 23 experience of the other 999 exposure on the streets, I'm
 24 familiar with the challenging environments. So I felt
 25 that it would be not unreasonable to understand the

1 nature of their training and the tactics involved.
 2 Again, the visible leadership element. I did carry the
 3 full kit at the time in case -- in the unlikely event of
 4 being placed in a relevant position.

5 Q. Thank you. So we're going to look shortly at your CPD,
 6 which identifies your training for the AIT team. Would
 7 it be right to say that the AIT team would be the team
 8 that can be deployed to a marauding terrorist firearms
 9 attack, as it was at that time?

10 A. That's correct. Then MTFA and now MTA.

11 Q. So you had an understanding of that training, you were
 12 able to work in that team, but would it be also right to
 13 say that you were well aware of warm zone working as
 14 part of that training?

15 A. Absolutely, yes.

16 Q. Thank you. Can I ask you then about some of the other
 17 specialist teams that we've heard about and to
 18 understand whether you had an operational role with NWAS
 19 in those teams. We've heard reference to MERIT and
 20 MERIT doctors. Were you a North West Ambulance Service
 21 MERIT doctor?

22 A. In 2017 I was not because the MERIT system was being
 23 developed at that time and I had a sort of peripatetic
 24 role that allowed me to be flexible anyway. When
 25 I formally retired from full-time in October 2018,

1 I then joined the MERIT cadre and undertook the formal
 2 MERIT training and have this month just ended that as
 3 we've arranged the succession plan, if you like, and it
 4 has recruited sufficiently to allow me to finally stand
 5 down from that.

6 Q. Can we just identify -- we've used MERIT as an acronym,
 7 but MERIT stands for medical emergency response incident
 8 team, doesn't it?

9 A. Yes, the true words behind it have almost disappeared
 10 and MERIT is just used.

11 Q. So I am asking you that because we're going to deal with
 12 in due course your allocation of role when you attended
 13 at the arena, and certainly in an expert report that's
 14 been provided you've been identified in a role that
 15 included being the MERIT doctor number 1. That's why
 16 I ask you about whether you were a MERIT doctor at the
 17 time.

18 A. I understand the question. I was not a MERIT doctor
 19 at the time. However, from MIMMS and from other
 20 training, I was able to adapt into the role and
 21 post-event it was, I think -- the actions were
 22 consistent with the training that is now delivered.

23 Q. So before we move off this topic, at the relevant time
 24 in May 2017, how were MERIT doctors identified? What
 25 did you have to do to become an NWAS MERIT doctor?

1 A. So MERIT -- there was a formal recruitment system, there
 2 was an invitation to apply. Then and now, the associate
 3 directors, medical directors, who were developing it
 4 were very keen to draw from a range of backgrounds
 5 because it's felt to be helpful given the range of
 6 events that are likely to be having to be dealt with.
 7 So they undertake a formal job application, CV
 8 presentation, they come from a range of backgrounds,
 9 including pre-hospital care, air ambulance,
 10 anaesthetics, general practice primary care.

11 You then undertake a specific detailed training for
 12 the medical incident adviser role and for the forward
 13 doctor role. There's a -- I think it's about a five-day
 14 induction and then there are annual refresher
 15 requirements.

16 It's perhaps helpful to say that the need for
 17 medical presence in a major incident is laid out in
 18 quite soft terms in national guidance documents and are
 19 implemented -- operationalised in rather different ways
 20 across the country.

21 I think in the north-west it's one of the most
 22 developed, both in terms of the cadre -- we now have
 23 something in the order of 35 on the rota, two on call at
 24 any one time.

25 Q. Thank you. So would it be fair to summarise that MERIT

1 doctors are on call 24 hours a day, 7 days a week to
 2 provide advanced medical care on scene at a range of
 3 emergency incidents up to and including major and mass
 4 casualty incidents?
 5 A. Not precisely. Almost exactly correct. But it's a
 6 gloves off, if I can say that, role. So the term that
 7 you used there, to provide advanced medical care, is
 8 not -- is explicitly not the role. So it's to provide
 9 support and advice to the ambulance command and control
 10 structure, gloves off, and the action cards 17 and 18 in
 11 the major incident define those roles and explicitly
 12 say, "Do not become involved in individual patient
 13 care".
 14 Q. Can I then in terms of -- before moving to your third
 15 role with NARU can you -- were you part at any point of
 16 the Special Operations Response Team within North West
 17 Ambulance Service?
 18 A. I don't think so. Effectively, no, in 2017. Way back
 19 when it was Mersey Regional Ambulance, before the
 20 merger, I undertook, for the same reasons I'd previously
 21 outlined, granularity, I undertook SORT training.
 22 That's more to do with the establishment of
 23 decontamination facilities and so on. So yes, I'd
 24 undertaken some training in deploying and packing
 25 inflatable shelters and shower systems and so on. So

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1 I'd undertaken that training but I was not a member of
 2 SORT, particularly, I don't think, since 2006.
 3 Q. Thank you.
 4 I'm going to now then deal with your third role that
 5 you had in May 2017, which was your role as a medical
 6 adviser for the National Ambulance Resilience Unit.
 7 Is it correct that you were asked to apply by NARU
 8 for that role and you've held it substantively since
 9 June 2016, but had been working in an acting capacity
 10 from January 2016?
 11 A. Yes. I know I said that in my statement and it sounds
 12 slightly imperious so I should perhaps correct.
 13 SIR JOHN SAUNDERS: We won't take it that way.
 14 A. Thank you, sir.
 15 I was asked to support NARU, the vacancy that arose,
 16 hence acting in January 2016. That I was asked.
 17 In the June appointment, the definitive, that was
 18 a formal open advert and due process was followed and
 19 I applied and was appointed.
 20 MS CARTWRIGHT: Thank you. You tell us in your witness
 21 statement that in that role and at the time of the
 22 incident, you were the responsible medical adviser for
 23 the 15 Hazardous Area Response Teams across England and
 24 Wales.
 25 A. Yes. Technically, the medical adviser to NARU -- if

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1 we can use NARU, if you're happy with that -- the
 2 medical adviser to NARU, one part of what NARU is
 3 responsible for are the 15 HART units. There are other
 4 parts of resilience that NARU is commissioned to address
 5 on behalf of NHS England and the medical adviser role
 6 covers those other aspects as well.
 7 Q. Thank you. You tell us in your witness statement that
 8 in that role, you're involved with the coordination,
 9 training and operational compliance of HART across the
 10 country.
 11 A. Yes. Could you just ask the question again because
 12 I just want to be clear about the clinical as opposed to
 13 the operational compliance?
 14 Q. In your witness statement you describe that as a result
 15 of that role, you were involved with the coordination,
 16 training and operational compliance of HART across the
 17 country.
 18 A. Yes, definitely involved. So there's a small team of
 19 which I'm -- there's a small senior team within NARU,
 20 let's say five. If I had a minute, I'll be more
 21 precise. There are individuals within that -- again,
 22 portfolios -- senior colleagues on that team who are
 23 responsible directly for the compliance of operational
 24 standards, for example, maintaining the safe system of
 25 work and so on. So they're technically responsible for

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1 the compliance, head of compliance, head of capabilities
 2 provision, and the clinical adviser is to make sure that
 3 all of those other elements are consistent with good
 4 paramedic clinical care injected into the
 5 semi-permissive environments, so clinically assuring
 6 everything else that NARU does.
 7 Q. Thank you. Just to give us an understanding from the
 8 time when you were acting in that role from the January
 9 of 2016, roughly how much of your working week or time
 10 would that role with NARU take up?
 11 A. Flexible, but contracted around 2 days per week.
 12 Adjustable with other jobs, so sometimes one would be
 13 present with NARU for 5 days, but essentially 2 days
 14 a week.
 15 Q. Thank you.
 16 SIR JOHN SAUNDERS: I thought you had probably got too many
 17 days in your week, but you obviously had a lot of
 18 responsibilities to do. Not a very serious remark.
 19 A. It was a privilege to be able to work across, and there
 20 was some synergy between the different roles.
 21 SIR JOHN SAUNDERS: I'm sure. Can I just go back? It's
 22 a phrase we're not very familiar with in the way you've
 23 used it. You talk about the MERIT doctors and their
 24 role as being a gloves-off role and I understand that
 25 now to be in the context of not wearing gloves because

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1 not actually treating; is that right?
 2 A. That's right.
 3 SIR JOHN SAUNDERS: So perhaps not a normal use of the
 4 phrase gloves off?
 5 A. Yes.
 6 SIR JOHN SAUNDERS: That's all right, I think I understand.
 7 A. It's a simple way of saying it, but not with clinical
 8 gloves on because we are, hands behind back, looking,
 9 advising, interpreting, guiding. There may be other
 10 doctors injected into scene, which we may come on to,
 11 but for those particular roles, it's explicitly --
 12 SIR JOHN SAUNDERS: The logic of that and the limits of it?
 13 May there be occasions when MERIT doctors have to get
 14 involved because it's an actual urgent clinical matter
 15 which other people are not dealing with?
 16 A. In a major incident -- I understand the question, sir,
 17 and there are enthusiastic doctor colleagues who are
 18 very keen to undertake those acts as you've described.
 19 In a major incident, the object of the exercise is to
 20 get the patient to the ten waiting members of the major
 21 trauma team in the resuscitation bay in the hospital as
 22 expeditiously as we can.
 23 In a major incident, enhanced pre-hospital care,
 24 certainly very far forward, tends to be a ... It
 25 consumes staff and resources and we've got to be...

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1 The... It can have the opposite effect of being a force
 2 multiplier. So the idea of the MERIT doctor is the
 3 force multiplier. It's -- because the -- as we saw on
 4 the night, the vast majority of the work is, entirely
 5 appropriately, carried out by the technicians and
 6 paramedics, those initial life-saving interventions.
 7 That's what they are there for. We have many more of
 8 those. There are roles for gloves-on doctors, but they
 9 are -- in the national plan, they are further back at
 10 the casualty clearing station, for example, and we do
 11 train to calibrate and encourage the doctors who are
 12 very keen to get forward.
 13 Last week, I was on an exercise with such doctors,
 14 making sure that we calibrated them to be working in the
 15 casualty clearing station in the exercise and have the
 16 patients brought to them, where they can be effective.
 17 SIR JOHN SAUNDERS: Thank you very much.
 18 MS CARTWRIGHT: Perhaps just to finish the topic, there's
 19 a document that is not on your evidence proposal, but
 20 I can reference it in due course. For the MERIT doctors
 21 it's identified that in the event of a major incident
 22 they will provide direct support to the North West
 23 Ambulance Service operational and tactical commanders
 24 in the form of forward medical adviser and the Bronze
 25 and the Silver commander?

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1 A. Yes, so at the moment we have two MERIT doctors on
 2 today, 24/7. If they're activated, those two will
 3 fulfil those two roles that you've just described.
 4 Q. Thank you. I think additionally, in terms of your role
 5 that you have with NARU for the 15 HART teams, you had
 6 a son who at the time was himself a HART paramedic?
 7 A. That's correct, yes.
 8 Q. And he was part of the Merseyside HART team?
 9 A. He was at the time part of the Merseyside HART team and
 10 not on duty on that evening.
 11 Q. We'll come on to deal with that in a moment. I just
 12 want to finally then -- you provided your training
 13 records from North West Ambulance Service but I don't
 14 think they adequately reflect the extent of your
 15 experience and so you've identified your CPD
 16 documentation that's part of your re-validation process
 17 as a doctor. So perhaps I'm going to ask Mr Lopez if we
 18 could just identify one page of those documents just to
 19 give a flavour of your experience and training at the
 20 relevant time.
 21 It's {INQ030913/16}. If that could be expanded,
 22 thank you.
 23 Just if we work through together, just to give
 24 a flavour of your experience and involvement at the
 25 relevant time. We can see the first entry on the page,

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1 on 24 June 2016 you're involved in a NARU CPD workshop
 2 for chemical, biological, radiological and nuclear
 3 attacks; can you see that?
 4 A. Yes.
 5 Q. If we work down, we can see in November 2016, you were
 6 part of a NARU national conference for 10 years of HART
 7 in the UK, a stocktake 10 years on.
 8 A. Yes.
 9 Q. Looking both at operations and some clinical standard
 10 operating procedures which had been attended by all HART
 11 managers from the relevant UK ambulance trust?
 12 A. Yes, that was an opportunity to say, if you like what's
 13 gone well, what might we change, what are the
 14 aspirations.
 15 Q. We can see reference to pre-hospital trauma life support
 16 course in April 2016. If we move down to
 17 16 August 2016, we see there identified:
 18 "Ambulance Intervention Team refresher training."
 19 A. Yes.
 20 Q. And I think it's right, if we work through these
 21 records, and I'm not going to do that, in the April of
 22 2017 you had further refresher training to be part of
 23 the Ambulance Intervention Team?
 24 A. Yes, I think the first training was undertaken with
 25 Greater Manchester Police firearms teams in 2013. And

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1 then a six-monthly refresher up until essentially
 2 I retired from full-time. I think the last was in 2018.
 3 Q. Thank you. If we work down again we can see in
 4 October 2016, again you had involvement in -- attended
 5 that course as the NARU medical adviser in respect of
 6 casualty care in conflict and crisis.
 7 A. Yes, that's one example. We interface with our military
 8 colleagues --
 9 Q. We don't need to go into the detail of that. Finally,
 10 by way of example, in September 2016 you were involved
 11 in the NARU workshop, where standard operating
 12 procedures were drafted for MTFAs, particularly triage
 13 and early treatment.
 14 A. Yes.
 15 Q. So in terms of your relevant training and experience,
 16 would you agree that you had a great deal of knowledge
 17 and experience in respect of major incidents?
 18 A. Yes. Throughout, that was the intention, and not
 19 wanting to self-certify, but peer scrutiny each year,
 20 both for the rheumatology and for the pre-hospital work,
 21 including major incidents, so my concern has always been
 22 to make sure that externally it can be judged as best
 23 endeavours, if you like, to be as prepared as possible.
 24 Q. Thank you.
 25 I'm going to ask you about exercising because we've

1 been provided with part of the preparation materials
 2 that North West Ambulance Service had created before
 3 a training exercise called Winchester Accord. I don't
 4 think we need to display the documents, but within that
 5 planning material you are identified as someone that was
 6 due to be part of the exercising for Winchester Accord
 7 in a role as part of the Ambulance Intervention Team.
 8 So we can see those in the documents and I don't ask for
 9 those to be displayed.
 10 First of all, can I ask, were you involved in
 11 Winchester Accord?
 12 A. No. So it's feasible (?) I would be invited because the
 13 flexibility of role would mean it would be really useful
 14 to attend, but in fact that was a Monday to Wednesday
 15 and I had a clinic on the Wednesday at Broad Green --
 16 SIR JOHN SAUNDERS: Okay, you couldn't attend. That's fine.
 17 Thank you.
 18 MS CARTWRIGHT: For completeness, in the document,
 19 {INQ013559/18}, you're identified as "AIT uplift staff".
 20 So what does uplift staff mean, please?
 21 A. It's the AIT role that we discussed earlier, so the
 22 uplift is essentially -- was a budgetary device to allow
 23 ambulance services across the country to invest a little
 24 bit in that AIT team.
 25 Q. Can I ask then, as part of the materials provided to

1 you, I think some debrief information about
 2 Winchester Accord was provided. Can I ask, did you play
 3 any role in the debrief of Winchester Accord?
 4 A. None. As you say, I was provided with that debrief
 5 information with best intentions by the team, and I read
 6 it, but I did not play any part in it and I have not
 7 seen it until it was provided as part of this process.
 8 Q. Thank you. Then just to complete the questions around
 9 Winchester Accord, did you play any role in taking
 10 forward recommendations from Winchester Accord?
 11 A. Not personally, directly, because within NWAS that would
 12 fall to others directly. There are systems for sharing
 13 learning from exercises that would be part of a national
 14 system known as JOL, joint organisational learning,
 15 which is allied to JESIP, which the inquiry will no
 16 doubt be aware of. So indirectly, I may have become
 17 aware, but directly, to answer your question, no.
 18 Q. Thank you. Can I ask you then, with you mentioning
 19 JESIP, did you have good knowledge, as of May 2017, of
 20 the JESIP principles?
 21 A. To be honest, not as good as I have now. The slightly
 22 less complete answer is, yes, enough to undertake the
 23 role. I had some exposure. But since becoming an
 24 actual MERIT doctor, 2018 to 2021, the detail of that is
 25 part of the training and in the morning there's a little

1 mini-test for all of us, so you have to -- and so
 2 comparing my understanding of it now with then, I had
 3 less understanding then.
 4 Q. Can I ask you then, as part of the training you had to
 5 be operationally able to function in the AIT team, which
 6 has its role with responding to MTFAs, as it was at the
 7 time, did you have knowledge of the "Responding to
 8 a marauding terrorist firearms attack and terrorist
 9 scene: joint operating principles for the emergency
 10 services, edition 3" or JOPs?
 11 A. "Yes" would be the short answer. It's part of the
 12 initial and continuing training that we would do.
 13 Q. We've dealt with Winchester Accord, but had you been
 14 involved with any other training exercise where there'd
 15 been the tri-services or the three blue light services
 16 exercising together?
 17 A. Over the years, I've been involved in lots, including --
 18 it depends whether you mean directly MTFA or other major
 19 incidents?
 20 Q. Yes.
 21 A. Because in terms of other major incidents, for example
 22 there was a three-day event based at Cheshire Police
 23 where it was 24/7, round the clock, including press
 24 briefings and so on. So lots and lots of exercises over
 25 the years. We can probably list them if you really

1 wanted to.
 2 Q. As of May 2017, did you understand the importance of
 3 there being co-location and --
 4 A. (Overspeaking) yes, yes.
 5 Q. Did you understand the importance of a forward command
 6 post?
 7 A. Absolutely, yes.
 8 Q. And for there to be co-location but also
 9 interoperability between the three services?
 10 A. Absolutely, yes. In JESIP, it's really based on the
 11 MIMMS principles, with additional tri-service
 12 co-location and so on. So it's part of the same
 13 knowledge base and operating principles.
 14 Q. I'm going to move next to your involvement on the night,
 15 but before doing so, bearing in mind you've provided an
 16 extensive CPD, which evidences a number of years, is
 17 there anything else by way of relevant training that you
 18 want to tell the inquiry about that's relevant to your
 19 role on 22 May 2017 that we've not dealt with?
 20 SIR JOHN SAUNDERS: That's a very open question.
 21 MS CARTWRIGHT: It is. There's a lot of documents.
 22 A. Some of my CPD, on reflection, would include working
 23 with the advanced paramedics, helping to develop that
 24 cadre of some 45 in the north-west. So that would
 25 include both educational sessions with them, learning

1 with them, but also helping to develop them, and also
 2 helping to supervise them when they were then -- by
 3 telephone, the so-called top cover support, undertaking
 4 difficult decisions once operational. I think that's
 5 probably relevant to interactions on the night when
 6 working with the advanced paramedics and the confidence
 7 that I had in their abilities and the way that I would
 8 then -- we will go on to explain, how we related to, for
 9 example, the advanced paramedics on the night.
 10 SIR JOHN SAUNDERS: Just help me about one specific thing
 11 and just one only: in relation to the training of
 12 paramedics, and including within that technician 1 and
 13 technician 2, we've heard about the hierarchies, one of
 14 the most significant treatments which would have to be
 15 delivered on site at this sort of disaster was applying
 16 a tourniquet. Would you expect every one of those
 17 paramedics at whatever level, going down to
 18 technician 1, which I understand is the lowest level, to
 19 be able to apply a tourniquet, to be trained to do so?
 20 A. Now, yes, definitely. Ten years ago, definitely not.
 21 To be perfectly honest, I can't remember the extent to
 22 which it had been -- so it was definitely rolled out to
 23 the AIT because that was part of the kit.
 24 SIR JOHN SAUNDERS: And HART?
 25 A. I would say I think, yes. I think yes. My colleagues

1 will be wringing their hands in exasperation. But
 2 I think yes, I just don't know for 100% certain at that
 3 time all the way down through the grades.
 4 SIR JOHN SAUNDERS: Thank you. Don't worry about them being
 5 exasperated: they'll be able to tell us later, so we'll
 6 get the information.
 7 MS CARTWRIGHT: Thank you. Moving now to the events of
 8 22 May, please, 2017. You tell us in your witness
 9 statement that on Monday, 22 May you were at home, when,
 10 at approximately 23.20 hours, you received a call on
 11 your NWS-issued mobile telephone from a colleague,
 12 Michael Jackson, who was the NWS chief consultant
 13 paramedic.
 14 A. Yes.
 15 Q. Can you tell us what Mr Jackson said to you at that
 16 time, please?
 17 A. The precise words, I don't recall, but essentially it
 18 was: a heads-up, there's something serious, it seems to
 19 be real. Whether he actually said explosion or MTA,
 20 I don't recall, but certainly I was aware that it was
 21 something of that nature. So a serious and sizeable
 22 incident.
 23 Q. When you described it as a heads-up, what was Mr Jackson
 24 asking you to do if anything?
 25 A. Not directly asking me. Just to explain the

1 relationship, right back from 2001, we worked together
 2 at the senior management level in both Mersey Regional
 3 Ambulance and in NWS and indeed shared an office as an
 4 example.
 5 We've many previous examples of -- we would respond
 6 to similar serious incidents and we would keep each
 7 other and other relevant colleagues informed. We might
 8 not necessarily be informed down through the standard
 9 activation system. So he wasn't asking me to do
 10 anything, he was letting me know and the unspoken
 11 expectation was that he and myself would be responding
 12 if available, because I wasn't on duty, so if I had been
 13 unavailable then I wouldn't have responded, but I was
 14 available.
 15 SIR JOHN SAUNDERS: You weren't being contacted officially?
 16 A. Exactly.
 17 SIR JOHN SAUNDERS: Would you expect to be contacted
 18 officially, bearing in mind your willingness to go out
 19 to these sort of events, by some control centre.
 20 A. Formally, no, because I wasn't formally on call -- the
 21 associate medical directors have an on-call system and
 22 I was not formally on call. However, as part of the
 23 support to front line visible leadership and so on, had
 24 it been in Liverpool, which is more my natural
 25 location -- the control staff are very familiar because

1 I had been in there every New Year's Eve for 15 years,
 2 so there would be the informal relationship that would
 3 activate. But the Manchester group would not be
 4 familiar with my face or (inaudible).
 5 SIR JOHN SAUNDERS: Thank you.
 6 MS CARTWRIGHT: Within the earlier account from February of
 7 2018, you indicate in that conversation with Mr Jackson,
 8 "we agreed we'd be responding".
 9 A. Yes, in a nutshell. The standard system will respond,
 10 but if this is, as it turned out, big and severe enough,
 11 then we would respond and see if we could support the
 12 core response.
 13 Q. In terms of responding, in what capacity or role did you
 14 consider at that time you'd be responding? Or if you
 15 didn't, that's equally fine.
 16 A. No, no. For example, we had exactly the same
 17 conversation when both of us respond to Grayrigg, the
 18 train crash in Cumbria some years previously. I think
 19 it was earlier in 2017 or possibly in 2016 when the
 20 Ellesmere Port explosion -- the new ferry explosion
 21 occurred and I responded to that. There's first of all
 22 a notification heads-up, but then there's very much an
 23 awareness that there are a number of levels at which one
 24 might be able to contribute, either hands-on and going
 25 with full clinical kit, or gloves off -- so for the

1 Ellesmere Port new ferry one, for example, I sort of
 2 arrived at scene thinking I might be managing patients
 3 but was redirected as the information matured to go to
 4 the more senior command level, which is fine. So as the
 5 incident evolves, as long as the controllers know that
 6 we're active, then we can be slid up and down according
 7 to either -- literally next to the patient or right back
 8 in police headquarters.
 9 Q. You describe then contacting your son, Joseph Tunn, who
 10 we've already identified was a HART paramedic --
 11 A. Yes.
 12 Q. -- who lived near to where you were. And I think he had
 13 been on duty earlier that day; is that correct?
 14 A. Yes.
 15 Q. Was your son also happy to respond to the incident?
 16 A. Yes. He chooses to be part of the staff responders
 17 scheme where members of the NHS can respond to their
 18 local community when there are 999 calls close by, such
 19 as cardiac arrests. Given the nature of this incident,
 20 I felt it at least reasonable to offer him, in the same
 21 way as Mr Jackson had offered to myself, the invitation
 22 to participate, and clearly he chose to.
 23 Q. Thank you. You've identified the timing of the call
 24 from Mr Jackson of 23.20. The North West Ambulance
 25 Service have provided various timings from data

1 interrogation. Again, I'm not going to display it, sir,
 2 but for your reference it will be {INQ040368/11}.
 3 We can see from that data that you were allocated at
 4 23.29.59. We are going to deal in a moment with
 5 transcripts of calls, but they post-date that time.
 6 Can you help us as to how it is you were allocated to
 7 that incident at 23.29.59, please?
 8 A. Allocated is a mechanical incident where we are attached
 9 to the call. So if I'm driving to a 999 -- so, for
 10 example -- for -- well, anyway, for the legal log, it's
 11 important that we get attached to the job, and that's
 12 a thing that the ambulance control will do.
 13 On the evening -- the time of arrival at the arena
 14 is pretty precise, but the earlier times are times
 15 approximate and as available. So we would start moving,
 16 but we might not even be allocated, because allocated
 17 means you've got to confirm with control that we're
 18 en route and we are attached to the job, so that
 19 everyone else can see that we are attached to the job,
 20 and that may well have been done after we had begun
 21 moving.
 22 Q. Okay. I think we can see that you made your way to the
 23 scene in your vehicle MX1975.
 24 A. Correct.
 25 Q. Which would then be the call sign linked to the vehicle?

1 A. Technically it's linked to me, but yes.
 2 Q. I think the calls we're going to look at in a minute are
 3 actually your son speaking to control; is that correct?
 4 A. Essentially we went as a pair in my work vehicle and
 5 I did the driving and he did the communications en route
 6 because driving is on blues is quite a high workload and
 7 he was available to do the comms and was able to explore
 8 different communications channels en route.
 9 Q. You say in your witness statement:
 10 "During the period between receiving the initial
 11 call from Mike, telephoning my son, and leaving my home
 12 address, if I was not already dressed in my NWS greens
 13 at the time, [you] would have quickly got changed into
 14 uniform and readied [yourself] to leave [your] property.
 15 [You] then collected [your] son from his home address
 16 en route to the incident and [you] recall that [you]
 17 advised NWS emergency operations centre via the Airwave
 18 radio that [you were] making [your] way to the scene."
 19 A. Yes.
 20 Q. And that's the allocation I think we've just dealt with.
 21 A. Yes.
 22 SIR JOHN SAUNDERS: And they would need to know who you are
 23 and in what capacity you're going to attend, presumably,
 24 do they?
 25 A. The designation MX carries that -- well

1 (overspeaking) -- well, in Cheshire and Mersey
 2 control -- well, it designates a medic, a medical
 3 responder. And in Cheshire and Mersey control, exactly
 4 as they'd done on previously incidents: he's on the job
 5 and we'll find out what he's doing as the job evolves.
 6 It's so that they know that -- for example, commanders
 7 can make contact or give updates or be comforted by the
 8 knowledge that support is en route.
 9 SIR JOHN SAUNDERS: Yes, thank you.
 10 MS CARTWRIGHT: You tell us in your witness statement that
 11 you drove to the incident using blue lights and sirens
 12 whilst your son, Joe, attempted to gain some further
 13 information as to what had happened via the Airwave
 14 radio.
 15 A. Yes.
 16 Q. You recall Joe making contact with his HART colleagues
 17 in an attempt to establish what Airwave Talk Group they
 18 were using so that he could listen in to the radio
 19 communications in order to gain a greater understanding
 20 of what had happened and to avoid us clogging up the
 21 Airwave telephone lines into control with requests for
 22 further information direct.
 23 A. Yes. So there are first choice communication channels,
 24 if you like, and then there are second and third choice
 25 communication channels that we might be able to

1 informally use. So the first choice is directly by
 2 Airwave radio to ambulance control, who were very busy.
 3 And one has to ask the question: is my call really
 4 necessary? The supplementary channels -- with HART
 5 already en route, the normal way for HART to work is to
 6 be on a separate channel that they can communicate with
 7 each other for regular operational reasons.
 8 SIR JOHN SAUNDERS: I just wonder whether we should short
 9 circuit this a bit. I'm always a bit nervous about
 10 communication channels because there are some things
 11 we're not always meant to be talking about.
 12 MS CARTWRIGHT: We are not to identify the Airwave channel
 13 and I think that has been --
 14 SIR JOHN SAUNDERS: I think we understand the point you were
 15 making.
 16 A. Group calls, if you like, sir.
 17 SIR JOHN SAUNDERS: Yes, okay.
 18 A. There are ways of doing group calls which allow us to
 19 listen in to conversations in progress without
 20 interrupting. Is that helpful?
 21 SIR JOHN SAUNDERS: Yes, thank you.
 22 MS CARTWRIGHT: Can I ask then, because we've already
 23 identified that your son was a part of the Mersey HART
 24 team, would that enable him just to make contact with
 25 the Mersey team or the wider HART team? We have heard

1 about the Greater Manchester HART team. What was he
 2 able to access at that time as you made your way?
 3 A. In detail, I can't remember which of the individuals he
 4 contacted, but he had been part -- he had been stationed
 5 with the Manchester HART team to begin with, so he was
 6 familiar with those individuals and then he, for family
 7 reasons, moved further west and became part of the
 8 Liverpool HART team. So he had access to colleagues in
 9 both groups and essentially making contact with them in
 10 order for us to be able to -- the critical bit is
 11 listening in without interrupting to the evolution of
 12 the intelligence around the event.
 13 Q. Thank you. Just to give us an idea, was there a lot of
 14 traffic on the HART Airwave, if I can call it that?
 15 A. Not a lot on the HART Airwave because they're pretty
 16 succinct. But there's a lot more traffic in other
 17 communication channels that were very busy.
 18 Q. You describe in the first account you provided to the
 19 police in February 2018 that the communications were
 20 a mix of the radio channels, listening to that, direct
 21 contact with Liverpool emergency operations control,
 22 phone and Airwaves, contact with members of the HART
 23 team.
 24 A. Yes.
 25 Q. So did your son manage to make phone contact with any

1 specific HART team members?
 2 A. I think he did. I think that was the one where we were
 3 having the conversation about which chat group -- shall
 4 we call it that? -- which Talk Group we're using in
 5 order for us to be able to listen in.
 6 Q. Do you know whether any other situational awareness was
 7 provided from that HART personnel at that time about the
 8 incident or the evolving incident?
 9 A. What you have in the log about the exchange of
 10 information was about the limit --
 11 Q. Okay.
 12 A. -- initially as we were on en route, so fairly succinct.
 13 Joe asked the questions, do we know if there's an active
 14 shooter, do we know if -- which of course we didn't
 15 at the time.
 16 Q. Can we then look at the two transcripts of calls we do
 17 have.
 18 Mr Lopez, if we could please display on screen
 19 {INQ034310/1}, please.
 20 We can see at 23.34.43, Mike X-ray 1975, which
 21 you've already identified as your vehicle.
 22 Control say:
 23 "Go ahead."
 24 "Control, this is Eddie Tunn and Joe Tunn making in
 25 Eddie's car. We're heading towards Manchester. Can you

1 give us any details whatsoever as to what's going on
 2 at the minute?"
 3 To which control gave you and your son the following
 4 information:
 5 "Yeah, roger that. Confirmed major incident.
 6 Shrapnel bomb explosion. Fire have confirmed up to now
 7 a minimum of up to 18 fatalities, numerous injured. If
 8 you can make to Thompson Street, that is the confirmed
 9 RV for now. That's Thompson Street. I don't have
 10 postcode I'm afraid. The fire station on
 11 Thompson Street. If you can make there and the Talk
 12 Group for managers..."
 13 And that was given, which is operationally
 14 sensitive :
 15 "Control, all received. Over."
 16 To which that was confirmed. And then we can see
 17 a little further down:
 18 "Can I just double-check: have we any reports of
 19 gunfire on scene? Just thinking about PPE. Over."
 20 To which control respond:
 21 "I'll just get that confirmed. I did hear PM
 22 mentioned gunfire, but I have not heard back since
 23 standby one."
 24 Can you just identify, what does PM stand for
 25 in that context?

1 A. I don't know. I think it might be... I don't know.
 2 Q. Thank you. So looking at this call, whilst you're not
 3 able to say definitively whether Mr Jackson told you
 4 about whether it was a bomb or not, certainly by
 5 23.34.43, you and your son were aware that the incident
 6 was in respect of a bomb explosion?
 7 A. Yes, that is correct. To be honest, we had a pretty
 8 fair idea, but that idea may change in the light of
 9 things emerging, and we went along this timeline you're
 10 taking us along, it becomes clear.
 11 Q. Thank you. Then if we just see the follow-on transcript
 12 of the call at 23.36.18. Your son having -- I'm
 13 assuming it's your son?
 14 A. Yes.
 15 Q. Having asked about any reports of gunfire, control
 16 responded:
 17 "Roger, that's confirmed, gunfire has been noted on
 18 the log. I've confirmed shotgun wounds to the leg. I'm
 19 just getting a new -- a new Talk Group."
 20 And again that was given:
 21 "New Talk Group is..."
 22 And that's provided. Then your son confirmed he was
 23 switching to that Talk Group:
 24 "If you get chance and you get any more info, feel
 25 free to pass it our way en route."

1 So your son having requested whether or not there
 2 had been gunfire, how did that alter what the discussion
 3 was taking place as you proceeded at this time bearing
 4 in mind control had told you there was confirmed gunfire
 5 and confirmed shotgun wounds?
 6 A. Well, it helps to confirm that there is an actual
 7 incident with casualties, which isn't always a given
 8 at the start of the process. So I'd confirmed that
 9 we would certainly make in the direction of scene. We'd
 10 been given an RVP. And at that point, we would continue
 11 towards RVP, but make a dynamic assessment as we got
 12 closer as the information became clearer.
 13 Q. I'm going to come on to that dynamic risk assessment in
 14 a moment. But before doing so, you also tell us in your
 15 witness statement -- I'm at your paragraph 13 now --
 16 that you also recall at one stage your son asking
 17 a colleague, although you are unsure who, whether there
 18 was any confirmed secondary devices. And you believe
 19 he was advised that this could not be confirmed at that
 20 time.
 21 A. Absolutely. I mean, obviously I love him dearly, but he
 22 and I both know it's an unproductive question because
 23 we will never get confirmation about secondary -- the
 24 absence of secondary device until the next day,
 25 realistically .

1 Q. Dealing then with your dynamic risk assessment as you
 2 proceeded, you say this in your witness statement:
 3 "I had to decide en route whether to deploy directly
 4 to the scene of the incident as opposed a rendezvous
 5 point and my decision in this respect was multi-faceted:
 6 given my role as a senior clinician and my son's role as
 7 a trained HART operative, I was satisfied that our
 8 skills would be useful at the scene for what
 9 I understood to be a large-scale incident."
 10 Correct?
 11 A. That was our direction of travel. There was a dynamic
 12 risk assessment to be done before we enact that, but
 13 yes.
 14 Q. You go on to say:
 15 "In addition, I was satisfied that we were both
 16 well-equipped in terms of the training we both had
 17 received to deal with what I understood to be a serious
 18 incident."
 19 A. Yes.
 20 Q. "I was also conscious that the operational tactical
 21 commanders would be exceptionally busy, such that
 22 contacting them via the Airwave radio and waiting for
 23 their express direction to deploy to scene could delay
 24 my arrival as a senior clinician and was likely to
 25 distract the operational or tactical commanders from

1 other primary tasks they were required to complete.”
 2 A. That was the thought process at the time. It’s slightly
 3 assured by subsequent events because we were still
 4 really going to the RVP, we were clearly going to be
 5 needed, and then the decision was RVP or scene, one or
 6 the other. They’re not very far apart and you might
 7 want to come on to the rationale.
 8 Q. You go on then to say this:
 9 “In addition to these factors [that I have just read
 10 out and you have agreed], I was further reassured from
 11 hearing the communications over the Airwave radio that
 12 other unprotected resources were being deployed to scene
 13 such that I was able to conduct a dynamic operational
 14 risk assessment concluding that I felt safe that we
 15 should make our way directly to scene and determine our
 16 next steps after speaking with the operational
 17 commander.”
 18 A. Yes. So in theory, the rigid plan has us make contact
 19 with the command structure, go to the RVP, wait at the
 20 RVP until the commanders have got time to bring us
 21 forward. The decision which I made on the night, well,
 22 Joe and I made on the night, was the commanders are
 23 calling forward other unprotected resources. If they
 24 had time, we surmised that it would be reasonable for us
 25 to be called forward as well, therefore we will make

1 our — in the light of that information, we will go
 2 directly to the control point at scene to shorten
 3 things.
 4 SIR JOHN SAUNDERS: Obviously it’s the right thing to do and
 5 no one will suggest to the contrary. But actually
 6 strictly, should you have done it or should you have
 7 just followed the direction that you go to the RVP, then
 8 you wait? Otherwise it’s chaos if everyone decides
 9 where they are going to go for themselves.
 10 A. Absolutely, which is why I made the reference to —
 11 well, both the reason for the — well, first of all, the
 12 background and, secondly, the dynamic operational risk
 13 assessment and, thirdly, the reporting to the control
 14 point because it’s not just avalanching into scene in an
 15 uncoordinated way, it’s ... The processes would have
 16 been followed, the outcome would have been the same —
 17 SIR JOHN SAUNDERS: We’re not being critical, it’s obviously
 18 the right thing to do.
 19 A. I understand, sir. I think one of the realities that
 20 comes out of the rigid plans is they have to be
 21 flexible. Had we contributed to confusion, then there
 22 would have been appropriate criticism, but if we could
 23 reasonably anticipate that going to the RVP and then
 24 being called forward from the RVP, because others were
 25 being called forward from the RVP, if we could short

1 circuit that without harming the response then we should
 2 do that.
 3 SIR JOHN SAUNDERS: Which you obviously did, yes.
 4 A. Yes.
 5 MS CARTWRIGHT: Can I ask then, as part of what you were
 6 hearing on the radio, you describe about other
 7 unprotected resources, and so just so there’s no
 8 ambiguity, being called forward, what are you referring
 9 to and what do you mean by that, please?
 10 A. So —
 11 SIR JOHN SAUNDERS: You’re talking about ordinary ambulance
 12 crews, aren’t you?
 13 A. Yes, in plain English, ordinary ambulance crews were
 14 being called forward. Now, I can’t remember it word for
 15 word, there will be tapes of those conversations.
 16 I can’t even remember which Talk Group we were in. But
 17 I could hear that those — thank you, sir — those other
 18 ambulance crews were being called forward —
 19 SIR JOHN SAUNDERS: I’m not meaning to be rude to the crews
 20 by calling them ordinary.
 21 A. Absolutely. They were being called forward, so we made
 22 the decision that it was safe enough — it’s never safe,
 23 but safe enough — to begin work.
 24 MS CARTWRIGHT: In making reference to the interrogation
 25 work that has been provided by the North West Ambulance

1 Service, we know from that data that you arrived at
 2 scene at 00.07.13.
 3 A. That’s my understanding, yes. To be honest, I’m not
 4 sure exactly what scene means, whether that’s
 5 a geofence, you know, an automatic, or a recorded. But
 6 I think it’s a perfectly reasonable time to work off.
 7 Q. It has “GIS replay” next to that entry if that assists
 8 you.
 9 A. That’s following the radio, which we... I suspect that
 10 will have been... I don’t know what they’re defining as
 11 “scene”.
 12 SIR JOHN SAUNDERS: It’s pretty realistic?
 13 A. Yes, that’s fair.
 14 MS CARTWRIGHT: Can I ask then, as you arrived at scene, had
 15 you heard any other information as part of listening to
 16 that Airwave traffic that had given an update to what
 17 control had told you about there having been firearms
 18 discharged that had caused injuries?
 19 A. No further explicit information, but clearly injuries
 20 and, as we have described, unprotected resources coming
 21 forward, so work to be done, and the surmise is that
 22 it’s now safe enough to proceed, but not excluding, as
 23 we know from other incidents in 2017, not excluding the
 24 possibility that there may be other threats around.
 25 Q. Had listening in to that Airwave traffic identified who

1 was in the command roles for North West
 2 Ambulance Service?
 3 A. I honestly can't remember although I had no difficulty
 4 when we got there with the key commander.
 5 Q. I was just wondering more broadly because obviously
 6 we're going to deal with who you had contact with at the
 7 arena itself, but at a wider level as to the command
 8 structure did you have any knowledge of others who were
 9 in key roles, command roles, as you arrived at the
 10 arena?
 11 A. The short answer to that would be no because it'll all
 12 be happening in the background. It's kind of parallel
 13 process rather than serial. For example, who was in
 14 strategic role, who was in the tactical role and so on,
 15 no, no information at that time, because we will be
 16 briefed.
 17 Q. Thank you.
 18 A. In this case -- well, we'll be briefed when the
 19 practicalities allow it --
 20 Q. Thank you.
 21 A. -- which is essentially on arrival.
 22 Q. Thank you. Had you received any information, additional
 23 to the transcript of calls that we've heard, about the
 24 number of casualties or as to the extent of the
 25 casualties at the scene as you proceeded?

1 A. I think -- well, I don't think there's any significant
 2 enrichment of the information beyond that quite rich
 3 information that there had been a significant, very
 4 sadly, number of fatalities and injured to be dealt
 5 with. So we had... When you're approaching these, you
 6 need to know whether it's five, 50 or a football stadium
 7 and we knew it was in the 50 to 100 order, that scale.
 8 We had an approximate sense of scale.
 9 Q. Can I ask then to what sort of plan or discussion you
 10 and your son had had about what you would do when you
 11 arrived at scene?
 12 A. We were just expecting to do our normal thing, which is
 13 we would find out what the command structure is,
 14 we would be able to offer a range of roles, we could
 15 take on a range of roles as allocated by the commander,
 16 so keep it flexible until we get there.
 17 Q. Thank you. I think just to complete as well the dynamic
 18 risk assessment you completed about going to scene, you
 19 also indicate that:
 20 "Had we arrived on scene and been told that we were
 21 to stand down by the operational commander, [you'd] have
 22 accepted his or her instructions without question."
 23 A. Yes, absolutely. Quite often in these, we start moving
 24 towards and then before we even get there, we get stood
 25 down, we are stood down, because information emerges

1 that we're not actually required or, alternatively --
 2 yes.
 3 SIR JOHN SAUNDERS: I think that comment in your statement
 4 is specifically related to the fact that you decided to
 5 go straight there --
 6 A. Yes.
 7 SIR JOHN SAUNDERS: -- rather than to the RVP.
 8 A. Yes.
 9 MS CARTWRIGHT: You then just move on and you say:
 10 "On arrival in the vicinity of the incident, Joe
 11 guided me as to where to park my vehicle. As having
 12 previously worked as a paramedic in Manchester HART, he
 13 was familiar with the incident locality. I parked the
 14 car on Victoria Street, just at the bottom of
 15 Hunts Bank. We exited the vehicle, collected our
 16 clinical equipment, donned our non-MTFA PPE, and
 17 proceeded up Hunts Bank towards the entrance to
 18 Victoria Station."
 19 A. Yes. So there was a decision there about do we need the
 20 ballistic PPE or do we just go with normal clinical.
 21 And given the discussions we've had about other
 22 unprotected responders already moving into scene, and
 23 there's a delay in acquiring the ballistic PPE, we
 24 felt -- just get on with it.
 25 Q. When you say "a delay in acquiring it", do you mean

1 (overspeaking) just putting it on?
 2 A. Yes, putting on it. It was in the back seat of the car,
 3 but one always has to decide how much time you're going
 4 to spend putting additional PPE on versus getting to the
 5 patient, and it varies every day, depending on the
 6 nature of individual jobs, including one on Sunday,
 7 which required actually donning...
 8 Q. Can I just ask you briefly by way of completeness for
 9 the transcripts we have of calls, we know from the GIS
 10 replay that your arrival at scene is recorded as
 11 00.07.13. There's a further transcript of calls, and
 12 I'm not going to ask for it to be displayed because it's
 13 simply one sentence. Sir, for your record it's
 14 {INQ023583/1}.
 15 At 00.04.30, the Mike X-ray 1975 puts out a call to
 16 the operational commander. So it just records:
 17 "Mike X-ray 1975 to operational commander."
 18 And there's no response. So was that an attempt by
 19 you or your son to contact the operational commander?
 20 A. Yes, is the short answer. Can you just confirm the time
 21 of that so I can understand (overspeaking)?
 22 Q. 00.04.30, lasting for 7 seconds.
 23 A. So this is at 4 minutes past and I arrived at 7 minutes
 24 past, so I suspect that's at the time of parking, we're
 25 beginning to seek to make contact with the operational

1 commander, perhaps as we're walking up Hunts Bank, would
 2 be the natural thing to do, but clearly busy, so we just
 3 thought we would go face-to-face.
 4 Q. Then can I ask you -- you've described about collecting
 5 your clinical equipment. Can there be clarity then as
 6 to what you had with you at that time, please, and
 7 available?
 8 A. Essentially, full clinical kit, consistent with what
 9 a rapid response vehicle would carry so: airway
 10 breathing circulation, drugs, dressings, and so on,
 11 in the nature of the day job, responding to 999, one
 12 might be the ordinary resource, anything from diabetic
 13 to heart attack to trauma, so it covers that range of --
 14 Q. Would you have a defibrillator with you?
 15 A. Yes.
 16 Q. Would you have a major incident pack with action cards?
 17 A. Yes.
 18 Q. And did you take all of those with you when you left
 19 your vehicle and headed towards --
 20 A. I certainly took the clinical kit. I'm not sure I took
 21 the -- there's a sort of board that we use for counting
 22 casualties. I'm not sure whether I took that up because
 23 others had it as it turns out. But basically we took
 24 all the kit we thought would be necessary and then
 25 didn't have to use it, but that's a supplementary bit of

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1 information.
 2 Q. So can I ask you -- you described the board and you say
 3 you didn't take yours, but was there a board used that
 4 you have described that had the tally for patients, P1
 5 through to P3, present at the station that you saw?
 6 A. I know there was the command post just on the right-hand
 7 side of the entrance from the roadway. I'm not sure
 8 what exact system we... I can't remember what exact
 9 system. I knew that the commander that was there at the
 10 time would be keeping a tally as part of the standard
 11 training. We use a range of ways of doing it in
 12 rehearsing, including writing on the side of a white van
 13 if it becomes necessary. Seriously.
 14 So we can have informal or we can use formal
 15 systems, it doesn't really matter as long as we make
 16 a decent record. But that's the command tally.
 17 Q. But in terms of the board that I think you're describing
 18 was available in your vehicle that you didn't take, just
 19 describe what it is. Is it right that it allows you to
 20 keep a tally of all of the P1s, P2s and P3s?
 21 A. Yes.
 22 Q. It also enables you to identify the hospitals and the
 23 number of places that hospitals have been used?
 24 A. Not directly. I mean, we have a separate way of doing
 25 that, which is the matrix, which was an extremely useful

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1 part later on. But the boards are actually quite
 2 simple. Essentially, they are keeping a count.
 3 Q. And then just -- sir, I'm wondering -- before we take
 4 the morning break, if you could just describe what you
 5 saw as you and your son left your vehicle and headed up
 6 towards the station.
 7 A. We made our way through various layers of police,
 8 identifying ourselves as we went. They were helpful in
 9 directing us to the particular control point. We
 10 arrived at the control point, which will be familiar to
 11 everyone. I was drawn to or directed to the ambulance
 12 command little huddle to the right side. The entrance
 13 to the lower -- to the ground floor and a number of --
 14 and evident that there was an access roadway with
 15 a number of ambulance vehicles parked to my right as we
 16 came up Hunts Bank and it was evident that the
 17 concentration of attention would be within the ground
 18 floor "inside".
 19 Q. Can I ask then, in terms of the non-MTFA PPE that you
 20 had on, did that include a helmet?
 21 A. Yes.
 22 Q. Did it include clothing that identified that you were
 23 a doctor?
 24 A. Yes.
 25 Q. And did you have any tabards with you that would

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1 identify at a major incident the different roles people
 2 were playing?
 3 A. Yes, we do have tabards and I can't remember -- because
 4 I use a bulky kit -- a high-visibility doctor kit vest,
 5 which allows me to carry kit between patients without
 6 having to use a bag. So I think that will have been
 7 what I was wearing. I honestly can't remember whether
 8 I took the tabards up, ready to use. It'll be on video,
 9 but I can't remember exactly.
 10 Q. Thank you. Then just dealing with that huddle that you
 11 approached, you describe in your witness statement,
 12 I think -- did that include Daniel Smith?
 13 A. Yes. I'm reliant on the statement because my recall at
 14 this time is slightly more vague than it was at the time
 15 of making the statement. Dan Smith was just in the
 16 process, I think, of handing over to Steve Hynes. So
 17 that was happening, I think, just as we approached.
 18 There's a sort of "Don't interrupt, listen in, make
 19 yourself available, let them do their job and we'll then
 20 be told what we're doing".
 21 Q. I think within the wider sequence of events we have had,
 22 that sort of handover, and particularly handing over the
 23 tabard from Mr Smith to Mr Hynes was at 00.02.
 24 A. So that's just happened as we've...
 25 Q. So can I just be clear, you approach the huddle. Who

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1 was in the huddle then?
 2 A. It will have been Steve Hynes. There was AN Other,
 3 which I can't remember who it would have been, that was
 4 standing beside him, perhaps acting in a support role.
 5 One of the ambulance colleagues. Because I don't work
 6 in Manchester, I don't necessarily know them by name and
 7 face.
 8 MS CARTWRIGHT: I'm going to come on next to deal with that
 9 and what was discussed in that huddle.
 10 Sir, I wonder if we could perhaps take a 10-minute
 11 break at this stage for our morning break.
 12 SIR JOHN SAUNDERS: We'll have a quarter of an hour break.
 13 Is that all right for you?
 14 A. I'm comfortable.
 15 SIR JOHN SAUNDERS: Quarter of an hour.
 16 (11.24 am)
 17 (A short break)
 18 (11.40 am)
 19 MS CARTWRIGHT: Dr Tunn, you have described the individuals
 20 you saw as you approached the station. Can you describe
 21 what you were told as you approached those individuals,
 22 please?
 23 A. I'm referring to my statement just to refresh my memory.
 24 SIR JOHN SAUNDERS: Absolutely. Do it whenever you want to.
 25 A. I know exactly what the functions were, but I just want

1 to... Essentially get a bit of a briefing, agree some
 2 actions and begin those actions. That's the kind of
 3 headline to the paragraph.
 4 I'm seeing here, item 19 in the statement: handover,
 5 brief outline of the geography of the incident, location
 6 of casualties, the location of the walking injured, the
 7 so-called priority 3, the P3s, that they had been moved
 8 away. I was advised that the upper floor, from my point
 9 of view now, was essentially out of bounds because the
 10 briefing clearly at that point was, at that time, there
 11 were no live casualties on the upper floor. That was
 12 now a police-controlled area and we clinical staff were
 13 no longer operating in that. So there was a clear limit
 14 in respect of upstairs and there was a clear
 15 understanding of two -- effectively two collections of
 16 patients, those on the ground floor and those P3s who'd
 17 been moved to one side.
 18 SIR JOHN SAUNDERS: Just help me. We've heard that the CCS
 19 was set up at the bottom of the stairs and that the HART
 20 team set up a CCP actually nearer the entrance, indeed
 21 I think outside the entrance to the station, which
 22 sounds counter-intuitive.
 23 A. I'm very happy to help and expand on that, but I'll take
 24 direction in terms of how much information you want.
 25 SIR JOHN SAUNDERS: Is that surprising that the CCP would be

1 further out towards the ambulances than the CCS?
 2 A. The definition of CCP and CCS -- CCPs will be usually
 3 informal, dynamic, the initial collection. They are
 4 often defined by what we're referring to as the zero
 5 responders and the affected public themselves. The
 6 dynamic of that, people will remove themselves from
 7 a fire, they will remove themselves from a gas explosion
 8 in a fairground or whatever it is, so the CCPs will be
 9 natural or contrived initial collections of casualties,
 10 usually evanescent, lasting only briefly, before then
 11 coalescing into a casualty clearing station, where more
 12 extensive equipment or interventions may take place and,
 13 generally speaking, HART is actually setting up a CCS
 14 and not setting up -- because one doesn't set up a CCP.
 15 So I would suggest that the question is -- and I'll
 16 explicitly address the question of that geography,
 17 ma'am. But just technically, HART would be setting up
 18 a CCS, they're laying out kit, they're laying out
 19 treatment packs, they're laying out -- they can use
 20 tarpaulins, which help -- and it is explicitly part of
 21 the HART standard operating procedure that the first
 22 group will do a forward look and a second group will
 23 begin to prepare because there's a range of -- in
 24 a collapsed building, it'll be a while before the
 25 casualties will come out but we'll have a CCS ready to

1 treat them once we've got them to where we're ready to
 2 manage them.
 3 On this occasion, there were things happening in
 4 parallel, so we may want to come on to -- I'm just
 5 trying to think, to get the chronology right. It would
 6 be reasonable, as a first estimate at the time, for the
 7 CCS, I will call it, being set up just outside the
 8 entrance to the ground floor. It would be reasonable as
 9 a reasonable first guess as to where would be a sensible
 10 place to put people.
 11 SIR JOHN SAUNDERS: Okay.
 12 A. What was happening in parallel with that, though,
 13 because I think that CCS was being set up at about --
 14 just after the 23.00, at the top of the hour. It was
 15 somewhere in that first quadrant between 23.00 and
 16 23.15, I think. At that time, patients were flowing
 17 down the stairs at the rate of one a minute is my
 18 understanding from the analysis. So at the same time as
 19 the instruction has been given to set up a CCS at
 20 a reasonable place to do it and as part of the standard
 21 operating procedures, my comments about the CCP --
 22 there's a natural collection with the very well-intended
 23 and very helpful zero responders, the police, the arena,
 24 the friends and family themselves moving patients down
 25 the stairs.

1 So as there is an intention to set up the CCS at
 2 what seems a reasonable place, there is evolving what is
 3 initially a CCP by the nature of the incident before one
 4 is able to ---
 5 SIR JOHN SAUNDERS: That develops into the CCS essentially?
 6 A. That matures into the CCS because there's an opportunity
 7 cost around --- "No, we don't want them there, we want
 8 them here", and that involves --- that's an inefficiency
 9 that creeps in. So it's well-intended and it's actually
 10 useful later in the evening, the outside, but the
 11 reality was, "Thank you for setting that up, folks, but
 12 actually we're concentrating our efforts in here now for
 13 the time being".
 14 SIR JOHN SAUNDERS: Thank you.
 15 MS CARTWRIGHT: Can I just take you back to that first
 16 briefing you had as you and your son arrived? Can
 17 I just be clear that your son was with you as you
 18 approached Dan Smith and Mr Hynes?
 19 A. Yes.
 20 Q. Can you first of all, in terms of the briefing or the
 21 handover that you were given, give us some idea how long
 22 you were in discussion with them?
 23 A. Not entirely sure, but it would be of the order of
 24 2 minutes, something of that order I would imagine.
 25 Because it's a very brief METHANE report, the mnemonic

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1 that we use.
 2 Q. That's what I was going to say. You have just mentioned
 3 a METHANE. Was there a formal METHANE report given to
 4 you as part of that discussion you had?
 5 A. The first METHANE given by the first crew is the formal
 6 bit. We try to teach that it's actually very useful to
 7 reuse METHANE during the evolution of the incident. So
 8 we use that as a framework because things like the exact
 9 number of casualties for example will mature as the
 10 incident goes on. So it will have been based on that
 11 but it will have --- so ---
 12 SIR JOHN SAUNDERS: Did you use similar information to what
 13 METHANE would but wasn't actually a formal METHANE
 14 message?
 15 A. Probably not formal, but essentially a METHANE message.
 16 MS CARTWRIGHT: Can you confirm who was leading the
 17 information that was given? You have described
 18 a handover from Mr Smith to Mr Hynes. Who was the
 19 person giving the information or was it a combination?
 20 A. I think it's fair to say a combination.
 21 Q. Did they explain who was the commander?
 22 A. It was obvious at that time that Mr Hynes was and that
 23 I think Mr Smith was then moving to operate inside.
 24 Q. So had you appreciated that Mr Smith had been
 25 discharging that role at an earlier time?

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1 A. Yes.
 2 Q. And was there anything said to you as to why Mr Smith
 3 was handing over to Mr Hynes at that time?
 4 A. The why, no. It's not unreasonable that, in the same
 5 way you were talking about MERIT doctors before, it's
 6 not unreasonable that colleagues, paramedic colleagues,
 7 would decide to divide the roles between them, and as
 8 one takes over, the other might, as Mr Smith has very
 9 significant extended clinical skills ...
 10 Q. So going to the exact number of casualties, were you
 11 told at that point how many casualties, first of all,
 12 there were and then the breakdown of those casualties
 13 between P1 to P3?
 14 A. Absolutely not --- well, I really don't think so. There
 15 will have been a very rough estimate that all the ones
 16 in there are --- if the P3s have been moved, these are
 17 your P1s and P2s, and it's a visual impression ---
 18 Q. When you say "in there", you are indicating into the
 19 station?
 20 A. The ground floor, through the entrance and into the area
 21 as it widens out.
 22 Q. You mentioned the geography of the incident and location
 23 of the casualties. Where were you told that the P3s
 24 were?
 25 A. Generally speaking, the standard arrangement is that

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1 they'll be moved to a safe location and also monitored
 2 because P3s may --- their injuries may evolve and they
 3 may become more ill.
 4 Q. Were you told where that place was at that time?
 5 A. Not exactly. I know they'd been moved away from the
 6 immediate seat. I had the impression that they were off
 7 to one side. Part of the technique for managing is to,
 8 in the early phase, not focus too much on the P3s. Yes,
 9 they're injured, yes, they've got distress and comfort
 10 and pain relief and so on, but actually the immediate
 11 life-saving need to be done on the P1s and P2s. So we
 12 tend to put them to one side and focus ---
 13 Q. What in that 2-minute or so briefing or handover were
 14 you being asked to do?
 15 A. Well, Mr Smith was then going back inside and I was then
 16 going to do... A formal designation of role, probably
 17 not, but a pragmatic... Well, first of all, an
 18 awareness of what other doctors might or might not be
 19 present and understanding what their competencies and
 20 qualifications might be, specifically in terms of the
 21 event.
 22 Q. So just pausing there, had Mr Hynes or Mr Smith given
 23 you an idea as to how many doctors were already there
 24 at the scene?
 25 A. At some point (inaudible: distorted) the ground floor

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1 area.

2 Q. Can you just identify, was that Dr Daley?

3 A. At the time I had not previously met him. I have since

4 been — he has been identified to me, to use that

5 phrase, as Dr Daley, yes.

6 Q. So you're saying there was no formal designation, but

7 I just want to be clear, because when you arrived at

8 scene you were quite prepared to stand down, having

9 chosen not to go to the rendezvous point but go directly

10 to scene. So no formal designation, but what were you

11 told or being asked to do?

12 A. Well, effectively, begin one of the — let's say the

13 forward doctor role. When I reflect on the incident on

14 the night, there are action cards, 17, 18 and 26, 26 or

15 28, which define those roles. Now, having just been

16 handed over a very brief handover, it's then a question

17 of: let's work out which of these ones I'm going to

18 focus on. Obviously keeping in — all of them require

19 being advisory to the command structure, so they're all

20 advisory, not command roles. And my initial first few

21 minutes is: let's think about this flexibly, we've got

22 a choice of possibly three roles, let's find out what

23 we've got already, understand the resources available to

24 us, and then we would naturally have a conversation

25 about, right, I'll do 7, you do 8, 17, 18 and then 26.

1 So effectively I undertook, I think, 7 — elements of —

2 sorry, 17, which is the forward doctor, 18, which is the

3 medical incident adviser, and 26 or 28, which is in my

4 pack, which is — but it's in the major incident pack

5 anyway, which is effectively loading support to —

6 loading them up, to be honest, was the main job of the

7 night was loading.

8 Q. Can I ask, you're sat here today telling us of those

9 three action cards and roles, but should it not be

10 a case that you are given a role in accordance with the

11 major incident response plan and the action cards,

12 rather than deciding which of the three you were or

13 doing all three, that actually someone should be

14 commanding an individual into that role?

15 A. There is an element of that, but not entirely, because

16 we have to decide which ones are the priority. So

17 we have to decide what resources are available to us, so

18 who have we got, what are the roles, and so it's

19 a conversation with the commander rather than

20 a directive, because the commander doesn't know at that

21 point exactly who he's got, what the competencies are

22 and so on, so my job is to support the commander and

23 have the conversation: right, I'll have a look, let's

24 see what we've got, I'll let you know where I'm up to,

25 and we'll decide, if you like, together. So it's

1 a joint decision.

2 Q. You're describing a joint decision, but I just want to

3 be clear, as you arrived on the scene, having deployed

4 directly to the station rather than going to the

5 rendezvous point, whether actually at that stage there

6 was a discussion of, "What role do you want me to

7 perform now I am here"?

8 A. Yes, absolutely.

9 Q. Did that take place at that time?

10 A. Yes. But it was actions rather than role. So link with

11 Mr Smith. Effectively that becomes the forward doctor

12 in the arena and at the entry point.

13 Q. In terms of the action cards themselves — so you have

14 given us a range of roles and action cards that covered,

15 and I think you described action card 17, which would be

16 the medical adviser MERIT doctor 1.

17 A. Medical incident adviser, yes.

18 Q. Action card 18 would be the forward doctor, MERIT

19 doctor 2?

20 A. Yes.

21 Q. Then you described — was it casualty clearing station

22 medical lead or a loading support?

23 A. Yes.

24 Q. I think they're slightly different, but which was the

25 third action card that you're indicating could have

1 covered the roles that you were discharging at the

2 scene?

3 A. Particularly loading. Particularly loading, which is 26

4 or 28, I'm not sure. I can find it here if that would

5 help.

6 SIR JOHN SAUNDERS: Don't worry. Thank you.

7 MS CARTWRIGHT: Again, to have yourself sort of covering

8 many different roles that are covered by different

9 action cards from the major response plan, is that

10 something that you'd expect to happen rather than having

11 a dedicated role?

12 A. Yes. The short answer is yes. And it's not necessarily

13 a bad thing. There may be no doctor at a major

14 incident, depending on the nature of it. In some parts

15 of the country, there is nominal cover but not

16 necessarily the intense level of cover that we have in

17 the north, the developed cover that we have in the

18 north-west. It's even more developed now than it was in

19 2017.

20 So I think it's perfectly reasonable — if you read

21 the cards individually, they are distinct roles. But

22 the question I would pose to myself is: so who's going

23 to decide who's doing which roles? The commander is

24 very busy commanding the ambulance resources and it's up

25 to the first doctor on scene to do a reasonable —

1 SIR JOHN SAUNDERS: Okay, you've got a limited number of
 2 doctors, they've got a number of things they've got to
 3 do, and it is a matter of prioritising them and doing
 4 more than one if you don't have enough doctors?
 5 A. Yes. Thank you, sir.
 6 Your question is suggesting that the commander
 7 should be explicitly allocating roles. I think the
 8 commander explicitly allocated an area of
 9 responsibility, which I was happy to take on and
 10 organise those roles myself. I think that's perhaps
 11 a constructive way of describing it.
 12 MS CARTWRIGHT: Can I perhaps progress the matter a little
 13 further before moving on. Action card 17 is for MERIT
 14 doctor 1, whereas action card 18, forward doctor, is
 15 envisaged for MERIT doctor 2. We do have another MERIT
 16 doctor at the scene, a Dr Gleason.
 17 A. Yes. And the time of arrival --
 18 Q. I don't have that immediately to hand.
 19 A. -- was I think 00.20, so after myself. So at the time
 20 of my arrival, we've got... On the... On the list of
 21 doctors, we've got their times of arrival, and in
 22 essence the one who was formally on call went to the RVP
 23 and then was deployed forward and arrived after I had.
 24 So naturally we had a conversation at some point during
 25 the evening about, do you want to take over, do you want

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1 to carry on, a perfectly amicable conversation about how
 2 we would organise. But at the time I arrived he wasn't
 3 on scene. I think I'm correct in saying that, I'll just
 4 check my... I've got it here... A list of doctors in
 5 my 17...
 6 (Pause)
 7 So on the list provided to me by the team, I'm not
 8 sure whether this is a...
 9 SIR JOHN SAUNDERS: Do tell us what it says on there and
 10 we can identify it later if need be.
 11 A. Technically, the on-call MERIT forward doctor, was he on
 12 call? Yes. Time allocated, 23.44. It says on this
 13 briefing:
 14 "Arrival at RVP, not specified. Arrival at scene,
 15 00.40. Collected by NWSA..."
 16 (Pause)
 17 Sorry, there is an inquiry number here,
 18 {INQ022520/1}, referring specifically to his arrival at
 19 scene.
 20 So the point being, I was there before him so
 21 I could begin to undertake some of the responsibilities
 22 and then, as more arrive, we begin to make sensible
 23 decisions about the division of labour. And indeed
 24 I did morph from one thing to another.
 25 SIR JOHN SAUNDERS: You said the main thing you were doing

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1 was loading, one of the main responsibilities. What is
 2 your function at loading?
 3 A. I'm very happy to deal with that but and I'm just
 4 conscious of the sequence because it comes later in the
 5 sequence.
 6 SIR JOHN SAUNDERS: Fine, okay. We're getting slightly
 7 bogged down.
 8 MS CARTWRIGHT: Can I just be clear? Because at the moment
 9 we have the expert report which has considered the
 10 different roles various NWSA personnel were performing
 11 on the night and within the table they've indicated that
 12 you were the medical adviser so I just want to be clear
 13 in your mind as you Read arrived and after you'd had
 14 that original briefing, you were essentially doing
 15 a combination of action card 17, medical adviser,
 16 is that correct, action card 18, forward doctor? You're
 17 nodding. You have to say --
 18 A. Yes. Sorry, ma'am.
 19 Q. I just want to be clear: action card 26 is casualty
 20 clearing station medical lead. Is that the third role
 21 or is it something different? Is it the loading officer
 22 that you envisage?
 23 A. Loading and -- I can find the exact one.
 24 Q. Action card 16 was loading point officer. Action card
 25 16A is loading point log. What's the third action card

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1 that you're thinking of as the third one in your mind?
 2 A. So I have a hard copy here, so if I can just have
 3 a moment to find it.
 4 (Pause)
 5 I know what I did, but just in terms of the...
 6 I think the external experts can tell you what the rigid
 7 outline guidance is and the reality is we adapt and the
 8 question is: did any harm come from the adapting, and
 9 I think the opposite, to be honest. But that's an
 10 opinion rather than a...
 11 So I have action cards -- yes, okay, action card 26,
 12 casualty clearing station medical lead.
 13 Q. In that briefing, what then was your son? Did he then
 14 join the HART team or did he --
 15 A. He became part of the resources, a generic resource
 16 inside, supporting his colleagues.
 17 Q. Can I ask you then, in terms of that briefing you had,
 18 the chairman has asked you questions about casualty
 19 clearing stations and casualty collection points, but
 20 from your perspective did you see anything when you were
 21 having this discussion that indicated any casualty
 22 clearing station was outside of the station at that
 23 time?
 24 A. I'm certainly aware, but exactly at what point I became
 25 aware, that we had the large coloured tarpaulins

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1 outside, which helped to designate places where
 2 casualties might be gathered. Those are the yellow and
 3 red tarpaulins that are used, deployed by HART.
 4 Q. Yes. Do you recall whether you noticed them in that
 5 area where you were having your initial briefing or
 6 handover?
 7 A. From memory, we've got the entrance, there's the
 8 commanders to the right, and I think -- and I certainly
 9 know later in the evening we were working on an area
 10 outside the entrance, I think under the canopy to the
 11 left-hand side of the entrance as you are facing
 12 inwards.
 13 Q. Did Mr Smith or Mr Hynes say anything to you about,
 14 "There is a casualty collection point in this location",
 15 or, "There's a casualty clearing station here"? Was
 16 there anything specific said about those things?
 17 A. No. Well, I think the indication was our casualties are
 18 gathered here, the exact use of term CCP versus CCS, as
 19 we discussed before, it was maturing from the one to the
 20 other. So I knew exactly where we were going to be
 21 working, I knew what I was working with, I knew where
 22 the casualties had been collected. It was independent
 23 of the designation CCS and CCP that were evolving.
 24 Q. Was anything said to you about zones during that initial
 25 handover?

1 A. I can't remember exactly, but essentially upstairs was
 2 out of bounds and by inference the hot zone. The
 3 casualties were being gathered together -- you can have
 4 a conversation about whether the ground floor was a warm
 5 zone or not and we never really know until the next day
 6 when the place has been searched, for obvious reasons.
 7 So we have a de facto warm zone, where we're working
 8 with -- yes, so we have a -- and then there are areas
 9 outside which, as far as we know, are cold.
 10 Q. Can I ask you, just so there's clarity: before you went
 11 in, was anything said to you by Mr Smith or Mr Hynes
 12 about the area you were about to go into, what zone that
 13 was?
 14 A. I don't recall precisely what words were used.
 15 Q. You have described the upstairs, the City Room or the
 16 higher floor, I think you've referred to it, as the hot
 17 zone. So what are you meaning by hot zone? What are
 18 you meaning by using that label?
 19 A. To be clear, that's a designation that I'm using today.
 20 What the actual designations were at the time, I'm not
 21 sure what the designations were. But effectively, the
 22 scene of the insult was up there somewhere and I did not
 23 at that time have an understanding of the exact anatomy,
 24 architecture of the building but up there somewhere.
 25 The requirement to know whether it was hot or not was

1 irrelevant because it had already been designated out of
 2 bounds and this was our area for working.
 3 Q. Was anything said to you about a marauding terrorist
 4 firearms incident or whether an Operation Plato had been
 5 declared at that time?
 6 A. I'm pretty sure that I had no information about that at
 7 that time, formally, of that information. Clearly you
 8 can tell from the transcript en route, we have that in
 9 our minds, but the designation of Plato... It's not
 10 a primary concern for... It has implications for other
 11 elements of the responders. There's certainly
 12 implications from the point of view of risk. In theory,
 13 some areas are out of bounds until the police allow us
 14 to access. So all of those are considerations.
 15 Fortunately, on the night, we didn't know -- I didn't
 16 know enough to stop me getting on with casualty care.
 17 Q. I'm asking you those questions because within the
 18 JOPs 3, a hot zone in a Plato is a specific terminology.
 19 So when you're describing the City Room as a hot zone,
 20 I just want to be clear, you're not describing that in
 21 a JOPs 3 hot zone categorisation?
 22 A. To be honest, we use it -- so it can be used in that
 23 formal sense, but we also use it for everyday issues,
 24 you know, a school chemistry lab with an explosion, with
 25 volatile chemicals, we'll just say that's a hot zone and

1 we'll work in the corridor outside, for example. So
 2 it's used more broadly as well as in the very formal
 3 Plato sense.
 4 Q. I think you described it a moment ago as "hot zone as to
 5 the scene of the insult". I think that was the phrase
 6 you used a moment ago.
 7 A. Yes.
 8 Q. So just looking now with your NARU hat on and your
 9 responsibility for HART, does having the same
 10 terminology to describe an area that means different
 11 things not potentially lead to confusion when a hot zone
 12 in a Plato sense means something different to how you're
 13 describing a hot zone?
 14 A. I think the hot zone in the general sense indicates risk
 15 and areas into which unprotected responders should not
 16 go. And that is of value across a wide range of
 17 incidents and is important in protecting staff and
 18 members of the public. The additional layer of Plato
 19 is ... it adds complexity. The exact...
 20 SIR JOHN SAUNDERS: Sorry to interrupt you, but the point is
 21 we've heard that for a hot zone in Plato, no one goes in
 22 until the armed police say it's clear. So you don't
 23 work in there.
 24 A. Yes.
 25 SIR JOHN SAUNDERS: A hot zone in a major incident means

1 people can work in there, but they need the protective
 2 clothing to do it. The simple issue is: having the same
 3 description, hot zone, for two different things, can
 4 that lead to confusion or does it just mean it's the top
 5 area, the most restricted area in whatever thing you're
 6 in? So does it lead to confusion?
 7 A. I think the short answer to that is no because who's
 8 going to go into the hot area? Only protected
 9 responders. Protected responders will then follow
 10 a very clear protocol, whether it's a Plato hot or
 11 a generic hot. They will follow a very clear protocol
 12 about access. So the designation of hot means
 13 protected. In the generic sense, it might allow HART to
 14 go forward on their own dynamic risk assessment which is
 15 a formal process. If Plato is in place then that would
 16 form part of that assessment and they would not be able
 17 to access unless... It's just an additional step. So
 18 I don't think it actually causes confusion given that
 19 HART, in ambulance terms, would be the only ones
 20 accessing a hot zone and the process for stepping into
 21 any hot zone is very regulated.
 22 SIR JOHN SAUNDERS: Thank you.
 23 MS CARTWRIGHT: In terms of then, again, just to be clear as
 24 to, as you went forward, had you been told it was safe
 25 for you to go forward into the station where the

1 casualties were?
 2 A. This is a conversation which is widely discussed for
 3 this and other incidents and is a concern for all of us
 4 because there's a designation of safe, which can take
 5 quite a bit of time to achieve. There have been
 6 a number of incidents in the last year, 2 years, where
 7 waiting for absolute clarity about safety has
 8 compromised -- has potentially compromised patient care
 9 and coroners have expressed interest.
 10 So absolute safety is not going to be a conversation
 11 that we're having because we can't have that -- we can't
 12 get to that stage, except in retrospect. So I'm using
 13 the expression "safe enough", and it was -- both the
 14 direct and the indirect information was it was safe
 15 enough. So the direct is Mr Smith is working in there,
 16 he's not in protective equipment, so the inference is
 17 it's safe enough. We've got unprotected responders
 18 being called forward because clearly there's been
 19 a decision to allow them to work there. So if it's safe
 20 enough for them and the members of the public and the
 21 injured people themselves, it's safe enough for me.
 22 Q. In terms of that being safe enough, was anything said to
 23 you about the joint understanding of risk from the other
 24 blue light services? Was anything said at that time?
 25 A. So I would surmise that that would be on the other side

1 of the commander, as it were. So what I'm getting from
 2 the commander is -- the commander and the informal...
 3 that I have just described is that on the other side of
 4 the commander those conversations have taken place. I'm
 5 not party to those. We are in here, in greens, so we'll
 6 get on with it.
 7 Q. So would it have been any part of what you were asking
 8 about where the forward command point was, who the other
 9 commanders were from the other blue light services?
 10 Would you need to know that?
 11 A. In that particular role, no. The commander is
 12 absolutely -- the ambulance commanders absolutely need
 13 to know and there may be some specific item, if there
 14 was a particular thing, the medical incident adviser
 15 might need to liaise with, in conversation with the
 16 ambulance commander, a Fire Service colleague about a
 17 particular toxic chemical or something of that order,
 18 but that would be a sideways conversation with the
 19 permission of the ambulance commander. Effectively, for
 20 my job, I didn't need to speak to any of the other
 21 services.
 22 Q. So leaving action cards to one side and labels, the
 23 reality as you left that huddle or handover was --
 24 what was the role you were going to do?
 25 A. Okay, so what I did was -- so I'm aware that now the

1 ambulance commander is looking to me to effectively be
 2 the MIA, the medical incident adviser, for now, because
 3 there isn't another person who's taken that role.
 4 That's fine. I'm known and visible in the organisation,
 5 so that's acceptable. As part of that, I will do
 6 a walkabout to gain information because at the moment
 7 I'm not actually -- the commander doesn't need me to
 8 make any decisions at this point, he's already set up
 9 Mr Calderbank, in terms of transporting patients away
 10 from scene at some point, and we'll come back --
 11 Q. Were you aware at that point that Mr Calderbank was
 12 doing that role?
 13 A. I'm not sure at that point but -- he was -- what I -- in
 14 similar -- sorry.
 15 SIR JOHN SAUNDERS: Let's just stop. We're at the moment
 16 going to go through what theoretically you would do,
 17 then followed by what you actually did. Can we just go
 18 to what you did and then we'll come back to the reasons
 19 for it if need be.
 20 A. Thank you, sir, that's actually, I think, shorter.
 21 SIR JOHN SAUNDERS: It's clearer. That's what's important.
 22 A. Make contact with the commander, effectively be now
 23 formally part of the response, be given permission: go
 24 into the room, go round, have a look, see what we've
 25 got. My thought process at that point is: what's the

1 patient to staff ratio? In the very early stages of
 2 a big incident we may be at one or two members of staff
 3 to 50 patients. When we get to the hospital we've got
 4 10 members of staff to one patient and so my question
 5 is: at that time what have we got? And it's roughly one
 6 or two members of staff to each patient. So that's
 7 enough for immediate life-saving care. So that's the
 8 first thing I want to know, together with a rough idea
 9 of numbers and roughly the limits of the geography.

10 Then I walk round briefly, just checking with each
 11 team of paramedics how they were, what they were doing.
 12 We have a system of, "What have we got, what do you
 13 need, are you managing okay with the initial life-saving
 14 interventions?" There were some patients who had
 15 a larger number and more senior people with them, I can
 16 recall individual -- not patients' names but individual
 17 colleagues. We would have a brief conversation. They
 18 would present me with their situation and tell me what
 19 they were intending to do. I would offer some element
 20 of reassurance, "We are here if you need me", but I'm
 21 going to go on round the room and come back out again
 22 having done that initial survey. Essentially, a hand on
 23 the shoulder, "We are here if you need us, but we'll let
 24 you go on with doing your job", which is what the
 25 patients need, not interfering with any of them, and

1 back out, having achieved that initial survey, and
 2 a notification to staff that if additional support is
 3 needed we'll start to think about how we support them.

4 MS CARTWRIGHT: You say in your witness statement:
 5 "Having completed my initial sweep of the concourse,
 6 I was equipped with sufficient information to enable me
 7 to offer my assistance to the process of evacuating
 8 casualties out of the station and into an ambulance for
 9 onward conveyance to hospital. A line of ambulances was
 10 already queued up outside the station for this purpose."

11 A. At that point that's when I was either told or -- it was
 12 indicated to me that Mr Calderbank was the designated
 13 officer for arranging that flow away and so I was
 14 essentially paired with him. There were some parallel
 15 actions going on at the same time, but that became
 16 a large part of the rest of the evening.

17 Q. In terms of the definition in the major incident
 18 response plan for a casualty clearing station:

19 "Treatment within the casualty clearing station
 20 should aim to stabilise a casualty with a view to
 21 getting them to a definitive point of care as soon as
 22 possible."

23 The inquiry has had provided a document that
 24 identifies the length of time that patients were then
 25 in the casualty clearing station before being dispatched

1 to hospital.

2 For a number of P1 patients, their presence at the
 3 scene ranges from varying times, but some P1 patients
 4 were there for up to 3 hours. Can you assist us as to
 5 what was happening on the ground and why it appears that
 6 there was a lengthy period of time before dispatch of
 7 patients to hospital?

8 A. Right. So we were very clear that our location was
 9 approximately 10 minutes away from definitive care with
 10 large teams standing ready. We were very clear that
 11 we -- from a clinical management point of view, we
 12 wanted to get flow going and we did not want -- we
 13 didn't want to do anything clinical that was going to
 14 delay. We weren't going to do extended care because if
 15 you're remote and there's a long run--time to hospital,
 16 50 minutes or something like that, then we might do
 17 things slightly differently. Absolutely minimal
 18 clinical interventions and then, "Let's load and go".

19 So the clinical management wasn't going to be
 20 slowing down -- there will have been one or two patients
 21 who were having initial paramedic management before
 22 being ready to load, but essentially we were keeping it
 23 to an absolute minimum because we were only 10 minutes
 24 from definitive care.

25 That's the absolute clear principle that was in my

1 head: let's get the flow going. That's why I was
 2 spending the time with loading.

3 There will be a range of severity within P1s,
 4 priority 1s, so some of the priority 1s should go first
 5 and some of the other priority 1s will go as soon as
 6 resources permit, and certainly, by choice, before P2s
 7 but not necessarily because sometimes the logistics just
 8 allow for a little bit of overlap.

9 So the clear intention -- there's no clinical reason
 10 why we should hold. It's entirely logistics and
 11 managing flow. To that end, we've been -- I've been
 12 looking at the type...

13 Three hours is a long time, a very long time, and
 14 for an individual patient it's not something I would
 15 want. As a headline, patients that I've managed in the
 16 last -- actual patients that I have managed in the last
 17 7 days, again, without going into detail, but it can
 18 take 40 minutes easily before we leave scene for
 19 a single patient because we're beginning to manage them
 20 and so on --

21 Q. Can I ask us to focus on what's happening on the night,
 22 particularly because what may be being dealt with on an
 23 ordinary state of affairs is not necessarily the
 24 scenario when you have a patient with a P1
 25 life-threatening injury that needs --

1 A. Those 40 minutes refer to everyday P1 patients.
 2 However, if we look at ... It's referred to as ... It's
 3 logistics essentially . So the ambulance history
 4 analysis, which is the last ... 368.
 5 Q. If we just display, please, Mr Lopez --- we've got the
 6 casualty clearing station map with the various
 7 information on, would that assist? {INQ040366/1}.
 8 A. That's helpful. I'm familiar with that, and that
 9 handwritten --- those handwritten annotations which
 10 describe where the patients were. The times there are
 11 the times that they arrived in the --- as I understand
 12 it ---
 13 Q. Thank you, Mr Lopez. This is the document. So this is
 14 where we can see the times for patients, but
 15 additionally the categorisation .
 16 A. Yes.
 17 Q. And certainly can I ask in terms of then when
 18 categorisation and patients were re-triaged and their
 19 priority status changed, where would that be recorded?
 20 A. So initially , the triage and re-triage would be done on
 21 the triage cards and there's space on the triage cards
 22 for additional observations and the triage cards can be
 23 folded to change the priority from a 2 to a 1, for
 24 example.
 25 Q. Just pausing there for a moment, did you witness that

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1 that was being completed in the casualty clearing
 2 station for all patients?
 3 A. I couldn't say that was being completed for all patients
 4 but I could --- in the initial survey the paramedics knew
 5 what they were doing and they are trained to do exactly
 6 that. They should be familiar with the --- well, they
 7 will be familiar with the cards. They'll be doing
 8 observations, which is what they do every day, and if
 9 the patient's changing category --- well, first of all ,
 10 they'll record the observations and, secondly, they'll
 11 change the status if that's happening.
 12 Q. Can I ask you then in terms of those action cards that
 13 you describe that have P1, P2 and P3, do they have the
 14 ability to record the observations which inform the
 15 status of the patient?
 16 A. That's correct.
 17 Q. But equally, those action cards also have the ability
 18 for when the patient then is dispatched to hospital that
 19 the slip is torn off and left with the loading officer
 20 as a form of identification of who's been dispatched;
 21 is that correct?
 22 A. That's correct --- just a tiny point of order there: they
 23 are triage cards, the action cards, referring to the
 24 roles in the major incident plan. But yes, the triage
 25 cards are what we are talking about.

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1 Q. But in terms of --- you describe you had a role with
 2 Mr Calderbank in terms of --- as loading officer, my
 3 understanding is that that process wasn't carried out on
 4 the night, that the slip off the ---
 5 A. It's quite possible. I mean, he... The number of times
 6 that that's actually happened in the UK is quite small,
 7 so we do try to do it on exercises, but it's not always
 8 completed.
 9 Mr Calderbank --- and we have a copy of his log
 10 indicating the nature of the patient and the destination
 11 hospital.
 12 Q. Can I then, just in terms of high level, just deal with
 13 a number of topics.
 14 For triage, your experience of what was taking place
 15 on the ground, was it that triage cards were being used
 16 as the tool for triaging but recording the patient
 17 observations?
 18 A. Yes, that's the impression. It's an overall impression
 19 because I'm not getting --- as per the action cards, you
 20 don't actually get involved in individual patient care,
 21 but yes, the gist is that is happening.
 22 Q. I think you describe in your witness statement that you
 23 didn't need to provide any direct hands-on medical
 24 assistance to any casualty.
 25 A. Yes. I mean, and that's very much by design but if

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1 there's --- in that initial walk-round, if there's an
 2 initial one where we think: actually, we're so short at
 3 the moment we haven't yet reached enough resources to
 4 manage the immediate life-saving, then I would assist
 5 in the immediate life-saving. But when we get to the
 6 established and under control system, then I should not
 7 really be doing that.
 8 Q. You describe in your witness statement that:
 9 "As more doctors arrived, [you] took a role in terms
 10 of allocating the more experienced doctors with those
 11 with less experience so they could work together."
 12 A. Yes. So there's a ... There's a ... Patient care but
 13 also a ... Responder welfare issue where, with best
 14 intentions, some very, very young doctors without
 15 specific training responded because of their --- because
 16 they lived locally with best intentions, good Samaritan
 17 style. One has the option to dismiss, but also the
 18 option to align them with actual experience and that's
 19 the decision I made on the night, was to make sure that
 20 they were paired --- not paired, there was two teams ---
 21 that we formed two teams.
 22 Q. Can I ask in terms of then the role that you've
 23 described that you had, is there anything else as you
 24 actually practically went about your duties that night
 25 as to a change in your role that we've not dealt with

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1 that you wish to explain to us now?
 2 A. Well, essentially, major incident medical incident
 3 adviser — the direct workload of that was less because
 4 the shape of the incident, we had the additional doctors
 5 doing care. The next function that had to be done,
 6 still within sight of the commander, so still able to
 7 offer support in terms of — because it is only an
 8 advisory role to the commander — being able to offer
 9 support there but at the same time, "Right, could you
 10 also do this", which is basically get patients moving.
 11 Q. "At no point during my being on scene did I provide
 12 hands-on care to any of the casualties. My role as an
 13 experienced doctor was to stand back in order to gain an
 14 overview of the management of casualties in its
 15 entirety, offering hands-off guidance as and when
 16 required."
 17 A. Yes.
 18 Q. "This approach allowed me to ensure that the treatment
 19 of all casualties were was appropriate and provided me
 20 with a real understanding of the prioritisation of each
 21 and every casualty such that I could assist, if
 22 required, with the decision-making regarding which
 23 patient was to be transported to hospital next."
 24 A. Yes. So there's two bits to that. One is there's a bit
 25 about enabling the paramedics to do their job, the job

1 they're trained for but not that familiar with in real
 2 life because I think we know that an average paramedic
 3 may see one or two major trauma patients per year only.
 4 So there is in that situation a natural anxiety or
 5 distress, so going amongst them and putting a hand on
 6 the shoulder to reassure and allow them to perform to
 7 the best of their abilities was, I think, a contribution
 8 on the night. But also the explicit — which was a kind
 9 of human factors element, which we do think generally is
 10 important, as well as the specific of, "Yes, tell me if
 11 you want something doing", but also, "You're doing fine,
 12 right, carry on, call us if you need us". So that's —
 13 and enabling — and then back out and then the second
 14 part that you describe.
 15 Q. Can I ask in terms of that overview role that you're
 16 describing, was there an issue with provision of pain
 17 relief to the casualties in the casualty clearing
 18 station?
 19 A. We... It's something I'm personally interested in
 20 developing. The priorities are immediate life-saving
 21 interventions and in this particular context the
 22 emphasis is on egress as quickly as possible. I do know
 23 that — well, I understand, I can't say I know, but I do
 24 understand that some patients will have waited quite
 25 a period of time in order to receive pain relief, which

1 I'm certainly very sorry about. I'm aware that — we
 2 had the paramedics and we actually had the morphine and
 3 indeed ketamine.
 4 I think in the process, the matching of patients and
 5 analgesia, we could look at that and it's something we'd
 6 like to improve. It's certainly part of our objective.
 7 I can't say that we had a problem with the supply, but
 8 I understand that patients will have waited to receive
 9 analgesia, pain relief.
 10 Q. It's right that you — we can see from the information
 11 on the log that you were at the scene until 03.10 and
 12 you are recorded as clear at 03.40.
 13 A. Yes. So the gap between the initial and the — was
 14 essentially working with Mr Calderbank to finesse the
 15 matching of crews, basically supporting him in his work.
 16 Q. And I think you describe that once all of the remaining
 17 casualties had been removed from the scene, you gathered
 18 all of the doctors that had been left and conducted
 19 a very short hot debrief where you gathered all of their
 20 contact details to ensure that follow-up welfare checks
 21 could be performed.
 22 A. Yes. There's always a question in a major incident
 23 about were doctor checks all carried out as they entered
 24 the scene and many of them had entered the scene before
 25 the command and control structure was even put in place.

1 So partly for security reasons we want to know, right,
 2 the people that we've been working with in these two
 3 groups, who are they, and partly for welfare reasons, so
 4 took their contact details and emails, and some of the
 5 NWS team did the follow-up afterwards.
 6 Q. In terms of then the subsequent debrief that took place
 7 in June 2017, we've been given information that you
 8 didn't complete a debrief form, but were you involved in
 9 the formal debrief process for North West Ambulance
 10 Service?
 11 A. This is the Etihad location?
 12 Q. Yes.
 13 A. Yes, I was definitely present. I don't know whether
 14 I filled in a debrief form, to be perfectly honest.
 15 I was shown a raft of the debrief forms to try and see
 16 if there was one that I recognised and I did not
 17 recognise one, so I think the answer is probably not.
 18 Q. Can I ask you then, in terms of the debrief itself,
 19 would you be familiar with the content of the debrief?
 20 A. Yes, I've been through — I was there. One of my NARU
 21 colleagues led it (inaudible) and I've been provided
 22 with the range of comments.
 23 Q. Can I ask you then in terms of just a number of
 24 matters — I'm not going to go to the document for this,
 25 but I will come to the recommendations that touch on the

1 directorate . But in terms of the triage and treatment,
 2 the content of the debrief suggests that there was
 3 a lack of understanding from operational crews in
 4 regards to triage and SMART triage packs. You'll have
 5 seen that from the debrief?
 6 A. Yes. Yes. So the packs are on... I think I'm correct
 7 in saying the triage packs are on all vehicles. If
 8 I had a wish list , then time to train front line --
 9 additional time to train front line ambulance staff,
 10 perhaps even in parallel with other similar grades in
 11 the NHS, would be a definite wish.
 12 So they don't get much training compared to other
 13 NHS professionals of same grade. They have trust
 14 manager training and that's about it, which is really
 15 very limited and it's highly competed for. So the
 16 reality in terms of how ambulance services have what
 17 doctors would recognise as study leave is just not
 18 afforded to the ambulance staff, so it is an issue.
 19 Q. I'm asking you specifically about triage because there's
 20 an email where it identifies that you were taking
 21 forward matters relating to a triage review. So if
 22 I just go to the recommendations first of all and then
 23 if you could perhaps just assist us with that.
 24 Mr Lopez, could we please display {INQ021289/17}.
 25 In recommendation 14 it identifies a recommendation:

1 "A process for the use of either the triage cards or
 2 PRF..."
 3 Can you just confirm that's patient referral form?
 4 A. Patient report form.
 5 Q. "... needs to be confirmed to enable clear
 6 identification of the patient's injuries and end
 7 location, what clinical information needs to be
 8 captured, clarity of where in the casualty management
 9 process the patient report form would be used."
 10 The owner for that was medical director DW. Did
 11 you have a role with taking forward that recommendation?
 12 A. Not specifically that within the directorate. I know
 13 there's reference to me being involved in a triage
 14 review elsewhere but not specifically within the
 15 directorate. Again, as we established at the beginning,
 16 not directly part of my portfolio within NAWAS.
 17 Q. So was there an issue on the night in the casualty
 18 clearing station of paramedics using the patient report
 19 form rather than the triage cards to complete the
 20 triaging of patients?
 21 A. I think ... I think ... I think it would be helpful to
 22 suggest that, in some circumstances, triage need not be
 23 done at all and that PRF is the definitive preferred
 24 document when numbers permit. So triage is only an
 25 evanescent phase and can be skipped completely in some

1 incidents. So it should only be done as a step on the
 2 way towards definitive care. As soon as we're doing
 3 definitive care, then we can move on to PRF as
 4 a preferred option.
 5 So there will be incidents when we miss out a CCP,
 6 miss out a CCS, miss out triage altogether, if resources
 7 permit.
 8 So it would be entirely natural in an incident like
 9 this that a crew may start with a triage card and then,
 10 if they are waiting for transport away from scene, that
 11 they move on to using a patient report form if they're
 12 there for a reasonable length of time, although, to be
 13 honest, most patient report forms are usually completed
 14 in normal day-to-day events en route to hospital and
 15 fully completed after arrival at hospital.
 16 Q. So just at a high level then, we can see the email where
 17 you're liaising with Mr Winchester. I am not going to
 18 have it displayed or go to it now. Just at a very high
 19 level, what was the triage review that you were involved
 20 in after the incident?
 21 A. That's different. The bit that you've just described is
 22 the internal training of staff within NAWAS for which
 23 I was not directly ongoing responsible. Yes,
 24 collectively, but not directly. However, external to
 25 that and actually as part of NARU, one of the other

1 debriefs indicated a very technical point on the triage
 2 cards which had arisen partly from, I think, one of the
 3 London coroners, where the triage cards applied to the
 4 dead. The coroners had expressed a requirement that the
 5 time of death and the qualification of the -- the
 6 identification of the person making that designation be
 7 recorded.
 8 So explicitly I was requested by NHS England to
 9 review the nature of the triage card in terms of
 10 that coronial direction and the action following on from
 11 that was that cards were either replaced or a sticker
 12 was applied to allow those things. So that was a very
 13 specific bit.
 14 There's been since then a -- and sort of in
 15 parallel, and Dave Winchester referred to it, there's
 16 been a review of the place of triage, in general, the
 17 concept, are we doing it well, it's done differently in
 18 other countries, so there's a wider review then.
 19 Q. Then moving away from that triage review and you
 20 identifying that that is slightly different to what is
 21 being identified in the recommendations from the debrief
 22 after the incident, can I move on just to one other
 23 recommendation that has a medical directorate alongside
 24 it which was recommendation number 6:
 25 "Staff should be familiar with what equipment or

1 drugs are available to NWAS during an incident."
 2 Were you involved at all with that?
 3 A. Sorry, I was distracted. What drugs?
 4 Q. The recommendation that has the owner being JBDW in the
 5 medical directorate:
 6 "Staff should be familiar with what equipment or
 7 drugs are available to NWAS during an incident."
 8 Were you involved at all with that recommendation?
 9 A. In taking it forward?
 10 Q. Yes.
 11 A. Not directly, but that's such a generic recommendation
 12 that staff should be familiar with the... That would
 13 be... That's entirely core training and education. I'm
 14 not quite sure what the specific ...
 15 Q. We'll leave that for somebody else then if you can't
 16 assist us and I'll move on.
 17 One of the other matters that's picked up in the
 18 debrief was that HART paramedics can't administer
 19 ketamine. Can you assist us as to why that's the
 20 position?
 21 A. Yes. So the designation of HART, national designation
 22 of HART, is to deliver core paramedic skills into
 23 semi-permissive environments. Core paramedic skills do
 24 not include ketamine. However, ambulance services --
 25 we've conducted, independent of the arena events, we've

1 conducted... I personally think that ketamine should be
 2 available to HART, not necessarily for major incidents
 3 but for particular HART incidents.
 4 The standard of care available to patients in
 5 permissive environments has evolved because ambulance
 6 services have got extended role paramedics. Those are
 7 not able to enter semi-permissive environments.
 8 In the UK, of the 10 trusts, I think six choose --
 9 because the trusts are responsible for HART paramedic
 10 practice, although they are supported by NARU, the
 11 trusts look after them. So six of the UK trusts, their
 12 medical directors have decided to -- I think it's six --
 13 have decided to deploy ketamine through HART. And
 14 I think it's four at this time who still do not deploy
 15 through HART, their directors choosing that it's core
 16 paramedic practice.
 17 We have persuaded the National Ambulance Service
 18 Medical Directors' Group to agree that all HART will
 19 have ketamine and we're in the process of implementing
 20 that and it will be in place, I would hope, within the
 21 coming year.
 22 Q. Thank you. Then finally this from me, please, Dr Tunn.
 23 Could I ask -- we've heard some little evidence about
 24 the Lifepak 15. So could I ask you this: what would
 25 happen in the case of a mass casualty incident where

1 there may be limited Lifepak 15s or the pack will be
 2 used on multiple casualties?
 3 A. The Lifepak 15, for those that don't know, is
 4 a particular model of monitor and defibrillator .
 5 There's no real reason why the defibrillator , which is
 6 not an issue in this incident, but there's not a reason
 7 why the defibrillator can't be used on multiple
 8 patients, and either with that or other models I have
 9 personally done so, where it's been necessary.
 10 The slight complication is that we work on a model
 11 of one patient, one ambulance, one Lifepak 15, and we
 12 record events on the Lifepak 15 because it's convenient
 13 to do so. You can make a little -- you can record
 14 a patient's ECG, for example. So there are a number of
 15 things you can record on it and I imagine if you move
 16 from one patient to another, those records might be
 17 corrupted. But it doesn't stop you taking the pulse
 18 oximeter and putting it on another patient or putting
 19 new defib pads on another patient and connecting the
 20 thermometer.
 21 So the core bits can easily be moved around. The
 22 recording bit, which we use for convenience, would
 23 become a bit confused but in the circumstances I don't
 24 see that as an issue.
 25 Q. In terms of the Lifepak 15, you wouldn't be recording on

1 there the medication a patient received, would you?
 2 A. You can record an event -- there's an event marker which
 3 puts a button on the timeline and then you can add
 4 afterwards. So typically, when we're conducting
 5 a cardiac arrest, for example, we'll quickly press
 6 a button to say, "adrenaline given", and then we can
 7 replay it and find out whether we got the timings of the
 8 adrenaline right or not.
 9 Q. When that takes place and a Lifepak 15 is used on
 10 a different patient, how is there an accurate recording
 11 of what that patient has had to make sure there's no
 12 overdose of a patient? If you were using a Lifepak to
 13 record the medication but then it's moved on and used
 14 for different patient --
 15 A. The Lifepak is not the only record. Yes, you can -- you
 16 can record it -- if you are working in the ambulance,
 17 you can record it and then you can finesse the timing of
 18 that because you know that you're going to be explicit
 19 on the patient report form and it helps to refine the
 20 time. But the primary record is the patient report
 21 form. So the Lifepak is only supplementary. The
 22 primary thing is either the folding card --
 23 Q. The triage card --
 24 A. (Overspeaking).
 25 Q. -- or the patient report form?

1 A. Yes -- I wouldn't rely on -- especially in those
2 circumstances.

3 MS CARTWRIGHT: Thank you. Dr Tunn, that concludes my
4 questions.

5 Sir, do you have any questions at this stage?

6 SIR JOHN SAUNDERS: I'm not sure I've got an answer to this.
7 If you could give it as briefly as you can so
8 I understand it, I'd be really grateful.

9 It has been pointed out to you that some P1
10 casualties, from the time they came down into the CCS to
11 the time they left to go to hospital, some of them were
12 there for 3 hours. You said that's a very long time and
13 you said it probably was logistics. Can you expand
14 slightly on the logistics which caused that length of
15 delay? The logistical problems.

16 A. It's not immediately my area of expertise, but I've
17 spent a bit of time trying to understand it.

18 SIR JOHN SAUNDERS: Hang on. It's what you saw on the night
19 because you were there. So what were the logistical
20 problems on the night which caused the delay?

21 A. Well, first of all, you start off with virtually no
22 ambulances available because we don't have a pool of
23 ambulances waiting. They've already got patients.

24 SIR JOHN SAUNDERS: You have to get ambulances there?

25 A. And there are data available which I've seen, which show

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1 that I think we had something like six in the whole of
2 the Manchester area available and I have a list here,
3 but there's a short list of available ambulances and
4 a very long list of not available because they're with
5 other patients.

6 SIR JOHN SAUNDERS: I understand that. First problem,
7 getting ambulances to the scene.

8 A. That's the first bit. The second bit is the first
9 ambulances that get to scene are, if I can paraphrase,
10 not ambulances as you know them because immediately
11 their crews have gone forward to deal with the patients.
12 So yes, you have vehicles, but they're shells, if you
13 like, because the first crews are with the patients and
14 outnumbered initially and therefore dealing with perhaps
15 -- I don't know exactly in the early phase but I've got
16 the timeline. They'll be committed into there. So it's
17 the second phase of ambulances that then come.

18 When it comes to the actual loading, we were trying
19 to -- we initially were loading in one stream at a time,
20 then we ended up with three streams. Mr Calderbank and
21 myself made some dynamic decisions, we were matching up
22 crews, their crew mate had gone off somewhere else,
23 we were mixing and matching, just trying to do all the
24 pragmatics to get things flowing.

25 We had something in the order of five, 10, 15, 20.

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1 By 11.15, we had about 25 ambulances or something of
2 that sort.

3 SIR JOHN SAUNDERS: We'll see the details of ambulances,
4 yes.

5 A. The majority of those initial ones will actually be
6 committed to patients.

7 SIR JOHN SAUNDERS: I understand that too.

8 A. So given that we've only got this number available,
9 we've suddenly found -- and it's a tribute to the rest
10 of the NHS that they've released the ambulances -- I was
11 astonished at the number of ambulances that were made
12 available.

13 SIR JOHN SAUNDERS: So it took a while to get the necessary
14 ambulances there who were available to take people to
15 hospital. So that's the delay, is it?

16 A. I think that's a very fair reflection.

17 SIR JOHN SAUNDERS: Sorry for cutting you off, I just need
18 to make sure it's in my own mind and I understand it.

19 A. I appreciate the opportunity, sir, to help clarify that
20 picture because it's the reality and I think detailed,
21 you know, analysis of computer tracks and stuff will
22 actually show that.

23 SIR JOHN SAUNDERS: Thank you.

24 MS CARTWRIGHT: There's some information that suggests
25 ambulances that were used to transport P1 patients had

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1 done other trips to hospital before, which don't seem to
2 be taking a P1 patient and we've heard some evidence
3 from Paramedic Hedges that she saw ambulances being used
4 to take walking wounded. Did you experience any of that
5 on the night?

6 A. I can say that I did not because, by the time I arrived,
7 just after midnight, the command structure had been put
8 in place. I'm aware anecdotally that ambulances were
9 being flagged down as they approached the scene, for
10 example.

11 MS CARTWRIGHT: Thank you. Sir, there are three core
12 participants who have indicated on the Rule 10 process.
13 There's a short area for Greater Manchester Combined
14 Authority, from Mr Warnock, there's the family
15 questions, and finally North West Ambulance Service
16 themselves.

17 I'm conscious of the time, but I wonder if at this
18 stage we could ask those three core participants how
19 long they envisage they will need with this witness so
20 we can make a decision. Mr Warnock, how long do you
21 envisage you will be?

22 MR WARNOCK: In fact, you have covered the area I was going
23 to explore, so I don't have any questions.

24 MS CARTWRIGHT: Thank you, Mr Warnock. On behalf of
25 Mr Gozem, perhaps if I could come to him next and ask

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1 how long he envisages he will be with his questions.
 2 MR GOZEM: I would think about 10 minutes or so.
 3 MS CARTWRIGHT: Then Ms Roberts on behalf of NAWAS had
 4 indicated I think 10 minutes.
 5 MS ROBERTS: A quarter of an hour.
 6 SIR JOHN SAUNDERS: If it's all right with you, we will have
 7 a 10-minute break now, because I think we'll have to
 8 have a break, and then we will complete the questions
 9 then. I am very grateful for the shortness of time that
 10 people have indicated.
 11 I understand your evidence is important, but it has
 12 taken longer than I think we anticipated. It's not your
 13 fault at all, it's because we're getting into details.
 14 So we'll do that. People must take the time they need
 15 to ask the questions, so we can get the answers.
 16 MS CARTWRIGHT: Thank you, sir.
 17 SIR JOHN SAUNDERS: So we'll break for 10 minutes, if that's
 18 sufficient for you.
 19 A. Thank you, sir.
 20 (12.55 pm)
 21 (A short break)
 22 (1.05 pm)
 23 MS CARTWRIGHT: Mr Gozem Queen's Counsel will now ask his
 24 questions on behalf of the families via the video link.
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1 Questions from MR GOZEM
 2 MR GOZEM: Good afternoon, Dr Tunn. I'm asking questions on
 3 behalf of the families and I would like to begin by
 4 thanking you on their behalf for your contribution to
 5 the response on the night.
 6 A. Thank you, sir, and my personal and my son's condolences
 7 to everyone involved on the night.
 8 Q. Thank you.
 9 I don't know whether you were able yesterday to
 10 watch the evidence of a HART team leader called
 11 Mr Schanck.
 12 A. I did not. I was working elsewhere.
 13 Q. Is he somebody that you know?
 14 A. I know him professionally, yes.
 15 Q. Can I just ask you some questions then about HART
 16 generally.
 17 You played, I think — and please tell me if I've
 18 got this wrong — a significant role in HART training,
 19 didn't you?
 20 A. I have been involved with HART in a formal capacity
 21 since 2016 when appointed to NARU. If I can illustrate,
 22 I spent three or four of the last weeks down at our base
 23 in the south of England, training new recruits into
 24 HART, working on their skills, particularly assuring the
 25 clinical skills that they're applying when they're

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1 deployed into the hazardous areas, which is the core of
 2 the training that taking place in those courses.
 3 Q. Yes. Are you aware that there is or was something
 4 called a team leader's ambulance Bronze commander's
 5 course?
 6 A. I'm not exactly sure of all the different courses.
 7 I can speak to commanders — the training that's going
 8 on for commanders at the moment. I'm not... Are you
 9 referring to specifically for HART?
 10 Q. Let me try and keep it as simple as I can, which
 11 I should always do. HART team leaders. Are you aware,
 12 do you know, whether they have specific courses to
 13 assist them with their duties as HART team leaders?
 14 A. Now, I have to admit I don't know the answer to that
 15 question. I'm very familiar with the courses that the
 16 HART undertake generally. I'm aware of the non-HART
 17 commanders' courses, but that precise bit, to be honest,
 18 I'm not sure.
 19 Q. All right, thank you. Are you aware of or familiar with
 20 the NARU HART team leader action card?
 21 A. I'm aware in general of what they do. The actual card
 22 wouldn't be something I'm immediately familiar with, but
 23 certainly I'm happy to explore the content with you.
 24 Q. I'm not going to test you on the content. It's just
 25 this: we were told that that particular card, which

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1 appears to be dated October 2015, hadn't been adopted by
 2 NAWAS by May 2017. Can you shed any light on that? It
 3 may be the answer is a simple yes or no.
 4 A. There is a gap between what NARU develops and what the
 5 individual ambulance trusts roll out. There is now
 6 a system of annual inspection by NHS England, supported
 7 now, from this year going forward, by CQC, so it gives
 8 a sense of the formality, with HART units being
 9 inspected on an annual basis. I think that's only in
 10 relatively recent years to ensure compliance with the
 11 core standards. So precisely that card in terms of the
 12 core standards, I'm not sure, but the system of
 13 inspection will certainly look at that in general.
 14 Q. Thank you for that steer, that's very helpful.
 15 The next topic is really about deployment of
 16 resources. I well appreciate that your specialism is
 17 clinical care, so I'm asking you these questions well
 18 aware of the difference between logistics, clinical
 19 care, and so on and so forth, I hope. In summary, you
 20 explained to the chairman the various factors that you
 21 took into account in deciding to deploy directly to the
 22 scene rather than going to the RVP, didn't you?
 23 A. Yes, that's correct.
 24 Q. I'm not going to go through those all now, but you did
 25 observe rigid plans have to be flexible, and one of your

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1 aims was to short circuit the wait at the rendezvous
 2 point without harming the response. Have I got that
 3 right?
 4 A. Yes, that's correct.
 5 Q. Thank you.
 6 Mr Schanck, who I mentioned a little earlier, was
 7 the team leader for the Liverpool HART, who were
 8 actually at the rendezvous point in Manchester at 23.43,
 9 so before quarter to midnight, and while, I think, you
 10 were still on your way.
 11 A. Yes.
 12 Q. They waited there until they were asked to go to the
 13 scene for a long time. They got to the scene just
 14 before 20 past midnight, 00.19.
 15 A. Yes.
 16 Q. And you'd got to the scene at 00.07. The question that
 17 I want to ask you is this: is there, do you think,
 18 a sensible proposal that HART team leaders -- well,
 19 there are two teams in the north-west, aren't there?
 20 A. Yes.
 21 Q. Might it be a sensible proposal to allow them some
 22 discretion when there is a major incident involving mass
 23 casualties to deploy to the scene because, as you,
 24 I think, acknowledged in your explanation, it's your
 25 experience that sometimes the EOC can become overwhelmed

1 and there can be delays in people actually being
 2 deployed from an RVP to a scene. So do you think
 3 there's an argument for them to be allowed discretion?
 4 A. For an incident like this, my answer would be no. I'll
 5 expand. So first of all, my sub-executive role allowed
 6 a degree of constructive disobedience, if you like, on
 7 the night. It's really critical that we don't have that
 8 kind of constructive disobedience on the part of --
 9 I know that you're not proposing that, you're proposing
 10 an explicit permission to negotiate, if you like.
 11 However, I think, particularly with HART, it's -- so
 12 first of all, we have to ask the question: was there any
 13 harm resulting from the delayed deployment? And I am
 14 looking in front of me at the number of other ambulance
 15 resources, including unprotected resources, that were on
 16 scene which were really large in number.
 17 Obviously with family members in HART, I'm
 18 passionately supportive of their work. However, we have
 19 to bear in mind, first of all, there will be major
 20 incidents in the UK -- and lessons from this are to be
 21 generalised -- there will be major incidents in the UK
 22 where HART are not available because of geography first
 23 of all because they're not ubiquitous. Secondly, we're
 24 acutely aware of the modus operandi of a number of
 25 incidents across the world where multi-site toward

1 incidents are happening deliberately at the same time.
 2 That pattern was certainly large in our minds.
 3 So if I can even say it would not have been
 4 unreasonable to move Liverpool HART to Warrington, not
 5 to the RVP, in order to cover the rest of the region,
 6 and we frequently do that when we are deploying one
 7 HART, we may move the other one to a halfway point,
 8 perhaps even not deploying them into scene, because
 9 there's the worldwide intelligence that there is a risk
 10 of further -- and indeed on the night there were
 11 suggestions of, as it turned out to be incorrect, but
 12 there were suggestions of incidents arising elsewhere in
 13 Manchester, possibly linked.
 14 So in terms of discipline, no. Yes, in terms of
 15 communication channels and a little bit of
 16 a conversation, perfectly reasonable, but not
 17 constructive disobedience on the part of HART and their
 18 clear awareness of the wider teaching(?) and tactical
 19 situation that requires holding back an element when
 20 we've already got some 25 ambulances in scene.
 21 The small increment that HART may -- a second HART
 22 unit might offer in that -- I think we're allowed to say
 23 six individuals -- as opposed to being standing ready
 24 for other deliberate incidents is a tactical decision
 25 which I think was reasonable on the night, to be honest,

1 despite the fact that those individual HART members were
 2 passionately interested in supporting their colleagues.
 3 Q. That's a very comprehensive answer for which I'm
 4 grateful, thank you very much.
 5 You mentioned that you thought it was a decision of
 6 which in effect you would approve to hold them back
 7 there. Are you secure in the knowledge that it was
 8 a conscious decision as opposed to just the operation
 9 centre being overwhelmed?
 10 A. So I understand and I simply don't know.
 11 SIR JOHN SAUNDERS: Okay. Sorry, you're being asked things,
 12 and I think Mr Gozem will have to accept that the doctor
 13 actually doesn't know the answer to that.
 14 MR GOZEM: Very well, very well. Thank you, sir. I'll move
 15 on.
 16 Final topic. Can you help us with this? The
 17 deployment of BASICS and MERIT doctors. It seems that
 18 there were quite a number who had self-deployed.
 19 I think you have already mentioned that.
 20 A. Yes.
 21 Q. Is that an area that you can see might merit some
 22 consideration? Could it be improved, calling on those
 23 doctors to turn out for an incident like this?
 24 A. So yes is the short answer. Those steps, I understand,
 25 are already underway. So declaration of interest, first

1 of all . Between 2018 and 2021 I was a MERIT doctor, so
 2 I'm aware of the processes and they are -- the two that
 3 are on call 24/7 from a rota of 35 individuals, 34 when
 4 I retire , will be called and will have particular roles .
 5 So whereas on the night I was perhaps flexing and
 6 adapting, there will be -- the system will remove the
 7 need for flexibility and the arrangements to get them
 8 there. So there was a MERIT doctor on duty on the night
 9 but he actually arrived a little bit later than me,
 10 hence the flexibility . But the arrangements to get them
 11 there quicker are in place.

12 The BASICS doctors, again a declaration of interest.
 13 I have been a member for a number of years and that's
 14 essentially a voluntary, charitable -- trained but
 15 nevertheless voluntary. They do not form part of the
 16 core response but they are widely used now in the
 17 north--west and there are very active groups in the
 18 north--west groups supporting day--to--day operations and
 19 they are in discussion with NWAS.

20 Indeed, the associate medical director who's
 21 responsible for this sector has himself been a BASICS
 22 doctor over the years. So it's maturing to the benefit
 23 of both the doctors so that they know when -- they know
 24 if and when to deploy and how and when they will be
 25 used.

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1 MR GOZEM: Thank you very much indeed, Dr Tunn. Those are
 2 all of my questions.

3 Thank you, sir.

4 SIR JOHN SAUNDERS: Before the last questioner, I'm just
 5 going to go back on something, again just for my benefit
 6 so I can get it absolutely clear in my mind.

7 From your point of view, one of the problems in this
 8 sort of incident and getting casualties to hospital
 9 quickly is getting (a) ambulances to support them
 10 and (b) crews to take them there. Right?

11 A. Yes.

12 SIR JOHN SAUNDERS: When you have something like this and
 13 you have an RVP point -- and I quite understand why
 14 that is necessary, but equally it's absolutely vital ,
 15 isn't it, that as soon as it is known that it is safe
 16 for ambulances to go from the RVP point to the, in this
 17 case, the arena, that they are actually told --
 18 information gets from out of the arena, "It's safe, you
 19 can come"? I know you say nothing's ever safe and
 20 I understand that point. But within the reasonable
 21 margin of appreciation, it's safe for you to come, let's
 22 get them all here, don't send any more to the RVP, move
 23 them here. You may not be able to answer this, but in
 24 your view, does that happen satisfactorily or did it
 25 then on the night?

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1 A. The short answer is yes. It was only in the last week
 2 or so when I was provided with the -- basically the
 3 arrival documentation for the ambulances and I was
 4 actually rather surprised at the number that went direct
 5 to scene and not to the RVP.

6 SIR JOHN SAUNDERS: That may be because at the initial stage
 7 they were actually being directed to Hunts Bank rather
 8 than to the RVP point.

9 A. I think that's a fair comment. Yes, I was trying to
 10 work out in my own mind exactly at what point the RVP
 11 became the preferred cause point.

12 SIR JOHN SAUNDERS: I think it's fairly quick, is my
 13 understanding, but I think some did go directly because
 14 they were told to go there directly .

15 A. The 28 or so or 26 that I'm referring to were by the
 16 quarter past the 11 quadrant -- sorry, just after the...
 17 By the time it got to 23.30, that number were at scene.
 18 Some of them subsequently, in later phases -- in fact
 19 indeed some of the same ambulances who took the first
 20 patients were recycled and went back to RVP which
 21 I think was reasonable because there's a limit --

22 SIR JOHN SAUNDERS: There would be traffic problems
 23 otherwise.

24 A. Exactly. It was just a pragmatic -- it was a way of
 25 making sure that the flow in was efficient .

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1 SIR JOHN SAUNDERS: Who's doing that? Someone on scene
 2 presumably, is saying, "Send us some more, you can bring
 3 them up now"?

4 A. In the major incident plan there is a function. Let's
 5 not use individual cards or roles but there is
 6 a function of parking officer .

7 SIR JOHN SAUNDERS: And there was here?

8 A. Yes.

9 SIR JOHN SAUNDERS: As far as you're concerned it worked as
 10 well as it could?

11 A. I have to pay tribute to the very difficult decisions
 12 that were made early on. The fact that we actually
 13 managed -- I think it's extraordinary that the NHS in
 14 Greater Manchester and indeed the north--west released
 15 the number of resources because that's not something
 16 that happens every day. There was something in the
 17 order of 60 resources deployed, which is just
 18 extraordinary.

19 SIR JOHN SAUNDERS: It seemed to me a bit bad that when they
 20 told you to go to Thompson Street Fire Station, they
 21 actually couldn't give you a postcode, so you couldn't
 22 use the satnav, you couldn't use your --

23 A. Yes. I can't speak directly to that, but it's a very
 24 common reality because when we get a 999 call, the first
 25 thing we ask is location. And that's part of the first

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1 phase of getting information. When we're getting
 2 supplementary information in, we don't start with
 3 postcode. So go to such—and—such a fire station or...
 4 And where is that? And that's not automatically — it
 5 doesn't automatically have a postcode attached.
 6 SIR JOHN SAUNDERS: But we do know, don't we, that on
 7 ambulances, the postcode is actually fed into the
 8 ambulance itself?
 9 A. Yes.
 10 SIR JOHN SAUNDERS: And then it takes them. So people at
 11 control must know the postcode.
 12 A. Well, the location of the incident is fed into the data
 13 terminal.
 14 SIR JOHN SAUNDERS: But not the RVP point necessarily?
 15 A. Well, either the incident, and you touched on the
 16 incident — exactly.
 17 SIR JOHN SAUNDERS: I think you're right in this case it was
 18 the incident which was fed in actually as to how to get
 19 to it rather than the fire station. Anyway, as far as
 20 you're concerned, these systems worked pretty well on
 21 the night?
 22 A. Yes. RVPs are well intended and quite dynamic and I've
 23 been — I have personally in normal operations fallen
 24 foul of trying to get to the RVP and actually coming
 25 across the incident where there may be assailants

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1 present, for example.
 2 SIR JOHN SAUNDERS: Thank you very much.
 3 MS CARTWRIGHT: Can I ask Ms Roberts to ask her questions,
 4 please.
 5 Questions from MS ROBERTS
 6 MS ROBERTS: Dr Tunn, five topics, please, which sounds like
 7 a lot and I'm hoping it won't be.
 8 Topic 1, equipment. Is it right that upon your
 9 arrival at the scene you had with you what you
 10 considered to be sufficient equipment should it be
 11 needed?
 12 A. Yes.
 13 Q. Did you in fact need to use any of the equipment that
 14 you brought to scene?
 15 A. No.
 16 Q. Is that because there was sufficient equipment on scene
 17 when you arrived?
 18 A. Yes.
 19 Q. And from what you could see throughout the duration of
 20 your attendance at scene, did you or those around you
 21 lack equipment?
 22 A. In essence, no. If you look — and the support for
 23 that is the number of vehicles. People will take their
 24 initial response bags forward, rapid response, both from
 25 the ambulance and the rapid response vehicles. Now, we

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1 might say, well, an individual item, you know, I needed
 2 this or I needed that, and it might not have been in the
 3 initial response bag. But there was a lot of kit and
 4 mine was a comprehensive kit which I've parked opposite
 5 the control point and didn't have to touch because we
 6 didn't need to deploy it.
 7 Q. Second topic, stretchers. We heard a lot in this
 8 inquiry, and understandably so, about the means by which
 9 those who were extricated from the City Room were —
 10 well, were taken to the CCS. I suppose, had stretchers
 11 been available in the City Room, they could have been
 12 brought down on stretchers. Were you aware from what
 13 you saw of the means by which people had been extricated
 14 from the City Room?
 15 A. I can speak to stretchers in a second, but in terms of
 16 the specific question, I wasn't particularly aware of
 17 how they'd been transported down because they were
 18 mostly, I think at that stage, on the floor on the
 19 ground floor.
 20 Q. Well, I'll ask you about that. Were you concerned that
 21 they were on the floor? Did that in itself give you any
 22 concern?
 23 A. No. Clearly, we have environmental considerations, but
 24 this is in a sheltered environment, we're in
 25 a challenging — it's a stable platform to work on, to

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1 be honest. It's a smooth floor, we can get ambulance
 2 trolleys in when we're ready to move. It's actually not
 3 a difficult place to work and I would routinely expect
 4 to manage — to do the initial management of patients
 5 where I found them if they're not in immediate danger.
 6 So if I found a motorcyclist on the tarmac, I will
 7 manage them there, and then move them to a more
 8 comfortable setting.
 9 So it's a stable place, and in terms of stretchers,
 10 if I should mention that, but stop me if you want, the
 11 provision of stretchers has been mandated by NHS England
 12 to go on the revised mass casualty vehicles. I would
 13 just caution expectations — and that will happen. But
 14 I would just caution — so that's the next iteration,
 15 which is in the process of being rolled out. It would
 16 have been rolled out by now had it not been for COVID,
 17 but with NHS England approval that's just been slightly
 18 deferred, but it's about to happen.
 19 I would just caution against expectations because
 20 they will not necessarily be in the right place when the
 21 next incident happens, with best intentions, with best
 22 plans. So I would not want — if it's me that's
 23 a victim or my family, I would not want to wait for
 24 a stretcher. I would not criticise the zero responders
 25 for making best efforts to move patients from immediate

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1 danger. That would be to be encouraged rather than wait
 2 for -- certainly from the point of view of comfort and
 3 dignity and even safety coming down the stairs,
 4 absolutely ideal. But in terms of the reality of the
 5 next incident or if it's a big enough incident, not
 6 enough stretchers or whatever, I would certainly
 7 caution -- the expectations would be that we would
 8 improvise in the very early stages with the best of
 9 intent, with due regard to dignity and safety.

10 SIR JOHN SAUNDERS: Just to follow up on that, are you
 11 saying stretchers on the mass casualty vehicles?
 12 A. So...

13 SIR JOHN SAUNDERS: I know there are things called mass
 14 casualty vehicles. There was one in Manchester, which
 15 actually wasn't used on this occasion at the scene.
 16 Is that what you're talking about would have the
 17 stretchers on or are you talking about routine
 18 ambulances?
 19 A. No, you've just referred -- so in two sentences, there
 20 is provision currently with some fairly hefty, not very
 21 nimble vehicles. There's been a review nationally and
 22 it was decided that those will be re-profiled into
 23 smaller, more nimble units. They will not only be used
 24 for no-notice events, but they will be used for planned
 25 events such as festivals and so on. That will allow the

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1 local -- this is distributed around the country. That
 2 will allow better muscle memory in terms of familiarity
 3 with the vehicle, which then means that when we come to
 4 extraordinary circumstances, it's a familiar tool in the
 5 armoury.

6 SIR JOHN SAUNDERS: Thank you.

7 MS ROBERTS: Third topic, please, and it's the CCP. You
 8 told us that the CCP would usually only be in situ, as
 9 it were, briefly before coalescing and morphing into the
 10 CCS. I just want to ask you about the CCP because we
 11 have heard, or it's been suggested I should say, albeit
 12 in questions rather than actual evidence, that the CCP
 13 could have been positioned or might have been positioned
 14 on the bridge, that's the overbridge which leads from
 15 the City Room to the stairs down which patients were
 16 extricated. Do you have a view as to the positioning of
 17 the CCP outside the door of the City Room on the bridge
 18 itself?
 19 A. Yes, I do, ma'am. The decision on exactly where to
 20 place a -- well, first of all, a CCP per se is not
 21 necessary. Likewise, a CCS is not necessary if
 22 circumstances permit. However, if circumstances demand
 23 then so be it. When one runs an exercise, the
 24 commanders on the ground might make slightly different
 25 decisions on different days, different teams might make

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1 slightly different decisions.

2 I have to say I was relieved to be presented with
 3 the arrangement that I met at 00.07 and relieved that
 4 we were not split across two levels, which would have
 5 made oversight so much more difficult. It would have
 6 meant a second transfer down the -- so it potentially
 7 would have made egress even more difficult. So I'm not
 8 quite sure how that decision was reached, but from my
 9 point of view, managing that next phase, as we were --
 10 and we acknowledge the length of time it took. But
 11 nevertheless I think -- first of all, I think no harm
 12 resulted from not working on the bridge, as you refer.
 13 Secondly, I think harm was avoided, potential harm --
 14 it's difficult to be sure, but I think potential harm
 15 was avoided by the arrangement that had already been put
 16 in place, meaning a single entirely workable space where
 17 we could get an overview between P1s and P2s, for
 18 example.

19 SIR JOHN SAUNDERS: Apart from anything else, you said
 20 upstairs was out of bounds?
 21 A. By that stage, but the inference is that a decision
 22 might have been made. But in the first few minutes
 23 after 11, when the indication was that patients should
 24 be moved downstairs, as I understand it from the CCTV,
 25 patients were flowing down the stairs at the rate of

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1 about one to two per minute for about 20 minutes at
 2 exactly the same time as crews were arriving on the
 3 ground floor at about the same rate. So they were
 4 meeting on the ground floor in almost ideal -- given the
 5 horror of the incident but in almost ideal manner.

6 SIR JOHN SAUNDERS: Thank you.

7 MS ROBERTS: Fortuitously, my point 3 has coalesced into
 8 point 4, which you've begun to deal with with us,
 9 Dr Tunn. It's right, isn't it, that between 23.07,
 10 which is when the first patient arrived or was brought
 11 to the CCS until 23.42, when the last patient was
 12 down -- it's a period of about 35 minutes -- that
 13 38 patients in total were brought down? So that more or
 14 less equates to the one patient per minute ratio that
 15 you have told us about; yes?
 16 A. Yes.
 17 Q. And you're aware, I think, also, that in total,
 18 59 patients were conveyed to hospital that evening,
 19 so that would include the P3s, presumably?
 20 A. I understand that that's the case, yes. There's always
 21 a little bit of an argument about exact numbers, even
 22 weeks afterwards, but yes.
 23 Q. Final point, please. It touches upon the questions you
 24 were asked towards the end of your evidence and upon
 25 which the chairman has also asked you. It's the

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1 logistics and it's an understandable concern that people
2 will have as to why, having been extricated to the CCS,
3 they were not immediately, or their loved ones were not
4 immediately taken to the hospital.

5 I think you told us that at the point at which the
6 explosion happened and the attack occurred at
7 22.32 hours, you told us that there were "virtually no
8 ambulances available". And I think you said this,
9 didn't you, that we, that's the organisation, don't have
10 a pool of ambulances waiting? That's right, isn't it?

11 A. So we... The general picture is that we've got calls
12 waiting for ambulances. We do not -- they're not calls,
13 they're patients waiting for ambulances, not ambulances
14 waiting for patients. Precisely on the night, I think
15 the information provided to me was that at the time
16 there were seven available, including urgent care, not
17 normal paramedic, and there were some 76 in the
18 Greater Manchester area which were actually with
19 patients or were committed.

20 Q. The document you're referring to -- this is a reference
21 for the lawyers and others who are listening, and for
22 you, sir. The INQ reference is {INQ040950/1} to
23 {INQ040953/1}. There are four documents in total. I'm
24 not asking for them to go on to the screen. That's for
25 people's references.

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1 Dr Tunn, is that where you got the figure of only
2 seven available at 22.32 in the Greater Manchester area,
3 but 76 unavailable? And is it right that they were
4 unavailable because they were treating patients and had
5 been called to other people across the
6 Greater Manchester area at that time? And again, within
7 that documentation that you've seen, it's right, isn't
8 it, that throughout the evening, and by which I mean to
9 the early hours of 23 May, those calls kept coming in to
10 the Ambulance Service, didn't they, requiring the
11 attendance of other ambulances in the Greater Manchester
12 area and in fact in the whole of the north--west?

13 A. Absolutely. I mean, the public --

14 SIR JOHN SAUNDERS: I think we can understand that. People
15 don't stop just having accidents or being ill and
16 requiring to go to hospital because there's been an
17 explosion, unhappily.

18 A. The public often respond really helpfully and reduce
19 their demand on ambulance, but it doesn't disappear
20 because people can't stop having heart attacks and so on
21 or having babies, and I think that in some of the
22 documents there is a reference to "it was already a busy
23 night".

24 MS ROBERTS: Yes.

25 SIR JOHN SAUNDERS: I've heard that, yes.

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1 MS ROBERTS: Thank you very much.

2 MS CARTWRIGHT: Sir, can I indicate, we've had a request, if
3 we could just have a 5-minute break, there's one topic
4 that the family members have indicated they'd just like
5 to consider with their lawyers. I apologise, but could
6 I ask you, please, to allow us 5 minutes just to
7 consider whether they're going to be asking a question?
8 They've indicated what the area is, it's in respect of
9 stretchers.

10 SIR JOHN SAUNDERS: Yes.

11 (1.40 pm)

(A short break)

13 (1.45 pm)

14 MS CARTWRIGHT: Sir, thank you for allowing the time. The
15 basis of a Rule 10 request has been made by Mr Cooper.
16 I have indicated to you the nature of the question. He
17 wishes to ask about stretchers.

18 SIR JOHN SAUNDERS: Okay, Mr Cooper, thank you:

19 MR COOPER: It arose very late in Ms Roberts' questions.

20 SIR JOHN SAUNDERS: I do understand that it has arisen very
21 late in the day and to an extent it's a bit peripheral
22 to this witness's evidence because, by the time he came,
23 actually everyone had been moved downstairs in any
24 event, so I have that in mind as well.

25

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Questions from MR COOPER

1 MR COOPER: Thank you, sir. Let me shortly go to it. For
2 those that are following, it's evidence that was given
3 by this witness only a short time ago and is transcribed
4 at [draft] page 111 of the realtime.

5 Just a short question for you, if I can, Dr Tunn.

6 I also represent bereaved families in this matter.

7 I want to remind you of what you said and just ask you
8 a couple of questions about it. You said in answer to
9 what Ms Roberts asked you concerning the mass casualty
10 vehicles and stretchers -- you said this:

11 "So it's a stable place, and in terms of stretchers,
12 if I should mention that, but stop me if you want, the
13 provision of stretchers has been mandated by NHS England
14 to go on the revised mass casualty vehicles. I would
15 just caution expectations -- and that will happen. But
16 I would just caution -- so that's the next iteration,
17 which is in the process of being rolled out."

18 And you go on to say it would have been rolled out
19 and you go on to say:

20 "I would just caution against expectations because
21 they will not necessarily be in the right place when the
22 next incident happens, with best intentions, with best
23 plans. So I would not want -- if it's me that's
24 a victim or my family..."
25

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1 And you go on. And my simple question is this for
 2 you: why are your expectations a little lower than
 3 in relation to that? What's causing you to have those
 4 lower expectations?
 5 A. It's not lower expectations, it's reality. So we will
 6 definitely have those and we will have a number. They
 7 will be distributed according to a plan which has been
 8 agreed with NHS England. I'm not directly -- well, NARU
 9 is supporting it. So they will definitely be there.
 10 But are they on the correct side of Manchester or
 11 Liverpool or London? They would be placed with analysis
 12 based on history, population, likely targets, all that
 13 kind of stuff. But it may be that the next incident
 14 happens somewhere more distant. So certainly they will
 15 be deployed and moved, and I've indicated that we're
 16 intending to make sure that they are used much more
 17 often and that muscle memory is very short and that they
 18 will be at the forefront of people's minds.
 19 But the reality is that either the location that an
 20 untoward individual chooses for a deliberate incident or
 21 an accidental incident may not coincide. So a train
 22 crash, for example, may not be near one of these
 23 vehicles. Yes, we can move the scene, but I was really
 24 trying to make the point that zero responders will,
 25 I would hope, improvise and move patients away from

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1 immediate danger using best possible means.
 2 SIR JOHN SAUNDERS: I think I get the point. If there
 3 aren't stretchers there, you don't just say, "We're not
 4 moving them because we haven't got any stretchers", you
 5 do the very best you can and you improvise as necessary.
 6 I have no doubt that you'd accept that the best way of
 7 moving people, for the patients and everybody else, is
 8 put them on a stretcher?
 9 A. Absolutely. That's why the provision has been made.
 10 It's not that I have lower expectations, it's just that
 11 I have to be aware of the potential for, unfortunately,
 12 the incident to be somewhere where the provision is not.
 13 MR COOPER: Sir, that's clarified the matter in my mind.
 14 I'm grateful for the inquiry allowing me to ask that
 15 question. Thank you.
 16 SIR JOHN SAUNDERS: Not at all. I'm sorry to have cut
 17 across you, as I always seem to do when people are
 18 asking questions.
 19 MS CARTWRIGHT: Perhaps then for completeness, can I check
 20 that nothing arises from Ms Roberts?
 21 MS ROBERTS: No, thank you very much. That was very
 22 helpful.
 23 MS CARTWRIGHT: Sir, I have no additional questions. Unless
 24 you have, that would conclude Dr Tunn's evidence.
 25 SIR JOHN SAUNDERS: Thank you.

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1 I'm very grateful. You've done a lot of work into
 2 the topic as well before you came and you were able to
 3 help us that much more because of that, so thank you
 4 very much for your assistance.
 5 A. Thank you, sir.
 6 SIR JOHN SAUNDERS: We will now break off until Monday
 7 morning at 10 o'clock.
 8 (1.51 pm)
 9 (The inquiry adjourned until 10.00 am on
 10 Monday, 29 March 2021)
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1 I N D E X

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3 DR EDWARD TUNN (sworn)1

4 Questions from MS CARTWRIGHT1

5 Questions from MR GOZEM102

6 Questions from MS ROBERTS114

7 Questions from MR COOPER124

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