Manchester Arena Inquiry

Day 110

May 26, 2021

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Wednesday, 26 May 2021
(9.30 am)
MR PATRICK ENNIS (continued)
SIR JOHN SAUNDERS: Mr Greaney.
MR GREANEY: Sir, good morning. First today, Mr Atkinson on behalf of the families.
Questions from MR ATKINSON
MR ATKINSON: Good morning, Mr Ennis. I ask some further questions on behalf of the bereaved families. I won't be long.
Mr Lopez, could we have {INQ013163/1}. Is this right, Mr Ennis, is this the version of the major incident plan that you would have had with you on the day?
A. I believe so, sir, yes.
Q. We can see the top of the page, under the row of images, the motto, I guess, of North West Ambulance Service:
"Delivering the right care, at the right time, in the right place."
A. Yes.
Q. That really is what this major incident plan in its various forms was designed to achieve, wasn't it?
A. Yes. Delivering the right care at the right time in the right place is, or was, the NWAS vision and values at the time. But that's also applicable to this major

incident plan as well, yes.
Q. Because moving beyond a vision, the plan, the actions of those guiding the execution of that plan, was designed to make that a reality, wasn't it, that the right care was delivered at the right time and in the right place to those who needed it desperately?
A. Yes.
Q. And so assessing -- in a situation where speed was of the essence to get the right care to those people?
A. Yes.
Q. If we could go on to {INQ13163/11}, please, Mr Lopez. This was the action card that applied to you. Not wanting to get sort of hidebound between whether you should or should not have assumed the acting operational commander role, was the reality that if Mr Smith hadn't arrived, you would have done, he arrived and so he did?
A. Yes.
Q. But really, the aim was, is this right, between you to ensure that these important things were done?
A. Yes.
Q. As a part of getting the right care to the right people at the right time?
A. Yes.
Q. We can see under 4(a):
"Liaise with police and Fire and Rescue Services,

establishing the nature of the incident and possible hazards."
In fairness to you, Mr Ennis, you did do that so far as the police were concerned because you spoke to them.
A. Yes.
Q. Both Inspector Smith, on the unarmed side, and also the armed officers who were in the City Room?
A. Yes, they were, yes.
Q. Giving you an appreciation, is this right, of the possible hazards?
A. Yes.
Q. In terms of the risks of working in that area --
A. Yes.
Q. -- on the one hand and the need for people to work in the area on the other?
A. Yes. I think that's fair to say from within the police, but from different branches of the police.
Q. Because as you told us, your reasoning in going up to the City Room rather than stopping when you arrived outside the station and delivering a METHANE from there was to get that greater sense of situational awareness that going to the room would give you?
A. Yes.
Q. And it was an advantage you had over Dan Smith that you had been into the room and seen for yourself what needed

to be done?
A. Yes.
Q. And the challenges that that was going to pose?
A. Yes.
Q. We can see (b):
"Assessing the scene, determining if it was safe to enter and then sending a METHANE report."
In terms of determining whether it was safe to enter, you had the information from the various arms of the police as to their assessment of it, and you could see that others were there and were doing their best?
A. Yes.
Q. And you could see that more was needed?
A. Yes.
Q. This was not a situation where you could just leave it to them, was it?
A. Sorry, when you say leave it to them?
Q. You couldn't just say: well, I can see that there are ShowSec, ETUK, police, members of the public, doing their best in here, so NWAS can just go home?
A. No, of course not, no.
Q. On the contrary, this was a situation for which NWAS had the staff who were trained to make a difference?
A. Yes.
Q. And that included you?

A. Yes.
Q. In terms of the METHANE, your attention was already directed to the E at the end of METHANE, identifying whether other emergency services are on scene and what further resources are required. If we can go down, I think it's the top of the next page, Mr Lopez, {INQ013163/12}, to (c):
"Ascertain the requirement for specialist teams."
Amongst which is identified HART. So both through the METHANE and as part of what the first personnel on scene are meant to do, it's identifying, "Do we need specialist teams?" And this was a situation, is this right, where you understood from the armed officers that there was a concern about safety in relation to this area and so this was a location for which HART was trained and indeed HART was designed?
A. Yes.
Q. So the clear message to you from that scene and your awareness of it was that HART need to be here?
A. Yes. This is true, yes.
Q. Meaning more than two?
A. Um... Well, I mean, my knowledge of the HART team is that they work as a team of six. But my knowledge of the HART team and what they were already doing that night was that they were already tasked to an incident,

so I was quite aware that they would be travelling in separate vehicles, travelling a distance, and they would need to or potentially would be leaving the scene of the incident they were tasked to at different times. So it wasn't unusual that they came initially as a team of two.
Q. But understanding all of that, you were in the City Room, it was beyond your control what time other people were going to arrive?
A. Yes.
Q. But what this is envisaging is not you magicking them up, it is you identifying that they need to be there?
A. Yes.
Q. And that's the message that needed to go out, wasn't it: as soon as they can be here, we need them here?
A. Yes. I agree with you, I think the HART team were certainly required in that area. I can't recall specifically at what point I was aware that the HART team were being tasked to that area. I don't remember specifically requesting that, but I believe it was part of the discussion with Dan Smith that it was mentioned that the HART team were en route.
Q. Because if you and Mr Smith were being guided by this, and these instructions, which you should have been, shouldn't you, because that's what they're there for,

then identifying the specialist teams who need to be there is part of that, inevitably part of that conversation, isn't it?
A. Yes, it is. One of the teams that's mentioned is the MERIT team. That was something that had already been mentioned that they'd been tasked there. So yes, that was something that had come up so I didn't need to ask for that because that was already being arranged.
SIR JOHN SAUNDERS: It's important for me to be able to distinguish in your evidence what you were thinking at the time and what you have learned subsequently. It's quite difficult to do, to disentangle it. Are you saying it was actually part of your thought process at the time, "I know the HART teams are tied up elsewhere", or is that something that you realised afterwards?
A. No, it was something I was aware of at the time because, before I responded to the incident, I was aware of the incidents that were ongoing in Manchester and I was aware that the HART team were already on an incident in the Stockport area. So at the time I responded, I was aware that the HART team may be required but that they wouldn't be travelling from their usual location and could be delayed as a result of this.
SIR JOHN SAUNDERS: So you actually thought of that as you

were on your way?
A. I can't recall at what specific point but I was aware of them as a resource and the fact that they were already tasked ——
SIR JOHN SAUNDERS: As you're looking at the scene in the City Room, you may be thinking to yourself, "This is a situation for the HART team but actually how long will it take for them to get here", so you're having to think of alternatives?
A. Um... It ... Obviously I can't ... I don't think there's a mention in any of the transcripts of me requesting the HART team, so I'm assuming that I didn't. I was aware that as part of the emergency operations centre plan and predetermined attendance —— although obviously it specifically mentions that they need to be thought about and requested —— I was aware that they were part of the predetermined attendance. We also have two HART teams, so I was aware that if for whatever reason the Manchester one was unavailable, there is a second one.
SIR JOHN SAUNDERS: Okay. I'll leave Mr Atkinson to carry on and I will come back to this at some stage.
MR ATKINSON: Just again, Mr Ennis, we appreciate that this wasn't just a decision for you as to who went in, but the whole point of Mr Smith taking on his role was to

identify what resources needed to be there, of which you were one. But given that, on what you're telling us, you knew, first, this was a situation for HART and, second, that they weren't there yet, what did you and Mr Smith identify as to the solution in the meantime, given that you needed to get to the right place at the right time, providing the right care?
A. There wasn't a conversation about finding an interim solution.
Q. Why not?
A. I don't know. At the time that I -- after the meeting with Mr Smith, that I went back into the City Room, until the HART team arrived, I was entirely occupied with the role that I was undertaking and whilst there were ambulances arriving at that location at the time, I was waiting and expecting the HART team to arrive behind me.
Q. And you had your radio with you?
A. Yes.
Q. At any point did you call down to Mr Smith or a control room to say, "Where are the HART team, we need them now"?
A. No, I don't believe I did.
Q. Because you did need them, didn't you?
A. Yes, I did need them.

Q. In terms of alternatives, it was your assessment, speaking for yourself, that it was safe enough for you to go back in and to carry on doing your job, wasn't it?
A. Yes.
Q. Did you make that clear to Mr Smith, Dan Smith?
A. I believe I made it clear to Mr Smith that it hadn't been declared safe up there. I passed the information that I had been given at the time, which was still that we believed there'd been an explosion but people had reported gunshots or having been shot, that I was happy to self-deploy back into that area. So yes, that information was passed on.
Q. So any discussion between you and Mr Smith about who else might, like you, self-deploy themselves back in there, given that HART wasn't there?
A. No. At the time of the discussion with Mr Smith, there were only the four NWAS people on scene: Dan Smith, taking the operational command role, Derek Poland and Dr Daley and myself. So at the time, there weren't any other resources so there was no discussion about the tasking of the next resources and, indeed, they'd be undertaking different functional roles --
Q. Forgive me, I am sorry to interrupt you, they would be undertaking different functional roles, but that would be a decision for Mr Smith as to whether they were going

to undertake different functional roles or whether actually the place they needed to be, the time they needed to be there, was with you in the City Room, surely?
A. Yes, but in undertaking the operational command role and following the action cards assigned to that requires the first people on the scene to populate the initial functional roles. So it wouldn't have been within the operational commander's -- it wouldn't have been usual practice in that situation to deploy people into the City Room in advance of fulfilling some of the what would be more... some of the earlier functional roles.
Q. Isn't the risk of that, just for your observations, because you were there, isn't the risk of that that operational roles are fulfilled at the expense of care for patients?
A. The major incident plan is obviously there to try and ensure that the overall major incident is managed as effectively as possible. An example of that would be a parking officer, which might seem a completely unimportant role to fulfil really early on when there are so many people who require help and assistance, but in actual fact if there isn't somebody early on in the incident assigned to ensure that the ambulances that are arriving arrive at the location required at the

rendezvous point and approach in the right direction, then at a location such as the arena, what might happen is that two ambulances arrive in opposite directions, causing a gridlock, and then the entire rest of the incident might be delayed as a result of that.
SIR JOHN SAUNDERS: I think we realise that. I think we're rather beating around the central point. What concerns people, as you were aware on that night, is that there were people working in the City Room, members of the public, unarmed police, everybody else, and there was one paramedic until the two HART people came along. People were crying out for paramedics in the City Room and what everybody wanted to know and what I have to try and give a reason for one way, and say whether it was right or wrong, is why there were not more paramedics.
Now, we well understand there are other priorities, that wouldn't be for you to decide, but for Dan Smith to decide. So I want to know: you thought it was safe enough for you to be there, okay, the armed police couldn't give you any guarantee there wasn't another unexploded device in there, but the place was ringed by armed police by the time you were working in there, they were all around giving protection. With great courage, no doubt, you decided it was safe enough for you to work as others were working there. What -- were you ever

asked by Dan Smith, "Is it safe enough for me to get paramedics, when we have got enough here to do it, to come up and help you"?
A. No, I wasn't.
SIR JOHN SAUNDERS: So you never gave an assessment to Dan Smith about it?
A. I don't believe that there was a conversation where I -- where he asked that of me or whether I explained to him that I felt it was appropriate for more paramedics to come into that area, no.
SIR JOHN SAUNDERS: So you've got a major incident, and within major incidents there are certain rules or suggestions about who can work in the red zone. Do you have discretion? So until the police tell you it's completely safe, which is a pretty unlikely characteristic, are you able to get unarmed, unprotected paramedics into the area or is it an absolute rule, until the police say so, we're not having any paramedics there?
A. No, I don't believe it's an absolute rule. A risk assessment would need to be carried out and then a decision.
SIR JOHN SAUNDERS: What does a risk assessment mean? Who carries it out on this occasion and how?
A. So the decision to deploy further paramedics into the

City Room would be one that the operational commander would ultimately have to decide upon. So I wasn't deployed into that area, I self-deployed into that area.
SIR JOHN SAUNDERS: I understand.
A. So that obviously wasn't a decision taken by the operational commander. But the decision to deploy further paramedics in there would have been one that an operational commander would have had to make and then justify.
SIR JOHN SAUNDERS: So to get situational awareness, he's got you there, Dan Smith has, so the sensible thing to actually find out is -- I am really sorry, Mr Atkinson, for taking this over -- he needs to know situational awareness and he's got you in the room working who can tell him?
A. Yes.
SIR JOHN SAUNDERS: And no conversation takes place?
A. I don't believe there was, no.
SIR JOHN SAUNDERS: Okay. If he'd asked you, "Is it safe, when we've got enough, can I send some paramedics in there?" because you're saying he must know they're needed and you know they're needed, what would you have said?
A. I believe I would have said that I couldn't guarantee it was safe, the firearms police have said that there was

a potential for secondary device, there are hazards in the area, such as the unstable roof, but that as far as I was concerned it appeared to be safe to work in there.
SIR JOHN SAUNDERS: Okay. Thank you.
MR ATKINSON: In terms of timing, I think you told us yesterday, is this right, that your assessment was that the lack of further paramedics coming into the room was, to an extent, offset by how quickly those in the room needing treatment were moved out?
A. Yes. I believe that had a bearing on how the incident carried on, yes.
Q. Just understanding that, I'm not going to put it up on the screen, for I hope obvious reasons, but we have a spreadsheet which sets out 38 of those removed from the City Room down to the casualty clearing station, what their P level was, their priority level --
A. Yes.
Q. -- and what time they got there. All right?
A. Yes.
Q. So if we use as perhaps helpful markers for that the time you went back into the City Room after speaking to Mr Smith, that's about 23.05 that evening, and the time that HART arrived, that's 23.14, when Ms Vaughan and Mr Hargreaves joined you -- all right?

A. Yes.
Q. So on my analysis of it, and others will no doubt correct it in due course, when you went back in, there were 21 priority 1s in the City Room who were going to be moved down to the casualty clearing station, all right? By the time HART arrived, only six of them had gone down the stairs. All right? And the last of them didn't leave until 23.40. That is almost half an hour after HART arrived. And would this be right, that so far as you and they were concerned, you had triaged them, but you hadn't treated them?
A. Yes, this is true.
Q. So these are priority 1 people in the City Room, after HART have arrived, after you have arrived, for over half an hour, untreated. If there had been more of you, they'd have been out quicker, wouldn't they?
A. Potentially, yes.
Q. And if there had been more of you, they could have received some treatment in the meantime?
A. Yes, some treatment, although the caveat to that would be obviously limited resources were likely to be brought into the City Room as it was felt more appropriate to move the patients to where the equipment had been gathered en masse.
Q. Similarly, in relation to priority 2, 16 of those on my

count, of whom only three had left the City Room by the time HART arrived, the last of whom not leaving until 23.42. Again, a little later, but over half an hour later. Again, people who needed to be treated as quickly as possible. As we have heard, for example from Brigadier Hodgetts, with catastrophic injuries, it really is vital that they are treated quickly.

A. Yes. Sorry, with respect, the priority 2 patients, although extremely injured, didn't have what we would describe as catastrophic injuries.

Q. Holding that thought, the triage process that you undertook and was then undertaken by Ms Vaughan and Mr Hargreaves was designed to identify who needed to be treated first?

A. Yes.

Q. In a priority 1 case, they may need treatment even from you in terms of tourniquets, in terms of putting them in a position where they could breathe?

A. Yes.

Q. Pausing there, did you do those things as part of your triage process?

A. No. You're correct, the first part of the triage sieve process is to identify if there is any catastrophic bleeding. I did not come across anyone who had a catastrophic bleed that required a tourniquet in terms

of that initial process. The other part asks, if on opening somebody's airway, if they then begin to breathe and then suggests the introduction of an oropharyngeal airway to maintain that airway and then the use of -- being positioned on their side in order to maintain their airway. So I didn't come across any patient that required those interventions in order to maintain their life.

Q. As you will well understand, Mr Ennis, I don't want to ask the details of this, but did you encounter people who had received that kind of help already in terms of tourniquets having been applied to them or having been moved into a position where they could breathe?

A. I didn't come across anybody who had an arterial tourniquet applied, I did come across patients who had improvised tourniquets in place. However, it was my assessment that these were not a tourniquet -- and this might sound pedantic, but the point of a tourniquet is to entirely restrict blood flow to a limb in order to prevent catastrophic bleeding that is occurring at such a rate that it can't be controlled by other methods. This requires considerable amount of pressure, Brigadier Hodgetts refers to the use of improvised tourniquets and suggests that they need a windlass, so something that's able to be wrapped around the strip and

twisted with considerable force in order to be able to completely constrict the blood supply.

I didn't see any patients who required the use of a tourniquet in that time and the tourniquets that I had seen applied weren't acting as an arterial tourniquet. What they were doing, in my assessment, was providing direct pressure over a wound in order to hold a dressing in place and were working effectively as that, but they weren't technically working as a tourniquet.

Q. The triage process. You'll be asked more in a moment when I shut up about that, but part of that process is not only identifying who needs to be treated first but making clear to others the order in which people need to be treated?

A. Yes.

Q. Because the idea is rather than you providing all the treatment yourself, you are grading them, which is a horrible way of putting it, but you know what I mean --

A. Yes.

Q. -- so others can then come in and treat them in the right order, and extricate them in the right order?

A. Yes.

Q. And that is, would you agree, why the cards are very important?

A. It is one of the benefits of the cards. However, the cards only -- the patients that you refer to, the large number of patients that you referred to were priority 1 and priority 2, so the cards would only distinguish between those two groups, they wouldn't distinguish the priority that existed within the group of either priority 1 or priority 2 patients.

Q. Understood. But by attaching a card, those coming in to join you in the triage process would know who you had already looked at?

A. Yes, they would.

Q. And when the decision was being made as to who to take out of the room first, those making that decision would know who the priority 1 people were?

A. Yes, they would.

Q. Very quickly?

A. Yes.

Q. And when they reached the casualty clearing station downstairs, those there would know who the priority 1s were without having to triage them again?

A. Yes, they would, although the process of triage is one that would be repeated, so if a patient arrived down in the casualty clearing station with a P2 tag on, for instance, the expectation would be that they would be immediately re-triaged and their category could

potentially change.
Q. But if they came down with a P1 label on, they would be the first priority, wouldn't they?
A. Yes. Over that of a patient with a P2 label on, yes.
Q. Realising that, and understanding from what you've already told us as to why you didn't have them with you, did you at any stage radio to ask somebody to bring them to you ——
A. No, I didn't.
Q. —— knowing that they were important?
A. No, I didn't, and I felt that because all efforts were being taken to, where possible, try and move patients in priority order, I felt that the patients that were being received in the casualty clearing station were in the main priority 1 patients initially. So although the cards would of course be beneficial, they would be of limited benefit initially in that all of the patients, would be, should be ideally, priority 1 patients.
Q. Understanding that, again that same document, the spreadsheet that helps us as to who was moved to the casualty clearing station when, of the first four that were moved down the stairs at 23.07, only two of them were priority 1s. And of the first nine who were moved down the stairs, only five of them were priority 1s. Do you feel if it had been more obvious who the

priority 1 ones were because they had things on them saying so, that would have been done better?
A. Potentially, yes.
SIR JOHN SAUNDERS: Is the reason for it that people are not necessarily acting under your instructions? We've got to imagine this is a pretty chaotic scene, so people were getting people out who may not have been your priorities?
A. Yes. I think in the early stages, I think it probably wasn't... The job of trying to establish who were the highest priority was obviously most difficult initially when there were the most patients to move. And then when the process was more established, I think it became —— it worked more effectively because of course there were less patients at any time.
The other part of it was that there were understandably people who were injured who were very vocally wanting to be moved and I believe that that was completely understandably for those who were moving patients, they were wanting to assist in that, whereas some of the patients who were more injured were, by virtue of their injuries, less able to speak and ask for help. So that was where it was necessary to direct them, and yes, to come back to your question, if there had been a label on there, it may have made the job

easier for those moving them.
MR GREANEY: Thank you, Mr Atkinson. Mr Jamieson has some questions.
Questions from MR JAMIESON
MR JAMIESON: Good morning, sir.
One new topic and one thing that arises from something you have just said.
The new topic is this: at various stages, those who were thought to have died in the City Room were covered in T—shirts or other materials?
A. Yes.
Q. And I can say, through painstaking analysis that others have done from the body—worn footage, that a number had been covered before you arrived in the City Room for the first time.
A. Yes.
Q. When you made your first broadcast at 22.54, so at 5 minutes to 11, and you recorded that approximately 10 were dead, were you counting those who had been covered as part of your number?
A. I believe I was, yes.
Q. You had not yourself approached those people who had been covered at that time?
A. No, I hadn't had the opportunity to assess them formally myself. Obviously that was something that I wanted to

be able to do that formed part of the triage process. So at that initial time it was just an impression that I gained and then obviously my clinical experience that... The triage process, it mentions that it isn't necessary to perform a top—to—toe examination in all situations. From clinical experience, although I'm jumping ahead somewhat because my initial —— you're talking about my initial impression of the room. Actually, in being able to see a patient who's not moving and not displaying any signs of life, that would be highly suggestive that they are in that category of being dead, unfortunately.
Q. I will return to that in just a moment, if I may. But we can agree that certainly at that time, the first broadcast, 22.54, you're relying in reality on the fact that they have been covered?
A. In part, yes. So the fact that they have been covered was obviously suggestive that somebody has assessed them and their level of experience or training, obviously, I was not aware. But in somebody's opinion, they believed that this person had died. But also, there was my clinical judgement on looking at the person that I could not see any breathing or signs of life.
Q. Just returning to the issue of somebody's assessment, you were the first paramedic into the City Room?

A. Yes.
Q. And so it follows that the person who made that assessment was not a member of NWAS nor a doctor?
A. No, this is likely to be true, yes.
Q. As you yourself acknowledged, you wouldn't know who that person was, whether they'd be an emergency responder or a member of the public?
A. No, that's true.
Q. Nor what their capabilities nor training would have been?
A. No.
Q. As you say, when you returned to the City Room, you performed your triage. I'm simply going to put it in this way, sir, if I may: I am not suggesting that you did not at any stage approach the individuals who had been covered, but can we agree in the light of two factors, which I acknowledge out of fairness to you, firstly, the amount of injured people in the City Room and, secondly, the directions that you are given by the triage sieve, which you've already alluded to —— can we agree that those who were covered were not a priority for triage?
A. The priority of triage, after establishing whether there is any catastrophic bleeding that immediately requires intervention, is to establish whether those who are ——

SIR JOHN SAUNDERS: Okay, I'm sorry to interrupt you. I think the meaning of this question is really to get at the order. So if their faces are covered, do they go to the bottom of the pile, as it were —— sorry, that's a really bad expression —— the bottom of the list. So when you come to do your triage on them, did you leave them to the last or did you do them first or did you do them as you came to people as you were going around or what?
A. Sorry, the next part is to establish those who are unconscious, so they should be the next priority to be assessed, and those who are quiet. So to be able to categorise them as unfortunately dead and beyond help requires that —— that there is an assessment of them to ensure that they are not breathing.
SIR JOHN SAUNDERS: So in which order? That's what we're trying to get at. Do you look round the room and look for catastrophic bleeding and go to that person first?
A. Yes.
SIR JOHN SAUNDERS: And then you look for people who are not moving?
A. Yes.
SIR JOHN SAUNDERS: Does that include the people whose faces are covered?
A. It does, and I ... As you have mentioned, it was a very busy and chaotic scene.

SIR JOHN SAUNDERS: Absolutely.
A. And trying to recall the specific order in which I moved around the room is obviously extremely difficult. The fact that remotely I could see with each of the people who had been covered that there was no obvious breathing or signs of life and that someone had deemed them to be dead was obviously a large part of my decision—making. But my intention would be to try and assess all of those patients as a priority ahead of those who were obviously breathing and those who were obviously talking.
SIR JOHN SAUNDERS: Thank you.
MR JAMIESON: Thank you, sir. Indeed, I think, Mr Ennis, that's ultimately as far as I wanted to take it. The fact that somebody had assessed them as having died was a part of your decision process in prioritisation on the triage? That far, I think, we can agree?
A. Yes.
Q. Thank you. May we just please look at the major incident plan to see —— well, to see the guidance that that provides? Please, Mr Lopez, {INQ013132/36}, at the bottom.
If we look at 8.1.1, "Deceased casualties", it's really the final sentence of the first paragraph and the final sentence of the second that I want to focus on:

"NWAS responders triaging a person as dead should complete the label noting their PIN (clinical) number."
Pausing there, which would indicate to anybody who came to look at the label later that it was a qualified person who had made this decision? You're nodding, Mr Ennis. I wonder for the transcript if you would say yes.
A. Sorry, yes.
Q. Thank you:
"In addition to the date and the time that the casualty was triaged, confirmation of death may only be carried out by a medical doctor."
And then the final sentence:
"The deceased should in general be left uncovered. However, where the deceased person is in public view, consideration should be given to covering the body in order to maintain patient dignity."
But this important qualification:
"The triage tag should remain clearly visible."
The virtues of that process, may I suggest, are that dignity can be maintained, but it can be seen at a glance that the person who has triaged the person as dead is somebody, I'll simply say, with the capability to do that?
A. Yes.

Q. That would have been another benefit to having the cards with you in the City Room?
A. Yes, although the process of applying the labels, applying the cruciform cards to patients when I had them available from the HART team, along with the HART team, the priority was to ensure that we were correctly labelling the priority 1 and 2 patients. The process of formally labelling those who had unfortunately died was one that took place later. So although the process of making the decision may have happened earlier, the actual process of applying the label, because this was a time-consuming process, was one that we didn't undertake until all of the priority 1 and 2 patients had been moved out of the room.
Q. What that means is that focus was placed on those who weren't covered?
A. No, sorry, I wasn't suggesting that we hadn't assessed the patients who were not moving at the time, just that the process of labelling them with the cruciform cards didn't occur until afterwards. The cards... There are -- the black cards that contain the word "dead" are kept separate from the other cards, so the process of labelling focused on those who were priority 1 and 2, the process of assessing patients prior to that and establishing the priorities, including the category of

dead, had already taken place before that.
Q. I don't know if you had any more questions on that topic, sir. I've finished. Thank you.
Just moving on then to the final matter that arises from what you have just said and it's about tourniquets. May I just check this: as part of your triage process, leaving aside for the moment those who had been covered, did you assess everybody in the room who had either a P1 or a P2 injury?
A. I obviously cannot be sure. But my intention was, yes, to try and assess every patient in the room. I honestly wouldn't be able to confirm with absolute certainty that that had taken place, but that was my intention to do that, yes.
Q. I'm very deliberately not mentioning any particular individual, but may I just clarify two factors with you. Your assessment of all of those you considered was that none had a tourniquet in the sense that Brigadier Hodgetts and you as a professional would describe it?
A. Yes.
Q. And that none required one?
A. That's not to say that... The application of a tourniquet for a true catastrophic haemorrhage, which is what is being referred to at the top of the major

incident triage sieve, is the application of a tourniquet for a catastrophic haemorrhage. That is a haemorrhage that is occurring at such a rapid rate that it is likely to lead to the death of the person before even an airway or a breathing problem. So this is -- as Brigadier Hodgetts' evidence suggests, this is learning that came out of the conflicts in Iraq and Afghanistan that led to a change in trauma treatment.
The category of catastrophic haemorrhage though is one that really refers to the type of bleeding that occurs in the first few minutes and that is where he particularly refers to the "platinum 10 minutes".
Q. Yes.
A. So there are other categories of bleeding, so major haemorrhage that would be expected to be dealt with further through the primary survey -- so the C for catastrophic haemorrhage first, followed by airway, breathing, circulation. So the arrest of major haemorrhage would come in the second C.
Q. I am sorry to cut across you, but is that the sort of treatment that would be provided at the CCP?
A. That's the type of treatment that would be provided mainly at the -- potentially at the CCP, but more definitively at the CCS. It may be that there are ongoing haemorrhages that could require a tourniquet.

However, they wouldn't fall into the category of the catastrophic haemorrhage. The catastrophic haemorrhage management is one that's really designed around people who are there in the first few minutes after an injury takes place.
So again, to refer to Brigadier Hodgetts, his tourniquet concept that's designed to be applied by laypeople would be one that would potentially fall into that category. That's where that would be useful, in that first platinum 10 minutes where -- unfortunately before any people who are responding remotely had been able to get to the location.
Q. May I just check my understanding of what you have said for the future? If somebody has suffered a catastrophic haemorrhage and it has been abated in some way short of a tourniquet such that there is still bleeding but not at that stage catastrophic, presumably as a layperson it would seem that any further bleeding from that individual would be a very serious matter?
A. If it were a catastrophic haemorrhage, then by definition it wouldn't be able to be managed by simple methods. So the majority of bleeds may be managed with the application of, for instance, an improvised dressing applied to the area. A catastrophic haemorrhage by definition is one where it continues to bleed and it

cannot be managed in that way and so only indirect pressure in stopping the arterial blood flow to that limb would stop the bleeding.

SIR JOHN SAUNDERS: Is the 10 minutes significant? Because if you don't actually put on a tourniquet, an effective tourniquet, within that period, actually the patient cannot be saved?

A. The 10 minutes is rather a sort of an arbitrary point, but what it's really saying is that the earlier -- after an injury where there is a catastrophic haemorrhage, the earlier a tourniquet can be applied, the sooner the blood loss can be stopped and the more likelihood there is of survival. The 10 minutes is referring to really any bleed that persists longer than that and in which the patient is still fortunately alive is probably not one that would be classified as a catastrophic haemorrhage. That is not to say that you couldn't have bleeding that would --

SIR JOHN SAUNDERS: That's quite a circular definition, but I understand it. Presumably, you're describing, that's a catastrophic bleed, that's not a catastrophic bleed, there are probably grey areas, aren't there?

A. There are.

SIR JOHN SAUNDERS: And it's a fairly subjective decision too?

A. The other thing is, the word catastrophic obviously suggests, quite rightly, that this was a bleed that is very rapidly going to lead to the death of the person. That's not to say that a bleed that isn't catastrophic couldn't also lead to that person's death.

SIR JOHN SAUNDERS: And needs some sort of tourniquet?

A. The tourniquet is quite specific to a catastrophic bleed that's happening on an extremity and externally. Whereas there are various other types of bleed that could be happening to either the trunk of the person or could be happening internally. The tourniquet is only --

SIR JOHN SAUNDERS: I can understand that.

A. It is just that one category. So there are -- it's very possible that there is a bleed that falls short of being in that catastrophic category that could still unfortunately lead to the person's death. But the treatment for that in the initial period wouldn't necessarily be a tourniquet, it would be other methods to control bleeding, and there are a variety of further methods to try and control bleeding and resuscitate the person that would be used. A tourniquet is one of those things but only for a particular type.

SIR JOHN SAUNDERS: Right.

MR JAMIESON: I'm not going to go any further into the specifics of this because it's for a future chapter.

But may I just ask this general question and then I'll sit down.

Your assessment of those two things, that there were no, no disrespect, I use him as a shorthand, Brigadier Hodgetts tourniquets in place and nobody needed one, was your assessment of those matters impacted by the workload that you had in the City Room?

A. I think on the one hand it would be -- it's fair to say that there was -- there were a lot of patients there and a lot of patients to try and categorise. So for me to say that I can completely confirm that I was able to accurately and thoroughly assess every patient would be something I can't confirm.

Equally, the type of bleeding that we are talking about as a catastrophic bleed is one where the bleeding is happening at such a rate that it cannot be missed. Really, the evidence that Brigadier Hodgetts gave was explaining that these are distracting injuries in that blood is, not to be too graphic, pumping or spurting from somebody. So understandably, this is a distraction. I didn't witness any type of bleed that would fall into that category and again, not to labour the point, but that type of injury would have unfortunately led to the death of the person before I'd arrived because that platinum 10 minutes had

unfortunately passed before I entered the City Room and certainly before I undertook the role of triage.

MR JAMIESON: Unless some imperfect remedial action had been taken. Thank you, sir.

SIR JOHN SAUNDERS: Thank you very much.

MR GREANEY: Thank you, Mr Jamieson. Ms Roberts next on behalf of NWAS, and could I ask her, please, to pick a point between quarter to 11 and 11 for us to have our break.

Questions from MS ROBERTS

MS ROBERTS: Thank you very much.

Sir, I'm going to begin, if I may, please, with a correction of which your inquiry team are aware. It's designed, I hope, to help everybody.

Mr Ennis, during yesterday afternoon's session, you were asked about the time at which you first received triage tags, the cruciform cards, and it was suggested to you that a likely moment for that to have taken place was at 23.29 because we can see an interaction between you and the HART operatives.

Sir, in fact the footage has been viewed and viewed a number of times, and the body-worn footage of a Police Constable Dennison at 23.17.35 shows Mr Ennis taking triage tags out of Leah Vaughan -- she's one of the HART members, out of her rucksack. That's confirmed in other

body—worn footage of another police officer, Mr Hill, and during the course of further sightings of Mr Ennis within the City Room, he can be seen with triage tags in his front pocket. That's from 23.17 onwards.
SIR JOHN SAUNDERS: So it's 23.17 instead of?
MS ROBERTS: 23.29, which was what was suggested yesterday. It was quite an understandable inference that was put to him, but that's as I understand it.
MR GREANEY: I wouldn't like to proceed for the time being on the basis that that is the time. It necessarily needs to be checked.
SIR JOHN SAUNDERS: No doubt all the information will be supplied to Mr Greaney and other CPs and they can look at it themselves.
MS ROBERTS: It can. That's why we alerted the team to it.
Briefly if I may, Mr Ennis, because you've dealt with this subject a good deal more this morning via the questions that you've, if I may say so, very properly been asked, it's really triage versus treatment.
So there is a clear understanding by all those who need to understand the difference between the two, because we know that you went back into the City Room at about 11.05 to conduct what you told us yesterday was the triage sieve. Is that right?
A. Yes.

Q. You took on, I think, although not formally assigned the role, but you took on the de facto role of primary triage officer?
A. Yes.
Q. Could you just tell us simply and clearly what that role involves?
A. The main role —— initially, as the only person fulfilling that role it was to ensure that all patients were categorised into one of the four categories, whether that's priority 1, 2, 3 or unfortunately dead, and then they are then prioritised for treatment appropriately.
Q. How do you categorise them?
A. The process of categorising them initially starts with —— at the top of the sieve is identifying any catastrophic haemorrhage, which we've mentioned, that wasn't seen. It then asks that anybody who's able to walk, so any of the priority 3 patients, so despite injuries, if they're able to be mobilised away from the area, that they are moved, and that's something that the event medical staff assisted with.
Q. Just pausing there, would that also include, so far as the priority 3s are concerned, those who are able to walk of their own volition, but those who are able to be assisted out?

A. Yes. The priority 3 category, it does refer to those who are mobile, so walking wounded, but certainly because of the number of people in the area, it certainly seemed appropriate that anybody that could be, with minimal assistance helped, would still fall more appropriately into that category. Anybody who couldn't mobilise with minimal assistance would therefore fall into the priority 2 category.
And then to identify those who are priority 1 would be either those who had a catastrophic injury, those who were unconscious but were breathing on assessment of their airway, or those whose respiratory rate was outside of normal range, so either less than 10 or over 30, or those whose pulse rate was over 120 or had a delayed capillary refill time.
Q. Right. Is that what you were doing within the City Room when you went back in there?
A. Yes.
SIR JOHN SAUNDERS: Are you able to say —— obviously because of the number of injuries you're working as fast as you can, but can you give me some idea of how long it would take you to categorise? Obviously it's going to vary, but give me some sort of average per person.
A. I would say —— it's a deliberately simple process. The major incident procedure talks about the fact that

actually often people with less clinical knowledge can sometimes be better at performing the role because they don't overcomplicate it with their knowledge of injuries. But actually, it is a simple and quick process, so although it sounds like it could be quite complicated, really as soon as the walking wounded have been moved it can be performed very rapidly and it will depend on the individual patient. It could be as simple as somebody's unconscious and their airway is opened and they start to breathe. There may be no further assessment required in order to deem them as priority 1.
So anybody who's obviously breathing in a manner which is outside of the normal range, that could be assessed remotely and that would immediately put them into the priority 1 category without any requirement to assess further.
SIR JOHN SAUNDERS: And the answer to the question is?
A. Sorry. The answer is it depends, but could be... It could be that actually it can be decided in a matter of a couple of seconds without having to physically put hands on the patient or it could take a matter of, say, 6 seconds in order to check a pulse rate, which would be the minimum amount of time needed to establish that somebody had a tachycardia, which would be something that would put them into that priority 1 or potentially

priority 2 category. So I'd say anywhere between 1 second and 6 or 10 seconds.
SIR JOHN SAUNDERS: Thank you.
MS ROBERTS: So a rapid process?
A. Yes.
Q. You've told us that the P3s, you would want those to either walk or be able to walk themselves out of the City Room ——
A. Yes.
Q. —— or be, with mineral assistance, guided out of the City Room. Why was there a necessity for the P3s to leave the City Room?
A. As part of the major incident plan, it asks that all of those who are initially uninjured would be moved to —— it suggests a survivor reception and then the priority 3 patients move. What this means is that they are leaving an area which is potentially dangerous, but they also are —— by virtue of being injured people who are in pain, are likely to be, although they require assistance, they could somewhat distract from those who were even more injured, so it renders the area more manageable.
Q. Thank you. You're dropping your voice a little. It's very important ——
SIR JOHN SAUNDERS: If you don't mind me saying so, I'm

finding you quite difficult to hear as well. It's all these bits of glass which people aren't used to having. Undoubtedly, everyone else can hear you except for me, but just for my benefit.
MS ROBERTS: Thank you, sir.
I'm going to ask you now about zones. I am not sure you touched on this yesterday, so can you just help us with understanding what your knowledge at the time was, because I appreciate there might be a difference now, but at the time what was your knowledge of zones? First of all generally and then in relation to this specific incident.
A. I had undertaken major incident training before this, so I had a reasonable working knowledge of the application of zoning in a major incident and also in a marauding terrorist firearms type incident. So I understood the difference between hot zone, warm zone and cold zone in these different types of incidents. At this particular incident, although not formally discussed, I was under the impression that the City Room was a major incident hot zone in that that was the area that the explosion had taken place in and in which there was a potential for a secondary device.
Q. Right. So a major incident hot zone?
A. Yes.

Q. I think from what you told us yesterday we can put Operation Plato to one side because it didn't form part of your consideration, you knew very little if anything about Operation Plato, and that certainly hadn't been communicated to you on the evening?
A. No. I knew what a marauding terrorist firearms incident was and I knew what the difference in terms of zoning and management at a major incident —— if it was a firearms incident. But the term Operation Plato is one that wasn't familiar to me. The implications were, but not that term.
Q. So far as your consideration was on the night, this was a major incident, the City Room was a hot zone?
A. Yes.
Q. So far as the paramedic response, the NWAS response, is concerned, what was your understanding about which paramedics, if any, could enter a hot zone in a major incident?
A. My understanding is that the HART team were the operatives who would be trained and able to be deployed into that area.
Q. Anybody else within the NWAS response?
A. No, only those with a HART level of PPE would be usually, as per the plan, deployed into that area.
SIR JOHN SAUNDERS: I'm interested in this, as I asked you

whether there was any discretion in relation to that, and you said then there was some discretion.
A. So the plan suggests that the correct people to be deployed into that area are the HART team. The plan is —— it is a plan, it's a guide, it isn't decided —— sorry, it isn't a definitive thing. But I think it's fair to say that an operational commander would need to perform quite a robust risk assessment and would be deviating from the plan if they decided to deploy paramedics without that level of PPE and without the HART level of PPE into that area.
SIR JOHN SAUNDERS: As you explained, you can get situations where HART may just not be there for quite a long time, in which case you have to make that sort of decision presumably?
A. Yes, and it'd one that would need to be justified, particularly if anything were to go wrong and any harm were to come to those people, then the operational commander would then be held to account because they would have deviated from the suggested plan.
SIR JOHN SAUNDERS: Thank you.
MS ROBERTS: And deviate from the plan is precisely what you did, in fact, because you are neither HART nor were you wearing the kind of protective equipment, the ballistic equipment for example, that they would have been or

might have been wearing?
A. Yes.
Q. So you self−deployed into the hot zone, flexing the plan that you've told us about, and thus operating outside what ordinarily takes place or ought to take place within a major incident hot zone?
A. I think the ... Until obviously seeing the City Room, it wasn't apparent that that was a ... that indeed it was definitively a major incident or that it was potentially a dangerous area.
Q. But at 11.05, when you went back in there, that was patently obvious to you?
A. Yes.
Q. Yes. When you went back into the City Room at 11.05, that was after your discussion with Dan Smith, who was by then the operational commander; correct?
A. Yes.
Q. Right. Can you help us, and forgive me if you've already told us about this, but the discussion that you had with Dan Smith when you and he congregated on or around the station concourse in what was to become the CCS, what discussion was there about whether you were content to go back into the City Room, first question, and second question, whether anybody was going to be going with you?

A. I don't recall ... Sorry, I ... I believe that I suggested that I was going to be going back into the City Room and didn't wait for instructions from Dan Smith to tell me whether he agreed with this or otherwise. I think I explained to him that was what I intended to do. At the time, I don't think there was any discussion about anybody else joining me in there based on the fact that the other NWAS personnel who were there were required in other capacities.
Q. We're going to look at the major incident plan, the reference for which is {INQ013132/21}.
Down towards the bottom of the page, it's the paragraph, please, that begins 4.6.1.
"First resource on scene."
That was you?
A. Yes.
Q. It's the second paragraph:
"An initial assessment of the incident (METHANE situation report) must be reported back to the EOC promptly."
Just pausing there, it's my understanding, Mr Ennis, that shortly after arriving at scene, and by which I mean the vicinity of Victoria Station, at 22.46, that's when you passed what's been referred to as the partial METHANE; is that right?

A. Yes.
Q. Is that when you were outside the station, I think on Hunts Bank itself?
A. Yes. I think that's when I was still making my way up towards the station.
Q. So we know that you arrived on scene at 22.42, so within 4 minutes of your arrival you had passed that information back to the EOC −−
A. Yes.
Q. −− the emergency operations centre? All right. It says this:
"The acting operational commander..."
And just pausing there, because you were first responder on scene, you became the de facto or the acting operational commander, is that right?
A. Yes.
Q. So again, this is referring to you:
"The acting operational commander must not become involved in treating patients but concentrate on establishing initial command and control of the incident."
We know, Mr Ennis, from what you've told us, that you went into the City Room within 7 minutes of passing that initial or that partial METHANE at 22.46 and into the City Room you went at 22.53. You were asked about

the plan yesterday and why you had deviated from it or not followed certain aspects. I would like to ask you, please, about the top of {INQ013132/22} −−
SIR JOHN SAUNDERS: Just before you leave that, do you mind, as we're there? I know it's interrupting your flow.
I just wonder how realistic this is and whether it's actually designed for when an ambulance turns up or two ambulances at the same time with a number of people because calling you acting operational commander is all very well, but you have actually no one to command but yourself.
A. Yes, that's absolutely correct.
SIR JOHN SAUNDERS: If you look at the next paragraph, what it's telling you is you have got to concentrate on establishing initial command. It says you have to establish key functional roles, parking officer, casualty clearing officer, all the rest of it, but there was no one there to designate to that?
A. No, this is true.
SIR JOHN SAUNDERS: I just wonder where you've got, as you were, an advanced paramedic turning up before everybody else, which is presumably part of the job, I wonder how this really fits in with that. Were you thinking, "I'm an operational commander, I've got to think of who's going to be the casualty clearing officer and the

parking officer"?
A. Well, I was thinking that at the point of -- that if I needed to take on the operational command role that the next bit would be to establish the functional roles.
SIR JOHN SAUNDERS: When somebody came?
A. When the next people came, yes, absolutely. If the next resources to arrive had been emergency ambulances rather than --
SIR JOHN SAUNDERS: Dan Smith?
A. Yes, rather than senior people (overspeaking) would have been very different.
SIR JOHN SAUNDERS: I understand that. Sorry, I'm really sorry to cut across you again. You're left in this situation with a choice, aren't you: I either stay here and wait for the ambulances to come and I don't know when they're coming because I know there's a lot out anyway or I actually go and look at what's happening and see what needs to be done?
A. Yes, this is true.
SIR JOHN SAUNDERS: So were you thinking to yourself: I'm deviating from the major incident plan, a deliberate deviation, or is there really no choice in that situation but for you to go and do what you did?
A. I don't think there was any choice, no, because I think that the key part of this really is to get across that

what this really wants you to do as the first person on scene is fight the instinct as a paramedic to just help the immediate people you come to and try and gain information and step back from dealing with any patients. I think that's the overriding thing. The practical application of it is very much going to be in flux because the first person to arrive on scene could be a very new paramedic, for instance, the next person who arrives could be a more senior paramedic. So the role of acting operational commander is one that could be -- it could be very much in flux. But I think the important overriding thing is to try and gain as much information as possible, which --
SIR JOHN SAUNDERS: And get it back to the EOC?
A. So they can get the right people there. That was my intention and I hope that I did that in --
SIR JOHN SAUNDERS: I understand that. Obviously, no plan can actually provide for every circumstance and tell what you to do.
A. Mm.
SIR JOHN SAUNDERS: But realistically, the idea of you waiting at the front for the person who turned up, whenever they were going to turn up, to tell them to be the parking officer or something just seems not very sensible?

A. I suppose at the point of waiting, the idea -- I mean, it would depend on the major incident, obviously. This plan is designed as a kind of one size fits all for a variety -- it wouldn't be possible to account for a major incident that occurs on -- you know, it's different on a motorway or a train. The application of it is obviously going to depend on the geography and the unique layout and things like that. But the idea of remaining at the periphery, liaising with other agencies and starting to put things in place is the appropriate one. I think the assumption is that some of that information is apparent from there, where actually it might not be and it might be necessary to assess the scene more accurately --
SIR JOHN SAUNDERS: But what you did enabled you to get situational awareness and you can actually liaise with the only other commander on the scene who, as it happened, was in the City Room?
A. Yes.
SIR JOHN SAUNDERS: Thank you. Sorry, Ms Roberts.
MS ROBERTS: It's very helpful, if I may say so, sir.
Deficiencies in this plan, or any plans, when applied to the real world, as this was confronting you and others that evening, are something obviously of concern, but Mr Ennis, I'm sure many will be grateful

that in fact you did deviate from this plan and, as the chairman has said, choose the second of two options, in other words instead of waiting at the front of the entrance and waiting for other ambulances to arrive, you went straight to the City Room and were able to obtain that situational awareness of which you have told us.
Deficiencies, I suppose, so far as the plan is concerned, are evidenced on {INQ013132/22}, the very first paragraph of which:
"First resource on scene. Driver. The driver from the first resource on scene will establish a communication link between the operation commander and the EOC and facilitate further communications between the two. The driver will stay with their vehicle."
Well, you were not only the first responder, you were the driver, there was just you, wasn't there?
A. Yes.
Q. Just moving down the page, it's the section within the blue box that begins:
"It is imperative..."
And you've been asked a number of times about why it was or the inference being why it was that those other paramedics who began to arrive just short of 11 pm, why they didn't go into the City Room and assist those who most needed assistance. It says this, does it not:

"It is imperative that the first three vehicles or first six staff on scene establish command and control of the incident. They will not..."

So it seems to be mandatory:

"... become involved in patient triage or treatment until appropriate command and control has been established to the scene."

Again, it will be for others to decide because this isn't your -- you didn't write this plan.

A. No.

Q. This isn't your plan and it will be for others to decide whether, as we have said, in the real world, confronted by a catastrophe that this was, whether that is sensible or workable.

That said, I would like you to help us --

SIR JOHN SAUNDERS: It seems on the face of it a bit arbitrary --

MS ROBERTS: It seems mandatory --

SIR JOHN SAUNDERS: -- six staff -- well, it may be mandatory, but the actual selection, the number, seems quite arbitrary.

MS ROBERTS: Yes. We're going to, if I may, if we may, sir -- and I'm in your hands and certainly those who sit alongside me as to when we take that break, but can we just finish perhaps with the plan?

SIR JOHN SAUNDERS: Do.

MS ROBERTS: Thank you.

In terms of the numbers who were there. Could you just help us with your understanding, Mr Ennis, as to why those first few paramedics on scene, those first few responders, have to set up and establish command and control of the incident when, as you have told us, perhaps every human aspect, every aspect of their being as both a human but also a paramedic might want them to be treating patients rather than setting up command and control? What is the importance of setting that up?

A. I'll try and keep the answer brief, but basically just to ensure that the overall incident is managed as effectively as possible so that the most can be done for the most. And focusing too early on individual patients or on patient treatment could be to the detriment of the overall management and therefore to the overall --

SIR JOHN SAUNDERS: We well understand that. The idea of you stopping by the door and treating someone who's got very minor injuries and leaving someone with terrible injuries upstairs would not be for the benefit of the overall system. We'll hear, no doubt, why it falls to the first six staff as being the people who stay down there and do it, but no doubt there will be some explanation of that. I think we well understand why

you have to stand back and try and devise a plan which is going to help the most people in the quickest possible time.

MS ROBERTS: And also those who follow on from you, whether that's the next five, doing the maths, or whether that's the next three or four who follow on behind you. I'm trying to understand, so that everybody can understand, is there a thought process being applied here to outcome? In other words, as to where the patients are going to go and where they and how they will receive the best treatment to enable the best outcome for them? Is that what establishing command and control at this very early stage is all about?

A. Yes. It's fair to say, although... Ultimately, the requirement is going to be to get all of the patients to the correct hospitals and although I'm probably not the best person to talk about the mass casualty distribution plan, but as an advanced paramedic working at times on the trauma cell, so providing advice to paramedics throughout the whole of the north-west about how to deal with the trauma patients, I was very familiar with the Greater Manchester trauma network and the particular specialties that could be provided by particular hospitals, whether that be major trauma centres, trauma units or regular hospitals.

All the patients ultimately need to be at hospital but it's important that it's the correct hospital that is able to deal with their particular injuries. And that would be penetrating trauma, for instance, to Manchester Royal Infirmary --

SIR JOHN SAUNDERS: I think we all well understand you need to get the right people to the right place where they're going to get the best treatment.

MS ROBERTS: Thank you. We're going to turn to a separate topic, which is, again, touching on something you said yesterday, both in your knowledge generally of how busy the service was and busy the service was more specifically that particular evening, because you told us that having been working earlier, you had seen the screens and you had seen the level of activity of paramedics and ambulances earlier that evening.

A. Yes.

Q. So you had your general knowledge based on your experience and your expertise within the organisation then, but you had the specific knowledge of your operational duties that evening; is that right?

A. Yes.

Q. I think what you told us yesterday was that you did know, as the advanced paramedic for Manchester, that you had seen the control screen, you had seen how busy the

organisation was, and on top of that general pressure upon the organisation, that it was a busy Monday evening with, I think you told us, about 60 outstanding 999 calls, that's 60 patients waiting for ambulances. Was that just in Greater Manchester or was that across the north—west?
A. No, that was just for Greater Manchester.
Q. Just for Greater Manchester. And we know, Mr Ennis, and we don't need —— in fact, it might actually help if we briefly have these two on the screen and then it might be sensible, I think, to take a break at that stage.
The first INQ reference, please, is {INQ040952/1}. At 22.32, so seconds after the explosion itself, the available ambulances —— it says ambulances, there are other vehicles listed, in Greater Manchester and we can see that they total seven. Could you help us, please, with the difference between emergency ambulance, urgent care and intermediate vehicle?
A. Yes. The emergency ambulance is one that is manned by usually a paramedic and an emergency medical technician, so capable of responding to a full range of emergencies. The urgent care vehicles are those that are manned by urgent care clinicians, so not trained to deal with emergencies, and intermediate is one also not prepared

for emergencies, so designed to deal with, for instance, medical admissions to hospital rather than responding to emergency calls.
Q. So of those seven vehicles, only four had on them staff who were able to assist with emergencies?
A. Yes.
Q. If we can turn to the next INQ reference, which is {INQ040953/1}, which is the summary of the unavailable ambulances that evening. And over the page, please, as well {INQ040953/2}. So 76 of the ambulances not available because they were either at scene, meaning the address of the incident or emergency to which they had been dispatched; at destination, meaning they were at the hospital having picked up that patient and conveyed them to the appropriate hospital —— and again just so we're clear, as I understand it, once they've taken that patient to hospital, they can't simply deposit the patient at hospital and leave, can they?
A. No. Very many of these patients would be on the ambulance stretcher and would have to be transferred on to a hospital bed that may well not be immediately available. So there is a time that needs to be taken there in order to hand over the care for that patient.
Q. Thank you. That can come off the screen.
SIR JOHN SAUNDERS: Just to make clear, you knew they were

busy that night from what you had seen, but you wouldn't have known that information, would you?
A. No, not to that level. No, I wouldn't have known the specifics but the rough picture there that we had very few ——
SIR JOHN SAUNDERS: You knew we might be in for a long wait to get sufficient ambulances here tonight?
A. Yes.
MS ROBERTS: Just so we're clear, that wasn't available to you in terms of that level of detail. That's work that's been done to explain that. I think you did tell us that you were aware on the evening, having seen the screens earlier, that there were about 60 999 calls still waiting for an ambulance.
A. Yes.
Q. And that's presumably because the ambulances were busy dealing with other patients elsewhere as we have just seen?
A. Yes. Monday evening is traditionally one of the busiest times of the week for the Ambulance Service and for the hospitals. This was no exception. There were other emergencies. One of the emergencies being responded to was a cardiac arrest at the same time as this was ongoing.
MS ROBERTS: I just want to pick up on the chronology and

some of the numbers that have been given, and I can do that either now, if everybody else who is in court is happy to do that, because I also want to pick up, if I may, please, on the ambulance expert report, which is listed within Mr Ennis' evidence proposal. So I'm in your hands, sir, as to whether we do that now and the witness.
SIR JOHN SAUNDERS: It's clearly going to take some time to do that, so we'll have a quarter of an hour break now. Thank you.
(11.02 am)
(A short break)
(11.22 am)
MS ROBERTS: I'm going to turn to a chronology and we can take this first part, I hope, relatively swiftly. I'm going to give out a series of times. I don't ask you to comment on them, but I think it might help —— I hope it will help —— people in their understanding of events.
So explosion at 22.31. We've looked at the available and unavailable resources across Greater Manchester at that time. By resources, I mean paramedics and ambulances.
You arrived at scene at 22.42.
You gave the first, the partial METHANE at 22.46.
You went into the City Room at 22.53 and at 22.54,

you gave an additional METHANE.

At 22.57, Mr Ennis, you are captured on the body-worn footage of a Christopher Dawson, a police constable, saying as follows and it was read to you yesterday:

"In a minute we need to start thinking about getting some casualties moved out."

By casualties, had you formed a view at that stage as to what priority those casualties were or did you mean all casualties?

A. Although I don't think I had -- I hadn't been able to triage people, but there were already people who were obviously most in need of treatment, so I was referring to those.

Q. So there was, so far as you are aware, and you could see, a plain need to move people out of the City Room, and we can all understand why you formed that view, and communicated it to the police at 22.57.

We were told yesterday of communications that Inspector Smith had made and in fact we heard those and read transcripts of them when he gave evidence about 2 weeks ago.

The communications, I think, that were put to you yesterday were at 22.48 and at 22.50. At 22.48 and at 22.50, those communications about which you were asked,

you hadn't even met Inspector Smith by that time, as I understand it, because you weren't in the City Room with him until 22.53. Do you follow?

A. Yes.

Q. Back to the timetable then, so 22.57, the need identified by you to move people out. The need being identified by Inspector Smith to, "Get NWAS and every available NWAS to scene".

But 22.58 is the time of the arrival of the first ambulance. It's not until 22.58 that that happens. You were asked yesterday about the decision, whose decision it was to move patients out by tables, by barriers, or in fact by whatever means.

At 22.59.22, the body-worn footage of Police Sergeant Gary Linney captures Inspector Smith saying:

"If they can get them out, you know, the tables or whatever, and just take them out to the entrance."

And again, at 22.59.37, the same police officer's body-worn footage captures Inspector Smith telling another of his officers, a Sergeant Beasley:

"Just anybody who is injured and can go if they can carry them out, tables or anything, we can do that."

Can you remember at that time -- in fact you left the City Room at 22.59, so can you remember whether you heard Inspector Smith or any of the police officers

within the City Room at that time communicating that to their officers?

A. I can't recall at what specific time it occurred, but I do remember the suggestion being made, I think by Inspector Smith, of moving people out in that manner and I agreed that that was the right thing to do. So yes, at around that time I do remember.

Q. You were asked yesterday about fire and the stretchers that they may or may not have had with them had they attended scene. I don't intend to ask you about that, Mr Ennis, but in addition to any stretchers that fire could have brought to scene, did you see or take notice of any stretchers that were already on scene, in other words that were at the venue itself or on site?

A. No.

Q. You left the City Room at 22.59. At 22.59 was the arrival of Dan Smith, who became operational commander, Dr Michael Daley, a MERIT doctor, and Derek Poland, who became parking officer. So at 22.59 there were four NWAS personnel on scene; correct?

A. Yes.

Q. I'm moving to the period between 23.00 hours, so 11 pm, and 23.22. At 23.01, first of all, and we know by this stage that HART have been summoned to attend the scene, so they are on their way at this stage, but they have

not yet arrived, so at 23.01 -- could we go, please, to the sequence of events, which is {INQ035612/183}.

Top photograph, please, Mr Ennis. At 23.01, you have made your way down from the City Room, having given that second METHANE at about 22.54. You are in conversation with, to your left and straight ahead of you, with no helmet, that's Dr Daley, is it not?

A. Yes.

Q. To your right and looking at you, that is operational commander Daniel Smith; correct?

A. Yes.

Q. Diagonally opposite you, wearing a white helmet, is Derek Poland who become parking officer; am I right?

A. Yes.

Q. The gentleman with the purple gloves on, as I understand it, was a British Transport Police officer, Matthew Martin.

A. Yes.

Q. So that captures, does it, at 23.01, the available NWAS personnel who had attended the scene; correct?

A. Yes.

MR GREANEY: Sir, I'm sorry, but I don't believe that is correct. Because we know that three other paramedics had arrived just shortly before this and been deployed to Trinity Way, namely Martin Nelson, Callum Gill and

Leigh−Sa Smith.
MS ROBERTS: That's absolutely right. So at scene in this vicinity at the front entrance of Victoria Station in what was to become the casualty clearing station, there were four NWAS personnel. And the three to whom Mr Greaney correctly refers in fact were not back at the front of Victoria Station, as I understand it, until about a quarter of an hour or so later. I'll be corrected if I'm wrong about that, but as Mr Greaney rightly says, they were deployed elsewhere.
SIR JOHN SAUNDERS: You knew nothing about them presumably?
A. No.
MS ROBERTS: You were referred earlier by my learned friend Mr Atkinson to the numbers of people who were moving down from the City Room down to the casualty clearing station. I'm not asking for this to go on to the screen, but I'm asking for note to be taken, please, that the timings given, which begin at 23.07 −− sir, for your reference, the CCS map and key is at {INQ041266/1}, not to go on the screen, please. Those are arrival times at the CCS rather than departure times from the City Room.
SIR JOHN SAUNDERS: Okay.
MS ROBERTS: Footage has been seen as best as it can be of how long it took to move those 38 patients from the

City Room to the CCS.
Mr Ennis, we know you were back in the City Room at 23.05. We know that the first of those patients, priority 2 and 1, arrived at the casualty clearing station from 23.07. So allowing for a little time for those people to be moved in the manner in which they were moved, it follows, doesn't it, that when you got back into the City Room that approximately that time was the time at which the casualties began to be extricated from the City Room and down to the casualty clearing station?
A. Yes.
Q. At 23.15 was the point at which two members of HART, Chris Hargreaves and Lea Vaughan, arrived into the City Room and began their triage within a minute. Did you speak to those two individuals when they came into the City Room?
A. Yes.
Q. Was the purpose of that to give them a brief update and to make them as aware as they could be before they started their triage?
A. Yes, it was.
Q. So at 23.16, I think it was, when they are first seen triaging, at 23.16 there were already ten P1 and P2 patients within the casualty clearing station at that

time, and within the casualty clearing station about 14 or so paramedics. So as I say, about ten of those P1s or P2s with 14 or so paramedics.
Moving through those timings, as we will, and as we can fairly rapidly, I hope, you told us that you knew that HART had already been deployed elsewhere so that although they would be on their way, they could not by definition be there with the same speed and alacrity that you were because you knew they were elsewhere?
A. Yes.
Q. Did you know where they were?
A. Yes, I knew that they were tasked to an incident in the Stockport area.
Q. They were about 15.5 miles away from the arena when they were notified of this incident, and in fact it was Annemarie Rooney, the Silver or tactical commander that evening, who at 22.40, in a communication, can be heard to say, "Get HART here". So within 9 minutes or so of the explosion, HART had been deployed to go to the arena and arrive there they did.
At 23.22, the other HART, that's the other members of that particular HART team, were all at the station, by which I mean at scene. And at 23.22, when those other members of HART were at or in the station itself, and by that of course I don't mean Mr Beswick, who

remained downstairs in the casualty clearing station area at the point at which those other two, Chris Hargreaves and Lea Vaughan went in, but those three, having arrived at scene at more or less the same time, the other three arrived as a two and a one, as I understand it, so that all six were there by 23.22.
SIR JOHN SAUNDERS: Ms Roberts, I hesitate to interrupt, but you may be getting close to the longest question and I have yet to hear anything that this witness can actually answer. It may sound a bit like a speech to me, which is often easier to follow when I've got a script as well. But you're painting the picture?
MS ROBERTS: I am, I hope, and I hope by doing so, and as I said I know that I'm doing that, but I feel it's important for those, both within the room and elsewhere, to understand the chronology and to understand the numbers of those who were there, of those who could have been there because of the understandable concerns of those here and elsewhere as to why more people weren't there at appropriate times or what was felt to be an appropriate time and why more people didn't deploy, for example into the City Room, at an earlier stage.
I think it's important that people understand where they were.
SIR JOHN SAUNDERS: It's certainly the answers that I wish

to get through the evidence generally because it is a genuine concern. I'm just wondering whether it's most appropriate really having someone simply as a mouthpiece saying yes to things he doesn't actually know the answer to.

MS ROBERTS: Well, as I say, I'll move on because we've dealt with the chronology.

SIR JOHN SAUNDERS: Okay.

MS ROBERTS: As I say, it's designed to assist both you, sir, and others in noting down those specific times and in filling in matters that perhaps otherwise ——

SIR JOHN SAUNDERS: And certainly it would be helpful for me to have your chronology in writing at some stage. I've tried to note things down as we're going along, but I can't actually keep up with everything. So certainly in writing at some stage would be really helpful.

MS ROBERTS: Absolutely, sir.

Finally, I'm going to turn, I hope expeditiously, to the ambulance expert report which was within this witness's evidence proposal.

Can I just check ——

SIR JOHN SAUNDERS: Are we dealing with potential criticisms of this witness that he can deal with?

MS ROBERTS: I know the witness has read these particular reports. I'm only going to ask him about one. No, sir,

it was to pick up really in relation to the response of Mr Ennis. There are criticisms within the report, but there are, as you know, sir, a lot of very positive things that are said within the reports that again give context to decisions made by Mr Ennis and the actions he took that particular evening.

SIR JOHN SAUNDERS: Provided they are things he can properly comment on. I haven't been applying many of the rules of evidence, as you're aware, but if we can have things that he can comment on, it would be helpful because we will, of course, hear from the ambulance experts, who will be able to give their views in due course.

MS ROBERTS: We will, sir. I will ask this question then, picking up on something that Mr Ennis said yesterday.

When you told us, Mr Ennis, that you were being a little self—critical, it was at a point at which you'd spoken about this event to others, both Kerslake and I think a BBC interview was also put to you. Why self—critical? What are you critical of yourself about?

A. I think it's probably the nature of many clinicians, many paramedics to be quite self—critical and always want to have done better. In terms of this particular incident, I think I felt everything could have been done faster or more efficiently. That was my general thought, was just to —— rather than focus on things that

perhaps went well or worked out well, was to focus on the things that I felt could have occurred better, but I think that's my nature.

Q. Was one of the things you were self—critical of, I think you said this yesterday, the time it took you to pass that METHANE or to gain that situational awareness?

A. Yes, it was, yes.

Q. Are you aware, having read the ambulance expert report, that they think that you in fact passed that information expeditiously?

A. Yes.

Q. Has that changed your view or your self—criticism or do you remain self—critical?

A. It has changed it somewhat. I think when I read the report, I think it helped to put things in context of perhaps the time frame that they expected this type of information to be passed back, which made me perhaps feel slightly better about the time it had taken me.

Q. Just finally this: we know that a theme of the evidence of some of the police officers from whom we have heard was that they wished, and understandably wished, for more paramedics to be in the City Room. What is your evidence, please, about whether you think it would be helpful for police officers, those who are able to respond quickly and effectively, for them to have a good

understanding of the pressures under which the Ambulance Service operate on a day—to—day basis so as to inform them of the realistic speed at which, and numbers in which, NWAS or any other ambulance service can respond?

A. I think that would be useful. I think we work very closely with the police on many incidents and generally the ambulance and police have a very good working relationship.

SIR JOHN SAUNDERS: Don't you think they have a pretty good idea as it is?

A. I think they do, but I still think they probably don't quite understand just how differently we work as an ambulance service to the police, just the nature of their work is it's very much preventative, so therefore the numbers that they have available may be far greater than ours. I think although there are probably many occasions when they are waiting for long periods of time on perhaps the streets of Manchester, waiting for an ambulance to come for an individual patient, which does give them an understanding to some degree of how busy we are.

The expectation that they had on this night perhaps would suggest that they didn't really understand the context of how many ambulances or paramedics we have or

would have. So yes, that might be helpful.
SIR JOHN SAUNDERS: It depends, doesn't it, a bit on the explanation for why paramedics didn't get up there sooner? Is it because there just simply weren't -- they were all out doing their job and there just aren't enough ambulances in Manchester to cope with this or is it decisions taken to deploy people elsewhere and how justified they are?
A. I think it's a multi-factorial thing. The picture prior to the incident of how stretched we are, this is something which is certainly across the whole country, not unique to Manchester or to the north-west. The decision to direct resources and ambulances from patients who are in need of ambulances to this incident is one which was taken effectively but is a difficult one, particularly based on the fact that the incident itself was coded as an amber, so of course anything that was red, so a red 2 or red 1, would be higher category so technically should be the one that receives the ambulance.
SIR JOHN SAUNDERS: So if it was red, if it had been coded red, are you saying they would have got more ambulances there quicker?
A. No -- well, I can't comment on the specific decisions that were made. And certainly my understanding is that,

as it was dealt with as a major incident, then that supersedes the usual coding. But in terms of the normal dispatching, any red category call would be sent an ambulance before an amber category call, and it would need to be a justifiable clinical decision to override that and send the ambulance to what is a lower category call. So I am not suggesting that it delayed any response to the incident, but I'm suggesting that there are difficult decisions that need to be made in order to get the ambulances that are needed to this incident and also manage the incidents that are still ongoing, which are also potentially very serious.
SIR JOHN SAUNDERS: I well understand, I'm sure everybody understands that for an incident like this there will be difficulties getting enough ambulances there. I'm afraid that even if Ms Roberts gets all the understanding and joint talking that there may be, if you've got policemen who are essentially not anything like as well trained as paramedics treating injuries and they're having difficulties, I think they'll be screaming out for paramedics however much understanding there is, as will members of the public.
A. I agree.
MS ROBERTS: And everyone can well understand why.
Finally, and it's just picking up on some evidence

that Sergeant Kam Hare -- and we all well remember his evidence on 19 March. He said -- did you see his evidence?
A. I saw some of his evidence.
Q. I am going to ask you about something he said towards the very end of his evidence when he told this inquiry that since the events of 22 May 2017, there had been an enhanced awareness and certainly an enhanced delivery of first aid training that certainly he had had and potentially others within GMP. Were you part of that enhanced or part of that training with the police or not?
A. No, I wasn't.
Q. Right. Again, just going forward, trying to understand how a response next time, if there is a next time, how it could be better and how it could be improved, would it help, do you think, if those who are on scene themselves at the point at which something happens or those who can deploy to scene very rapidly thereafter but who are not ambulance personnel, if they had better first aid training and better medical training, basic medical training, to provide a stopgap, if you like, before the ambulance personnel can get there?
SIR JOHN SAUNDERS: You can just say yes to that, I think.
A. Yes.

MS ROBERTS: Thank you very much.
Thank you, Mr Ennis, thank you, sir.
SIR JOHN SAUNDERS: Just before you finish, we know there were the in-house first aid team there. Were you able to see how they performed? If not, say not.
A. I could. I thought they were doing an excellent job of providing first aid.
SIR JOHN SAUNDERS: Basic first aid?
A. Yes, I did.
SIR JOHN SAUNDERS: Thank you.
MS ROBERTS: That's helpful, sir, thank you.
MR GREANEY: It's a little earlier than we would normally take a break, but we will need a short break to enable the next witness, Dan Smith, to come into the courtroom and I will also need to meet him before he does so.
SIR JOHN SAUNDERS: How long does that mean?
MR GREANEY: I hope no more than 10 minutes, so long as he has been brought upstairs.
SIR JOHN SAUNDERS: Obviously take the time you need.
Thank you for your evidence.
A. Thank you.
SIR JOHN SAUNDERS: It may be that you think we're all being very critical, and actually maybe somewhat unrealistic, talking about major incident plans and all this, that and the other, when you're put into an emergency

situation which even you with your experience cannot ever have faced before.
A. No.
SIR JOHN SAUNDERS: So we accept that we are being slightly unrealistic and it's just not real life. But we are keen to see whether things didn't happen as they should have happened. Everyone is keen to know why it was that the paramedics weren't there first as a matter of public interest and we need to get to the bottom of it.
So we are not intending to be critical of you. Many of the things you did were absolutely right and you operated in an area which you were not convinced was safe for you to operate in and you carried on doing what you could to get people out of there as quickly as possible. But I will have to look at whether everything went right in the face of all the evidence.
A. Yes, thank you.
SIR JOHN SAUNDERS: Thank you.
(11.50 am)
(A short break)
(12.03 pm)
MR GREANEY: Could Mr Smith be sworn, please.
MR DANIEL SMITH (sworn)
Questions from MR GREANEY
MR GREANEY: Would you begin by telling us your full name,

please?
A. It's Daniel Peter Smith.
Q. In May 2017, were you a consultant paramedic with NWAS?
A. That's correct.
Q. And were you the lead paramedic for Greater Manchester?
A. Yes, sir.
Q. Meaning that you led the paramedic teams in that area?
A. Yes.
Q. Had you by that stage received training enabling you to undertake the role of both operational and tactical commander at major incidents?
A. Yes.
Q. Were you familiar with the NWAS major incident response plan?
A. Yes.
Q. And had you received training in that plan?
A. Yes.
Q. Were you familiar with what an MTFA and Operation Plato were?
A. Yes.
Q. And had you received any training in those?
A. Yes.
Q. Were you the NWAS operational commander at the scene in the response to the arena attack between your arrival at the scene, just prior to 11 pm, and your replacement

by Stephen Hynes shortly before midnight?
A. Yes, sir.
Q. Just before we delve further into your evidence in relation to that night, I'm going to make two things plain, and this isn't really for your benefit, it's for the benefit of those who are watching either in this hearing room or remotely.
The first of those two things is that although you did not at any stage enter the City Room, some aspects of your evidence may be distressing. Secondly, as with Mr Ennis, who entered the witness box and left it just before you, we will not be dealing in your evidence in this chapter, chapter 10, with any deceased or injured person by name. I know that you understand that.
A. I do, yes.
Q. Instead, it's likely to be necessary for you to return in chapter 12 to deal with particular individuals.
Let's turn then to 22 May. On the night of 22 May, were you at home?
A. I was, yes.
Q. Were you not on duty?
A. I was not on duty.
Q. And not on call?
A. No.
Q. At 10.41 pm, did you receive a call from a colleague

Annemarie Rooney?
A. That's correct, yes.
Q. At that stage, I think you were in bed?
A. Yes, just getting into bed.
Q. Annemarie Rooney was someone that you knew well?
A. Yes.
Q. And would it be fair to say that she was a close professional colleague?
A. Yes.
Q. I'm going to check, Mr Smith, that everyone in the hearing room is able to hear you, because you are quite softly spoken —— keep your voice up, I know that you will.
In that call at 10.41 what did Annemarie Rooney tell you?
A. It was a short phone call. She alluded to an incident at the Manchester —— I think she probably called it the Evening News Arena as most people do —— and referenced that it was believed to be a bomb or a terrorist attack.
Q. We know that she was to become NWAS Silver commander/tactical commander and to deploy to GMP force headquarters. Did you learn that that was the plan in that telephone call?
A. Yes.
Q. Was it also agreed in that call that you would make your

way to the scene, that's to say to the arena?
A. Yes. That's correct.
Q. We know that you were to become the Bronze commander. Was it agreed at that stage in that call that you would take that role?
A. No, it wasn't.
Q. So at that stage in that call, what did you understand was the purpose in you travelling to the arena?
A. As part of the response to -- at that point, obviously, we weren't aware what was happening, but as part of the response to the incident that was unfolding.
Q. So really just to travel there and to take whichever role you were best suited for --
A. That's correct, yes.
Q. -- as a senior figure within NWAS? That discussion that you had between the two of you, was that the result of any formal plan or scheme or simply some form of informal agreement?
A. It was an informal agreement. I don't even know if I'd call it an agreement now. It was an informal act which she took in terms of notifying me of the incident. I wasn't part of any plan; it was in response to her receiving the information and she felt she wanted to -- I assumed she wanted to advise me of the incident so I could mobilise.

Q. I must have misunderstood. We heard, I don't know if you heard the evidence, from Mr Dexter, the GMP ground-assigned tactical firearms commander, and he was informed of the events at the arena as a result of an agreement that he had with a member of his staff that he would be told about any serious incident. Did you have such an agreement with Annemarie Rooney?
A. Yes, and with others. We're a very small team, so I think it would be natural that any incident of this nature, we would all phone each other.
Q. That may very well be entirely sensible. So there was some form of informal agreement between you, Annemarie Rooney, and others about your managerial level, that in the event of any one of you becoming aware of a serious incident you would inform one or more of the others?
A. Yes.
Q. And that is what happened that night?
A. Yes.
Q. As a result of that discussion, did you get dressed and start to make your way to the arena straightaway?
A. Yes.
Q. As you'll appreciate, I'm not going to ask you where you live, even in general terms, but you didn't live very far away, did you?
A. No, not far at all, sir.

Q. Did you travel towards and indeed to the arena in your NWAS unmarked vehicle?
A. Yes.
Q. On blue lights and sirens?
A. Yes.
Q. On the way there, do you remember that you received two messages, certainly one whilst you were on the way and perhaps one just as you were arriving?
A. I do, sir, yes.
Q. What we're going to do, just so that everyone can follow this, is we will listen to each of those recordings. Some of the messages that you passed, indeed all of the messages that you passed later on when you arrived at the arena we won't listen to because of some of the background noises, but we must inform people to the greatest extent possible.
First of all, those two messages before your arrival at the arena. The first one at 22.50 hours, and Mr Lopez, I know that you have tested these. We're going to have the recording played, which is {INQ015056/1} and on screen at the same time and following the recording, the transcript, {INQ015056T/1}.
(Audio played to the inquiry)
So you were told at that stage that there was an AP, an advanced paramedic on scene, namely Paddy Ennis. Was

he someone that you knew?
A. Yes.
Q. That he had provided a situation report; indeed we know that that had happened at 10.46. You were told that the RVP was Thompson Street. Did you at that stage understand the difference between an RVP and an FCP?
A. Yes.
Q. You observed:
"I'll maintain RVP for now in case it's an MTFA-type incident."
What did you mean by that, that you would maintain RVP?
A. So my recollection of that message was around that we should -- that NWAS should maintain an RVP response. So if you go a little bit further up:
"Just to confirm that someone on scene is saying the scene is safe."
It's obviously possible that the information I was given at first wasn't quite what was happening, and then someone may have declared the scene completely safe for us to -- and it wasn't a major incident. At this early moment we don't really know what's going on, so I think my instruction there around "maintain the RVP" is that we should continue to send our major resources to an RVP for the time being until we've got confirmation of the

scene safety message.
Q. So the thrust therefore of what you were communicating at that stage is: there might be a marauding terrorist firearms attack underway at the arena, if there is we aren't going to deploy even HART into that area —— you're nodding your head —— as a result, everyone should at this stage muster at the RVP at Thompson Street, as you were told?
A. Based on that information it would be an RVP deployment until we knew more, yes.
Q. And no one would deploy until you got a —— I think you called it a safe message?
A. I think until we had assessed the scene in terms of what's happening from a safety perspective, yes.
Q. Obviously you knew Paddy Ennis was there and he was going to be an important part of establishing that it was appropriate for you to attend the scene.
A. That's correct, yes.
Q. Let's listen to the second recording. This is timed at 22.56 and must be as you're very near to the arena or just arriving. Mr Lopez, the recording is {INQ015152/1}, and the transcript again on the screen and following, please, is {INQ015152T/1}.
(Audio played to the inquiry)
So the RVP, as you were informed, had changed from

Thompson Street to Hunts Bank. Did you know the geography of the railway station?
A. Generally, yes.
Q. So did you know where Hunts Bank was?
A. Yes.
Q. Whilst we're dealing with issues of geography, did you know the arena itself?
A. Yes.
Q. Did you know the City Room?
A. Not as the City Room at the time, if that makes sense.
Q. It does.
A. The McDonald's foyer is probably what I would have known it as.
Q. You knew there was a foyer?
A. Yes.
Q. And would you have known before you arrived that night how to get to that foyer from the war memorial entrance?
A. Yes.
Q. So you'd plainly been there on a number of occasions before?
A. Yes.
Q. In the result, having received that message, did you go to Hunts Bank?
A. Not in my car, but I did walk up.
SIR JOHN SAUNDERS: Do we actually know or are you able to

say the inaudible bit of that message, that they're going to get back to you on?
A. I think from listening to it now, sir, it sounded like, "Have you got an exact location?" But I couldn't... I don't know if there was a specific point on Hunts Bank.
SIR JOHN SAUNDERS: That makes sense.
MR GREANEY: So you didn't drive your vehicle to Hunts Bank?
A. No.
Q. As I know from your statement, you drove it to somewhere else. Did you in fact park by the cathedral?
A. I did, yes.
Q. Was that because you couldn't get nearer to the arena or for some different reason?
A. One, I felt it would be quicker because of the way the roads are set up at that point, you had to sort of drive round of a bit of a diversion, but my experience on attending, not incidents obviously of this nature in its entirety, but certainly incidents where there's a risk potentially from violence and things, is sometimes taking a walk towards that incident gives you opportunity to take in what's happening and assess the scene in a general way.
So as I was approaching the cathedral, I took the decision that, actually, if I park my car here, I've got

the opportunity to walk towards the arena and I can get a greater understanding of what's happening.
Q. So do you mean that you thought that you would be able to at least start to gain situational awareness if you walked that short distance from the cathedral to the arena?
A. Yes.
Q. Having parked up your vehicle, did you take from it and with you two clinical response bags?
A. Yes, sir.
Q. Which contain your clinical equipment?
A. Yes, sir.
Q. Were you dressed in uniform at that stage?
A. Yes.
Q. Did you also put on something else?
A. I think in my statement, I say that I put on a tabard, but I haven't: I've carried it to the arena and it was put on shortly after my arrival.
Q. And you also mentioned that you put on a helmet at the time, although quickly you dispensed with that or it disappeared?
A. That's correct.
Q. You took with you a tabard. Was that a tabard that you believed said "incident commander" on the back?
A. Yes.

Q. So that you could be readily be identified, both by NWAS itself and by other emergency services as the person performing that role?
A. Yes, if I was to undertake it, yes.
Q. That was really my next question. By the stage that you pulled your car to a halt, did you believe that you were going to be the operational commander?
A. No. I don't think that was confirmed in my mind. It was obviously part of, you know, as you're driving to an incident like this, you start to think things through and it was certainly part of my thinking: will I become the operational commander here? I took the tabard really because it's a part of the major incident kit that I've got in my vehicle. It may not necessarily have been worn by me but I took it in case it was...
Q. What I want to address is what was going to determine whether you should or shouldn't be operational commander. We know that in accordance with the major incident response plan, the first responder on scene would effectively act as operational commander until someone more appropriate arrived, although that seems not in fact to have occurred in the result.
On you arriving, what to your mind was going to determine whether you would or would not be the operational commander?

A. Who else was there, because there may have already been a qualified commander on scene that would have -- that had taken over that role. As you can see from the sequence of events, Mr Poland arrived very shortly after me into the arena. Had he already been there 5 minutes, I knew it's very likely he would have taken the operational commander role. So from a qualified commander's perspective, when we take on an incident, very often it's the first qualified commander on scene that would take that operational command role. So it's very much dependent on my time of arrival (overspeaking).
Q. So it's the first appropriately qualified member of staff who arrives?
A. To take the -- understanding, obviously, that we instruct the first person on scene to take the acting or temporary operational commander role, but to formally sort of assign the incident as operational commander, it's the first qualified commander to arrive usually.
Q. And would you expect them to retain that command role unless there was some reason for them to be replaced?
A. Ordinarily, yes. That would be incident-dependent and some incidents last days.
Q. Of course.
A. So yes, it would be incident-dependent but ordinarily,

yes, the operational commander would be maintained.
Q. As you'll appreciate, I'll come back to that very much at the very end of my questioning.
As you left your vehicle and walked towards the scene, did you immediately know or suspect that a bomb had been detonated?
A. There was a smell in the air that indicated an unusual smell. I've referred to it before like Bonfire Night. There was certainly a smell in the air that indicated to me that a bomb had been detonated yes.
Q. And did you become aware of people in the area who had injuries?
A. Yes. Certainly as I turned on to Hunts Bank, I became more aware and I know as I turned on to Hunts Bank, I passed somebody that was being supported to walk, that had some obvious injuries, and thought in a moment that I would stop them and ask them to come back with me, but then still at that point I didn't know what was happening within the complex itself. So I felt it was more appropriate to allow that movement away at that stage until I knew more. I didn't want to take somebody back into a dangerous situation.
Q. In the first witness statement, the first of four that you gave, and I'm at page 3, I'm not going to read out every word of this, but you indicate that you started

seeing casualties and that you were able to see, even at that early stage, effectively shrapnel.
A. Yes. I think I'd already been told something about nails, but I could see there was clothes torn, there was an obvious -- there were obviously small wounds on people as they were walking away from me, so either it was glass or shrapnel.
Q. You go on to observe that you thought that the injuries you were seeing at that stage were consistent with an explosion as opposed to a firearms attack?
A. Yes, that was more to do with the clothing, the effect on clothing on some people.
Q. So it was starting to develop as a consistent picture. You'd heard in the first radio message that Paddy Ennis had said that there was a nail bomb, you were seeing injuries consistent with a shrapnel bomb, and do you recall that a police officer at the scene also indicated to you that it was believed that the explosion had been caused by a suicide bomber?
A. Yes, that's correct, yes.
Q. We see your arrival at the railway station itself in a series of stills, and these enable us to time it at 22.59. So within 18 minutes of receiving the call, you've arrived at the arena.
Mr Lopez, this is the sequence of events, you'll be

familiar I'm sure with the INQ reference, but for the transcript I'll give it, {INQ035612/169}.

22.59.25. Dr Michael Daley, the NWAS MERIT doctor, is approaching the war memorial entrance from the direction of Hunts Bank, and he is in company with you. So at what stage had you met Dr Daley?

A. To the best... Obviously I can't... I can't see myself on that. I think that's -- the person circled is Dr Daley?

Q. Perhaps a lesson in not always accepting the narrative. Let's have a look at the next image, which hopefully you will be in, {INQ035612/171}.

Someone will have watched this CCTV very carefully as part of Inspector Russell's team. Can you see yourself in that image, which is timed, I think, 24 seconds later?

A. I can, sir, yes.

Q. You can?

A. Yes, sir.

Q. So it looks like there is a correct identification. You're there with Dr Daley. Had you just met him in that moment or had you met him as you were walking up or can't you remember?

A. I don't think it was walking up. My recollection is we were inside when we first met and I don't appear to

have equipment with me there so I don't know if I had been in and come back out quickly because I don't have my bags on my shoulder or anything there. My recollection of the night is, as I walked into where the war memorial is, I didn't see which direction he came from, but Michael Daley was suddenly there.

Q. Was he someone that you knew?

A. No.

Q. But did he explain to you that he was the MERIT doctor?

A. Yes, he did.

Q. Are you wearing the tabard in that image?

A. No.

Q. So you hadn't put it on at that stage?

A. No.

Q. So by that point, should we understand that you had not decided or been told that you were the Bronze commander?

A. Yes, that's correct.

Q. You didn't know it at that stage?

A. No.

Q. Let's just look at one more image. {INQ035612/172}, please, Mr Lopez.

This is 23.59.53. You and Dr Daley enter the station via the war memorial entrance and you appear to be using your radio. So are you the person on the right as we look at this photograph?

A. Yes, sir.

Q. Are you wearing a tabard by this stage?

A. No, in fact I've just -- it's on the floor, I've just dropped it.

Q. By reference to the time of this photograph, can you tell us when it was that you did become operational commander?

A. Yes. Shortly after this, at I think it's 23.01, I met with Paddy, Mr Daley and Mr Poland a little bit further into the concourse, had a brief discussion, and at that point I took over operational command.

SIR JOHN SAUNDERS: I'm sure everybody realises there's a mistake on the time there, 22.59.

MR GREANEY: It is 22.59, sir, you're quite right. I hadn't noticed that. Thank you.

At 23.00.39, three other paramedics arrived, so that's just after you. And having missed the last 10 minutes of Mr Ennis' questioning, you won't have seen that we did identify that. Let's look at the photographs. {INQ035612/178}, please.

23.00.39. Three paramedics that have been seen outside enter via the war memorial entrance, and on the version of this that I've been looking at they weren't identified, although I knew who they were. They are Martyn Nealon, Callum Gill and Leigh-Sa Smith.

SIR JOHN SAUNDERS: Did they arrive in one ambulance or more than one ambulance or does nobody know or are they in a car?

MR GREANEY: I'm sure someone will know but I don't know the answer to that question.

SIR JOHN SAUNDERS: We will find that out.

A. If I can help, I believe it's one ambulance.

Q. It's one ambulance? Thank you very much indeed.

Next image, {INQ035612/179}, please. The three paramedics seen entering at 23.00.39 then met up with operational commander Daniel Smith and Dr Daley is nearby.

Then {INQ035612/182}, please. We can see that whilst you are in conversation with them, Patrick Ennis is on his way down the staircase from the overbridge.

Then at 23.01.06, paramedic Derek Poland has joined the group, so he's arrived by now, and the group includes you, Dr Daley, paramedic Matthew Calderbank, and I think probably also the three paramedics that we have mentioned.

At the stage at which you are speaking to the three paramedics, were you the most senior NWAS representative there?

A. Yes.

Q. Were you the most senior, in fact by some margin?

A. No, Mr Poland was an operations manager, so another senior member of staff, but I was the most senior.
Q. And as I've said, the paramedics are Nealon, Gill and Smith. What we know is that following their discussion with you, they go to Trinity Way to treat, I think, a single patient. So did you direct those three paramedics to do that?
A. I did. On my arrival -- as I'm walking up Hunts Bank I was approached by a police officer. I understood it to be the police officer who came in with me but I think during the evidence it possibly wasn't because that was police sergeant. But that police officer was directing me to a patient or patients around the rear of the arena, so the Trinity Way side of the arena. So on my arrival, I could see there were patients obviously presenting at the Victoria Station side, but was conscious that I was told at least one patient existed on the other side of the arena and so I dispatched an ambulance round to that side.
At that point obviously I have no idea exactly where patients are presenting around the arena complex.
Q. Did you know by that stage, as you made that deployment, that the seat of the explosion was the City Room or the foyer, as you knew it?
A. I'd been... I'd been told, I believed, in one of the

messages about the -- near to the old McDonald's. But I don't think at that point I was completely clear on where the seat of the explosion was. I was still dealing -- obviously I'd only been there approximately 1 minute.
Q. A very short time. What you didn't think was that Trinity Way was the seat of the explosion?
A. No.
Q. Let's just be clear about what's happening at this stage. As you make that deployment, that's at a time when you hadn't spoken to Paddy Ennis?
A. Yes.
Q. Would it be fair to say it was a time at which you had no significant situational awareness?
A. Other than what I'd been told on the radio message.
Q. Yet what was happening was that a major part of the resources, NWAS resources, available at that stage went off before you really knew what was going on, didn't they?
A. They did, but in part that was in an attempt to gain situational awareness. Obviously in retrospect, the majority of the patients, seriously injured patients, were obviously in the City Room. But at that point I did not know that, and I could have been in the wrong place, it could have been that I needed to send

resources to the other side and we needed to -- I needed to re-think where I was, because at that point nobody -- other than the RVP being given as Hunts Bank, we weren't aware of any FCPs or anything like that.
SIR JOHN SAUNDERS: You've just told us of the picture when we saw on the scene that when Ennis comes up, these three other paramedics are still there. Is that what the picture shows?
MR GREANEY: No, I think by the time Mr Ennis arrives and has a discussion with Mr Smith, they have gone by that stage.
SIR JOHN SAUNDERS: Do you know that? Can you remember?
A. I can't remember the opening hour. Certainly the first 20 minutes went by very quickly, so other than what's presented to me, sir.
MR GREANEY: We can have a look again to see if it does clarify, but I have a fair degree of confidence --
SIR JOHN SAUNDERS: That's what I was expecting to be the situation, so I was quite surprised when you said the other three paramedics were there at the same time but it may be before any conversation has taken place.
MR GREANEY: That was probably my misuse of language. Let's have a look of those images again.
{INQ035612/178}, first of all. They're arriving.
{INQ035612/179}. You're there and speaking to them.

We can see the time, 23.00.50.
{INQ035612/182}. There is Mr Ennis walking down the stairs, and in the bottom image, 23.01.06, are you able to say whether the three paramedics, Nealon, Gill, and Smith, are still there at that stage or if they have gone as you look at that bottom image?
A. 23.01.06?
Q. Yes.
A. They're still there in that image at that point.
Q. And if we just look at one more then, {INQ035612/183}. So the top image, 23.01.24. You are now beginning to talk to Patrick Ennis. Have those three paramedics departed by that time?
A. Yes.
SIR JOHN SAUNDERS: Thank you for clearing that up.
MR GREANEY: To return to the point I was exploring, as you will well appreciate, having seen Mr Ennis' evidence yesterday and today, you probably realised it before now, one of the issues the inquiry is concerned to understand is why particular NWAS resources were deployed to particular locations and moreover why more paramedics were not deployed to the City Room. So just at this early stage, I want to see where we've reached.
At that point in time, just gone 11.00, there were, I think, seven NWAS officers or representatives present.

So obviously Paddy Ennis, you, Mr Poland, Mr Daley, and the three paramedics that we've just been speaking about. Have I understood correctly?
A. I believe so, yes.
Q. Yet, here you are deploying, not far from 50% of those available resources away from the station itself, certainly away from the City Room, Trinity Way. The question therefore is: was that a sensible deployment of such substantial resources?
A. So in my view, at that point, yes, I needed to -- the police officer was very clear that they had a critically ill patient on the other side of the arena. It was important that I understood what was happening on that side of the arena as well as the side that I was on. So that deployment isn't just about a single patient, but is about -- in the picture I'm pointing at one point and I do remember discussing, trying to get the number off their radio so that they could contact me if they needed to directly to give me information as to what was happening on the other side.
So in my view at the time, given the information or lack of information that I had at that point, what I did know was that, as described to me, a critically ill patient or patients were presenting on the other side of the arena and I deployed to try and assist me with my

situational awareness.
Q. And given that you in part were seeking situational awareness by deploying three of them to that location, did you speak to them by radio or in person at any stage shortly afterwards?
A. No, but a further resource arrived on scene who advised me that certainly the ... Sorry, I'm just being cautious not to talk about an individual patient. The patient that was presenting on the other side had been -- was being managed by a resource and I was informed that no other resources were required on that side. But it wasn't through that crew, it was via another manager who'd arrived.
Q. As we just saw in the image at {INQ035612/183}, you were in discussion with Paddy Ennis, and in a short time we're going to receive your evidence about what was said between the two of you.
But first of all, as you told us, it was during the course of that conversation that you were to decide, is this right, that you were operational commander?
A. Yes, that's correct.
Q. Was that something that you decided or was it something that you were told you should be?
A. No, I decided.
Q. By that stage, Mr Poland was also there and he was also

a senior figure within NWAS? You're nodding your head.
A. Yes.
Q. Was there any discussion between the two of you about who was best suited to that role or did you just decide it should be you?
A. I'm not convinced I would describe it perhaps as a discussion, but we certainly -- my recollection -- I'm aware it's not Mr Poland's because we've spoken about it since the incident -- my recollection is that I did say to him, "Do you want to take this", and I sort of pointed at the tabard, invariably meaning: do you want to take operational command? And from that moment on, he said no, so I was operational commander. That wasn't an attempt to offload operational command, I think we were both competent and trained to take that role. We had a choice and I took it.
Q. Just before we return to that conversation with Paddy Ennis, I want to look at the major incident response plan and what it required of an operational commander. As we know from your earlier answers, you're familiar with that plan.
SIR JOHN SAUNDERS: You're the lead paramedic in Manchester; is that right?
A. Yes. Clinically, I have -- so there's differing roles.
SIR JOHN SAUNDERS: Does that make you senior to Mr Poland?

A. In rank it does, but we're not an organisation that really focuses much on rank but officially yes --
SIR JOHN SAUNDERS: No, maybe not, but if it was going to be the senior person who took the operational commander job, that would have been you?
A. It would be me, yes.
MR GREANEY: Thank you, sir.
We'll just learn a little bit more of what's expected of an operational commander by the major incident response plan. {INQ013132/16}, please.
As I go through just two short parts of this, if there is any part that you think that I'm passing over or missing, please, with your knowledge of the document, draw it to my attention.
So paragraph 4.2.3:
"Operational commander.
"NWAS major incident action card 4 [and we'll look at that in a moment] outlines the operational commander's key responsibilities. The action card must be used during the management of an incident."
Did you have action 4 with you that night?
A. Yes.
Q. Whereabouts on you did you have it?
A. It's always kept -- well, all the action cards are kept in my high-vis pockets.

Q. Did you at any stage refer to that action card?
A. Not immediately, but later on in the evening.
Q. In terms of the stage at which you referred to it, are you able to help us with a time or a point in events?
A. No. It was probably -- I would be guessing it would be after half an hour of my arrival.
Q. We appreciate the limits of the answer you gave, but some time around about 11.30 is the best you can do?
A. Yes.
Q. "The operational commander works [it continues] at an operational level and has responsibility for the activities undertaken at the scene."
So do you agree it's a heavy responsibility, "responsibility for the activities undertaken at the scene"?
A. Yes, it's a difficult role, yes.
Q. "As such they will be located at the incident scene, ideally alongside the operational commanders of the other responding agencies at a forward command post. Where this is not possible, the operational commander must ensure regular multi-agency face-to-face briefings take place."
I'm just going to pause to ask you some questions about that section. Was there, so far as you were aware, ever a forward command point?

A. No.
Q. Why not?
A. I will take responsibility for aspects of that. I think it was in my mind about a forward command post. There's two particular points within the incident where a forward command post is either mentioned to me or by me, one being the arrival of a Network Rail incident -- I think they're called incident officers, who approached me and I directed him -- we were stood outside of the war memorial entrance and I directed him to stay there. I said, "This seems like the most natural place".
And later on -- sorry, and before that, there was a radio message, where I was informed about the RVP changing, and I spoke about Hunts Bank being more akin to the FCP rather than the RVP. But the reality is on that night, neither I nor any other operational commander made efforts to go to it or to arrange an FCP and that's an error on the night that I totally accept.
Q. That's a very fair concession. Did you ever locate, that's to say co-locate, with the commanders of the other emergency responders?
A. No. The commanders for the Greater Manchester Fire and Rescue Service obviously arrived after Mr Hynes had taken over my responsibility, so the opportunity certainly to co-locate with them did not present itself

to me during my time.
Q. That certainly wasn't your fault as you had ceased to be operational commander before they even arrived on the scene.
A. Yes, sir, yes.
Q. But we do know that the Bronze commander for GMP, Michael Smith, was there and was within the City Room. Did you co-locate with him at any stage?
A. No.
Q. Did you speak to him at any stage?
A. No.
Q. Did you even know that he was there?
A. No.
Q. The plan provides that:
"The operational commander must ensure regular multi-agency face-to-face briefings take place."
And I do appreciate that on Station Approach you were speaking to the more junior officers, but it would seem to be fair to suggest to you that you didn't ensure regular multi-agency face-to-face briefings of the sort that the plan had in mind, namely between commanders?
A. Not between commanders, no. I think you can see there's a lot of interaction with police officers either from Greater Manchester Police or British Transport Police and a lot of interaction with a number of sergeants that

were in and around the train station -- sorry, the station concourse. But I did not know who the Bronze commander was for the police.
Q. Can I make plain that everyone will appreciate that you were very busy from the first moment you arrived, and I hope that this doesn't feel like nitpicking, but in a sense we have to test your actions as against the plan if for no other reason to ensure that lessons are learned and we work out whether the plan was a good one.
Were you familiar as of 22 May with JESIP?
A. Yes, I was.
Q. And with JOPs?
A. Yes.
Q. And is joint working critical to the effective response to an incident such as that with which you were confronted that night?
A. Yes.
SIR JOHN SAUNDERS: That's the perceived wisdom. Why?
A. Because it is a joint effort in responding to the needs of everybody that's been involved in it, so it has to be a joint effort, otherwise we work very much in isolation, and I know there's a point within the Ambulance Service expert report where they talk about us working in isolation and I don't actually agree with that point. I think actually we worked well with the

police officers that were there. I'm sure the point that you are coming to the conclusion of is that my role as operational commander should have meant that I was speaking directly to the operational commander of the police and we did not achieve that on the night.

Whilst I think we worked very well together as -- really, it's three organisations, isn't it, because of British Transport Police -- I think we worked well together, we just did not achieve that joint command position on the night.

SIR JOHN SAUNDERS: So how did that matter on the night as far as you're concerned?

A. I think, having listened to Inspector Smith's evidence, I think it would have at least allowed him to have a shared awareness of what my intentions were. It would have allowed me to have a greater understanding of what his asks and intentions were. I think in my statements I've stated quite clearly that, in part, one of the reasons that I didn't actively try to seek the operational commander from the police at first was because, actually, I felt that the police were conducting themselves in a fantastic manner and were really achieving what I personally needed them to achieve.

I know now, having listened to Inspector Smith's

evidence, that actually we weren't achieving what he wanted us to achieve, and I think if we had got together on that night, it may not have changed any decision of mine or his, but it would have meant we had a joint awareness of each other's intent.

MR GREANEY: So this was exactly the point that I was coming to and you got there before me. Don't worry. The reality is that if you'd had direct communication with Inspector Smith and he had communicated to you the feelings that he told us about so powerfully, at the very least you would have taken that into account in deciding whether to deploy greater resources into the City Room?

A. Yes.

SIR JOHN SAUNDERS: So the obvious thing is you're communicating with policemen who are around you, downstairs, and they're doing what you want them to do. But actually, isn't the principal purpose of communicating with Mr Smith that he actually knew the situation overall from a policing point of view? He would have better knowledge of the safety of the scene?

A. I don't disagree with anything you are saying, sir. I freely accept that I should have made -- as I'm sure inspector should have done -- we should have made a more concerted effort to get together. I totally accept that

he would have had -- I think my view of where he was positioned is that I would never have put an FCP in the City Room. That was too close and didn't have situational awareness outside that was needed because very soon in the incident it was clear that there was a lot of patients outside as well as inside.

So I wouldn't have put the FCP where he stood, but you know, I have freely accepted, sir, it was an error on my part that I should have made more of an effort to find out where he was and speak with him.

SIR JOHN SAUNDERS: Thank you.

MR GREANEY: That's a very fair concession to make, if I may say so.

Could we have that page back on the screen, Mr Lopez, because I hadn't finished with it.

It continues:

"The operational commander ensures that the tactical plan is carried out, and that they understand the major incident strategy. Importantly, they must understand and be able to discharge their responsibilities within these. As the operational commander they will provide leadership and management to the other NWAS functional role officers and any other direct reports."

That night, and during the hour that you were operational commander, or thereabouts, was there an NWAS

tactical plan of which you were aware?

A. No. Could I expand on that slightly?

Q. Of course you can at any stage.

A. It would be my -- I would not expect one that quickly into an incident, a tactical plan will take time to develop. Certainly in the opening hour of an incident, really, the tactical plan is formed around the action cards that are set. So whilst in an ideal situation on a planned event there will be a very clear tactical plan specific to that incident, I would not expect a tactical plan to be there, certainly not within the first -- definitely not within the first half hour of an incident and I would struggle to see one coming through in the first hour, really, because it would take time to develop and actually in that first hour, really, the tactical plan is to follow your action cards and do your best for patients.

Q. Why is it going to take, on your evidence, at least an hour for a tactical plan to be developed in circumstances in which a bomb has been detonated, there are people dead and many injured and in desperate need of treatment?

A. The tactical plan, how it's written there, is often the result of a TCG being formed, of shared situational awareness and joint co-location with tactical

commanders. So I think actually Inspector Smith mentioned it, didn't he? That you almost expect the operational commander to develop the initial operational and working plan, which will have elements of tactics and strategic direction within it. Actually, then as you get into more of a -- it is phrased very badly, but a battle rhythm in terms of how an incident is then managed, you are then more likely to get tactical plans.

My experience, because obviously I work at a tactical level as well, is often if I'm notified of an incident, often I will give a very -- sort of two lines, to an operational commander, which is establish situational awareness and joint co-location, get your JESIP principles in place. We will then develop a tactical plan as we go through.

With a no-notice incident like this where we're suddenly -- I wouldn't have expected Annemarie to be able to get me a tactical plan in place before I start my operational plan. We would have been very clearly delayed.

Q. Thank you for such and full and clear answer. I think where we've reached is that you weren't aware of the tactical plan at any relevant time, so you shouldn't -- you weren't able to ensure it was carried out, but you regard that as entirely understandable because one could

not have been produced within the timescale that we are talking about?

A. In my view, yes.

Q. Was there an operational plan?

A. A written one, no. But I had obviously -- it's my... It's my responsibility obviously to develop an operational working plan at scene.

Q. Absolutely.

A. Again, I think when we exercise we tend to try and write an entire plan, whereas actually my experience of this incident and others is that you'll do some steps first, start that action off, and then start to develop other actions around it in an attempt then to actually build an operational plan that's working for that particular incident. So on the night, did I write down an operational plan? I did not. But did I have sort of clear steps in my mind as to what I wanted from particular individuals or what I wanted at scene? Yes.

Q. One of the things that we've been exploring with other witnesses, GMP witnesses, is the importance of recording decision-making. I'm not going to suggest for a moment that it'd be sensible to suggest to you that you should have stopped what you were doing and started writing down an operational plan, but would it be a good idea for the future for somebody in your position, the NWAS

operational commander, to have some different way of recording decisions that doesn't take him or her away from their activities, such as a loggist or a dictaphone?

A. Yes. I think a dictaphone -- we have issued dictaphones to our commanders now, we all carry dictaphones with us. My personal view on this is that a dictaphone, yes, obviously would assist with that logging. We are just embarking on body-worn cameras, which you will note from this inquiry are extremely useful and that would be something that I think commanders should be moving to.

A loggist, if I'm honest, if you'd asked me before this night, I'd have said absolutely, but now I just don't think someone writing anything would keep up. The decisions are so fast and so quick that anybody trying to write something would quickly fall behind. It would become almost impossible.

SIR JOHN SAUNDERS: So it's obviously a benefit to us now if you have a dictaphone or something written down in looking at what may have gone better, but actually at the time of the incident happening, does it help you manage the incident better and if so how?

A. No, I don't think it does to be honest. I think the only things that would... No, actually, I don't think writing things down at the opening of an incident would

be beneficial to anybody other than discussions afterwards.

MR GREANEY: What it might do is to ensure that people do make decisions when they need to be made -- I'm not saying that you didn't make decisions -- and also by expressing their reasons it would force them to analyse whether they were good reasons. So may it have that benefit?

A. My honest opinion would be there would be a better way of doing that and that may be having someone on scene to do that to a commander. So I don't think writing it down, and this is just my personal view, I'm not an expert on major incidents by any stretch of the imagination, but writing it down on the night would not be possible. But certainly somebody doing that challenge behaviour maybe, but I have to go back to this night and say that decision after decision after decision in really quick succession, I would find it difficult even to have someone alongside me to just explain to them why I have taken that choice. You just almost have to do it.

Q. That's a helpful insight, thank you. What we're trying to do, or one of the things we're trying to do, is to learn from the experiences of people like you who were there on the night and doing these jobs.

A. If I may expand just on that point, that first hour -- obviously, it's incident-dependent -- is so quick, but I do think, and it's not something we tend to train to do, but I do think there comes a point that perhaps there's a break, wherever a natural break could happen in an incident, where there's almost an opportunity to go back round and say all the things I have done, are they still correct? We tend to do that at a tactical and at a strategic level but we perhaps don't do that as much at an operational level and it may be something that would be useful in the future.
Q. What you said to me along the way of your answer was that although, understandably not documented, there was an operational plan, and I'm going to press you a little on that. Do you mean that at the moment you assume the responsibility of operational commander, you devised an operational plan in your own head or was it something that evolved subsequent to that?
A. I think it starts to -- well, it probably started even before I became operational commander. As I'm walking up -- I do know Victoria well, I know the city centre well, in my mind I'm thinking if ambulances are going to Thompson Street, what direction are they going to be coming from, so you even start to think about those things as you're arriving.

Once I became operational commander, separate obviously to the ambulance crew, and wanting to know what was happening on the other side of the arena, one of the early things I asked Mr Poland to do is to go out to the front and I was really conscious that I'd already seen quite a lot of, not being critical, but poor parking on that front road. I thought if we lost that road to ambulances it would make the incident a lot more difficult to manage.
Q. By road, are you talking about Station Approach?
A. Yes, Station Approach outside. So I was very conscious almost immediately that I wanted that road being kept clear because if we'd lost that, if we'd blocked that road, we would have caused serious problems to the operation if we were to remain at the train station. So there's things like that being developed constantly in my mind.
Q. I do want to know more about your operational plan but I suspect that I am better off probing that further once we've got to the point at which you have received information from Paddy Ennis. So we'll just leave that for now.
Before we depart from the plan, I want to ask you about one further aspect of it. The key communication lines and partnerships for the operational commander are

operational commanders from multi-agency partners, so that's just reinforcing the idea of joint working. We won't go over that again. Then there are a series of other persons or categories of person listed.
Was it your responsibility as operational commander at the scene to set up a command structure in relation to at least some of these roles?
A. Yes, most of them.
Q. So obviously it wasn't your job to appoint the tactical commander?
A. No.
Q. And Annemarie Rooney had already assumed that role. But I just want to run through this list and identify which of these people you did appoint.
First of all, casualty clearing officer. Did you appoint such a person?
A. Yes.
Q. Who was that?
A. Mr Birchenough, James Birchenough.
Q. Casualty clearing medical lead. Did you appoint such a person?
A. I asked Dr Eddie Tunn to oversee medical provision within the casualty clearing station. If I'm honest, I don't think I specifically said, "You are the casualty clearing station medical lead", but certainly he was

aware that he was overseeing the medical provision within the casualty clearing station.
SIR JOHN SAUNDERS: Just repeat the name, Dr?
A. Eddie Tunn.
MR GREANEY: Primary triage officer?
A. Yes.
Q. Who did you appoint to that role?
A. Joanne Hedges.
Q. Was there a secondary triage officer?
A. No.
Q. On reflection, would it have been better if there was?
A. Secondary triage is around the re-triage within the casualty clearing station. I think relatively quickly we were quite comfortable that patients were receiving care within that area. But it is within the plan. I am conscious that I believe the expert report sort of discusses that it can be excluded if it's required and they didn't see any issue with it. My view on the night was that we had clear triage processes in place, certainly at the casualty clearing station, and they were being adhered to.
SIR JOHN SAUNDERS: I just need to know: does that mean you gave it positive consideration and decided not needed or it just didn't come up in your mind?
A. Yes. There was a point, as I said, towards the end of

my time as operational commander that I did refer to the action card and these are obviously listed on there, and it was a positive decision not to do that, yes.
MR GREANEY: Parking officer. I think you appointed Derek Poland to that role?
A. Yes, at scene, but often a parking officer is away from scene as well so there was a further parking officer appointed at a tactical level for the rendezvous point at Thompson Street.
Q. Was that person appointed by the tactical commander, Annemarie Rooney?
A. Yes, I think via the operations centre, but yes, away from scene.
Q. But at scene you appointed Mr Poland?
A. Yes.
Q. Loading officer. Was there a loading officer?
A. There was. That was Matt Calderbank.
Q. And then safety officer? Before you tell us whether there was one, what is the role of safety officer?
A. So a safety officer —— basically to provide a written risk assessment or to assist the commanders. They're a direct line to the operational commander. They provide a risk assessment of risks on scene as they see them, to support the operational commander in the risk management, and then they provide a role in terms of

ensuring that any risk mitigation that's put in place is being adhered to ——
Q. Such as PPE?
A. Yes, so helmets or cordons, that sort of thing.
Q. In any situation in which a bomb had exploded in the City Room and in which —— did it occur to you there was a possibility of secondary devices?
A. Yes.
Q. There was a role for a safety officer?
A. Yes.
Q. Did you appoint a safety officer?
A. I did not.
Q. Why not?
A. It was an omission on my part. This isn't me offering an excuse. I have never actually been at a scene where a safety officer was in place. It was just something that did not enter my head and obviously, as I say, towards the end of my time, I reviewed this, I did note the safety officer but just did not take steps. That's an omission again.
Q. That's a fairly made concession. But I think later on, when you were making decisions about whether to deploy staff into the City Room, the question of whether they would be exposed to a risk by going there was one that was part of your consideration?

A. Yes.
Q. And from what you've said, if there had been a safety officer reporting directly on that issue of risk, you would have been better informed?
A. I'm not convinced I would have been better informed. There would have been somebody in a role specifically considering risk, but I can't say, because I didn't appoint them, but whether they would know any different information to what I knew on the night —— so I can't say. I don't think I'd agree that I would be better informed by a safety officer. It would have been better or more robustly documented because their role is to write down a risk assessment and they may have supported, but their role isn't to manage the risk. So their role is to identify and risk assess, but it still falls under my decision—making whether someone moves forward or not.
Q. Absolutely, but in order to make that decision, you need information, don't you, about risk?
A. Yes.
Q. In terms of becoming informed, we know you didn't ever speak to the Bronze commander for GMP who was in the room. Did you ever visit the City Room yourself?
A. No.
Q. And upon Paddy Ennis going back into the City Room at

11.05, did you speak to him again at a relevant time?
A. My recollection is that we did, and I know there's no recording of the radio transmission between us, but my recollection is we did have. There's nothing to show that, so ... whether that is a poor memory of mine because one thing I've noted throughout this really is that memories are very different to what happened. So something that's been good to see through this process with the CCTV is that it almost —— it will dispel some of my memories from the night that were quite clear but were actually not quite accurate.
I thought I'd spoken to Paddy on the radio, but there's no evidence to suggest that happened, so I don't think we did.
Q. Just putting that recollection to one side, which you're fairly accepting may well not be correct, where was the source of reliable information for you about risk in the City Room?
A. Paddy Ennis. And also other officers. So you know, we were getting information from police officers down in the concourse area of Victoria Train Station and from armed officers that had arrived. So there was information down there being provided to me. At one point I remember asking —— I think it was one of the armed officers —— what the actual concert was because

I wasn't aware what the event was. They told me and so we were gaining information all the time from downstairs.
Q. It seems, from what you have said, the source of information was that very short conversation you had with Paddy Ennis ——
A. Yes.
Q. —— at 23.01 and what you were picking up from the constables and sergeants who were coming from the City Room to where you were?
A. Yes.
Q. We'll just finish off this point and then I'll suggest to the chairman that we break for lunch.
The HART team leader. I think it wasn't necessary for you to appoint a HART team leader because that was already Mr Beswick?
A. They're already appointed, but yes they were there.
Q. I don't know whether, but I am quite confident irrelevance that night, a decontamination officer was an irrelevance that night?
A. Yes.
Q. And an equipment officer?
A. No, I didn't appoint one.
Q. And a forward doctor. What is that and did you appoint one?

A. A forward doctor is somebody that would move forward almost from the FCP forward into an incident if it was required and, no, I didn't appoint one.
MR GREANEY: I'm next going to return to where I said I would, namely your conversation with Paddy Ennis and ask you about what passed between the two of you. That, sir, is something better dealt with after lunch.
SIR JOHN SAUNDERS: Thank you. One hour. Is that all right for you?
A. Yes, thank you.
(1.12 pm)
(The lunch adjournment)
(2.10 pm)
MR GREANEY: Thank you, sir.
Mr Smith, as I've said, we'll turn next to a conversation that you had with Paddy Ennis. What we know, and you will know from watching his evidence, is that he had entered the City Room at 22.52, going into 22.53, and left at just before 23.00 hours.
He then spoke to you at 23.01 before returning to the City Room at 23.05. We'll just have on screen, Mr Lopez, that image we had earlier, {INQ035612/183}. This is your discussion with him.
The discussion he had with you as a matter of fact was exactly 30 minutes after the explosion had occurred.

You're nodding your head?
A. Yes.
Q. Again, as a matter of fact, that's the period that by that stage people had been injured and in need of treatment. So some time had already passed is the point I'm making.
A. Yes, sir.
Q. When Paddy Ennis came to you at 23.01, did you know from where he had come?
A. I'm not sure I did, actually, when he approached me, but he made it clear where he'd come from during that conversation.
Q. Let's go to that. Could you do your best to tell us in your own words, and I will try not to interrupt, what he said to you and what you said to him?
A. Obviously, I couldn't confirm the exact content of the conversation. I think it's best summarised that —— summarised —— sorry, I'm not —— I'm shortening what he told me. I was certainly aware by the end of the conversation that he had come from what we now know to be the City Room —— I still don't think we called it the City Room on the night. So I was aware of where the main casualties, as he had seen them —— because obviously this is still very early, this is 1 minute after I have arrived on scene so I was still very aware

that there were patients around. So I was aware that he had come from the City Room.
I was already aware that a suicide or potential suicide bomber had been involved, but he certainly confirmed that to me. He confirmed that obviously, very tragically, there had been a loss of life and I think that was a key piece of information to me because, as ridiculous as it probably sounds to everybody listening to me now, at that point I'm not convinced I was fully sort of appreciating the gravity of the situation that we were dealing with, albeit we'd been given the information. A key moment for me was his message of " fatalities ", which just brought home, I suppose to me, what we were dealing with and the gravity of what we were dealing with.
I'm not 100% sure he gave me exact numbers. But he certainly made me aware of a number of priority 1 patients. I didn't question him at that point on whether he had formally assessed them as priority 1, I made the assumption that he had either triaged them or was making a visual judgement of priority 1 patients. But it certainly again indicated —— I was aware at the end of the conversation that we had a number of seriously injured patients in that area of the arena.
We had a discussion or by the end of that

conversation I had taken my thought towards where we were going to move those patients to.
Q. Pause there. Obviously I'm interested to establish (overspeaking) and as a starting point I just want to understand what was said between the two of you.
A. Certainly that we would be moving the patients, so my thoughts had turned to casualty clearing and where we were going to manage the ongoing care of the patients. And we had, I guess provisionally, actually, at that point, but certainly I'd made clear by the end of that conversation the casualty clearing was very likely to be on the concourse of the Victoria Train Station and certainly from seeing the CCTV evidence, and during that conversation I'm almost pointing towards the area that I thought would be adequate for a casualty clearing station.
Q. We're going to see some images in a short time of you not at that moment but shortly afterwards apparently directing where activity was to take place. Let me be clear about where we've reached. By the end of your discussion with Paddy Ennis, you knew that the seat of the explosion was the City Room, even if you didn't know it as such at that stage?
A. Yes.
Q. You knew that there were people who were dead in that

room?
A. Yes.
Q. And you knew a number of people were dead in that room?
A. A number, yes. He didn't give me -- he didn't specify a number but he certainly told me fatalities.
Q. A number of fatalities?
A. Yes.
Q. You knew that there were other people in that room in need of urgent medical treatment?
A. Yes.
Q. Did you also know that Paddy Ennis, having left the City Room, there was no other paramedic, in fact no paramedic, in that area?
A. No, I don't think I did know that at that point, no. To expand on that, did I ask that question, "Who's up there with you"? No, I didn't. I knew that Paddy was on scene, I was not aware of any other NWAS personnel on scene at that point other than those that had been to me. But I don't think I specifically said, "Are you on your own?"
Q. So can I put it this way: what was your working assumption? Was it that on Paddy going back into that room, he would be the only paramedic, or that he would be there and others might be, or didn't you know?
A. I think, looking back now, I think my view was that

he was on his own.
Q. As we know, you were right. In the circumstances, as they were presented to you, was there an urgent need to treat those who were present in that room or at least some of them?
A. I think there was -- I knew that there were seriously injured patients in that room, and obviously part of what we needed to do was provide them with care and treatment.
Q. And to do so urgently?
A. To set up the system to do so urgently. I think you've heard other evidence, but part of my job at scene is not necessarily -- and I totally appreciate that this will seem strange to people, but it's not necessarily to direct immediate care and treatment but it is to start setting up the system to enable us to manage all the patients, not just those in the City Room, there were patients elsewhere --
SIR JOHN SAUNDERS: Let's take it step by step. I think you're answering the next question in a way.
A. Sorry.
SIR JOHN SAUNDERS: No, no, it's all right. How they were going to be treated is the next question, but you didn't know at that time that there were a number of patients who required urgent treatment, and then you had to

decide how best to do it?
A. I did know, yes.
MR GREANEY: And was it your job to ensure that those who required urgent treatment got it as soon as possible?
A. Yes.
Q. In those circumstances, and bearing in mind you were working on the basis that only Paddy Ennis was in there, should it have been your priority to get paramedics in numbers into the City Room?
A. It should have been my priority to set up the correct system to manage those patients. I'm not trying to deflect the question, such as I then had to -- or was required to -- turn my mind to how we were going to provide that urgent treatment. An option would be, obviously, to send lots of paramedics into the City Room, an option would be -- there are a million options that were available to me. My job on that scene, as the operational commander, was to establish command and control, all the things that have already been mentioned, and as part of that establish the correct and best possible system for those patients. I don't think I'd agree that it immediately translates that I have to send lots of paramedics into that room or lots of professional clinicians into that room. It translates that I have to set up the correct system to

manage that incident.
Q. You say there are millions of options. In broad terms, aren't there two options? You either provide initial treatment in the City Room or you get the casualties to somewhere else where they're treated? Those are the options?
A. Yes, but obviously we're a minute into the incident at this point and whilst the City Room, as we now know, was the main focus, I had a much bigger scene to be concentrating on.
Q. Can you pause there for a moment? This had been an explosion, as you knew in the City Room. If casualties had managed to leave the City Room and go to Trinity Way, logically they were going to be less injured than others who were still in the City Room. Do you agree?
A. Um... No. I think 1 minute into the incident for me, I don't think that was completely clear because, yes, an explosion had happened in the City Room but I was not clear enough on the incident and in fact, as we know, a critical patient did go out a different way to the City Room, to the Victoria concourse. So no, I don't think it's fair that within a minute I was totally aware that all our critical patients are in the City Room. It is obviously clear that there were a number in there,

but I did have a broader scene that I had to think about.
Q. Can I just ask you to reflect on that answer for a moment? You had been told of one explosion and only one explosion?
A. Yes.
Q. And you knew that was in the City Room or you did by 11.01 or shortly afterwards?
A. I knew that an explosion had happened in the City Room. I don't think —— within a minute of getting there I'm not convinced that I was totally clear that that was our only site of patients.
Q. It wasn't the only site of patients, and that I entirely accept, but was it not obvious that most of the most seriously injured, and that therefore most of those in need of urgent treatment, were going to be in the City Room where the bomb had exploded?
A. Where a bomb —— no, I don't think it was obvious. I know that sounds... I know that sounds really difficult. But at a minute into it, yes, I'd been told there had been an explosion, but obviously other things were being mentioned at the time. I needed to understand what was happening at that scene and, yes, I was aware with Paddy about patients in the City Room and that there had been an explosion in there. But

I don't think I was clear at all that that was the only site of injury at that point. Obviously it became clear as the incident progressed, as other patients weren't presenting elsewhere, that that was the site. But I think at 1 minute past, within a minute of arrival, I wasn't totally confident that this was the only ongoing incident in the arena.
SIR JOHN SAUNDERS: Did you ask Paddy about that? He was the first on the scene and would be the scene commander, as it were, before you got there.
A. No, because I knew —— well, we did discuss actually that it had been an explosion and I think we even —— he did mention or we discussed certainly shrapnel. But Paddy was giving me information about the City Room at the time, it was important for me to understand if there was anything else going on. That isn't about just me not sending in paramedics to the City Room, but it is —— it was important for me to establish if anything else was going on, and I did indeed speak to, again whether it was a sergeant or a PC, asking if anything else was going on elsewhere to his knowledge because, as far as I was aware, you know —— sorry, not as far as I was aware —— the arena is a very large venue and whilst an explosion had occurred in the City Room, other things could have happened or been happening.

MR GREANEY: So accepting that at 23.01, having been confronted with an appalling reality, it took you even as an experienced senior paramedic time to process, but by 23.05 or 23.10, don't you think that you should have been saying to yourself, "Now is the moment to make sure we get paramedics in numbers into that City Room"?
A. I think it's probably safe to say that by approximately 23.10 I was probably clearer on what was happening around the arena. So if the question is: by 23.10 approximately was I more confident that the City Room was the main site for me to be dealing with, then yes, I was. But then I obviously have to then turn to our processes for managing that type of incident. So I was aware obviously that there was an explosion, that this was ——
Q. Did your processes prevent you from sending further paramedics into that room?
A. In my view, yes.
Q. How can that be so when at 23.15, two HART operatives did go in?
A. Sorry, actually my processes really say that I, at the time, should not have allowed Paddy to go back into that room. By 23.15, as HART operatives arrive, they are a different resource available to me, so they do then provide —— there was a potential for extra ——

Q. We know about what they provide —— sorry, I didn't want to cut you off and I have jumped ahead to 23.15, which I don't want to. Let's stick to 23.10 for the time being.

By that stage, the information to you has increased, your thoughts have had an opportunity to process, and by that stage you know that the issue, or at least the main issue, for you to confront is that City Room, do you not?

A. Yes.

Q. You know that you have multiple casualties in that room, including P1s?

A. Yes.

Q. And you know or you believe that there is just a single paramedic in there with them?

A. Yes.

Q. Obviously there are others in there, but in terms of NWAS resources, there is one paramedic. By that stage, was it not crying out for you to send further paramedics into that room, and if not, why not?

A. In my view, the policies and procedures, or the procedures that I am permitted to follow at the time, did not allow for the deployment of any of the resources that I had at scene into the City Room. I qualify that by saying that HART operatives are able to work in ——

and I know there's been a lot of discussion around whether it was a warm zone, an inner cordon ——

Q. We'll get to that. Just make the point you wanted to make.

A. The options available to me are dependent on that, whether it's zoning or whether you want to call it an inner cordon, in terms of a major incident response, the options available to me —— and I do understand completely the thought process of wanting or needing lots of paramedics in that room, but the processes available to me to do that —— or my view is that the processes restricted me from doing that.

Q. I just want to unpick that, but thank you for such a full and clear answer. Should I understand from the answer you have given that at that time, so 23.10, before there is any HART operative there, if it hadn't been for the processes you described, you would have deployed more paramedics into that room?

A. Not necessarily I would have deployed. The options available to me (overspeaking) ——

Q. Why wouldn't you have deployed more into the room?

A. I would have —— it would have depended on the risks and the ability of those that were with me. So at 23.10, the resources that I had available to me didn't obviously include the HART team, but did include some

clinicians downstairs. My role is to make sure that I've got the command functions in place to make sure that I've got triage in place. We obviously had patients already attending at the casualty clearing station, so there were patients. So I would have needed to have —— if I was going to deploy into that room, it would need to take a process for me to understand the need for it, and you know, the need for it is obviously the patients within the room, but also the risks associated with it.

My operational plan, though, at 4 minutes past, 5 minutes past, was that patients needed to come out of that room.

Q. I promise you, I'm going to get to whether that was the right decision in the circumstances. May I assure you again, everyone will understand the pressure under which you were operating and I acknowledge that here we are, more than 4 years later, spending hours poring over decisions you were making in seconds. Please don't think that I overlook that.

But the upshot of your decision—making that night was that between 23.05 and 23.15, with many, many casualties, including P1s in there, there was a single paramedic. And thereafter, between 23.15 and 23.40, when the final casualty who could be helped started to

be removed from the City Room, there were just three paramedics in there and one was not providing any treatment at all, for reasons he's explained.

Can you understand why, looking at those bare facts, many would say that just isn't right, there should have been more in there? Can you see that?

A. Of course.

Q. Is that the right reaction to the set of circumstances I have just described?

A. I think the expectations will always be that we will send multiple resources in to an incident scene like that. The reality, unfortunately, since I started training as a paramedic, has been that we would not, and that was the reason from my understanding of the 7/7 inquests, that that was the reason for the HART team deployment —— not deployment, sorry, the reason that the HART team were brought about was for that area working, because you know, as I say, since I started training as a paramedic, the thoughts have always been that paramedics don't work in that inner cordon area.

Of course, I understand the reason for the questions you're asking, but that has unfortunately been always our treatment pathway.

Q. Let's just take a step back and see if we can agree about this. First of all, on what you now know, would

it have been better for there to have been more paramedics in that room treating patients or would it have been beneficial?
A. I can't say that —— yes, yes, it would.
Q. Wasn't that obvious to you at the time that it would be beneficial to have more paramedics in that room?
A. I'm not convinced at the time I was...
(Pause)
SIR JOHN SAUNDERS: Let's put it this way, you wouldn't not send them in unless there was a good reason not to?
A. Yes, that's a reasonable thing to say, yes.
MR GREANEY: The reason not to was because you didn't think that you could deploy people apart from HART operatives into that area?
A. Yes.
SIR JOHN SAUNDERS: I need to be really clear on this: is that the sole reason or is it, "I've got to concentrate first of all on setting up the casualty clearing centre"?
A. By 5 past again, sir, I've been there 5 minutes. Certainly part of the decision—making is we do not deploy into, whether you term it warm zone or inner cordon, we do not deploy non—HART operatives into that area. So that is part of the decision—making. But actually, at that time, the resources available to me

are also needed to establish things downstairs as well.
So it's multi—faceted. I try and give reasons for a decision that was clearly a huge decision for me to take and it's something that I have to try and go through now to try and explain. There are multiple needs for clinicians on scene.
SIR JOHN SAUNDERS: Your red line is, "I don't send ordinary paramedics into a hot zone, I just send HART"?
A. Yes.
MR GREANEY: Was it your view at the time, to pick up on a point the chairman was exploring this morning and yesterday, that there existed any discretion to send non—HART operatives into the inner cordon?
A. I did listen to Paddy's evidence, but my view, my training at the time is that there was no discretion, that the policies and procedures were clear on that fact, that we do not deploy — we should not, we must not deploy into warm zones. [redacted] and I think

some of the evidence in this inquiry has been very stuck on where zones finished, where they didn't, how quickly they can be reviewed. [redacted].
SIR JOHN SAUNDERS: If you think about it, the consequence of that is, if the HART zones are not available, they're just not going to get there, you say no one goes in? Is that really what you were thinking or would you think?
A. Well, officially yes. Officially, that is what we were —— that is what we're asked to do (overspeaking) ——
SIR JOHN SAUNDERS: What Paddy Ennis says is it's a plan, it's a guide, but everybody knows that in certain circumstances you don't stick to it.
A. Yes. I'm not convinced that has been my training, sir, if I'm honest, certainly from a command perspective. And I think there's an important point there in that Paddy is an extremely experienced and excellent paramedic, but not a trained commander as such, and in my command training I think there was a very big

emphasis —— and I do not —— you know, I do not necessarily agree with it, but I think there was a very big emphasis on those zones, those rules, and hard as it is for me to say, when I walked away from that incident, I thought the criticism would be that I allowed Paddy to stay in that room, and that's the irony of the discussion we're having now ——
SIR JOHN SAUNDERS: They are inconsistent, those two things?
A. They are.
SIR JOHN SAUNDERS: I am sorry to interrupt you, Mr Greaney.
MR GREANEY: No, no, sir, you carry on.
SIR JOHN SAUNDERS: If the rules —— if the plan was as it is now, would you have sent them in?
A. I would have felt a lot more confident —— not confident, comfortable sending in extra paramedics. I will say, though, part of my plan also is that that area is not a good area for care of patients. So my plan would have always been, no matter who I could send in there, move those patients quickly. So I would never have established, in my view, a CCP or a CCS in that area, and I appreciate —— I'll be getting ahead, sorry.
MR GREANEY: We're going to go on to CCS and CCP. I have often confused myself about the difference and I'm going to seek your help. I just want to get to the bottom of this issue to the extent that we can.

I'm sure everyone will sense that you are trying to help us to understand. From what you're saying, it seems as if at the time you felt in something of a dilemma, that on the one hand you knew that there were in that room people urgently in need of medical treatment, even to the extent of needing it to save their lives, whilst on the other hand believing that the procedure that existed, the plan, didn't permit you to send them in? Have I captured how you were feeling at the time?

A. I think so. I think ... A long explanation for decisions that probably took seconds. It was a rapidly moving incident, but certainly part of my decisions were around the fact that for deployments into warm zones, explosion sites, my available resources really were HART.

Q. Did the thought occur to you at the time that if you went against the plan as you understood it, and you did deploy resources into that area, it might have adverse consequences for you, that you'd get into trouble?

A. I'm not sure it's more about trouble, but certainly ... No, at the time I made the decision, I wasn't thinking about criticism, I was thinking about procedures and my training. Certainly afterwards, which is the comment I made before, when I walked away from that incident, at

05.30 in the morning, obviously things are going round in your mind and I expected criticism for allowing Paddy to remain in that room, because officially he shouldn't have been in there and I should have told him to stay out.

Q. Bearing in mind that a very important part of your thought process was the risk that anyone going into this room would be at, was it important that you should have a clear understanding of what that risk was? A rather clumsy question but I hope you understand what I'm driving at.

A. I do, yes.

Q. Because that was the thing or an important thing that was inhibiting more paramedics going in?

A. It was. But actually, I think as much as I've criticised perhaps the JOPs that were in existence at the time, the reality is a previous presence of a terrorist and obviously the consequence of the bomb that we saw defined it as a warm zone. It was almost a given, to be honest, because it's not anything that —— it's not even something that would be ambiguous in my view, and this is obviously my view of the policies.

Q. We understand that.

A. It's not ambiguous, you know: a terrorist has been active in that area.

Q. So automatically it's inner cordon?

A. That's my view of the training we received at the time, yes.

Q. What we know is that by the time you're there, armed police effectively have got that room under control. Paddy Ennis felt safe there. Others felt safe there. Did you know that?

A. I was aware of the armed police. My —— I think my worry on —— not my worry, I think my view on scene around the armed police is that they were very present very quickly in numbers and that the potential for danger from —— again, at the time, a lot of training around marauding terrorists with firearms. I felt relatively quickly comfortable around the threat of firearms, but not around the threat of further devices and not around the threat —— or not threat, sorry, not around the risk of the detonation having occurred in the room and the subsequent damage that will have caused. So there are numerous ——

Q. Do you mean structural damage that might have caused some form of collapse?

A. Yes. So it would —— I've been a paramedic for many years and, you know, we don't treat people in the middle of an explosion site, whether that's a —— we would move them very quickly.

SIR JOHN SAUNDERS: Okay, that's a good reason for not treating in there and moving them, but the structural damage is not of itself a reason for not sending paramedics in?

A. It's part of the risk —— no, no, but it wouldn't be for not sending in (overspeaking) but it's part of the risk. I'd have to understand on any incident, this formed a part —— I would have to understand the risk to the responders. And again I have to say that —— and I think we are different now, but I do think the training at the time very much, obviously, concentrated on patients, concentrated on systems, but did also concentrate on our obligations as commanders, the deployment of personnel into a dangerous area, and something happening ——

SIR JOHN SAUNDERS: Okay, the safety of the rescuers is clearly an important matter.

A. Yes.

SIR JOHN SAUNDERS: I just think, just to —— I think both Inspector Smith and Mr Ennis, the phrase they used was "safe enough". And I think there is a distinction between they felt safe and they felt safe enough.

MR GREANEY: You're probably quite right to put me right, sir.

The way in which I have expressed the situation that the chairman's just described, or something similar,

is that there's warm and there's warm. So there's warm in the sense that a terrorist has just been through that room and there's warm in the sense that armed police have got that room locked down, although there remains a risk of a secondary device. The risk in those two scenarios is obviously different, albeit both may be warm. Do you understand my logic?
A. I do, and I think in one of my statements, and it's probably a term I shouldn't have used, I called downstairs "warmish" because ——
Q. Exactly.
A. For me, downstairs, again, you know, armed police were ever—present and, for me, the risk downstairs was again lower than it was upstairs. In part, that was to do with obviously the damage and the presence of the explosive devices within that room but also because we had a very clear concourse on my arrival, which was cordoned off relatively quickly.
Q. It seems that —— and this is not a criticism of you —— it seems as if your view was that even though the room was warmish, because there was an armed police lockdown —— you want to say something and I will let you.
A. Sorry, my warmish comment was about downstairs. Warm is upstairs, sorry.

Q. I have understood that. If I were to suggest it was warmish upstairs because of the armed presence, is that something you would take issue with, still warm but warmish?
A. I think because I knew the terrorist had been in that room and detonated a device in that room, my view is that the policies aren't ambiguous on that and that is a warm zone. You know, I didn't know which way the terrorist had been in, so by very definition I could have said downstairs was cold because I didn't know which way he walked in. But for me, it was a warmish zone downstairs, but I'd have to call it warm upstairs, I'm sorry.
SIR JOHN SAUNDERS: That is actually up the stairs. We heard from other paramedics that they were told, "You're not to go up the stairs". The bridge, was that warm?
A. I think ...
SIR JOHN SAUNDERS: Or is there another reason for saying, "Don't go upstairs"?
A. I think the stairs —— from my perspective on the night, I think upstairs was warm, and I get your point around the bridge. I think the stairs were just used as a geographical point of ease to say, "That is where the two zones are".
MR GREANEY: I suspect I've taken this as far as I can. The

reality of the situation is that because, according to the definition, the City Room was warm, that prevented the deployment of anyone apart from HART into that area?
A. Yes.
SIR JOHN SAUNDERS: What I would like to see at some time is some sort of analysis of the major incident plan to see whether it is clear there that it is discretionary, a discretion exists, or whether —— you don't need to do it now because I am still reading the document(?), but whether it is in absolute terms there, which is what you understood it to be or whether it could be read in a different way.
A. I think it may have been more beneficial than the JOPs, sir.
SIR JOHN SAUNDERS: Yes, but I thought you were actually using the major incident plan rather than the Plato JOPs.
A. The zoning would be from the JOPs, really, but I think our major incident plan refers to the JOPs.
SIR JOHN SAUNDERS: When you've been talking about inner cordon which is your major incident plan?
A. That was the plan, yes.
MR GREANEY: Paragraph 9.5.2 of the major incident response plan, {INQ013132/42}, addresses the role of HART but we'll need to do a review of the whole of the document

to see if there was anything even more explicit.
Thank you, sir, for not requiring me to do that on the hoof.
I'm going to move away from that particular issue, about which I'm now much clearer, unless, sir, there were any questions you wanted to ask about it.
SIR JOHN SAUNDERS: No, thank you.
MR GREANEY: Just a few questions before we move on to the CCP and CCS.
First, when Paddy Ennis deployed back into the City Room, and to be fair to you he made clear this is something he was deciding ought to happen, what role, if any, was assigned to him in accordance with the command structure?
A. I don't think it was assigned to him. I think ... You could call him a primary triage officer.
Q. That's what he thought he was.
A. In a way he was. But not the officer, he was completing primary triage —— the primary triage officer really is responsible for the people doing the primary triage. But what he was asked or what he was doing was going in, triaging, and providing a priority. So my view —— and, again, I've thought about this over the last 24 hours because of Paddy's evidence. My view is I don't think I did clearly define a role for him other than to say

prioritise . So I think, in fairness to Paddy, did the major incident have a role designed for him? On reflection , no, I'm not sure it did, because if I'd asked him to be the primary triage officer , really their role is to sort of make sure triage is done by other people, and he didn't have other people available to him.
Q. Indeed, we looked at that yesterday in fact .
A. So I don't think the role that he undertook is really defined within the major incident plan.
Q. Secondly, before we get to CCP and so on, is it a fair observation that you were not sufficiently concerned about his safety to tell him, instruct him, don't go there?
A. I didn't instruct him not to go there, but we did have a —— and, again, it's seconds of a conversation, but we did have a conversation about his risk . I think his words to me were, "It's as safe as it could be". If I'm honest, I have worked with Paddy for a long time, the decision around him going back in was based on patients and his tenacity and bravery to go back in that room. Officially I knew that I should be asking him to stay out and we worked together to do what we needed to do.
Q. In your mind, was it safe enough for him to go in?
A. No. In my mind, he shouldn't have been in there ——

well , in my mind and all the books, he shouldn't have been in there.
SIR JOHN SAUNDERS: Are we saying it's not safe enough to be in there because of what the major incident plan or JOPs says or are you saying: on what I knew personally about the situation in that room, of course he you knew much better than you, I considered it wasn't safe for him to work there?
A. I guess both, because the room was defined as warm, the risks were relatively understood, but the room was defined as warm and by definition that means that it's not safe enough for him to be in there.
SIR JOHN SAUNDERS: So it is by the definition basically?
MR GREANEY: So shall we move on then to deal with the CCP and CCS.
By 23.05, you were outside on Station Approach, I think. We'll check by looking at the sequence of events. {INQ035612/203}.
That plainly isn't the correct image. I'll come back to it in due course.
I do know that at 23.05, you're outside and indeed we can pick this up from the schedule which I know you've been provided with. Sir, it's another one of these schedules that we can't put on the screen. I do hope you have a copy of it.

Do you have a copy, Mr Smith?
A. I do, thank you.
Q. We're going to start at line 4230, the antepenultimate entry on that page. It's timed at 23.05.01. We can see if we look along casualty clearing station is the location and it reads:
"NWAS Dan Smith is stood outside the entrance to Victoria Station. He approaches PC David Shott, and tells him, 'Casualty clearing is there', pointing to the side of the station entrance."
Another officer arrives and again you indicate, "Casualties here", again pointing to the side of the entrance. Were you pointing out an area just outside the war memorial entrance?
A. I think I was pointing at an area just inside the war memorial entrance. I did read this, obviously, in preparation for today and questioned about myself. My recollection on the night, and it was something that proved to be completely incorrect as the night progressed, but the war memorial entrance —— when we do major incident exercises we tend to keep priority 1s on one side of the tent, or whatever we are using, and priority 2s on the other. In my mind, I thought we'd do that at the war memorial entrance and we'd have two nice, neat rows. Clearly, it doesn't work like that in

reality , something I learned on the night, and obviously that war memorial entrance wasn't going to be the big enough to house the patients that we had.
So as I understood from my recollection on the night, casualty clearing was to be inside the war memorial entrance along where the war memorial is and obviously we then went into the concourse as the night progressed.
Q. It spread out, I think, in both directions, both outside to some extent and, as you say, on to the concourse.
A. Yes, some of the patients outside were already there.
I think on my first picture arriving there, there were already patients sat on the pavement outside of that war memorial, whether —— I'd assumed they'd either been helped out or made their own way out, and then obviously we used the other side of the road as well.
Q. I think of those who came down from the City Room in the sense of needing assistance, either a stretcher or a person or a chair, five of them ended up on Station Approach itself.
A. Yes.
Q. But at all events, what I need to be clear about is when you said, "Casualty clearing is here", were you talking about a casualty clearing station?
A. Yes.

Q. As opposed to a casualty collection point?
A. Yes.
Q. We need to understand, or at any rate I need to understand, what those terms mean and so we'll return to the major incident response plan. {INQ013132/40}. If you'd enlarge the bottom half of that page, please, once you have it.
Paragraph 9.2:
"Casualty collection point (CCP). Following triage sieve, casualties will be evacuated in priority order to either a casualty collection point or directly to the casualty clearing station for treatment. Although the CCP process originated from the response to specialist incidents such as CBRN/hazmat or marauding terrorist firearms attack scenarios, its use is now commonplace for any multi-casualty incident. The CCP is designed to provide basic care for life-threatening injuries prior to a casualty being moved to the CCS or direct to hospital. Equipment to establish the CCP is carried by the Hazardous Area Response Team."
Pausing for a moment, in any incident in which there are a number of casualties such as the arena attack, should there be a casualty collection point?
A. You can use a casualty collection point. Again, it would be very incident-dependent. You can use one

or, as it quite clearly says there, you can move the patient directly into a casualty clear station. So you don't have to have a casualty collection point.
Q. So a judgement is made at the scene depending on circumstances?
A. Yes.
Q. Is that a judgement for the operational commander?
A. Yes, or for ... in an MTFA-type situation, the commanders that are working within the hot and warm zones.
Q. Then 9.3, "Casualty clearing station", over the page, please, {INQ013132/41}:
"Once a casualty clearing station has been established all casualties must be directed/transferred from the site or CCP to the facility for further triage (sort) or if appropriate to a P3 (walking wounded) holding area."
So again, further support for your view that you don't have to have a CCP, people can go straight to the casualty clearing station:
"Casualties will then receive treatment and subsequent transport to a location appropriate to their condition subject to availability."
And then various locations are listed:
"Treatment within the CCS should aim to stabilise the casualty with a view to getting them to a definitive

point of care as soon as possible."
Then just one further page to look at and then I'll have some questions. {INQ013132/59}, please, Mr Lopez.
This is appendix A and it sets out a diagram of how an incident would be expected to manage; is that a fair way of putting it?
A. Yes.
Q. Where we have the incident itself surrounded by the inner cordon. Then just outside, the FCP.
A. Yes.
Q. We've got a CCP and then, further away, the casualty clearing station, and so on.
A. Yes.
Q. So am I correct to conclude that, where there is a CCP, it will logically be nearer to the incident than the CCS?
A. Yes, in most -- yes -- no -- yes, it will.
Q. In the circumstances of this situation, what was your plan for a CCS or CCP?
A. So first of all, I think in my statements I've used the terms interchangeably and that's incorrect. My view on the night --
Q. Were you clear about the distinction on the night?
A. Yes, very clear. So why... I can only apologise for the statements --

Q. I'm sure you don't need to apologise.
A. -- that used the terms. I was very clear what a CCP was and I'm very clear what a casualty clearing station was. It is my view that we established a casualty clearing station on that night.
Q. In the area that you've described?
A. In the -- well, it started at the war memorial and went on to the concourse, and then obviously, as it says there, the P3 holding area was slightly separate, and we used the opposite side of the arena -- of the Station Approach to have the P3 area.
Q. Was there a casualty collection point --
A. No.
Q. -- that night in your plan?
A. Not -- no.
Q. A question that might be posed is: a CCP, as we know, involves more treatment than occurs on triage sieve, why was a CCP was not established either in the City Room or on the overbridge? Is the explanation for that that you couldn't do it because those areas were warm or is there some different reason or a combination of reasons?
A. I think there's probably a combination. My personal view is that it wouldn't -- just from experience, you wouldn't establish a CCP in the City Room because you're not moving the patients anywhere, that is the incident

site. I obviously have ——
Q. But it has the benefit if they do require treatment over and above triage sieve treatment?
A. Well, it's my view that they don't, so it's my view that they still only manage catastrophic haemorrhage and airways and Celox dressings in a CCP. A CCP is, in my view, somewhere that you would move a patient very quickly out of danger, you then manage them quickly, and then you move them on to a CCS. So I think my operational plan on the night was to move those patients as quickly as possible from where they were to the concourse, and the concourse became a CCS. I think you could always argue that, was it a CCP and then developed into a CCS because they'd been moved there first. But I have to be honest, it's my view that I didn't establish a CCP that night, I established a CCS.
Q. So you've explained your position in relation to the establishment of a CCP in the City Room and it may be your answer to the next question is the same: why not establish a CCP on the overbridge?
A. I'd answer that in two ways, two points really. I didn't consider that on the night. That's the first point. I didn't consider that.
The second point is, applying my mind to that question now, could I have done, I just think that would

have introduced delay. I genuinely think that would have introduced delay, and I appreciate that we could have —— that you can provide more care up there, and I appreciate totally that there were some difficulties on staircases, but I do think if we'd have held two areas —— we moved patients, in my view, quickly —— we'd have ended up with a very large area on that bridge. If you think about the footprint that we needed to use on the concourse, we would have had —— I just... This is on reflection, I want to be clear, I did not think about it on the night. But on reflection I just don't think that was an appropriate place to put a CCP. I just think once those patients had started moving, the very best we could do was just move them very quickly downstairs and I appreciate the difficulties, I do, and it was within perhaps a range of options that I could have considered on the night. Applying my mind now, I still don't think that was the right thing to do.
Q. You may have identified two reasons why a CCP would have been of benefit. First of all, as the plan itself states, a CCP is designed to provide basic care for life-threatening injuries. Secondly, there was the difficulty that you're obviously aware of, which you experienced on the night, that to get to the CCS people had to be brought down that staircase, didn't they?

A. Yes.
Q. And is a third benefit or potential benefit of the CCP, as Mr Ennis I think accepted yesterday, that where a patient is in a CCP, if they'd had a tourniquet applied or some dressing applied to deal with catastrophic bleeding, they will be checked to make sure that that is working?
A. Yes, I think that final point is possible, but I do still maintain —— I do appreciate the difficulties, but on the night how I observed what was happening, I thought that the movement of patients downstairs was happening very effectively. I will say to the dedication of the public and the police and other people in those movements and the teams they worked in, so I honestly —— and I have, you know... I have genuinely thought about this a lot given what's been discussed. It is still my view that it would have slowed things down, I just genuinely think it would, and I appreciate others may not, but that would be my view.
Q. I'm going to ask about one further issue on this and we'll move to the subsequent period, the period from 11.05 and onwards. You didn't ever visit the City Room, at least not during any relevant period?
A. No.
Q. Given that you were making decisions about risk and

about whether there should be a CCP, and if so, where, would it have been better if you had yourself visited that room?
A. Would it have told me anything different is perhaps a question I could ask myself. I think I was aware on the night that it was a warm zone, it remains a warm zone, the movement of individuals into that room, in my view, is not —— movement of paramedics into that room was not permitted. I allowed Paddy to stay in that room, or didn't stop Paddy from staying in that room, I deployed the HART, as I saw fit, and I know we'll come to that.
But did I need to visit that room to understand anything different? The only thing that I may have understood was actually the structural damage was a present risk, wasn't it? And I don't think I was completely clear on that on the night. I assumed it would be, I don't think I was completely clear how much of a risk, and we obviously know there was.
Q. Did you turn your mind to going to the City Room and decide for those reasons not to or is it something that didn't cross your mind that night?
A. I think it did cross my mind, but I think I was aware, as the ops commander, my role is to stand back and that's a difficult thing to do, but I was satisfied that

I had enough understanding to make the decisions I needed to make.
MR GREANEY: Sir, I'm going to move on to look at some particular events from 11.05 unless you had any questions?
SIR JOHN SAUNDERS: No, thank you.
MR GREANEY: You went straight from your discussion with Paddy Ennis to Station Approach, and you spent the next 50 minutes either outside on Station Approach or just inside; do you agree with that description?
A. Yes.
Q. I believe that in that period, you didn't personally provide treatment to any person; is that correct?
A. No hands—on treatment, no.
Q. I think it is important that I should ask you why, although I believe I know your answer.
A. It would be —— it's not part of the role that I undertook on the night to offer direct care. In fact we're explicitly instructed not to.
Q. You just dropped your voice.
I think the point you're making was your role on the night simply involved you not treating ——

A. Yes, I'm explicitly told not to do that, yes.
Q. Did your role continue to be that of operational commander?
A. Yes, until midnight, yes.
Q. Many of your interactions over that period of time —— and let me immediately acknowledge you were extremely busy and operating under considerable pressure, but many of those interactions we will need to consider in chapter 12, as I warned you when we met earlier today.
But I do just want to focus on a number of events that reveal or might reveal some aspects of your general approach.
Back to the schedule, please, now to page 2 and to line 4506. 23.06.44. On the screen, Mr Lopez, I hope this reference is correct, the sequence of events, {INQ035612/209}.
There we are, 23.06.47. PC Grace Barker —— we had reference to her yesterday in Mr Ennis' evidence —— approaches him as he arrives and says, "We need ambulances", effectively and she enters Victoria Train Station with three off—duty officers (sic) and she takes them to you and Dr Daley.
If we look at line 4506 we can see the conversation that develops between you and PC Barker. Because you say to her:
"Stay out here."
PC Barker replies:
"Three doctors."

You then say:
"I don't care who they are."
And PC Barker states:
"Right, fine, that's my question answered. Let's get out of here."
And an unknown voice is then heard to say:
"You've got to stay out there, you can't come back in."
Do you recall those events?
A. I do. I didn't realise it was that early in the night, but I do recall them, yes.
Q. On the face of it, there are three doctors who want to enter the station in order to provide assistance where it's required. Again on the face of it, you're saying, "No, I don't care who they are, they're not coming in". Is that a fair description of what happened or not?
A. Absolutely, yes.
Q. You will appreciate that someone, a member of the public or a member of the families watching, might say, "Why on earth were three doctors who could bring such value to that response not allowed even into the station?" So I must give you an opportunity to explain that.
A. Yes. Remembering, obviously, I'm 6 minutes into my attendance, that we're in the middle of a terrorist attack, and people without ID being allowed through

cordons should not be happening. It's as simple as that. That is a safety —— it's a tactic that we know can be used. Access to these areas should have been restricted. There is nothing wrong with us going back out of the cordon which they've just come through, checking IDs, seeing who they are, but absolutely I needed to have that area locked down by the police, and allowing anyone turning up at a cordon saying, "I'm a doctor", is just not acceptable.
Q. Is that the position you adopted just because that was the procedure or is that the position you adopted because they might be at risk coming in, or they might present a risk if they came in, or a combination of all of them?
A. If we... They may be at risk but my first thoughts are they could be a risk. There is nothing to say that those three —— obviously we now know who they were, but there's nothing to say that those three didn't use that as a tactic to get into a secure area and cause further havoc.
So 6 minutes into my plan, as far as I'm concerned, I've got a piece of tape across the front of the concourse that says this is a cordoned area by the police. If people need to come through that, we need to have proper systems in place to do that.

SIR JOHN SAUNDERS: Really, that's the police's responsibility?
A. Absolutely, yes.
SIR JOHN SAUNDERS: So really you think PC Barker was not doing her job properly by letting them in without identification?
A. Yes. But you can't criticise somebody for -- you know, "Some doctors have arrived, I want to get them in", she knows the situation clearly that's going on in front of her, but again one of my roles is to protect the health and safety of that CCS, and I absolutely needed that cordon locked down.
SIR JOHN SAUNDERS: Did you ask if they'd got ID?
A. I just wanted them out first. We could do that away, but what I didn't want was patients being laid down next to people that had just been allowed through a cordon. And I know certainly from part of our debrief process that other doctors were just allowed through cordons and it was part of the debrief that we fed back in that those cordons need locking down when we're in the middle of a terrorist assault.
MR GREANEY: In the end those doctors did get in, but not for another 14 minutes.
A. It may be a question for Dr Daley. This is purely a recollection. As I said, it may be completely

incorrect, but I've got a slight memory of maybe asking Dr Daley to double-check on who they were. Also doctors -- there are many different doctors, so we need to be aware that they've got the necessary training to be able to work in a casualty clearing station and things as well. That was not my primary concern. But if we were to allow them to work in a casualty clearing station, we need to know they're able to do so.

I have just got a slight memory that I may have asked Dr Daley to double-check on who they are, but I wouldn't say that was for definite. It may be a question for him.

Q. The position therefore seems to be that there were three doctors who wanted to give their assistance, who would undoubtedly have been of assistance, do you agree?
A. If they were doctors, yes, but at the time --
Q. If they were doctors? Well, they were. And it sounds as if at least part of the reason they weren't admitted was a procedural matter because there was a cordon they shouldn't go through?
A. Yes, it's procedural, but it's about protecting -- you know, I was bringing patients into an area, we needed to be able to make sure that area was protected. The very worst thing that could happen was people got into the casualty clearing station and caused more death or

destruction through further attack. That's what we were faced with.

I was 6 minutes into an incident. There's no way that we should be allowing anybody through unless we are clear on definitely who they are.

Q. Just before we move on in time, although only to 11.07, whilst we're dealing with doctors, I asked you just before lunch about forward doctor and the role that person performed. What I understood from your answer was that the forward doctor was someone who would move from, I think you said, from the FCP forward to the scene of whatever had happened.
A. I think so. We use slightly different terminology now but I'm sure at the time the forward doctor would work in a forward position on the incident.
Q. And I think you had at least two doctors there, Dr Tunn and Dr Daley?
A. I'm not sure Dr Tunn was there at that point.
Q. Dr Daley was present at any rate --
A. Dr Daley was.
Q. -- and we have seen him many times in the images.

He was therefore a resource that could have been, from an early stage, deployed forward into the City Room; is that correct?
A. Yes.

Q. Is the reason that he wasn't the same reason that you wouldn't deploy ordinary paramedics?
A. Yes.
Q. Namely it was a warm zone?
A. Yes. Under the CCA, any NHS responder on scene comes under the same rules as the Ambulance Service. So anyone responding on our behalf would come under those rules.
Q. At 11.07, the first casualty arrived outside on a makeshift stretcher and you were there at that time.

In the next 35 minutes, so up until 23.42, a further 37 patients arrived, of whom 25 were on makeshift stretchers. Those are my calculations. I'm always available to be corrected.

Do you agree that the use of a kind of makeshift stretchers that were employed was obviously unsatisfactory?
A. Yes.
Q. So let me ask a few follow-up questions. First, were you aware that the Fire and Rescue Service have -- were you aware in May of 2017 that they have a capability in relation to the extraction of casualties from a scene?
A. Yes, I was. I was aware of their capability under the MTFA response, yes.

Q. As these casualties were being brought from the City Room to the CCS, did it strike you at any stage that the Fire and Rescue Service were nowhere to be seen?
A. If I'm honest, no, it didn't.
Q. Secondly, as we've understood it, on NWAS ambulances there would be a form of stretcher. I think we're told it's called a scoop stretcher.
A. Yes.
Q. Did you direct that, rather than using cardboard hoardings and so on, that the NWAS scoop stretchers should be used?
A. No.
Q. Why not?
A. So the process of moving patients on makeshift stretchers started, I think there or thereabouts, as the first sort of ambulances started to arrive with me. So the process had started and, as I've said previously, and I know this sounds wrong now because we can look back on the incident and clearly see that there were struggles on the night. I didn't notice the struggles of people happening. So I can only say to that I did not notice those struggles that people had. It seemed to me on the night that things were working, they were working efficiently, they were working well, and

patients were being moved very quickly to where we wanted them to be.

The use of scoops, again, being totally open, I did not consider on the night, and I didn't consider because I just —— I did not notice the problems that people were having.

I will say —— I think there's an entry in this SoE where somebody states, it's a police officer who says that they have got someone stuck, I think, somewhere, and there's a discussion around that. That wasn't clear to me that that was a stretcher problem at the time.

I have a recollection of someone asking me specifically for a stretcher and us having a discussion about they're too heavy to go up the stairs. I didn't consider scoops.

What I will say is I have obviously thought about scoops now and I have also obviously thought about Skeds. I know what the experts have said in their view that scoops could have been used. They were a possibility but I genuinely on the night just thought that it was working. And I know people are going to see that evidence and think, well, how could you have thought that, but genuinely on the night I just thought it was working.

Q. Well, hopefully people will make a fair judgement about

your evidence in light of the evidence that you have given. That's all I want to ask you about stretchers.

We've been going for an hour and 15 minutes. I don't have very much longer in my questions, sir. What I propose is that I press on to the end of my questions and then we take a break and have CP questions after that if you are content with that and the witness is.

SIR JOHN SAUNDERS: You're happy?
A. Yes, thank you, sir.
MR GREANEY: Next, line 5287. As I indicated, I'm only going to a handful of entries. This is page 3. We're now at 23.13 hours. We can see an image of this on the screen at {INQ035612/252}.

Just before 11.14, the HART paramedics Chris Hargreaves and Lea Vaughan enter the railway station. Given that it was your responsibility for activities at the scene, as we saw from the plan earlier, was it your job to decide where they should be deployed?
A. Yes.
Q. And did you decide where they should be deployed?
A. Yes.
Q. And where did you decide they should be deployed?
A. They were deployed into the City Room.
Q. Is it fair to conclude from the fact that as soon as

they arrived, they were deployed there, that you did recognise there was a need for paramedic support in that room?
A. Yes, and they were the option I had.
SIR JOHN SAUNDERS: Can I just check, did you tell them to go there or did you ask them whether they'd be prepared to go there?
A. It was a discussion —— well, I didn't ... Forgive me, actually, I may have misled you there. I didn't speak to Chris Hargreaves or Lea Vaughan, I spoke with Simon Beswick. So the discussion was with him about deployment. He then deployed the two that we had available into that room.
MR GREANEY: Thank you for clarifying that. Otherwise there might have been a little conflict in the evidence. So I have understood, you speak to the HART team leader?
A. Yes.
Q. The HART leader, forgive me.

You make plain that you wish them to be deployed into the City Room, he then speaks to them and makes sure that they are content to do so?
A. Yes. Well, I don't know —— I —— yes, I suppose content to do so. There was a discussion about the capability. I definitely told Simon Beswick that Paddy was upstairs. I gave him a brief description of what I knew around the

suicide bomber and patients upstairs. Obviously by that time there were a number of patients already downstairs, and more flowing down in the next sort of 5 minutes.

So a discussion was then had about his team's capability and again it may sound like it's ages long, this is seconds of conversation and the decision is that they can deploy. Obviously, he then goes and talks to them about their ability to deploy and what they then do while they're there.

Q. At 23.25 -- and, sir, this is now page 4 of the schedule -- well, at 23.22.53 in fact is when it starts -- you passed a radio message to control. We can't play it because of certain background noises, but we can, I hope, display the transcript on the screen. {INQ034313/1}.

You have, as I have understood it, made a call to control. You then say:

"Thank you for the channel. Obviously you're aware we're at a major incident down here. Just a further update. So METHANE report: major incident is declared; it's inside Manchester Evening News arena; it's a confirmed shrapnel bomb, multiple casualties with penetrating shrapnel wounds; currently we've got a small area but obviously inside we are still looking at unsafe areas from the bomb."

By unsafe areas, did you mean the City Room?

A. Yes.

Q. "Numbers of casualties -- so far we've confirmed a number of fatalities and we've confirmed at least 15, one five, priority 1 patients. Currently we've got a large number of emergency services on scene, obviously we need to set up an RVP. So if we can make sure that all further resources other than specialist resources ..."

And when you speak of an RVP there, what are you talking about?

A. I'm talking about Thompson Street, a rendezvous point for our vehicles at Thompson Street.

Q. So am I right that by this stage, there are, we can probably work out exactly how many, there are many casualties within the CCS who need to be transported to hospital?

A. Yes. So we're 20 minutes after my arrival now so I think -- yes, I'd have to count them, but yes there are a number downstairs.

Q. So you are starting to gear up, am I right, to move those casualties to hospital and you're seeking to make arrangements for ambulances in numbers to go to the RVP at Thompson Street?

A. Yes.

Q. It then continues:

"MX0595..."

That I think is you?

A. It is, yes.

Q. "... 15, one five, priority 1 patients. Currently we've got a large number of emergency services on scene."

Over the page:

"Obviously we need to set up an RVP, so if we can make sure that all further resources other than specialist resources please go to an RVP, not to scene, I don't wanna clog the roads up. So that's all other resources must..."

So you've passed a METHANE message with information about each letter of METHANE, and as I've said, you're trying to gear up for a number of ambulances to transport to hospital?

You then carry on a little bit further down the page:

"At this moment if you can make sure the Silver commander's on this channel, I'm going to need to start knowing over numbers and stuff. I've established triage officer, casualty clearing officer and a parking officer. They're at scene and we've got teams moving forward into the building to assess the damage inside."

When you said, "We've got teams moving forward into

the building to assess the damage inside", what teams were you talking about?

A. I have obviously used the plural version there, but I assume I'm talking about the HART team that had gone in.

Q. So you're talking about Lea Vaughan and Chris Hargreaves --

A. Yes.

Q. -- who have been in to assess the damage?

Thank you very much. That's all I wanted to ask you about that.

Were you going to say something?

A. No, it's okay.

Q. I'm just going to really summarise what happened thereafter. In the minutes that followed, you had a conversation with the TAC adviser, Steve Taylor, over the radio, and with control. That I don't need to ask you about.

You then had a conversation with the Silver commander at 23.34, the top of page 7, in which again you were seeking to establish with her what arrangements were going to be made for the transportation of casualties to hospital.

Then at 23.39.27, you spoke again to the Silver commander. She gave you information about the

allocation of particular numbers of patients of a particular type to particular hospitals; is that correct?
A. Yes. And I did that on purpose because on scene what I'd said to certain individuals is, "If I ask for this information over the air, you can all have the information". Rather than trying to brief everybody, everyone can listen in, write it down, and it was the casualty distribution part, basically.
Q. So what you can't have is a situation in which one hospital or a few hospitals are overwhelmed by the number of casualties who arrive and so someone has to make a decision under the distribution plan about which patients or types of patients are going where and that is what was being put into effect at 23.39, shortly before the final casualty arrived in the CCS?
A. Well, yes, so that will have been put into place. I think the reason I wanted Annemarie to read the numbers out was so we were all clear on the command structure, the numbers that were to be at each hospital. It was just an easier way from my perspective of briefing everybody on the same thing over the radio channel.
Q. At 23.43, you spoke to control again and made plain that you needed at least 40 vehicles given the number of

casualties that you were dealing with.
The balance we can summarise in this way: you continued to be involved in making arrangements for the transportation of casualties to hospital?
A. Yes.
Q. The final question that I need to -- the final topic that I need to ask you about relates to your replacement as operational commander. By 23.51, Stephen Hynes was at the scene, and we can show an image of this. {INQ035612/412}.
23.51.31. You're there in the body of the station, just in from the war memorial entrance:
"Operational commander Daniel Smith and paramedic Derek Poland talk with NWAS paramedic Stephen Hynes."
So Stephen Hynes is an officer of NWAS?
A. He is, yes.
Q. What, at that stage, was his position within NWAS?
A. He was deputy director of operations.
Q. Was he your line manager or one of them?
A. He was my manager's manager.
Q. Your manager's manager. So plainly, therefore, senior to you in position?
A. Absolutely, yes.
Q. Did you have a conversation with him at that stage?
A. I did, but a brief one, because it was around the time,

you're quite right, that you were trying to coordinate the movement of patients away. So I gave him a very brief summary of what was happening but asked him to wait for a further briefing because I wanted to -- I was in the middle of doing a number of things and I just wanted to get those things done. So I almost had sort of -- "This is what we've got, bear with me a second, I just need to get this and this done, and then we'll have a proper conversation".
Q. And I think it was 9 minutes later, at midnight, that you formally handed over to him?
A. Yes.
Q. There are a couple of aspects of the conversation or conversations that I want to ask you about. Firstly, do you remember that at some stage over those 9 minutes he asked you where the Fire and Rescue Service was?
A. Yes. I don't know if it was during the first conversation or the second but yes, I do remember him asking me.
Q. Was that in fact the first time that you realised that they were not in attendance?
A. It's the first time, yes.
Q. Or the first time you registered it?
A. I think the first time I'd registered it in my mind that actually, "Yes, where are the Fire Service?"

Q. Did he tell you that he was taking over from you as operational commander?
A. He did.
Q. In your statement you say you assumed that was happening because he, Stephen Hynes, and/or senior management were unhappy with some element of your command.
A. Yes.
Q. When you formed that view, what was it about your command that you had in mind?
A. I didn't, I just ... I was asked when I was writing my statement as to why I thought that could be and at the time I just said, I assumed someone was unhappy with something, but I didn't on the night know what that was or ask any questions as to why. I didn't think it was the time or the place to do so.
MR GREANEY: Thank you very much indeed, Mr Smith, for answering my questions.
SIR JOHN SAUNDERS: Right. There is an area which I would like to ask, but I'm acting entirely from my memory of evidence which has been given and therefore if my memory is incorrect, would you mind stopping me --
MR GREANEY: I will.
SIR JOHN SAUNDERS: -- because I'm acting simply on my memory of evidence given quite some time ago?
The HART team. When they arrived, how many were

there?
A. Well, three originally, and then another one arrived, and then two arrived. But to be clear, I only know that because of the process that's been applied for this inquiry. So on the night, when I was first presented with the HART team, I was presented with two operatives to move forward. I wasn't aware at that point where the others were and where they were in terms of ——
SIR JOHN SAUNDERS: So you're waiting for the HART team to come because they can go into the City Room?
A. Yes.
SIR JOHN SAUNDERS: And no doubt you would want to get, within reason, as many up there to help as you could, right?
A. Yes.
SIR JOHN SAUNDERS: So had you known that there were six around, you'd have got them all up there?
A. That would have been part of the discussion, I think, yes. Perhaps I explained myself incorrectly. When Simon and I had a conversation, he provided me with two, so the assumption is that I had two available to me at that point, which is correct.
SIR JOHN SAUNDERS: You'd know that the team is normally six, wouldn't you?
A. Yes, but I assumed that others were coming, which they

did later on.
SIR JOHN SAUNDERS: You were never told they were there to send them upstairs?
A. I don't recall being told that the rest of the team had arrived. That said, there is clear CCTV of the team being behind me at some point. So I must have been aware, sir, that they were there. I don't recall having a conversation with Simon Beswick ——
SIR JOHN SAUNDERS: And that is pretty soon after the two of arrived because they all arrived in the same ——
A. It's about 10 minutes later, yes.
MR GREANEY: I think by 11.21, they're there.
A. Yes.
SIR JOHN SAUNDERS: Again, this is entirely my recollection, which I hope is correct, the others who weren't deployed upstairs, and might have expected to be, were actually deployed to set up a casualty collection point, which rather surprisingly was going to be further out than the casualty clearing station. It seemed quite surprising at the time because it seemed the wrong way round.
MR GREANEY: Your recollection is correct, I believe.
SIR JOHN SAUNDERS: Did you direct them to go and do that?
A. No, I wouldn't have directed a casualty collection point to be further —— that wouldn't make any sense.
SIR JOHN SAUNDERS: It didn't at the time, actually.

A. I may have directed... I don't have a recollection of it but I may have directed them to say a CCS because they carry equipment to —— sorry, the casualty clearing station, maybe we need to change one of these names, but the casualty clearing station, you know, they carry obviously a lot of kit that can assist in a casualty clearing station. So I think it's very much likely that I would have said, "Assist with the establishment of the CCS now that you're here or now that you're available to me". I just ...
SIR JOHN SAUNDERS: There seemed to be a real lack of communication going on here.
A. I just —— I honestly don't know how anybody could have thought we had a CCP at the front of the CCS.
SIR JOHN SAUNDERS: The right place for them was upstairs in the City Room?
A. Yes.
SIR JOHN SAUNDERS: And they never got there?
A. Yes.
MR GREANEY: Do you think there's in any sense a risk that because things were so busy on Station Approach and just inside that you became distracted from what was actually happening in the City Room?
A. I think it was busy. But I think if you're an operational commander of a major incident of a mass

casualty nature, it's always going to be extremely busy. I don't think I was distracted from what was happening in the City Room. I've said in my statement, and I want to be clear on that as well, that I am not critical of —— I completely accept that I could have asked for more information as the night went on. The only thing I can say to that is I honestly thought that the operational plan was working, that there were no challenges particularly with it, and I also ... It went so quickly. I know Inspector Smith spoke about it, but I've never known an incident fly in time like that one did. We just seemed to get —— you know, it was... It's difficult. It's difficult in that role, and that's not me trying to give excuses, but the time just seemed to fly from us.
Q. I'm just going to press you a little further on that and ask you to consider this. It's the same point about whether your attention was diverted, might be a better way of putting it, from what was happening in the City Room to what was happening really in front of your eyes. Is the fact that you didn't take any steps, it would seem, to find out what was happening in the City Room between 11.05 and when you were relieved of operational command not, do you think, an indication that your attention was diverted?

A. No, I did have comms in the room during that time but mainly once the patients had been down. Obviously Paddy went back in at 11 ——
Q. 11.05, yes.
A. —— 11.05, sorry, and I think people were down by 11.42—ish.
Q. Yes.
A. So it was 35 minutes and I totally get that, and there was definitely comms —— sorry, there was definitely a communication with him at some point, but as I said all the way through, I definitely had a much bigger scene to manage —— again I know this is difficult to hear because clearly we now know different, but at the time I was really satisfied that the operational plan was working, and I genuinely didn't know there was (inaudible).
SIR JOHN SAUNDERS: Finally on that, we've heard in a number of different contexts of how handovers interrupt the process because you have to brief people and things like that. Therefore who's in charge is not actually hierarchical, certainly in some, so the mere fact that someone who's senior to you turns up should not mean that they take over. Is that the same with NWAS?
A. Yes, and it happened on the night. Dr Eddie Tunn was an associate medical director, much more senior to me.

Mike Jackson on the night was a chief paramedic, who is much more senior to me. So a number of people turned up who are senior to me, clinicians who were senior to me in rank as such, and did not take over operational command.
SIR JOHN SAUNDERS: And that's why must have thought, they must have thought I was doing something wrong because they took over?
A. Yes.
MR GREANEY: Sir, can I make a suggestion? The Greater Manchester Combined Authority had made a bid for questions but they no longer wish to ask any questions. That means, I think, that we have questions from the bereaved families and then from NWAS. I think that if we take a short break and if everyone is prepared to sit on —— mainly you, sir —— until 5 o'clock, there is a real chance that we will be able to finish Mr Smith's evidence today.
SIR JOHN SAUNDERS: That applies to everybody. I'm not the only one going to be sitting here. If we have a 10—minute break, would you be happy enough to go on until about 5.00 if the consolation is that you get it over with?
A. Yes, sir.
SIR JOHN SAUNDERS: Is everyone else happy? Okay,

thank you. We'll have a 10—minute break.
(3.51 pm)
(A short break)
(4.03 pm)
MR GREANEY: Sir, I'm going to invite Mr Gozem to join us via the link. For Mr Smith's benefit, he'll be asking questions on behalf of the families.
Questions from MR GOZEM
MR GOZEM: Mr Smith, can you see me and hear me?
A. I can, thank you.
Q. Thank you. Can I begin by saying to you that I have no doubt, and I'm sure nobody has any doubt, that absolutely you wanted to do the very best you could on that night, not just for yourself but for all of the people who were there and your efforts are much appreciated. But as you know, I think as you foresaw in some of the interviews that you underwent, this process is one that is necessary for learning.
A. Absolutely.
Q. Can I begin by asking you this: had you acted as an operational commander before?
A. Had I performed the role before?
SIR JOHN SAUNDERS: Yes.
A. Yes, I had, yes.
MR GOZEM: Because you hadn't undertaken any operational

command training, had you?
A. Not recently. So when I did operational command, it backdated —— so it was before NARU, so the National Occupational Standards. It was around sort of 2004 through to 2009. So I was operational commander at that point for a large number of incidents because that was a role I undertook. It was a role we don't have any more in the Ambulance Service but it was clinical practice supervisor and then assistant operations manager. At the time that role responded to any incidents of note, really, as the operational commander. It's fair to say back then things were very different in terms of our training, in terms of our record—keeping on training, NARU didn't exist, so the national course didn't exist. So I think in my statement when it says I haven't received any training, that's not true. What I haven't done is received what we would now expect from an operational commander simply because obviously I have moved to tactical command having done the operational command.
Q. You're quite right, your statement does say that you had never undertaken any and that is why I wanted to ask you about it.
Derek Poland was perhaps a more recently trained operational commander than you, wasn't he?

A. Yes. In fact, actually, we started on operational command at the same time, so had been doing it the same length of time as me. I moved on to tactical commander or had training to enable me to do tactical command. Derek had remained at operational commander level, yes.
Q. I'm just going to ask you this for your comment: with hindsight, do you think it might have been better if you'd let him become operational commander?
A. It would have been an option. I don't know if I'm better or ... I don't have a view on whether Derek would have made a better operational commander than me. It was an option, we discussed it, I took operational command, and I felt competent and able to do so and did it to the best of my abilities, as we've already discussed.
Q. All right. There could be many advantages, couldn't there, in having an operational commander, for instance like Derek Poland, and a tactical adviser on scene working together; is that right?
A. Yes, but I'm not a tactical adviser. That's a very different role to a tactical commander. I was trying to interpret your point there. Yes, a tactical adviser —— sorry, I should answer the question. A tactical adviser can support an operational commander. To the best of my knowledge, and certainly not during the time I was

there, there were no tactical advisers at scene.
Q. Would it have been any advantage at all to have a tactical commander assisting an operational commander?
A. I think that's an interesting point. I think I anticipate a question later around any recommendations I would like to influence. I think, as I have put in my debrief questionnaire following this incident, I think there is a need to seriously consider the operational and tactical level command structures and whether tactical should be certainly at an incident of this nature at scene. At the time, it was absolutely —— and myself and Annemarie didn't even need to discuss where she was going. It was totally accepted that as tactical commander she would be going to GMP Headquarters.
I put in my debrief paperwork that I think we should have some discussion about that. Nationally or in Greater Manchester at the moment the view remains that the Silver command ordinarily will be in one place and that's at GMP Headquarters, but I absolutely agree with you, I think there are —— there is a need for us to just have a think about how that works, definitely at a spontaneous incident. It's very different for a planned incident or even an incident that we've had some warning about and we're able to establish structures. But I do think where there is a sudden,

mass casualty, a no—notice sudden incident, having a tactical commander at scene, I think, personally, and I'm no expert, would be useful.
On the night you could argue: well, why didn't you do that? That just wasn't in my psyche because we absolutely worked on the ground of commanders at scene are operational, end. But I agree with you, sir, I think there's potential for us to learn something there.
Q. Thank you. On a very simplistic level one of the advantages might be —— we've heard that many of you carry these action cards with you. But it sounds very much from the evidence that the inquiry has heard that there's very little time for anyone who's responding to a sudden mass casualty attack to take the card out of their pocket and look at it and think about what they might do. Is that fair?
A. I think it's very fair, and I think that speaks to my point earlier when I was questioned around could a loggist perform a role of almost reminding you what you have and haven't done. I think it's very fair and I think that's a tactical adviser type role. Again, I think in 2017 we were not discussing tactical advisers being at scene. But that is certainly something that we do consider and talk about now, in response now.

I think their role is about not challenging as such but just making sure that things that should have been done have been done and I think that's very useful.
Q. For instance, you've told, in answer to Mr Greaney's question, the inquiry what appointments you made. You very fairly accepted that there were two appointments you think you should have made that you didn't make, safety and equipment officer; is that right?
A. They are appointments I didn't make. I think from an equipment —— safety I would accept. Equipment I should have made as per the plan. I'm not sure it would have assisted on the night particularly because it's my view, and again it may not be correct, but it's my view that we were okay for equipment, excluding the stretchers aspect.
SIR JOHN SAUNDERS: There is a particular vehicle, isn't there, which you can get to come to these which have a large amount of equipment on them?
A. Yes, but I'm ——
SIR JOHN SAUNDERS: If I can be reminded by somebody at some stage, what's it called?
MR GREANEY: The national mass capability vehicle.
A. That's not predicated on the establishment of an equipment officer.
SIR JOHN SAUNDERS: But couldn't he say, "Shouldn't we get

that here"?
A. They could have done, yes.
SIR JOHN SAUNDERS: Did you think of it on the night?
A. No, I didn't.
SIR JOHN SAUNDERS: If it occurred to you, would you have got it there?
A. I think probably by the time I'd done that... I was going to say would I have done it because by the time I'd thought of it and done it, probably the advantage of that vehicle probably would have disappeared, if that makes sense.
SIR JOHN SAUNDERS: It makes sense, but I'm not sure you would be going through that mentality.
A. That's why I stopped. On reflection, actually, yes, an equipment officer may well have said, "Actually where is this equipment vehicle", although the thing is on my action card, not theirs.
MR GOZEM: And just going beyond that particular vehicle, I have read such a lot of material containing your accounts of this incident in the various interviews you gave. In some of them, and I'm not going to take you to them, but do you accept that you said, "Yes, we did have a shortage of blankets and we went back to the ambulances to get blankets", and so on? Isn't the point of an equipment officer that he effectively puts all of

the equipment out in a convenient place, sometimes called an equipment dump, that people can go to without them having to go back to individual ambulances?
A. Yes, you're right, that's the role. I think my point was that when we did, or when it was reported that we had an issue around blankets, as an example you quite rightly point out, there was at one point oxygen cylinders, it was very quickly rectified. I accept your point, though, that an equipment dump could be done.
And that was also part of —— when I very first trained in major incidents, it used to be about the first 10 ambulances almost unloading everything they had, that was kind of a thing that we did. And with the advent of the new equipment vehicles, we kind of stopped talking about that because the special equipment vehicles were going to come. Actually my view is we should get back to the 10, the first 10 vehicles dumping their equipment again because they are going to be there a lot quicker and normally, obviously it would be incident dependent, and would provide that equipment dump very quickly.
Q. Thank you. Moving on now. Again, you very frankly answered Mr Greaney's questions about the whole concept of co-location and communication and your lack of contact with Inspector Smith. You'll recall that?

A. Yes.
Q. I think in general terms, you would accept, wouldn't you, that you really did not have enough information about what was going on in the City Room?
A. I don't know if that's connected so much to Inspector Smith. I guess my comments around myself and Inspector Smith are we were both the Bronze commanders for our individual organisations, we should have been in the same place. I have to be honest, for me that would have meant Inspector Smith coming outside and staying there, not me going inside. So I think the two things are slightly different.
But if you're asking: do I think I had adequate information about the City Room? I knew roughly the number of patients, I knew a bomb had gone off, I knew we had P1s, and I knew they needed to come out. My view was that I had enough information to develop my operational plan.
Q. Let me take you then —— do you remember Mr Greaney took you to the major incident plan? I wonder if we could have it up on screen, please, Mr Lopez. It's {INQ013132/16}.
I wonder if you could highlight the bottom of the page for us, please, enlarge it. Thank you.
It sets out in the part that was read to you:

"The key communication lines and partnerships for the operational commander are..."
And then there is a series of bullet points. I think by and large you went through those with Mr Greaney. Then there's this paragraph at the bottom, which I'm not sure was covered. Can I just read it out to you:
"For complex incidents, for instance a rail crash or multi-sited incidents, for instance a terrorist attack, the incident may be divided into sectors. This will require a separate commander for each sector. These commanders, eg sector commander 1, 2, et cetera, would be subordinate to the operational commander managing the incident scene. Ultimately, the tactical commander will determine the operational management structure depending on the scale or nature of the incident."
So having read that to you, can I invite your comment on this. This was a complex incident, wasn't it?
A. Yes.
Q. It was a complex incident that involved a site that, as you just frankly said, you weren't going to go into, presumably because of its zoning, if you were going to speak to Inspector Smith he'd have to come out? Is that right?

A. Well, partly due to the zoning but partly due to -- my view is an FCP would need to be outside for the very same reasons as I was asked before about the distraction, the City Room -- you know, could being outside distract you from the City Room? Absolutely. Could being in the City Room distract you from the large incident just outside of the City Room? Absolutely. So being in either place, the FCP for me needed to be out the front, and that's why, when I said about meeting Inspector Smith outside, that was more what I was getting at, that the FCP would need to be outside.
Q. All right. But did it ever occur to you that designating the City Room as a sector at the scene and appointing a sector commander, presumably somebody from HART, would have provided you with access to the best possible information from the City Room throughout events?
A. Did it occur to me? No. I will qualify that with some view now. The expert report discussed the potential that Paddy could have been made into a sector commander and I get that. I think if I was to answer honestly, when we have discussed -- I've never been on an incident ever where sectors have been put into play. The sectors when we discussed them normally during training tend to be, and as an example they put there, a rail crash,

where you've perhaps got three upright carriages and two carriages that have fallen down an embankment. You would sector the upright carriages and then sector the carriages that are further away. I did not on the night make any consideration to should I treat these as two incidents.

When you do sector, you would often start to have to set up the command structures around those sectors separately as well, so you may well have to -- you could end up with two CCSs and two -- so it can sometimes make it more complex. If I was to apply my mind to it now for that incident, I accept the point that the experts are making that Paddy could have almost become a sector commander just to feed information. But I'm not convinced that the incident, albeit it looks a long way -- the incident was in one place and I think for me it was one incident.

I'm not sure if I -- God forbid, if I attended that incident now, would I sectorise it? I'm not completely convinced I would, but I accept I'm not an expert in this. I managed the incident how I felt was right on the night. The experts consider the possibility of sectorisation and I can't dismiss that now.
Q. No, but it's not dependent upon it being a multi-sited incident, is it? It also includes a complex incident.

Do you agree that you would have benefited from more information coming to you on a regular basis from the City Room?
A. So the first question was -- it was a complex incident, and of course it was, and I accept that it says that for complex incidents the incident may be divided into sectors. I think I've responded in terms of the sectorisation.

Did I need more information coming from the City Room? I think I still remain comfortable that I had the information needed for me to make the decisions I needed to make.
Q. We heard Paddy Ennis' evidence yesterday and he very generously accepted that he could have asked for more help and said that he acknowledged that you were in effect right to expect him to. But that rather goes against the whole ethos, doesn't it, of someone who's being asked to stand back, take stock, and pass information, not, as you put it in NWAS, putting gloves on, getting involved? Paddy Ennis was deeply involved in what was going on in the City Room, in triaging patients, wasn't he? And is it not a little unrealistic, if not unfair, to expect him in those circumstances also to be able to look around and give you regular situation reports?

A. No, and I think that's -- that part of my statement that was discussed yesterday. I wasn't for 1 minute suggesting that the onus was on Paddy to do so. I totally accepted in that paragraph that I could have asked him as well. I also accepted that I didn't. I did get some information from -- I'm really clear on this: I definitely did get more information than perhaps we've captured from that City Room.

I think we said 35 minutes that he was up there. During my sort of operational command element, dealing with those patients, I think I had adequate information to do the job that I needed to do at that point.
SIR JOHN SAUNDERS: The reality is that because you were, rightly or wrongly, we'll have to think about, rigidly following the major incident, you didn't need much information.
A. No.
SIR JOHN SAUNDERS: Once you knew that there had been a bomb gone off there, as far as you were concerned, none of your people were going in there except the HART team?
A. Yes, sir.
MR GOZEM: Yes. You don't think, should you find yourself in a similar situation, you'd appoint a sector commander to get information from the City Room?
A. If the exact same -- well, if I found myself in the

exact same situation again, clearly our policies and procedures have changed now anyway. And yes, maybe I would consider a sector commander. My response before was -- on the night I didn't consider it and I do think that I got the information -- if it's for an information flow, I did get the information. It would be different now.

SIR JOHN SAUNDERS: Because you'd need more information about how safe it was?

A. Yes. Now there's potential that some more may have gone in -- we're talking theoretically here -- in which case I may have needed a sector or it may be that a primary triage officer then becomes or the HART team leader -- I think it's very difficult to apply now what happened on the night, if that makes sense.

MR GOZEM: Are we agreed, I want to be clear that I've understood your evidence, that there was nothing to prevent you sending HART team operatives into the City Room, was there?

A. There was nothing to prevent me from sending HART team operatives into the room?

Q. Yes.

A. No, there wasn't.

Q. We know that you sent two.

A. Yes, that's correct.

Q. In simple terms, then, why didn't you send more?

A. During the original or the initial deployment of HART, there was only two available to me.

Q. Yes.

A. So that was, I think, 23.15 that they mobilised in. Then at 23.20, which I think is when the next sort of four arrived at scene -- I think it was said at 21 previously, I ... I don't recall being made aware that they were ready to deploy. And that again, you know, may talk back to an error on my part, it may talk back to just not knowing that they were ready to deploy, but I don't remember being made aware they were ready to deploy.

SIR JOHN SAUNDERS: I have been brought more up to date with this. Apparently it was Mr Beswick's decision not to send the others in, I'm told. That rather indicates a rather split command going on --

A. It does.

SIR JOHN SAUNDERS: -- and it should have been you. Actually you did have Mr Beswick there, you didn't have just two to go in, you had three.

A. Yes. He could go in. I think from a physical sense there's no reason why he couldn't go into that room, but my experience of the HART team leader -- it's very incident-dependent, but invariably the HART team leader

will lead their team. So yes, he could physically go in but he would still be in a leadership position, if that makes sense, rather than doing the physical work that the HART were completing. At a number of incidents you will get the HART team leader staying quite close to the operational commander because they are communicating with their team by radio and they then feed that or discuss things with you --

SIR JOHN SAUNDERS: Did that happen?

A. It may be that that's where I got more information. I certainly got information and it's just not here but I certainly did get information. I think one of my updates -- I have looked at the numbers and that has come from information that's come out of the City Room. So there is an information flow, I just can't recall it, I'm sorry.

MR GOZEM: Is the position that you felt that the regime that was in place, once the two HART operatives went in was working, working well, and that's why you left it without sending any more in right through to the end?

A. It's certainly true that I felt that the system was operating well. As I say, I honestly don't recall being offered the second two paramedics. I think, if I've understood correctly, Mr Beswick has said that he didn't offer them. I honestly just don't remember being

offered the next two HART team members.

Q. Do you remember having a discussion with him about setting up the CCP or CCS?

SIR JOHN SAUNDERS: It was the CCP he was talking about. Again that's just my memory. And you don't have a recollection of it, I gather?

A. No, I just wouldn't ask somebody to set up a CCP outside of a CCS. If I've given an instruction of that nature, then it may be a mis-communication on my part or both. I am fairly confident it would have been to assist in the -- not assist, sorry, to set up or assist within the CCS. I just -- it would just make no sense to have a CCP outside.

MR GOZEM: Let's not -- that's the wrong way of putting it -- split hairs about whether it was a P or an S outside. Did you see his evidence, him talking about using a tarpaulin to set up the area?

A. Yes. That was outside, yes.

Q. Right. So that's what he did, is it?

A. I don't know if Simon Beswick did that -- I'm sorry, the tarpaulin that was set up outside? I couldn't tell you when that was set up. I just know it did get set up at some point. Whether that was an attempt at a CCS, I don't know. I've allocated a casualty clearing officer at that point, so the station becomes the

responsibility of that individual in terms of how it is being managed and set up, if that makes sense. Sorry.
Q. I think it does. Let's see if we can wrap this up. There's no question, is there, that when HART arrive, you are in command of the HART resources?
A. Yes.
Q. So whatever he was doing, it was always open to you to say, "I want you to stop doing that and I want you to do something else", for instance had you wanted him to go to the City Room?
A. Yes.
Q. And the reason that you didn't do that seems to be a mixture of in part you didn't know that they were there or when they arrived and, secondly, that you didn't think any more resources were needed in the City Room?
A. I thought the operational plan was working and if any more resources were needed, then that would have been requested and dealt with. But I honestly don't remember them -- I also don't remember them being offered to me or arriving, but I believe -- please believe me when I say it may be very clear that I was told they'd arrived, I just don't recall it.
Q. All right. Did the issue of pain relief for those who were in the City Room and who had been there for quite

a long time since the explosion ever cross your mind?
A. No, it didn't. I think Mr Ennis spoke about this a little bit yesterday, didn't he? It would be unusual to manage -- no, it would be unusual to administer pain relief in that setting. I think there are potential options available, not to NWAS on that night, but there are oral inhaled pain management medicines that you can give in those situations. I do know for a short time the HART team were trialling something of that nature. But on the night, it wasn't discussed with me, it wasn't -- it didn't form part of my thinking and I think rightly or wrongly, it wasn't something that would be routinely done in that sort of area.
Q. But it was hardly a routine incident and there were some people who were very severely injured, yet conscious, weren't there?
A. There were, but when I say routinely done in that area, when you are working in a warm zone, which they were, the casualty management plan is obviously to remove those patients as quickly as possible, and pain management would not be part of -- as it clearly says, and again this is procedural stuff, as it clearly says in the procedures, immediately life-threatening treatment, and then move -- you know, are we in a different position now? Possibly because we've got

more options for working in warm zones. But at the time I don't think -- I'm not saying I was correct, but I don't think it was part of our routine work to do pain management in a warm zone. And I know that will sound distressing to people, but at the time that was the training that we had.
Q. This much I wonder if you can agree with: had there been more paramedics, HART paramedics, in the City Room, it is likely that the evacuation of patients from the City Room would have been concluded earlier. Do you agree?
A. Well, the option I had was a further three. I think the carrying -- you know, the individuals that were up and down doing the carrying were doing that as quickly as possible. So no, I'm not sure that an extra three individuals in the City Room in terms of paramedics would have sped up the process of moving patients unless -- and I think Paddy spoke yesterday, didn't he, around the prioritisation, he was talking about how they were so rapid that he was keeping up with them. So I accept that maybe he could have directed quicker, but I'm not sure those extra two... Maybe I'm the wrong person to ask actually in terms of I wasn't in the City Room, but I'm not convinced it would have made the process of moving patients quicker.

Q. Well, let's put it another way so that we don't seem to be splitting hairs. Would it have made the process of identifying the patients who were ready to be moved quicker?
A. Potentially. But I'm not aware of any delays of that nature. Potentially it could have made that quicker but from what I have seen and the timelines involved in moving those patients, I think that system appeared, both in the evidence presented and on the night, to have been very quick. Once it commenced it was 30-odd minutes and it was complete, which is a lot for that number of patients.
MR GOZEM: Sir, those are my questions. Thank you very much, Mr Smith.
SIR JOHN SAUNDERS: Thank you, Mr Gozem.
MR GREANEY: Mr Atkinson next, please.
Questions from MR ATKINSON
MR ATKINSON: I ask questions on behalf of the bereaved families as well.
Just on that last point, if there had been more paramedics, HART paramedics, in the room, would it have been more effective in identifying those who needed to be moved out first?
A. I don't know how I can... I don't know if I'm best placed to answer that. I think in general terms, you

might be able to -- you know, more paramedics make sense, you could argue that it's more efficient. But I'm not -- I don't think I'm sighted on everything that transpired in the City Room enough for me to be the right person to say actually: this was a gap which could have been filled there and would have made it more efficient. I'm not trying to -- please, I'm not trying to avoid the question, I'm just not sure that I can answer that question with any authority.

Q. Just in this sense and then I'll move on: if you had more people qualified and able to do the triage, to identify those who were P1s, to label them, if you know what I mean as P1s, and say, "This one next", then those who were trying to get them out would know more comprehensively who the P1s were and who needed to go?

A. I accept the point, but I'm not aware of any delays. So if you're asking me the question is that -- "Would that have made things quicker on the night", I am not aware of any delays experienced by those teams. I'm not saying they didn't happen but I'm not aware of it so I can't say that that would have made things quicker because I'm not aware of any delays that were in existence.

If you say in general terms if there are mass numbers of casualties, they all need labelling, and

there are teams collecting, and the more paramedics there are to do that, the more efficient it will be, of course. But I don't know if we needed more than two.

By the time the three arrived, which is the last 20 minutes of the movements of those patients, I don't know if that would have made much of a difference because it was three paramedics in a room then with however many were left at the 20 minutes left mark.

Q. Just on however many were left, would you accept that in terms of your assessment of resources as an operational commander, you really had no independent knowledge of what was needed in the City Room at all, did you?

A. As in have I formed the view myself?

Q. You had some information from Mr Ennis in a brief conversation before he went back up, you had not spoken to the GMP operational commander, you had not spoken to any firearms commander. And so in terms of assessment of risk and in terms of understanding of what was needed, that was all you had, wasn't it?

A. Well, I'd spoken -- I'm not sure. I'd certainly spoken to firearms officers downstairs and police sergeants downstairs. And obviously Paddy in terms of -- and accepting that it was brief but it was still a conversation and obviously his updates through -- so I formed a view -- and I think on the night, if you

think back to what I knew and what was true, I actually had a fairly decent understanding of what had happened and what was needed.

Q. So was it your understanding that this was not a marauding firearms terrorist --

A. Firearms certainly, yes.

Q. -- but a bomb had gone off? Were you aware of whether the police had assessed that there was a risk of secondary devices or not?

A. I was aware that risk assessments were being completed. As an example, explosives dogs were searching and that sort of thing, so I was aware that was in play, and certainly slightly later, probably getting towards the time that Mr Hynes took over from me, there was another conversation around the risk of secondary devices and obviously, shortly after Mr Hynes took over from me, we had controlled explosions and things.

Q. In terms of an assessment of the City Room more specifically in that regard, did you know what the police assessment of that was in the time that you were operational commander?

A. At one point I was certainly told -- and this is downstairs by police -- that the City Room hadn't been cleared. In fact I was told that nowhere had been cleared for secondary devices, if I'm honest. So it

wasn't specific to the City Room, I was told that nowhere had been cleared.

Q. In terms of the HART team and their role and your understanding of it and who asked them to do what, can we just follow it through, because you'll appreciate, Mr Smith, that certain families I represent have read your various witness statements and that gives rise to some concerns on their part which we'll see if we can help them with. I don't know if you have all your statements there.

A. I do, yes.

Q. I know that at one stage we were deprecated from putting statements up on screen. If it would help as we go along, I'm very happy to give references.

To start with, please, Mr Smith, your statement to the Greater Manchester Police of 29 January 2018. {INQ005445/8}, if you would. Do you see a paragraph beginning "also around this time"?

A. Yes.

Q. "Also around this time, the HART team arrived. I can't recall if it was a little bit before or after. The HART team leader for that night was Simon Beswick and he asked me where they were needed and what I wanted them to do. I told him to start setting up in the area where we were stood as the casualty clearing/collection point

would likely to be here and asked him if he was okay with that."

And the CCTV —— I'll be corrected by Mr Greaney when I'm wrong —— shows that you spoke to Mr Beswick outside the station by the war memorial entrance.

A. Yes, I think it's slightly —— yes.

Q. "He agreed and started setting up their equipment. I advised him currently the limit of exploitation was to the bottom of the stairs inside the arena."

So the stairs that go up on to that higher level towards the City Room?

A. Yes.

Q. "At this point it was still very early in the incident and I was satisfied that we were in a safe area currently. We were still not sure of the threat/ possibility of secondary devices or firearms. Following a discussion with Simon, I was aware that two HART team members with PPE were volunteering to assist in what would be defined as the hot zone, the area where the terrorists remained."

Are you there talking about the City Room?

A. Yes.

Q. Was it your assessment it was a hot zone?

A. No. But I was told on the night, after my period of command, that it had been designated a hot zone. It was

my view all the way through, really, that it wasn't a hot zone. It obviously had been at a point. So I actually disagreed with the designation, although I wasn't in a command position at that point.

I've said in my statement that it was a hot zone because my understanding when I gave this statement was that that was in the end what it had been defined as. As it happens, from what I've seen now, it was designated a hot zone and then got reduced down to a warm zone. That is my understanding from some of the evidence I've seen, but I am not convinced —— on the night, sorry ——

Q. Just on the night?

A. On the night, for me, I didn't think that was a hot zone.

Q. And you weren't proceeding on the basis in your decision—making that it was one, were you?

A. Pardon?

Q. You were not proceeding in your decision—making on the basis that it was hot, you were proceeding on the basis ——

A. It was warm, yes.

Q. And you go on to say:

"The two people who put themselves forward were Lea Vaughan and Chris Hargreaves."

And we know that they went in. All right?

If you then have your statement of 1 November 2019, which is {INQ025656/9}. In paragraph 32 what you say is:

"Since this incident, I have considered with great reflection the fact that three staff under my control entered a zone that, in accordance with the standard major incident response, they should not have been permitted to enter into and I accept that on strict interpretation of policies and proportion, they should not have been permitted to enter the City Room."

Just pausing there, are the three you're talking about there Mr Ennis, Ms Vaughan and Mr Hargreaves?

A. Yes.

Q. On your assessment, as you have told us, of the City Room, Ms Vaughan and Mr Hargreaves were permitted to enter it in accordance with the policies and procedures?

A. Yes.

Q. Can you help us with what you meant there?

A. So either ... I don't know. So either I was still at this point —— because it is only during this process that I've been clear that it wasn't designated a hot zone. So either I was still of the view that the hot zone designation was in place or it's a mistake in my

statement.

Q. I'm sure it's just me. Was it not your assessment on the night that it was a warm zone?

A. My assessment on the night was it was a warm zone and when I was told later on that night, that it was a hot zone, I actually queried that in my mind, thinking, well, there needs to be active terrorist activity for it to be a hot zone, so I don't know why it would be a hot zone, if that makes sense. So on the night ——

MR GREANEY: I'm really sorry to interrupt. I've become a little confused. I may have created a confusion. We obviously have two different descriptions of zoning. We have the NWAS zoning and we have the Plato zoning. I think that when the witness describes an area as warm, he's using the Plato zoning and is therefore describing what NWAS would describe as the inner cordon.

A. Yes.

MR GREANEY: Am I correct?

A. Yes.

MR ATKINSON: Thank you. And that being so, would that have stopped Ms Vaughan or Mr Hargreaves as HART operatives from going in?

A. To a warm zone, no.

Q. To the City Room as you understood it to be?

A. Yes.

Q. So here when you're saying that the procedures ought to have stopped you letting them in, is that just a mistake in the statement?
A. It's either a mistake in the statement -- but what I was trying to say is that my view on the night was that it was a warm zone and it was treated as a warm zone. But on the night -- later -- well, later in the evening, into the next day, I was told that the City Room had actually been a hot zone. That is, as I understand what's then come out through this inquiry, not strictly true. When I made that statement, either I'm still of that view and I haven't found out that that's not the case or I have made a mistake in my statement. Does that make sense? Sorry, I've ... I don't know if I'm explaining it right.
SIR JOHN SAUNDERS: Don't worry, that's fine by me, thank you.
MR ATKINSON: We'll move on. Still the same paragraph:
"I further appreciate that there may be questions in light of permitting three members of staff to enter the City Room as to why I did not allow more staff in to that area to treat casualties. In this respect I am content that allowing more staff into that area would have resulted in the establishment of a CCS [casualty clearing station] type area and my operational plan

throughout was that patients should be triaged and removed from the immediate blast zone as soon as possible for onward treatment in an area that was more suitable for this purpose."
Then you go on to say:
"Furthermore, care of casualties within a warm zone should be limited to management of airway and catastrophic haemorrhage."
So on the face of that, it appears that there you were suggesting that the reason you didn't let more people in was because you didn't want to inadvertently thereby create a casualty clearing station in the City Room?
A. Yes, but I think we're talking broader there. So when I am applying that comment what I mean by that is the expectation, which is wholly understandable, is that all those paramedics that were downstairs would just go up to the City Room and work in that City Room. That is not what I wanted. Again, I noticed in the expert reports that they disagree that sending up more HART could have resulted in a CCS. I'm not sure that's what I meant. What I meant was the expectation around sending considerable numbers of paramedics into the room would have resulted in that area all of a sudden becoming a CCS. That would not have been right for the

patients.
SIR JOHN SAUNDERS: The reality is that if you're sending people in and it was HART you were sending in, you would be sending them in and saying, "Get them out as quickly as possible"?
A. Yes.
SIR JOHN SAUNDERS: And that's what you're going in there to do?
A. Yes. I think what I was trying to do there was (overspeaking) --
SIR JOHN SAUNDERS: You were trying to deal with the public perception that you should have flooded the area with paramedics, okay.
A. Yes. That's all.
MR ATKINSON: Finally on this point, can we go to your statement of 16 July of last year, {INQ034766/4}, paragraph 11:
"When the team leader for HART, Simon Beswick, arrived I briefed him about the incident and asked what resources he had available for the purpose of forward triage. I am aware that HART teams comprise five paramedics and a team leader. Simon told me he had two members of the team willing to move forward. I knew that HART work in pairs to carry out basic triage and I was content with the deployment of two HART operatives

in the City Room and authorised that deployment.
"At this time the operational plan was progressing with patients coming down into the concourse area. I do not believe I was aware that only three members of HART were present at the time of our discussion although that fact does not alter my view that I was content to send up two members of HART staff. Simon, as the team leader, did not deploy, which is what I would expect. He provided valuable support in setting up the command structure in and around Victoria Station."
You go on in the next paragraph to talk about needing specialist resources to establish a casualty clearing station.
And in that context, were you talking about Mr Beswick as a specialist resource to help with that?
A. Sorry, I'm just reading where I go on to require specialist ...
(Pause)
Yes. What were you asking, sorry?
Q. I was just trying to, by looking at your statements, to see if we can get your help in terms of clarity. Did you talk with Mr Beswick about him having a role in setting up the casualty clearing station?
A. I don't think I would have directed him personally. I'm more likely to say "him" meaning the team, if that makes

sense, the HART operatives.
Q. Just to understand, you knew there were three of them that had arrived thus far?
A. Yes. Simon and the two, yes.
Q. And two of them were going to go into the City Room, so that left him?
A. Yes.
Q. So were you not in reality asking him to help you set up the casualty clearing station?
A. No, I would have —— well, if I was saying to him set up the casualty clearing station it was because I wasn't —— it would have been about his team, not just him. I wouldn't expect —— I would expect —— so HART carry equipment, as you know, and they carry equipment to assist at a major incident. When I say, "Set yourself up here", what I mean is, "Set yourself up here, you guys should be forward". I don't mean forward into the City Room but forward at Victoria Train Station.
So if I've instructed him to —— and I don't recall doing it, but if I have, to set up the CCS, I've instructed his team to set up the CCS not necessarily him, perhaps not appreciating he was on his own at that point.
Q. Following on with that in terms of the message that Mr Beswick would have understood given that he knew that

there were further HART operatives on their way as to where they were to go and would you agree that clearly if there were HART operatives arriving at that time or within minutes of it, the place they needed to be was following their two colleagues up into the City Room to speed up that process?
A. Well, what should have happened was that there should have been a conversation between Si Beswick and his two forward operatives that are in the room to say, "What support do you need", and then, if they said, "We're okay", or not, as could have been the case, then his request should have been then a request to go forward. So Simon Beswick is the communication link between the HART team that are inside the City Room and myself so I would have expected that conversation to happen.
Q. You were in charge?
A. Yes.
Q. So far as Simon Beswick was concerned you were in charge?
A. Yes.
Q. And do you agree that you did not say to him in terms, "Are there more HART personnel coming than these two"?
A. I didn't say that, but they always travel in a team of six, if that makes sense.
Q. That being the case, did you say to him, "Where are the

rest of your HART team? They need to go upstairs"?
A. No.
Q. Or, "When the rest of your HART team get here, they need to go upstairs"?
A. No. And that wasn't my intention. My intention —— we had deployed two, that is a balance of risk. My view is that you don't automatically send the whole team. So those conversations could have been had between Simon or me, I am not saying —— you know, this is not me blaming Simon by any stretch of the imagination, but it would not have been, as they arrived, an automatic send forward; there needed to be a discussion at that point.
Q. The message you may have been conveying to Simon was that the HART team that hadn't gone upstairs yet needed to be setting up the casualty clearing station. Because that, as you've agreed with me, is what you were saying to him.
A. I ... Yes. Maybe. I honestly don't recall that conversation. However, if I've said that and that was his interpretation of what I've asked him to do, then I don't know if that was before or ... It would be about the time that that happened. My honest recollection of what went on was that the two went forward, that I was happy with in terms of —— and I don't mean happy, but in terms of the balance and the risk that we were putting

them through. When others arrived, I don't recall a specific conversation about what those others do and I'm sorry if —— I'm desperately trying to help you but I do not recall what the specifics were about the rest of those teams.
Q. And there are two possibilities for there being a lack of a call from the room for more, would you agree? One, that they didn't need it, the other they were just too busy to say so? And from downstairs, you wouldn't have known the difference, would you?
A. We wouldn't and that's why in my statement I have completely accepted that whilst I didn't hear back I could have made more of a concerted effort to ask those questions. But alternatively I will also say that there was definitely conversations between myself and Paddy that haven't been recorded and I cannot say what the content of those were but there was definitely dialogue.
MR ATKINSON: Thank you, sir.
SIR JOHN SAUNDERS: Thank you very much.
MR GREANEY: Sir, I know that most in the room are content to sit until 5.15 if that will enable us to finish the witness. I'm looking to Mr Jamieson who I know has some questions.
SIR JOHN SAUNDERS: Are you all right to carry on? Are you

sure?
A. Yes.
SIR JOHN SAUNDERS: Okay.
MR JAMIESON: Sir, I previously indicated to Mr Greaney that my questions I anticipate will be in the order of 10 to 15 minutes and that will exhaust the time until 5.15.
MR GREANEY: I'm going to check with Ms Roberts whether she thinks there's a realistic chance of finishing by 5.15 if the time until then is used up by Mr Jamieson or whether she will have substantial questions.
MS ROBERTS: So far I don't have questions, but can I reserve my position until after I've heard from Mr Jamieson? Can we see how we go?
SIR JOHN SAUNDERS: Yes. We're probably testing people's patience but the reality is that the witness wants to get it finished and obviously it is neater if we can, but equally questions have to be asked.
Questions from MR JAMIESON
MR JAMIESON: I shall aim not to provoke questions from behind if I can.
Mr Lopez, please may I have on the screen the major incident manual, {INQ013132/37}. This is the first of three topics, Mr Smith. I also ask questions on behalf of the families and this is about tourniquets.
What we have is a diagram of the triage sieve to

orientate you and it comes from the major incident manual. The reason I put it on the screen is I wanted to draw your attention to the fact that the first stage of the sieve is the application of tourniquets to those that require it, and haemostatic dressings.
We heard in this inquiry at an earlier stage from Brigadier Hodgetts and he told us —— sir, I don't ask that this goes up but the reference is Day 68, page 21, line 4 {Day68/21:4} —— that in effect the thinking behind that being at the top of the tree is that the most commonly avoidable cause of death from combat—type injuries is external bleeding and specifically external bleeding from limbs. You are nodding. Is that something you knew as of 22 May 2017?
A. Yes, and —— yes.
Q. Thank you. On that day, until the arrival of HART, at around 23.15, the only NWAS resource in the City Room was Mr Ennis. Did you know, simple question, whether he had any, and if so how many, tourniquets with him?
A. I wasn't aware.
Q. Okay. The purpose of him being in the City Room was to fulfil the triage sieve; is that right?
A. Yes.
Q. And I make plain —— let me put this in context. The other things that you didn't know were —— I don't think

at that stage you had received any information about the type of injuries that people in the City Room had suffered. You were told about their severity ——
A. I was aware that it was a shrapnel —— during...
Q. Sorry to cut across you, but can I make it simpler? Had you been told whether, and if so how many, limb injuries?
A. No.
Q. How many might require the application of a tourniquet?
A. No.
Q. I make it plain, Mr Ennis' evidence was that none of those that he assessed required the application of a tourniquet, not something that's accepted, which is why I'm asking you. But in terms of your operational management of what was going on in the City Room, could you have confidence that he was capable of performing the triage sieve without knowing whether he had sufficient tourniquets?
A. Again, I don't wish to deflect from my responsibilities. I completely 100% accept that I am the operational commander and hold responsibility for that incident. But I would expect if a tourniquet requirement —— if tourniquets were identified as being required, I would expect that request to come to me rather than me needing to proactively manage every element of every aspect of

the incident. So the reason we assign roles is to try, perhaps unsuccessfully, to reduce the burden on the operational commander, who is doing a lot.
Again, I want to reiterate, I completely accept that I was the operational commander for that incident and that is not to enter blame towards any other clinician.
SIR JOHN SAUNDERS: We absolutely understand all that. What you're saying is in the normal course of events, if he needed tourniquets, you would expect him to tell you?
A. I would expect him the request to come to me, yes.
MR JAMIESON: Thank you. That completes that topic.
SIR JOHN SAUNDERS: Sorry to cut you off.
MR JAMIESON: The forward doctor, something that Mr Greaney asked you about before lunch. You were asked:
"What that is and did you appoint one?"
You said at [draft] page 123, line 2 {Day110/126:1}:
"A forward doctor is somebody that would move forward almost from the FCP forward into an incident if it was required and, no, I didn't appoint one."
We didn't have an FCP, but forward into an incident, had one been appointed at this stage.
And I'm not revisiting at the moment the issue of risk and who went into the City Room, but if there was going to be a forward doctor and if it was appropriate that's where they'd go, into the City Room?

A. Yes, without —— yes.
Q. Yes. In that light, may we just have a look at the major incident plan action cards to see what a forward doctor would do. {INQ013422/36}, please.
I wonder if we could crop in on the top of the page, please, number 3. I'm not going to read all of these. We can see it's the action card number 18 for the forward doctor. I'm not going to read all of the aspects of it. But we can see that number 3 includes:
"Working in liaison with the medical adviser for the triage treatment and transportation of all casualties in the sector allocated."
If we look at the bottom of the page at number 9:
"Work in the forward area to ensure that the most appropriate medical management of casualties is undertaken and that clinical records are commenced."
Perhaps of secondary importance.
And over the page, please, Mr Lopez, number 15 {INQ013422/37}:
"Provide technical medical advice to all services and agencies at the sector in which allocated."
Those are some of the functions of the forward doctor.
A. Yes. If I'm being frank, I was quite surprised at that line being in there because I would have thought that

was more akin to a medical adviser, but that's the action card for the forward doctor, yes.
MR JAMIESON: Thank you. That completes that topic, sir, unless there are any questions you have.
SIR JOHN SAUNDERS: No, thank you very much.
MR JAMIESON: The third topic is this, and it's really confronting something that is implicit, I suggest, in the evidence you've given so far. I'll deal with this in headline form, if I can. Your assessment of the risk presented in the City Room is that it was such that paramedics should not deploy there. In the light ——
A. I was corrected on that earlier, but non—specialist paramedics, yes.
Q. Yes, non—specialist without ballistic protection?
A. Yes.
Q. Putting that to one side, don't let me lead you if you disagree with that ——
A. Well, the ballistic protection is a slightly side issue because obviously ballistics is around the MTFA things, but the zone they were in is a HART team operative zone.
Q. So non—HART paramedics shouldn't go there?
A. Yes.
SIR JOHN SAUNDERS: Can I just say, my view of your evidence is it's not an assessment of risk by you, it's following the plan.

A. True, but I think the risk is based on what's happened, which defines the zones. So I wasn't going to disagree with it being a risk assessment because the risk defines the zoning.
SIR JOHN SAUNDERS: But it does it for you?
A. Yes.
SIR JOHN SAUNDERS: One you decide it is the inner cordon, they can't go in?
A. Yes.
MR JAMIESON: If I may say so, sir, that's precisely the next point I was going to make.
This wasn't a spur of the moment decision you were making, this was you, a senior representative of your organisation, construing the training and the plans that you had exercised, learned about, over the years, and that was your clear understanding of what those were?
A. Yes.
Q. P1 and P2 casualties. By their nature, by their classification, cannot self—evacuate, they can't walk? Otherwise they would be P3.
A. Yes.
Q. In the situation that presented itself at the arena, they were going to require somebody to take them out of the City Room and bring them to where the paramedics were in order that they could receive the interventions

that they required?
A. Yes.
Q. It was obvious as time progressed that the people who were fulfilling that function were unarmed police, members of the public, and stewards from the arena. I acknowledge again what I have said already, that you were fulfilling the plans and the policies as you saw them and it really is not for a lawyer in a courtroom to criticise a first responder about acceptance of personal risk.
But does it follow that it was an inevitable corollary of those factors, in effect those categories of people that I have listed, unarmed police, members of the public, stewards, were going to have to take risk that was considered inappropriate for paramedics in order that those P1 and P2 casualties would be treated?
A. Well, either that, or had myself and Inspector Smith discussed risk and been able to, I don't think we would have been, but been able to because obviously it continued as a warm —— so it follows that we would need to use the HART team in that area. There is a methodology that is probably even —— or slightly more undignified as in the way that it was done in terms of literally just dragging someone to a different area using the Sked, and using obviously Fire and Rescue

Service, et cetera, that could have been deployed on the night.

So the reason that I think we allowed to -- no, correction: the reason that I allowed to happen what happened is because I felt that that was working as an operational plan.

In terms of other options, in general, the HART team, as far as the Ambulance Service were concerned, were the individuals that needed to -- you know, could work in that area. So your question around did other people therefore have to put themselves at risk, yes.

Q. I don't want to revisit the issue about deployment of the HART team, you've been asked lots of questions about that, but on the facts of this, there was no way that two members of the HART team were going to evacuate all of those who had serious injuries in the City Room?

A. Not physically move them, no, but remembering that when they went forward, the movement -- well, the movement of patients was happening as I arrived. That movement of patients continued to happen and I think the first makeshift stretcher came out or arrived downstairs at 7 minutes past. That process was already -- so I allowed it to continue because I thought that it was working and I completely accept there are very different views to that now, but on the night, at the time,

I thought that it was working.

MR JAMIESON: Thank you.

SIR JOHN SAUNDERS: Thank you, Mr Jamieson.

MS ROBERTS: Unprovoked.

SIR JOHN SAUNDERS: Thank you. It's always good to be unprovoked.

MR GREANEY: Sir, the benefit of sitting to finish the witness today is that we will have an early finish tomorrow, I anticipate.

SIR JOHN SAUNDERS: Right.

Thank you very much. You've had a long day and a lot of questions to answer. You were there on the day and doing, I'm sure everyone agrees, what you considered to be the right thing. Whether it was the right thing is something that I am going to have to look at, obviously, with some care. But it was a very hard night for you in a very difficult situation.

Thank you. 9.30 tomorrow.

(5.16 pm)

(The inquiry adjourned until 9.30 am on Thursday, 27 May 2021)

I N D E X