Manchester Arena Inquiry

Day 111

May 27, 2021

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Thursday, 27 May 2021

(9.30 am)

SIR JOHN SAUNDERS: Mr de la Poer.

MR DE LA POER: Good morning, sir. The gentleman in the witness box is Dr Daley. I wonder if he may be sworn.

DR MICHAEL DALEY (affirmed)

Questions from MR DE LA POER

MR DE LA POER: We'll begin, please, with your full name.

A. Michael William Daley.

Q. Are you a qualified medical doctor?

A. I am.

Q. Before we introduce you in a little more detail, we'll identify the role that you played on the night of 22 May, so everyone can understand the context of your evidence.

Is it correct that you were the first NWAS MERIT doctor on scene?

A. Yes.

Q. Two acronyms in there. The first we're very familiar with, but MERIT, does that stand for Medical Emergency Response Intervention Team?

A. Incident Team.

Q. Incident Team. Thank you. We'll come in a little bit more detail in a moment to what a MERIT doctor is and does, but before we do so, are you a consultant

anaesthetist?

A. Yes.

Q. Is that a role that you undertake outside of NWAS?

A. Yes.

Q. Did you qualify as a medical doctor in 2004?

A. Yes.

Q. In 2006, did you select anaesthetics as a specialism?

A. I did.

Q. In the course of your career as a doctor, have you worked for the Greater Sydney Helicopter Emergency Medical Service?

A. Yes, I did.

Q. That perhaps, as is obvious to everybody, is in Australia?

A. It is.

Q. Next, we will turn to MERIT doctor and what that is. We'll start by identifying, please, when you first began in the role of MERIT doctor?

A. That was in the summer of 2015.

Q. What is a MERIT doctor, please?

A. The primary aim is to give medical support and advice at major incidents. It's primarily a hands-off role.

Q. Can I just ask you to pause there. I am terribly sorry and I hope you won't take this as a discourtesy, but we're having a bit of difficulty hearing you. I wonder

if you could just keep your voice up a little bit. I am conscious there will be people at the back who will need to hear what you say.

A. It is a largely advisory role, providing medical advice to those incident commanders in terms of patient prioritisation and where to send those patients within a region.

Q. Is it the case that a MERIT doctor will be notified of every incident that NWAS is called to or are there only specific incidents that a MERIT doctor is expected to attend?

A. Specific incidents. So it's major incidents and then there are various other things, so, for example, a prolonged entrapment of a patient, we would be called out to that in the past, and also if there are a lot of casualties at one particular incident which isn't technically a major incident.

Q. So the first category that you identified is perhaps the relevant one for us --

A. Yes.

Q. -- that in the event that a major incident is declared, is the process that NWAS will contact the MERIT doctor on call?

A. Yes.

Q. We don't need to go into the shift length or timings,

but is the set-up, or at least was it in 2017, that there will always be a MERIT doctor on call?

A. For the most part there usually is. It is not always because of the availability of the doctors who do it.

Q. We'll come to this in a moment when we turn to the 22nd, but I think you had been the MERIT doctor on call, but at the time that you were notified of the Manchester Arena attack, in fact you had finished your shift?

A. Yes, I had.

Q. So that is MERIT doctor. We will see mention within the paperwork of the acronym BASIC in the context of doctors. Does that stand for the British Association for Immediate Care?

A. Yes.

Q. So it is not a comment upon their level of skill?

A. No.

Q. In fact they are highly skilled doctors?

A. They are.

Q. What is the difference between a MERIT doctor and a BASIC doctor?

A. MERIT is part of the Civil Contingencies Act, it is compulsory across the country, whereas BASIC is a voluntary organisation. They largely serve the more rural communities where medical services are quite

scant.
Q. As part of the process of you becoming a MERIT doctor, did you undertake any specific training for that role?
A. Yes, we did.
Q. Just walk us through, please, the nature of that training.
A. So there is basically a week of training at the start of the job where we did various excises, including tabletop, command post, live exercises, and then how to deal with major incidents, the different types of major incidents. That was all done before we were allowed to go on to the on-call rota.
Q. Did you undertake that training in 2015?
A. I did.
Q. Was there any subsequent refresher training?
A. Yes. There's a training commitment for a few days per year, but also in addition to that, as part of my anaesthetic training, I did some further major incident training with that.
Q. Did any of your training include a scenario that involved an active shooter?
A. We did do a tabletop exercise which consisted of that, yes.
Q. In May 2017, did you know what Operation Plato was?
A. No.

Q. Bearing in mind what you understand about the role of a MERIT doctor, do you think that you should have known what Operation Plato was in May of 2017?
A. I think it would have given us a better understanding of what was going on at the scene, yes.
Q. As part of your major incident training, had you undertaken any exercise or instruction or been provided with any instruction in relation to the detonation of an IED?
A. No. We were offered the opportunity to take part in the exercise at the Trafford Centre, but I wasn't available due to other work commitments.
Q. Again, do you think that if you had received that specific sort of training, that would have made any difference to your understanding or involvement on the night of the 22nd?
A. No.
Q. Why do you say that?
A. Because I think the basics of a major incident are largely the same, there's only going to be some variation with the type of injuries you're going to see, which we had had other training in, and also I had read about as well.
SIR JOHN SAUNDERS: We have heard that blast injuries are different in their nature from other kinds of injuries

you knew all about -- or you knew about blast injuries?
A. I understood the fundamentals of them, yes.
SIR JOHN SAUNDERS: Thank you.
MR DE LA POER: As part of the training that you undertook in 2015 and/or the refresher training, did you have any instruction on the NWAS major incident response plan?
A. Yes, we were provided with it and shown the relevant parts that we would be active in.
Q. In May of 2017, was that a document that you felt you had a good understanding of?
A. I understood the role that I had to take. I understood broadly the concept of NWAS's response, but obviously I'm not going to read the ins and outs of every other person's role within that major incident. But I did know what I had to do.
Q. We are going to have a look now at one page of that major incident response plan. It'll come up on the screen in front of you. This isn't a viva, so you just take your time to read that, although I'm sure you will immediately be familiar with it.
Mr Lopez, {INQ013132/43}, please.
If we can crop in to the bottom of the page.
If you would like to read that passage to yourself. We will need to go over the page in just a moment, so indicate, please, when you have had the chance to read

it.
(Pause)
{INQ013132/44}. Just the two points at the top.
(Pause)
A. Yes, they're the points I was alluding to before.
Q. Does that encapsulate what you understood the summary of the role of MERIT doctor to be?
A. In brief, yes.
Q. Attached to the NWAS major incident plan are a series of action cards. We have seen a document which we can bring up on screen, but I'm sure you'll accept it from me, that in 2016 you signed for having received the action cards.
A. I did.
Q. Was that because you had received a physical copy of them?
A. I received the entire set.
Q. The entire set?
A. Mm-hm.
Q. I'm just going to invite you to consider three of them and those are the action card for medical adviser, the action card for forward doctor, and the action card for casualty clearing station medical lead.
A. Okay.
Q. So first, please, {INQ019210/1}. We can go over the

page, please, {INQ019210/2}.
This is the role of medical adviser. It indicates that there is a specific tabard for the role; do you see that?
A. I do.
Q. Then it identifies a number of activities. We'll focus on number 3 first:
"Liaise with the ambulance incident commander and obtain a full briefing. Work in conjunction with the ambulance incident commander for the triage, treatment and transportation of all casualties. Open dialogue with the receiving hospital or hospitals."
Then there is communication with the strategic medical adviser. That's point 3.
We can see at 4:
"Co−locate with the ambulance incident commander or operational commander throughout the incident. Regularly brief the strategic medical adviser."
Number 5:
"Do not attempt rescue or treatment of casualties."
We'll go over the page {INQ019210/3} so that the whole card is in evidence. We can see at number 7:
"Check all doctors' ID cards as bogus doctors are not uncommon at incidents."
I'm not going to take you through the others beyond

number 8:
"Appoint doctors to designated operational areas. Forward doctor to work with the operational commander, casualty clearing stations and the body holding area."
Thank you very much, Mr Lopez, we can take that down.
Was your role on the night of 22 May that of medical adviser?
A. I was asked to attend, but I asked in what respect because ordinarily there would be two doctors on call at one time. The first doctor should ideally locate at Silver or tactical command and then, if there is a second doctor, they would then go to scene and be the forward doctor. I think based on the proximity I was to the arena, I was asked to go to the arena and that's where I started −− met up with Dan Smith quite early on, and then I began the process of taking on the role of, I suppose, forward doctor from that respect.
Q. Forward doctor? So that's going to be the next one that I turn to. Are we to understand from your answer that you didn't see yourself in the role on the night of medical adviser?
A. I think throughout the night the things that I was expected to do, the roles that I took on evolved as the night evolved and changed with that. It was very clear

from the start that things needed to be set up, we needed to start putting wheels in motion to get the resources to where they needed to be and plan for the casualties to be brought out to us.
Then as the night progressed, more medical assistance arrived, paramedics and then later on doctors, and my role changed as that happened.
Q. It's important that nobody misunderstands me and thinks that I'm suggesting to you that somehow you had to occupy a straitjacketed set of positions. I think we can see from at least one of those that's identified there that you did undertake the role of checking identification of doctors.
A. Yes.
Q. In that sense you were occupying that part of the role of medical adviser. But we can also see from there that the medical adviser is not supposed to treat casualties.
A. Which in the early stages I didn't.
Q. You didn't to start with, but later you did?
A. Yes.
Q. Let's have a look, as you have mentioned it, at forward doctor. {INQ019224/2}. We can see the tabard at the top:
"3. Liaise with the operational commander and obtain a full briefing. Work in liaison with the

medical adviser for the triage, treatment and transportation of all casualties in the sector allocated. Ensure you have a method of communication [number 5] between yourself, the medical adviser and other medical assets on scene. You should be issued with a radio by the Ambulance Service."
Were you issued with a radio?
A. No.
Q. Do you think the fact that you didn't have a radio made any difference to the contribution you were able to make?
A. It made communication with the other MERIT doctor very difficult. I think that will be −− has been revealed in some of the transcripts later on. But on scene it didn't make a difference. I knew who I needed to ask for certain equipment, et cetera, and that worked fine on scene.
Q. We can see at 6:
"Work within the sector allocated by the operational commander. Regularly brief the medical adviser."
And then:
"The forward doctor may be deployed to the casualty clearing station, the body holding area or the incident ground."
Of those I think that I'd be right in saying that

you located yourself at the casualty clearing station?
A. Yes.
Q. We are jumping ahead, but as this is up on screen here, were you ever formally told you were the forward doctor by anyone?
A. Not formally, no. I assumed it.
Q. You assumed that?
A. Yes.
Q. At the point that you assumed that, did you have any discussion with anyone about where you might locate yourself as the forward doctor?
A. Well, when I arrived with Dan Smith, we had a discussion about where would be the best place to set up a casualty clearing station, and I said that I'd stay there and I would begin the sieve, the initial triage, and it just seemed like the natural place to be because of the way patients were going to be brought down from the foyer on to the concourse.
SIR JOHN SAUNDERS: One of the problems may be with these action cards, I don't know, that it almost expects you, all the doctors, to turn up at the same time ——
A. Yes.
SIR JOHN SAUNDERS: —— whereas actually you turned up before everybody else ——
A. Yes, that's right.

SIR JOHN SAUNDERS: —— and so you had to do those roles which were most necessary at the time, whatever they may be allocated to in the cards?
A. Exactly.
MR DE LA POER: Absolutely. So you are effectively, as the incident develops, picking different aspects of the medical roles which have been predefined in order to deploy the skills that you had to meet the needs, as you perceived them to be?
A. Yes.
Q. So far as where you were located, we'll come back to this when we look at the chronology, as I understand what you have just said, although you weren't instructed to be in any particular place, you made clear to Dan Smith, the operational commander, where you were going to base yourself?
A. Yes.
Q. And he didn't tell you that that wasn't the right place?
A. No.
Q. Or that you should consider anywhere else?
A. No. We did a risk assessment and decided that although there was a slight risk of locating the CCS on the concourse, the benefits outweighed any potential risk.
Q. We'll just note the third of the points there, the incident ground as being a place that the forward doctor

could locate himself. As I say, we'll come back, when we look at the chronology, in a little more detail to the conversation you had with Mr Smith. But in the context of the Manchester Arena attack, would the incident ground be the City Room?
A. Yes.
Q. Let's just go over the page {INQ019224/3} to put the balance of this action card into evidence ——
SIR JOHN SAUNDERS: Did you know Dan Smith before this night?
A. I'd met him briefly at an NWAS event before then, but I didn't really know him as such.
SIR JOHN SAUNDERS: Thank you.
MR DE LA POER: Well, I'm not going to take you through the remainder of these, particularly in the light of your evidence that you weren't occupying a single role. I've picked out the ones that I wanted to draw your attention to. There's one more of these action cards to consider, which is the casualty clearing station medical lead {INQ019220/1}.
SIR JOHN SAUNDERS: While we are looking at this, this is a different document that Mr Smith had, Dan Smith had?
MR DE LA POER: In terms of the action card?
SIR JOHN SAUNDERS: Yes.
MR DE LA POER: There is a separate action card for the

operational commander. As it's presented —— and Ms Roberts will tell me if I am wrong about this —— in the context of the major incident plan and as Dr Daley has told us, all of the action cards appear in a single document, one after another. Is that right?
A. Yes.
Q. Whereas NARU has produced separate laminated cards which individuals can have on their person, specific to the role that they might undertake?
A. That's correct.
Q. So NWAS has collated all of them in one place, for training purposes, I would imagine. But practically speaking, these are the action cards that individuals can have?
A. They are.
Q. Did you have any of these action cards on the night?
A. I didn't bring them with me on the night and I think we might get to that in further questioning, why. But I did have an entire copy of all the NARU cards at home.
Q. So not just the three we're looking at but ——
A. The entire set.
Q. This is, as I say, the casualty clearing station medical lead. If we turn over the page, please, {INQ019220/2}. We can see again at 3, not dissimilar to what we've seen already:

"Liaise with the ambulance incident commander and obtain a full briefing. On arrival at CCS, liaise with the casualty clearing officer ..."

That will be a paramedic; is that right?

A. Yes.

Q. And loading officer, again a paramedic?

A. Yes.

Q. "... to gain shared situational awareness before commencement of post."

And then a series of, would you agree, administrative tasks in that role?

A. Yes.

Q. We can see those there.

{INQ019220/3}, please. At 10 we can see:

"Specialist guidance to support the ambulance clinicians."

Is this role one that may involve the provision of treatment as you understand it?

A. Further down, yes.

Q. Yes. Which one do you have in mind?

A. It's number 10.

Q. Where it says "guidance and support", that may involve ——

A. Yes.

Q. —— hands—on treatment?

A. Yes.

Q. So in that sense different to the medical adviser and perhaps, would you agree, in terms of hands—on care, somewhere between the medical adviser who does not undertake any treatment and the forward doctor who does?

A. Yes.

Q. Again, as you've told us, your role on the night evolved. Towards the start of the role, were you effectively undertaking the role of the casualty clearing station medical lead?

A. I would say there were elements of all three that I was undertaking from the start.

Q. Thank you very much indeed, Mr Lopez, we can take that down.

We have looked at what was envisaged in terms of three separate medical roles at the scene. There is an additional medical role away from the scene; is that right?

A. Yes.

Q. The strategic medical adviser?

A. Yes.

Q. Did I understand you to be saying that, in theory at least, the first doctor positions themselves away from the scene and the second doctor goes to the scene?

A. Yes.

Q. That's the structure. What is the rationale behind sending the first doctor to a position away from the scene?

A. With it being a hands—off role, where you're not expected to actually treat patients from the start, you can stay at tactical and advise a broader group of people about what is happening and you can also get a better sense from the hospitals of what their capabilities and capacity is and whether a specific hospital is overwhelmed, for example, so you might need to divert patients to another one. That's the idea behind that.

Q. We'll turn now to 22 May and see that whilst that may have been the theory, in practice you went straight to the scene, didn't you?

A. Yes.

Q. As we have already alluded to, you had been on duty on 22 May as the on—call MERIT doctor; is that right?

A. That's right.

Q. Your shift had ended some hours before you became aware of the Manchester Arena attack?

A. At 8 pm.

Q. Did you understand that you had been relieved by another MERIT doctor when your shift ended?

A. No, you're not notified.

Q. So there's no handover?

A. No. Not unless an incident is actually ongoing. If there's no information to hand over, there is no handover process.

Q. Your shift simply comes to an end?

A. Yes.

Q. And you're ——

A. The next person is on call.

Q. In 2017, what was the method of communicating with doctors that they were required?

A. We were initially provided with pagers, but they proved to be very unreliable, so mobile phones were the primary method.

Q. Is it right that you first became aware of the Manchester Arena attack at 22.42?

A. Yes.

Q. Was that through a telephone call that you received from the Broughton trauma cell?

A. It was, but I actually heard from a member of the public just before that bomb had been detonated.

Q. So let's just take a step back then from that phone call. Where were you? I don't need the exact street.

A. I was walking through the city centre on my way home from the shops.

Q. Did you encounter members of the public?

A. Yes.
Q. And what, if anything, were you told or did you see that was ——
A. I saw a lot of girls running away from the arena, which was not unusual for that time of night, a concert finishing. A lot of them were crying, I thought a group had split up or something like that. It was as I was crossing Deansgate that a man walking next to me was on his phone and said that a bomb had just gone off. And then approximately 10 or 20 seconds later, my phone went.
Q. We don't need to bring up the transcript unless that would assist you, I know you have managed to refresh your memory from it. In summary, what was the content of that call?
A. I was asked if I was the MERIT doctor on call, I said I wasn't, but that I was in the city centre and I could see something had happened and asked what had actually gone on. I was told that a bomb had been detonated and there were potentially an active shooter, would I be able to assist, and I said of course, but I needed to run home to get some stuff and then I would be ready.
Q. What stuff at that time did you think you needed?
A. Well, I was in my own civilian clothing so I needed, as a bare minimum, a jacket and ID, what I could get hold

of quickly.
Q. We'll come to how this applies to others, but why was ID important?
A. Because we've basically been told that unless you've got ID and can prove who you are, you wouldn't be let into a major incident area.
Q. So you needed that. Did you have access to any medical equipment?
A. No.
Q. Are MERIT doctors issued with medical equipment for the time that they are on call?
A. No.
Q. Some might find that surprising. Can you explain the rationale as you understand it behind that?
A. With it largely being an advisory hands—off role, there is no specific requirement for doctors to be equipped with their own resources and equipment. In other parts of the country I believe the role of MERIT is merged with pre—hospital emergency medicine services where those doctors will have kit, but again those doctors might not necessarily have their own personal kit, it would be part of the organisation that they work for.
Q. Did the fact that you didn't have a minimum kit of your own make any difference to what you were able to do on the night?

A. It didn't help in the respect that I wasn't —— it was quite difficult to do basic observations or dressings. Gloves were another issue, I just didn't have enough pairs of gloves when I was going from patient to patient. I was very conscious of the fact that there might be blood—borne viruses or bacteria from the IED that I may be transmitting from patient to patient. It probably reinforced the fact that it's a hands—off role because I had to deal with cross—contamination.
Q. We are looking at recommendations for the future bearing in mind your experience on the night. Is it your view that on—call MERIT doctors should have a basic pack of kit that they can have with them when they're on call so that they can bring that to the scene or do you think that would be unnecessary?
A. It's usually unnecessary. I think this incident was different in that we, as a MERIT doctor, would usually arrive at an incident much later on, as resources have actually been put in place, and we could utilise the equipment from different ambulances on scene. I arrived there very early on and I think that only one other ambulance plus Dan Smith's car was on scene to utilise. It may benefit but I don't think it's essential.
Q. So the notification formally at 22.42. At the conclusion of that call, what did you understand you

needed to do?
A. I went home, dropped some stuff off, picked up my jacket and ID, and then made my way out down to the street level, and phoned the trauma cell to say that I was ready to be picked up.
Q. Was the procedure in 2017 that, generally speaking, transportation would be arranged to take the MERIT doctor to the scene or to Silver control?
A. Yes, because we're not blue light responders —— some doctors do have blue lights on their cars, I don't, and I anticipated that, based on the number of people that I'd seen and also the traffic in the area, that it would be actually difficult for me to get to scene and get to where I needed to be on foot and that's why I asked for transport.
Q. In the course of that call, having said that you were ready to be picked up, did it become apparent to you that in fact it would be faster for you to walk?
A. Yes.
Q. Is that what you said you would do?
A. It is.
Q. So that second call is timed, can you confirm, at 22.53?
A. That's right.
Q. We are now, Dr Daley, going to turn to look at some stills from the area around the war memorial entrance to

the Victoria Railway Station. Those who follow our proceedings will be familiar with them. You've had an opportunity to see them before you have come to give evidence today; is that right?
A. I have.
Q. So we will bring up, please, Mr Lopez, {INQ035612/169}.
Those that have viewed this footage carefully have identified that you are in company with consultant paramedic Dan Smith. It is not immediately apparent from that still because I think his body position obscures yours, but if we go to {INQ035612/171}, please, we can see more clearly that you're in that shot; is that correct?
A. That's right.
Q. So that is timed at 22.59.49, the previous one was 22.59.25. Essentially, does this still capture your arrival at the railway station complex?
A. It does.
Q. As is clear from the still, did you immediately see and speak to Dan Smith?
A. I did.
Q. At that stage, so far as you can remember, what was the conversation you had with Dan Smith?
A. I don't remember much about that. I just know that we tried to get a brief understanding of what had actually

happened because I think at that time some people were still saying that a speaker had exploded. But then we were also hearing reports of a bomb and a gunman. So I think it was just information gathering at this point.
Q. We're going to move forward a minute and a half from that still to {INQ035612/182}, please.
We can see the top still, so that you have the context, is Mr Ennis descending the staircase, having just left the City Room. You are identified in the lower still as being present, together with a number of other paramedics. There are three paramedics, Mr Gill, Ms Smith and Mr Nealon, together with Derek Poland and Dan Smith. Do you have a recollection of this huddle?
A. I remember the people being there but I don't remember any specific conversation.
Q. At that stage did you have a sense of how many paramedic resources were available?
A. No.
Q. We're going to see in the next still, please, {INQ035612/183}, just 18 seconds later, at the top that Mr Ennis has joined the huddle and the three paramedics who I first identified have now left the station. Were you aware of them receiving any instruction or leaving?
A. I don't remember them leaving, no.
SIR JOHN SAUNDERS: Does your yellow jacket have anything on

it which indicates who you are?
A. The epaulettes say "MERIT doctor", but there's nothing on the back.
SIR JOHN SAUNDERS: Okay, thank you.
MR DE LA POER: In your witness statement you mention having a recollection of seeing Mr Ennis.
A. Yes.
Q. I think as you recalled it in your witness statement you thought you had followed him into the station. Was that your understanding at that time?
A. When I say followed him, I don't mean literally followed, just a few moments after.
Q. Arrived a few moments after. Did you know Patrick Ennis?
A. No.
Q. At the time that we can see you in that still, did you have an understanding of where he had come from?
A. Yes.
Q. So you knew that he had been into the City Room?
A. I did.
Q. To the best of your recollection, can you help us with the conversation which took just a couple of moments that then ensued with Mr Ennis present?
A. He gave us an update as to the scene upstairs. We got a further update about the ideas of dead people, also

a rough idea of how many people were injured, the nature of the injuries, and also a mention of a few people he was particularly concerned about, but I don't recall any other specifics beyond that.
Q. So you had a general sense at least that there were people in the City Room who, in Mr Ennis' view, needed urgent attention?
A. Yes.
Q. Was there any discussion about zoning or cordons in the course of that conversation?
A. Not during that conversation, but I think myself and Dan had already —— when we first entered the station had gone to go over the footbridge and were prevented from doing so by armed police.
Q. Let's just pause there for a moment. So you have a recollection of an intention to go into the City Room?
A. Yes.
Q. That was whilst you were in company with Mr Smith?
A. Yes.
Q. Where do you think you got to before you spoke to the armed police officer?
A. The foot of the stairs.
Q. What did that armed officer say to you?
A. I seem to remember that he said one paramedic was up there, I think Dan knew that that was Paddy, and then

we were told that it wasn't safe to go up there, they didn't want anyone else going up, and we weren't allowed to.
Q. Bearing in mind that there was already one paramedic up there, as you had been told, did you challenge that officer in terms of what they were saying to you?
A. No. They knew what was up there, so that was one indication not to go. The other was also based on training and policy. So from my training, I would not expect to go into what I determined as a hot zone. We are not allowed to go into those, we are not trained to go into a hot zone without HART-level PPE. And also we have to be, it's very clear, accompanied by HART or someone else who's sufficiently trained, such as a fire officer.
Q. So that encounter with the armed officer that you've told us about, that occurred before you saw Mr Ennis?
A. I think it did, yes.
Q. Once you saw Mr Ennis and understood that he had been in the City Room, did you ask him whether he thought it was safe enough for you to go into the City Room?
A. I don't recall asking him that.
Q. By the end of the conversation did you understand that it was Mr Ennis' intention to go back into the City Room?

A. No.
Q. Where, if anywhere, did you think Mr Ennis was going at the conclusion of that encounter?
A. I don't remember. He may have well have been going off to speak to someone else in the Ambulance Service.
Q. Did you learn from Mr Ennis in the course of that conversation that there were other emergency personnel in the City Room?
A. I knew that there were police up there.
Q. Did you know whether they were just armed police or whether they were unarmed police?
A. I'd seen a mixture of armed and unarmed police on the concourse, so I assumed it was the same pattern upstairs.
Q. And did you identify any particular PPE on those unarmed police?
A. No.
Q. So at this stage, you've understood that Mr Ennis had been in the City Room, you had been told by an armed officer you couldn't go in there, but you had also seen unprotected, unarmed police officers in the vicinity of the City Room; is that right?
A. Not in the City Room.
Q. Not in the City Room but in the vicinity of the City Room, in other words coming off the footbridge

or --
A. I saw the police on the concourse, I didn't see those unarmed police coming down the stairs, no.
Q. I understand. At all events, once the conversation with Mr Ennis was over, did you speak to Dan Smith?
A. We had several conversations about where we thought we were going with the incident in terms of planning, on where to locate the casualty clearing station, where to cohort the different patients, expected casualties, and then getting all the resources into the correct place.
Q. Let's just show two stills shortly to get our timings. The first page is {INQ035612/192}, which is timed at 23.03.17, which is the final still we have of Mr Ennis down on the concourse. He is there identified as speaking to you. Do you have a recollection of speaking to him on his own?
A. I do remember speaking to him. It was, again, just another further update about the injuries of the patients upstairs and what we were going to do in terms of treating them.
Q. And we know from the CCTV that he goes from this conversation straight back to the City Room. But that was not something, as I understand your evidence, that you heard him say to you?
A. No.

Q. We can see 30 seconds or so later, {INQ035612/194}, that by this stage we know that Mr Ennis has gone back up the staircase, but you have walked in the opposite direction to that, out on to Station Approach; is that right?
A. Yes.
Q. We see you here in conversation with Mr Smith. Again, doing the best you can, just to help us with the sequence of events, was it about at this stage that you had the conversation about the casualty clearing station?
A. I think we'd already agreed where to set it up by this point, but at this moment I think we were discussing getting all the police vehicles moved out of the way because this was going to be the loading point for the ambulances when they arrived.
Q. Did you have any discussion about setting up a casualty collection point?
A. No.
Q. At the time that you were discussing the casualty clearing station, did you have a clear understanding of the geography of the Victoria Exchange complex?
A. Yes.
Q. So, for example, you knew how far the City Room was from the area you were standing in on Station Approach?
A. Yes.

Q. You knew about the substantial staircase between you and the City Room?
A. Yes.
Q. And of course, the pedestrian footbridge that connects the staircase to the City Room?
A. Yes.
Q. Bearing in mind that Mr Ennis had told you that there were casualties who he was particularly concerned about in the City Room, and bearing in mind that you knew about the staircase, did you have any discussion with Dan Smith about how those patients were going to move from the City Room down to the area that had been designated the casualty clearing station?
A. We just expected them to start being brought out by anyone who was available. From experience, I know that fire officers are normally very good at assisting us with transporting patients, but I don't remember having any specific conversation about stretchers or things like that.
Q. Did you think that there were any HART operatives on scene at this point?
A. What time is this?
Q. This is just after 11 o'clock.
A. No, there weren't at that time.
Q. And you knew that there weren't?

A. I knew they were... I think -- I remember being told that they were on their way but I don't remember seeing any on scene at that time.
SIR JOHN SAUNDERS: At that stage, you were expecting that no one would get any treatment from paramedics in the City Room, certainly until HART operatives arrived, and that they would just start being brought downstairs?
A. Yes.
SIR JOHN SAUNDERS: How was that going to be communicated to the people who were upstairs or did you just expect them to realise that it would be a good idea to get them out and brought downstairs?
A. I discussed it with Dan and then he went off to start making (overspeaking) in place.
SIR JOHN SAUNDERS: So you expected him to make arrangements in some way for people to be brought out, to come down?
A. For the patients to be brought down, yes.
MR DE LA POER: One thing you mentioned a moment or two ago was your understanding of the capability of the Fire and Rescue Service to transport people in difficult circumstances; is that right?
A. Yes.
Q. Did you think that the Fire and Rescue Service were on scene at this point?
A. I had registered that I couldn't see them on the

concourse. However, for a brief moment I thought they might have been on the other side, so for example on the Trinity Way entrance to the arena or might have been already upstairs. I then didn't really give it much thought about the Fire Service because I had other things to focus on.
Q. At this stage, and I'm talking about the time that you're talking about the casualty clearing station with Dan Smith, did you have an understanding that 30 minutes or so had passed since the detonation?
A. I've put in my statement that my recollection of time is really distorted. It felt like some periods had gone very, very quickly --
Q. Yes.
A. -- when in fact it had only been a few minutes, whereas some periods took a lot longer and it felt like a fraction of a second.
Q. You had been contacted at 22.42 and I'm not for a moment suggesting that you were keeping an eye on the clock, but you will have had a sense at just after 11 o'clock that at least 20 minutes had passed since the detonation because you knew when you'd been notified?
A. Yes.
Q. I would just like to focus a little bit on your thinking around what was going to happen to the people in the

City Room. You knew that HART weren't on scene. You hadn't seen any Fire and Rescue Service operatives on scene. You weren't expecting any paramedics to be in the City Room at this point, although at least 20 minutes had passed since the detonation. What thought, if any, did you give to exactly who was going to move those patients so they could start getting some care?
A. When it was decided that it was safe to send people in to get them out. At that point it hadn't been declared safe to us, and policy dictates that we do not enter unless it is safe for us to do so. And also, a lot of us have to be in the correct level of PPE in order to do that.
Q. As an experienced and qualified doctor, did you understand that following a detonation of the type that had occurred, for some people time really may be of the essence in terms --
A. Of course.
Q. -- of life-saving? What was your thinking, if anything, around having that sense of, as you would understandably feel, the desire to give them treatment and the fact that the minutes were passing as you had to wait for people to be properly equipped to go and help them?
A. I understood that there were very sick people up there,

but we also have a duty to the people I work with to make sure that they are safe, and we were in no uncertain terms told that it wasn't safe for us to go up. And particularly when armed police are telling you not to go and proceed, I'm not going to disobey those instructions.
Q. There came a point shortly after you started setting up the casualty clearing station where patients were being helped down from the City Room by police officers; is that right?
A. Yes, I do remember that.
Q. At the point that you saw that unarmed, unprotected police officers had been in the City Room in order to assist those patients out to you, did you reconsider whether or not that area might in fact be safe enough for unprotected ambulance personnel to go into?
A. I think by this time it had actually been -- we'd been informed that there was no active shooter, the chances of another secondary device were low, but the structural integrity of the building wasn't secure. So we also decided that the area where we'd decided to set up the CCS was a much better area in terms of lighting and just the general size of the area so we could keep an eye on all patients that were being brought down to us, and what we wanted to do was get these people down as

quickly as possible from a place that was still possibly dangerous to one of relative safety.
Q. I don't want any of my questions to be misunderstood, Dr Daley, but you were not there as operational commander, were you?
A. No, but I was party to some of the discussions.
Q. Absolutely. Did you see yourself as having an advisory role for the operational commander?
A. Yes, that's part of one of the medical adviser's duties.
Q. And did that advice role extend to setting up the practicalities of where the casualty clearing station, whether a casualty collection point, those sort of things, or are they outside your sphere of advice?
A. No, I was involved with those discussions.
Q. Once people started coming down the stairs, was it apparent to you that those that were helping the injured leave were having to improvise stretchers?
A. Yes.
Q. What, if any, thinking did you have in response to seeing that?
A. In some ways I thought it was absolutely remarkable that people were assisting the way they were. It wasn't a very dignified way of bringing patients down to us, but they were extricated from the scene a lot more quickly than they would have been had we waited for

stretchers, including scoop stretchers.
Q. So did you specifically consider at the time, "Is it appropriate for us to seek to get stretchers", when you saw that?
A. By this stage, as you've already suggested, time was marching on. We just wanted to get those patients out of that unsafe area to one where we could actually begin to treat them properly.
SIR JOHN SAUNDERS: We've heard an awful lot about the JESIP principles and the need for commanders to talk to each other to get a real idea of situational awareness. Are those the sort of things that you would be aware of or know about?
A. No. My role is to feed into the various NWAS commanders, not other services.
SIR JOHN SAUNDERS: Someone might say when you're naturally going to the scene and you're stopped by an armed policeman who says it's not safe, you might expect: well, actually we need to speak to a command, we need to know from them what the position is. Is that something which occurred or was talked about or anything like that?
A. Dan -- I can't speak for Dan, he may well have discussed it.
SIR JOHN SAUNDERS: But a man with a gun stopped you and

that's good enough for you?
A. Yes.
SIR JOHN SAUNDERS: Thank you.
MR DE LA POER: In terms of the advice role that you had on the night did, that extend to advising the operational commander in relation to inter-agency liaison or was it confined to advising the operational commander in terms of the NWAS response?
A. It's the medical aspects.
Q. The medical aspect?
SIR JOHN SAUNDERS: But it would have occurred to you, presumably when you see these people coming down and the way they are coming down, it's not just dignity, is it, it's actually overall rather safer to bring people down on something which is constructed to carry a body than something which is not?
A. It is safer, but at that stage we thought it was in the interests of the patients to get them out quicker.
SIR JOHN SAUNDERS: I do understand that, but at that stage were you then more aware of the Fire Service not being there?
A. I didn't think about it. My main focus was on the people being brought down.
SIR JOHN SAUNDERS: Yes, what to do with the patients as they come down to you. Thank you.

MR DE LA POER: {INQ035612/202}, please, Mr Lopez, of that emergency response. We can see you're there in conversation with Mr Smith at 23.05. Would that have been more discussion between you about the casualty clearing station and how you were going to set it up?
A. It was and I think we were also preparing for the first people to be brought down.
Q. Indeed. Next, {INQ035612/209}. We can see here three off-duty doctors presented themselves at the war memorial entrance. Do you have a recollection of seeing those doctors?
A. Not those specific doctors, no.
Q. But in accordance with what we saw was the role, or at least one of the roles, on the action cards, did you end up that night checking IDs?
A. I did.
Q. Is that because you are well placed to be able to spot those who might be passing themselves off as doctors?
A. Probably. The doctors will present with hospital ID, otherwise they weren't allowed to come in at this stage. I could also discuss with them their level of experience and their skill set to see where they'd be best placed.
Q. Why was that important?
A. I wouldn't want to give a very junior doctor with very little experience -- you know, hand them a very sick

patient to care for, I would probably want a more senior clinician to do that.
SIR JOHN SAUNDERS: Did you see lots of doctors on that night? Roughly how many turned up?
A. From the voluntary response who lived nearby, I think maybe six to ten, roughly.
SIR JOHN SAUNDERS: So they're just people who have heard about it in whatever way?
A. Yes. A lot of them live nearby in flats.
SIR JOHN SAUNDERS: And came in?
A. Yes.
SIR JOHN SAUNDERS: Of that, can you remember how many you allowed in as passing your test?
A. At this stage I think these doctors didn't have ID so they were just sent away. Other doctors presented later on where the scene had progressed and we had far more patients. There were several who worked in the same trust that I worked for then, they were allowed in, and then other doctors who I believed, but I didn't obviously want them to actually get involved with patient care, so I just made them sit with patients and observe them and ask them, if the patient deteriorates or there's a problem, come and discuss it with one of us. They weren't actually allowed to do any hands-on care, only the doctors who could verify.

SIR JOHN SAUNDERS: So another MERIT doctor turned up, the one who was actually on duty?
A. Other doctors in addition turned up later on, I think the other MERIT doctor and then also some of the BASIC doctors who responded later on as well.
SIR JOHN SAUNDERS: Thank you.
MR DE LA POER: I'm just going to select a couple of slides just to see if you can help us with your recollection and I do appreciate that may be a particularly big ask given how much you did that night and who you spoke to.
At {INQ035612/269} you are identified as speaking to a witness the inquiry has heard from, Helen Mottram. The whole still has to be blanked out for good reason.
A. Okay.
Q. The description is -- I'm sorry that your name has been misidentified --
SIR JOHN SAUNDERS: No, it hasn't. Dr David Dolan is the one who is there --
MR DE LA POER: Forgive me.
SIR JOHN SAUNDERS: Is he the other MERIT doctor?
A. No, I have seen this slide with the solicitors. Dr Dolan was, I believe, another doctor who turned up, volunteering.
MR DE LA POER: Do you have a recollection of seeing him on the night?

A. There were that many people there, I don't recall specifically.
MR DE LA POER: I understand.
SIR JOHN SAUNDERS: He does get mentioned a couple of times.
MR DE LA POER: Yes.
Next, page {INQ035612/287}. Here is identified another witness who the inquiry's heard from, Joanne Hedges. Do you have a recollection of speaking to Ms Hedges who was involved in the casualty clearing station triage?
A. Yes, there were two paramedics I worked with quite closely that night.
SIR JOHN SAUNDERS: She was the primary triage?
MR DE LA POER: As I recall it, yes.
Next, {INQ035612/357}. We're moving through the time period here, that was 23.20. You are identified as speaking to Mr Smith by the war memorial entrance. Do you have a recollection of speaking to Mr Smith throughout the night?
A. Yes, we did. We had regular catch-ups to assess what was going on and where we were headed with things.
Q. That's 23.37. Then {INQ035612/413}, please.
Station Approach. 23.51. By this stage, Mr Hynes has arrived. Did you know Mr Hynes before the night?
A. No.

Q. Did you understand that shortly after this conversation, he takes over the role of operational commander?
A. No.
Q. You weren't party to that handover or ——
A. No.
Q. Were you aware even that it had happened, that Mr Smith had been relieved of ——
A. I actually believed —— I think it was 15 or 20 minutes later, that Dr Eddie Tunn had actually taken over control.
Q. You thought it was Dr Tunn who had become the operational commander?
A. Later on, yes.
SIR JOHN SAUNDERS: I think you've probably answered this and I've immediately forgotten your answer, I'm really sorry, but the MERIT doctor on duty, did he come or was he ——
A. The other MERIT doctor who was on duty was Tony Gleeson. He arrived later on.
SIR JOHN SAUNDERS: So he did come? I just wonder whether he had been stood down as a result of you being there or ——
A. No, he did come.
MR DE LA POER: I'm going to, not by reference to slides, but we have just picked out a couple there just to

review your actions through the night in summary form. Did you remain for the most part in the casualty clearing station area?
A. Yes.
Q. Did you begin your involvement with the casualty clearing station, trying to arrange it in a way that meant the P1 patients were all placed in one area?
A. Yes.
Q. Given the number of patients that were coming down from the City Room, the speed at which they came to be arriving in the casualty clearing station, did that system break down?
A. To begin with, it was manageable and we were able to allocate the patients into P1 and P2 cohort areas. Then there was a brief lull and then after that, the patients came down, were being brought down very, very quickly and we weren't able to triage each patient as they came to the bottom of the steps. Then they were just being placed wherever there was space by the various people who were transporting them.
Q. Was that just a consequence of the geography and the speed at which they were being removed or do you think that there was a way that you could have planned for that before it occurred?
A. No, we planned the areas and the areas were sufficient

in size to do that, it was just the sheer speed and volume that they were coming down in.
Q. Did there come a point when you began to administer treatment to individuals?
A. There was, but it was later on than this. The patients who had been brought down, where I hadn't had a chance to triage them, other than greeting them at the bottom of the steps, I then had to go over to those and go around them and triage each patient. I was doing that in tandem with some of the other paramedics as well and then we were getting together and discussing the P1s and P2s and who we had most concerns about.
Q. So moving back a little bit in time, did you initially position yourself towards the bottom of the stairs to receive patients as they came down so you could triage ——
A. I think I did, yes. Certainly near the bottom of the stairs.
Q. So you were involved in that, in the early stages at least, of assessing or re—triaging patients as they came down?
A. Yes.
SIR JOHN SAUNDERS: So there effectively did become two points where casualties went to by the end because you were actually triaging at the bottom of the steps and

then moving them either to the P1 place or the P2 place; is that right or not?
A. No, the stairs is on the concourse, so it's not like the stairs was a collection point.
SIR JOHN SAUNDERS: But was it a different place from where you initially decided to have the P1s and P2s?
A. Yes, it was just a simple way to ensure that all patients were assessed as they came down and then could be allocated to the P1 or P2 area.
MR DE LA POER: I think you've told us there came a point in the evening where that system was no longer practicable ——
A. Yes.
Q. —— and you then had to go and see the patients once they had been put down?
A. I did.
SIR JOHN SAUNDERS: Was that in any way because you had insufficient idea of the number of patients you were going to have?
A. No, it's just the sheer ——
SIR JOHN SAUNDERS: The speed they were coming down?
A. —— speed they were brought down.
MR DE LA POER: One more aspect of the events on the night that I want to deal with that you touch on in your statement: you mention in the course of your witness

statement the availability of medical equipment and the fact that there was a shortage of particular items at particular times.
A. Towards the start, yes.
Q. Can you just explain that for us, please?
A. So it was basic -- I think it has already been discussed, the Lifepak, which is the machine -- it has a defibrillator, it can do blood pressures, pulse oximetry, heart rate, et cetera. They were limited, so it kind of affected the ability to continually monitor patients. I'm very used to continuous monitoring of patients as an anaesthetist and it's quite hard to get used to not being able to do that, particularly when you know patients are so unwell.
Q. So that was a shortage at the beginning that you felt, because of your background, particularly acutely?
A. Yes.
Q. I appreciate time is difficult to estimate, but had that problem resolved by the time, as you've described, that the original system broke down and the flow of patients increased substantially?
A. I think it was at this stage that the paramedics then started to arrive. I was actually then able to start directing the paramedics to the patients who I thought were sickest and needed more attention first.

SIR JOHN SAUNDERS: So did they bring the equipment with them that you felt was missing?
A. Yes.
SIR JOHN SAUNDERS: So once the ambulances were there, you had enough equipment or still not?
A. I believe later on, certain things like bandages, there was a shortage of some sizes of syringes, but nothing major.
SIR JOHN SAUNDERS: We have heard there is a large vehicle which carries a large amount of medical equipment, which could and is designed to attend to this sort of incident. Would it have helped if that had been there?
A. I think so.
MR DE LA POER: Was its absence something that occurred to you on the night?
A. No. The deployment of that vehicle isn't my responsibility. I just thought it would have arrived at some point. I didn't know where it was based. It may well have been at Ashburton Point in Trafford Park. So it could have come with the HART team, but it may well be another ambulance station in the north-west and I realise that assets take time to be put in their place.
Q. Two more aspects of your involvement on the night before we turn to the debrief document.

Firstly, the arrival of HART operatives. Were you aware of Mr Beswick, Ms Vaughan and Mr Hargreaves' arrival?
A. Yes.
Q. Were you aware of the deployment of Mr Hargreaves and Ms Vaughan to the City Room?
A. I did see them going up, yes.
Q. To your mind, was it your belief that that was the first time since Mr Ennis had come down that paramedics had gone up into the City Room?
A. Yes.
Q. Did you have any discussion with Mr Beswick about where he would position himself?
A. No.
Q. Based upon your experience, where would you expect the HART leader to position himself in an incident like this?
A. I would expect him to be liaising with Dan Smith.
Q. To liaise with Dan Smith?
A. Mm-hm.
Q. And once that liaison has happened, is that liaison going to determine where they position themselves or would you expect them to either be remote from the incident ground or at the incident ground?
A. I would expect them to begin -- to be at the incident

ground, so in the City Room.
Q. Were you aware that Mr Beswick did not go to the incident ground?
A. I am from watching the inquiry.
Q. But at the time?
A. No.
Q. We know that about 5 minutes after the deployment of Mr Hargreaves and Ms Vaughan, further HART operatives attended. Were you aware of a second tranche of HART operatives arriving?
A. I knew that more were on the way.
Q. Did you notice them when they arrived?
A. No, because I think I was busy at that stage.
SIR JOHN SAUNDERS: The importance of them would have been they could go up to the City Room?
A. Yes.
MR DE LA POER: We know that in fact they were assigned roles down in the vicinity of the war memorial entrance and Station Approach. Were you aware of that at the time?
A. No.
Q. Had you identified HART operatives not being deployed to the incident ground, is that something that you would have commented upon at the time?
A. I think at the time I knew that there were more HART

paramedics on scene, but I had assumed that they'd gone around the other side. I didn't know where they were deployed to.
Q. That's HART. There's one final question before I leave it. Bearing in mind your supervisory role that you undertook in a medical capacity of the casualty clearing station, do you think that it was a good allocation of the HART capability to participate in that based upon your experience of the night?
A. To participate in what?
Q. In the casualty clearing station, casualty collection point as it was also termed.
A. I honestly can't remember them really participating in the casualty clearing station in a clear way, so I don't think I can answer that question.
SIR JOHN SAUNDERS: What we were told actually was that they were setting something up with a tarpaulin, actually outside, I think, in the road, a different area from where the CCS was, maybe the loading area, I don't know. Were you aware of that?
A. I was aware of tarpaulin later on, but at that time when they were arrived, I wasn't aware what they were doing.
MR DE LA POER: Certainly you didn't perceive that you needed a HART capability specifically to help at the CCS?

A. At the CCS, no.
Q. Final topic in relation to the night before we turn tho the debrief and the chairman has touched upon it already, the arrival of other doctors. I'm not for a moment expecting you to remember precisely when and who arrived, but it's right to say, isn't it, that a number of doctors did attend and ended up helping at the casualty clearing station?
A. That's right.
Q. Was their contribution valuable?
A. Yes.
SIR JOHN SAUNDERS: So it didn't get in the way? Obviously they're all doing it with the best intentions, thinking they can help, but sometimes people turning up as volunteers get in the way rather than actually help.
A. I think there are two groups of doctors we're talking about. There's the group of doctors who lived nearby and volunteered and there are the junior doctors with no pre-hospital or major incident experience. They were useful at just getting on with basic assessment of patients. They were able to administer basic analgesia, do observations, et cetera.
Later on, we had another cohort of doctors who I worked with, some through MERIT, others were BASIC doctors who had responded and they had a better skill

set and were able to do more interventions with patients.
SIR JOHN SAUNDERS: So in general it worked well and it was a benefit having these people turning up?
A. Definitely.
SIR JOHN SAUNDERS: Thank you. I just needed to check.
MR DE LA POER: Finally from me as a topic area, the debrief. You participated in a debrief following the attack; is that right?
A. I did.
Q. We'll bring up that document, {INQ020623/1}. We can see the date of the debrief is 28 June, so just over a month later, and we can see that the participants are, as MERIT doctors, yourself and Dr Gleeson, who you have already mentioned, and then the BASIC doctors, three of them identified. Were those three attendees on the night?
A. Yes.
Q. Over the page to {INQ020623/3}, please, and we'll see the areas for improvement. I'm not going to take you through every single one of these and can I acknowledge from the start that because they are not attributed, they may have been from you, they may have been from other people ——
A. That's right.

Q. —— or they may have been part of a group discussion. Can I just draw your attention to the bottom one:
"The MERIT and BASIC NW doctors feel there needs to be some form of paging/messaging system to notify people of a major incident and for control to know all MERIT doctors' numbers."
Is that an area for improvement with which you agree?
A. Yes.
SIR JOHN SAUNDERS: It may arise out of the first ——
A. Yes.
SIR JOHN SAUNDERS: —— (overspeaking) Dr Gleeson's difficulty.
MR DE LA POER: Beyond what we've already covered in your evidence, is there any aspect of events on the night that is relevant to why that area for improvement was being identified?
A. I have already mentioned the pagers we were issued with when we joined MERIT didn't work very well, if at all. We had discussed the creation of a WhatsApp group, but at that time NWAS were very wary of using WhatsApp as an official route of communication and it has only been since the arena that the NHS as a whole has accepted WhatsApp as a secure method for communication for clinical governance reasons. Also added to this was the

discussion about whether we should be issued with personal radios, but I think that was being looked at when I left MERIT.

Q. So I suppose your last answer probably answers this question. Members of the public watching this may want to be reassured that the important role that MERIT doctors can play at an incident is optimised and they know about it in a timely fashion. Are you able to say whether or not that area of improvement has been adequately addressed?

A. I'm not. I left MERIT a few months ago and I think discussions about the radios were still ongoing.

Q. When you say you left it a few months ago ——

A. Last autumn.

Q. So in autumn 2020, that issue, so far as you were concerned, remained unresolved?

A. It did. We were all issued with everyone's numbers so we should have been able to use phones which worked well on the night. And again, I think most hospitals and NHS organisations now use WhatsApp for major incidents.

SIR JOHN SAUNDERS: It clearly didn't work very well on the night.

A. No.

SIR JOHN SAUNDERS: They rang you and asked you whether you were on call, where you'd expect them to know who was on

call.

A. What came out in the debrief was that the lady who was on the trauma cell desk was actually just being seconded into this role from completely something different. When the call came through, she panicked a little, went through the day sheet, just saw my name as the first MERIT doctor that was listed, even though I had finished, and then called me, erroneously, but ——

SIR JOHN SAUNDERS: And then apparently didn't call Dr Gleeson it looks like.

A. I looks like that, but I can't comment.

SIR JOHN SAUNDERS: Just looking at what we're looking at, it appears that he was actually called to go into Salford Royal Hospital and help there and then he was concerned that he was on call as a MERIT doctor so refused to go there and then had to actually ring himself to the trauma cell to find out what was going on.

A. That's right.

MR DE LA POER: Page 4, please, at the top {INQ020623/4}:

"The MERIT doctors feel there is a lack of awareness at commander level for MERIT and what their role entails."

Was that feedback with which you agreed?

A. Yes. It has also been addressed.

Q. That has been addressed?

A. Yes.

Q. What was the origin in terms of events on the night of that feedback?

A. I think it was just felt that certain people didn't really know what we were going to be on scene for. There was an expectation from some people that we'd be very hands on and we had to say, no, it's more of a hands—off role, and that's time and time again. But now commanders are briefed better on the role of MERIT, the call—out process, and also I believe it's part of NWAS mandatory training.

Q. In terms of commanders at the scene, there were two officially, Mr Smith, Dan Smith, followed by Mr Hynes, although your understanding was it was Dr Eddie Tunn who was the relief commander. Is it one of those three people or more than one that that concern is being expressed about?

SIR JOHN SAUNDERS: Not a criticism of them; it's a criticism of their training.

A. There were a lot of senior NWAS paramedics and officers on scene who I didn't know, and this comes out in one of the debrief points about lack of tabards. I didn't know who to speak to about specific points just by sight. It was only when I'd go up to someone and ask them for

something, but I was always told —— put in the right direction. I was always given assistance when it was asked for.

MR DE LA POER: Speaking of tabards, I don't think you wore a tabard that night.

A. No.

Q. Had you been issued one or more of the three tabards that might involve you at the scene?

A. No, we hadn't, but as a result of the debrief we were issued tabards with interchangeable badges depending on which role you were assuming.

Q. Had you been more clearly labelled, if you'll forgive me describing it in that way, do you think that might have made any difference to what people were asking of you or expecting of you beyond what you thought you were there to do?

A. I think so. It would have made me very, very visible. As I've already answered, the back of my NWAS jacket didn't have any writing on it to identify who I was. It was only the epaulettes which from a distance are not legible.

SIR JOHN SAUNDERS: But did Dan Smith on the night appear to know what your roles were?

A. Yes.

SIR JOHN SAUNDERS: So that wasn't a problem with him?

A. No.
MR DE LA POER: We can see mention there, as the chair has already raised, of the national capability mass casualty vehicle. Have you already dealt with that in the evidence you've given or is there anything further to add?
A. There's nothing really else to add.
Q. It didn't turn out and you thought that towards the end of the incident some of the equipment on that may have helped?
A. May have helped.
Q. {INQ020623/6}, the recommendations. We don't need to go through every single one of them. Did you support all of the recommendations that came out of the debrief process?
A. Do you mean do I agree with them? Yes.
Q. All right. So that can be taken as read. I'd just like to pick out one or two. Number 1:
"Major incident action cards require development for trauma cell."
Does that go back to your experience on the night of somebody who was less experienced who may not have followed the procedure ——
A. The deployment, yes.
Q. So we have dealt with that. Number 4 we have dealt

with. That arises out of the concern that you had that some people didn't understand your role?
A. Yes.
Q. And you have told us that that has been addressed.
6:
"An exercise testing the link between forward doctor, medical adviser, trauma cell and ROCC is needed to test this function."
Can you help us with what that means?
A. We do various training exercises throughout the year, we don't all attend each one because of our other jobs, so we're not always available. I didn't attend the job testing this function. It may well have occurred but I'm not the person to ask about it.
Q. Finally 8, I think we have covered this already, this goes back to the communication issues.
A. Yes.
Q. So it came out of this debrief that there was a specific recommendation in relation to communication and, as you have told us, you can't tell us now in May of 2021 whether that has been resolved because you left in the autumn of 2020?
A. Yes.
MR DE LA POER: Thank you very much indeed, Dr Daley. Those are the questions I have for you.

Sir, we have been going for just short of 90 minutes. Would now be a good time for a break?
SIR JOHN SAUNDERS: A quarter of an hour. Would that be all right for you?
A. Please.
SIR JOHN SAUNDERS: Thank you.
(10.56 am)
(A short break)
(11.12 am)
MR DE LA POER: Sir, can I invite Mr Jamieson who is taking the lead on behalf of the bereaved families, to ask his questions.
Questions from MR JAMIESON
MR JAMIESON: Good morning, doctor. I'm going to take the same structure with my questioning that Mr de la Poer Queen's Counsel did.
Firstly, some questions about 22 May and the events and then finally just a few questions about debriefs. All right? Just so you can follow the process.
A. Mm—hm.
Q. I wonder could we have another document on screen, please? It's {INQ013152/1}. This is the emergency operations centre, the EOC's, the call centre for NWAS, procedure on the deployment of MERIT doctors as you can see.

A. Yes.
Q. May we have the second page, please {INQ013152/2}. Can you see there at 2, there is a section:
"The purpose of a MERIT response."
I just wanted to read that and seek your view:
"The purpose of a MERIT response is to provide advanced medical care on scene at a range of emergency incidents up to and including significant, major and mass casualty incidents. This may include provision of surgical interventions over and above current levels of ambulance practice. It will also include provision of advice and support to emergency services staff already on scene."
I just wanted to understand how that worked with your and, in fact, others' descriptions of the MERIT doctor as a hands—off role.
The second part, the provision of advice and support to emergency services, that seems to tally. But the first part, the provision of surgical interventions, does that fit with your understanding of the role?
A. I think the key word is "may include". So that's if those doctors who are fulfilling the role of MERIT have the skill set and also have the equipment.
Q. Well, precisely. It's the second part that I wanted to ask you about, because obviously that would be

impossible if the particular MERIT doctor had no access to the equipment that would be necessary.
A. More importantly, the doctors might not necessarily have the skills to do that.
Q. Quite. Just thinking about the circumstances in which -- I think there were two particular circumstances, and it's repeated in this document, when a MERIT doctor might be called out: a mass casualty or a major incident, it speaks for itself, where there may be lots of casualties. The other circumstance was where somebody was trapped for an extended period of time, 60 minutes or more, I think, is the figure. Is it also in that circumstance where advanced interventions might be particularly needed?
A. They might well be, yes.
Q. If this is the relevant and current document --
A. Sorry, when is this document dated?
Q. It is dated 2015?
A. Okay.
Q. Yes, were you a MERIT doctor in 2015?
A. Yes.
Q. All right. So it comes in the disclosure and it is dated in 2015 and I don't understand there to be a successor. If I'm wrong about that, I'll be corrected. It seems on the face of it that those

responsible for deploying MERIT doctors would expect them to have a capability that may include the provision of surgical interventions.
A. Again it's the word "may". When we were set up as a team of MERIT doctors it was envisaged that we'd actually become a pre-hospital service within the north-west and the job descriptions that some of us were taken on with included enhanced roles, such as the ability to do surgical interventions or give pre-hospital anaesthesia. As an aside to that, we also had in the north-west the air ambulance, which did carry doctors, but those doctors did not have enhanced capabilities, so we pushed for that service to change and evolve, and as of August 2017, the North-west Air Ambulance had an enhanced care capability because those of us did MERIT wanted to establish a proper pre-hospital service within the north-west and that was achieved in August 2017.
Q. But allied to the helicopter?
A. It's called the North-west Air Ambulance, but we do have road vehicles as well.
Q. Thank you.
The other thing that I wanted to ask you about was -- there was just something you said in your questioning at the start of Mr de la Poer's questions

about where the first available doctor should go. Is this right, did I understand that your view is that the policy would suggest that the first available doctor should go to the tactical command group --
A. Yes.
Q. -- under the policy? I was interested, please, in your reflections on the night as to the wisdom of that, the policy, because you, I think, were able to arrive at the arena at 11 o'clock or thereabouts.
A. Yes.
Q. And it's obvious from all of the evidence that you've given that there was very much for you to do from that minute through the next hour and on through the evening. You were gainfully employed, I think?
A. Yes.
Q. We have heard other evidence about the delay that is often consequent on the setting-up of a tactical command group, how long that can take away from the scene of an incident. So do you have a view about where the first doctor should be directed in a major incident? Are they better to go, as you did, to the scene?
A. No. The primary role of a MERIT doctor is a hands-off role, advisory role. It is not a clinical role to begin with. If there are sufficient doctors we can then start deploying a forward doctor and other doctors as

necessary to engage with patient treatment.
Q. I don't want to dwell -- are you saying that the forward doctor is more important than going to the tactical -- I didn't quite understand what you said.
A. No, I didn't say anyone was more important.
Q. I'm sorry if I'm oversimplifying, bur the forward doctor would presumably be somebody at the scene?
A. At the scene, yes.
Q. That's an essential role?
A. The primary role is the medical adviser role who should normally locate with tactical. If there is a second MERIT doctor, they are deployed as the forward doctor to the scene.
SIR JOHN SAUNDERS: On the night, you were the only one there, so you were deciding which seemed the most important for you to do at the time?
A. At the time I was asked to go to the arena and I think, logistically, based upon my proximity to it, it made more sense for me to actually go there and I didn't really resist going there, rather than going to wherever tactical command would be. Once there, I then adopted whatever role out of the three action cards that we would take up was necessary at that particular time.
SIR JOHN SAUNDERS: And that seems to me, at the moment anyway, to be very sensible and worked as well as it

could.
A. Yes.
MR JAMIESON: There's nothing in my questioning that is seeking to undermine that. It's just, as a matter of logic, the receipt and the assembly of situational awareness away from the scene is likely to take longer than somebody at the scene, and even considering the hands—off role of the MERIT doctor, prioritisation and advice ——
A. That situational awareness can come from the Bronze commander at scene, who feeds up to the ambulance Silver or tactical. And then, based upon that information, the medical adviser will advise as to what the best course of action is in terms of moving patients, treatment and allocation.
Q. Precisely. So that information has to go through the chain?
A. Yes.
Q. From the Bronze to the Silver and onwards. All right. I don't think I'll take that any further, thank you.
May we turn to the events of the night, please? I think it would be probably useful if you have your statement in front of you. I'm not going to put it on the screen, but I'll give page references when they are necessary.

The first thing I want to ask you about is your recollection of being prevented from going upstairs by the armed officer. Obviously you've had the assistance of your legal team in the preparation for this hearing and your evidence, and I think I heard you say that you'd seen some of the wider stills in the case; is that right?
A. Yes.
Q. In looking at those stills, have you been able to identify one that shows you talking to an armed officer at the foot of the stairs?
A. No, I don't think I have.
SIR JOHN SAUNDERS: Did you see Dan Smith's evidence yesterday?
A. No.
SIR JOHN SAUNDERS: He doesn't identify this incident happening at all, which is why we're asking about whether there are any stills. We are aware, because it's obvious, that people's recollections will undoubtedly vary on this sort of event, which is fast—moving and probably one you have never faced before. So your memory is pretty clear that you were stopped, is it?
A. Yes.
MR JAMIESON: I think you have the point, sir.

SIR JOHN SAUNDERS: I don't think it can be taken any further, thank you.
MR JAMIESON: Perhaps the additional question is this: you talked about not having a radio and you talked about how you say you don't consider that impacted you on the ground. Was it ever communicated to you that the police officers in the City Room were in fact very keen for expert medical assistance to come up to them?
A. No.
Q. Had you been aware of that fact, would that have made a difference to what you did?
A. We might have pushed to see if things had changed, so it was a dynamic situation, so whether the threat level had been reduced or was declared safe. But that information was never conveyed to us.
SIR JOHN SAUNDERS: I just wonder whether you would really need to be told they wanted paramedics, qualified people up in the City Room?
A. We knew there would be an expectation for paramedics to be deployed, but I think I've said it several times that, based upon our policy, and also being told that the area wasn't safe, we had no expectation to go up there.
SIR JOHN SAUNDERS: Is there any flexibility in the policy as far as you're concerned? Because there are,

of course, degrees of safety.
A. There are, but at that time I didn't think it was safe.
SIR JOHN SAUNDERS: Is there any discretion in the policy?
A. I suppose you could take a discretion with that, but then that would probably be on your own head if something were to happen.
SIR JOHN SAUNDERS: I do understand that you may be held responsible.
A. If I say it's safe and then I take up ten paramedics and then another bomb goes off or the roof collapses, that's on me and I wasn't prepared to make that decision.
SIR JOHN SAUNDERS: The roof collapsing seems to be a concern of yours which ——
A. Not necessarily the roof collapsing, the structure. I had no idea what it looked like up there.
SIR JOHN SAUNDERS: Was it said to you about the structure?
A. No, but I assumed that if a bomb had gone off, there could be potentially a risk from that.
SIR JOHN SAUNDERS: Okay. Thank you.
MR JAMIESON: I do want to ask a couple of extra questions on this topic and I'm going to make absolutely plain to you, as I did to the witness yesterday, that I recognise two things: one, the governing policy that you talked about; and two, it is very easy for a lawyer standing in a courtroom to ask these questions who wasn't there.

All right? But what you talked about and what you have said more than once is responsibilities of safety to the other paramedics ——
A. Yes.
Q. —— and to those under your command or alongside whom you were working. But you placed yourself at the bottom of the stairs when patients started to be brought down?
A. Yes.
Q. You'd have seen that alongside unarmed police officers who were bringing them down there were members of the public; yes?
A. Yes.
Q. And stewards, some of whom were 18?
A. I don't recall their ages.
Q. All right, but young—looking stewards. Was it the reality of the situation that in order for those very sick people to receive care, those categories of people I have just talked about, including members of the public and the stewards, they had to take a risk which had been judged unsafe for paramedics?
A. Those people were already up there and were in a risky situation. What we decided was not to put any further lives into a risky situation based upon policy.
Q. The chairman has asked you about whether or not that policy had any flexibility in it, and in the light of

what you experienced on the night, should it have had flexibility in it?
A. I believe the action we took on the night was the correct one based upon the information available to us at that time.
SIR JOHN SAUNDERS: In a way, believe me, this is not a criticism, but you will understand that there is concern generally about the fact that paramedics did not go up when there were seriously injured ——
A. I'm very aware of that, yes.
SIR JOHN SAUNDERS: So we need to get to the bottom of it without, please, feeling that you're under attack in some way. You're absolutely not.
So you're saying: on the information that we had at the time, you made what you still consider to be the right decision. The query may be should you not have sought to get better information that someone at the bottom of the stairs saying, "Don't go up, it's not safe", and you thinking, the structure might not be safe because a bomb's gone off, on which you had no knowledge at all?
A. Again, going back to my training, we would not expect as a MERIT doctor or forward doctor to go into what I considered a hot zone without correct HART—level PPE and escorted in and out by a member of the HART team.

SIR JOHN SAUNDERS: Thank you.
MR JAMIESON: Thank you.
I'm going to move on to a different topic and it's as the first patient starts to come down the stairs.
A. Yes.
Q. And if it helps you, you deal with this in the last paragraph of page 3 of your statement. What I want to examine with you is —— perhaps we can deal with it in this way.
They were not coming down in order of priorities, it wasn't all P1s first and then P2s, it was a mixture?
A. It was a mixture.
Q. And the way you remember it is the majority of the first group that came down were P2s rather than P1s?
A. That wasn't necessarily the description of the sequence in which they came down, but in the first batch of patients the majority, I think, were P2s.
Q. And in fairness, I'm not troubling you with it, but there is a careful analysis that has been done, which tells us the order, and it supports that, if I may say so.
Were they coming down with any handover or indication as to the level at which they had been triaged upstairs?
A. Some of the patients came down with triage tags on them.

Q. Was that later?
A. I can't remember. Some had triage tags, others had had tourniquets applied, some patients had bandages, some of which were makeshift, and by that I mean clothing ——
Q. Yes.
A. —— but there was no handover.
SIR JOHN SAUNDERS: Do you mean real tourniquets?
A. Yes.
SIR JOHN SAUNDERS: So genuine tourniquets which are cutting off the arterial blood supply?
A. Yes.
MR JAMIESON: They are called, is it, CAT tourniquets?
A. It depends on the brand.
Q. Again, just to explore this issue a little, there's no criticism in these questions, but I just want to explore and make plain your task as it was. In effect, they have to be re—triaged as they arrive at the bottom of the stairs?
A. Yes.
Q. You have to make a very quick decision about how ill in the scheme of things this person is, with the next one coming down shortly thereafter. What you don't have as a result of all of the circumstances is the benefit of any explanation as to what has been going on upstairs with this particular individual?

A. That's right.
Q. And you give the example of a tourniquet —— and I'll say this, I'm very deliberately not talking about any individual in particular, all right? Somebody who has had a tourniquet applied, that suggests that they have had a significant bleed from a limb?
A. Yes.
Q. But as to how much blood that individual has lost and how long they have been bleeding for, that's not information that you had?
A. No, and it would also be very difficult for someone to actually gauge that. It's notoriously difficult to estimate how much blood is on the floor.
Q. I'm not making any criticism in relation to that. What you described when the flow of patients increased, your word, was overwhelmed, you became overwhelmed?
A. Personally overwhelmed, yes.
Q. And again, there is no criticism in my questioning in relation to that, but the risk of that is that in amongst all of these ill people, for somebody who is extremely ill, it will not be recognised just how precarious their health is?
A. Until I'd had a chance to review them or one of the other paramedics who was triaging with me.
Q. May I just ask you another question about tourniquets

since we're on it, and it's this: we've received some evidence, and just to put this in context, we know that the very first line of the triage sieve is the application of a tourniquet in an appropriate circumstance. We've received some evidence that the only appropriate time to do that would be for a catastrophic pumping arterial bleed. I just want the benefit of your expertise in relation to that.
Would a tourniquet also be indicated for a lesser but substantial bleed, particularly where it's likely that an individual is not going to receive evacuation to hospital for some period of time?
A. In certain circumstances it would be beneficial. If you have an ongoing venous bleed, you can still lose an awful lot of blood from that, so it would be beneficial to use a tourniquet.
SIR JOHN SAUNDERS: Are we talking about injuries to a limb rather than to the trunk?
A. No, no, you can't apply to a tourniquet to the trunk.
SIR JOHN SAUNDERS: It was because the part of the evidence you're referring to actually did discriminate on that basis as well.
MR JAMIESON: It did and it did discriminate between external and internal haemorrhages as well.
Just so we are clear, if it's bleeding from a limb,

as you say, it can be a lesser rate, but if it's unabated for a longer period of time, it's still gong to have the same ——
A. It depends on the degree of ongoing bleeding because there are also complications associated with tourniquets, limb ischaemia and then other damage beyond that.
Q. Okay, thank you. May I also ask you about Lifepaks or defibrillators, as we have heard of them. The principal use and purpose for those in the CCS was the monitoring and observation of patients?
A. Yes.
Q. Can we agree that there was not a stage where there was one available for every patient?
A. At the beginning there was only a handful.
Q. Was there ever a stage when there was one for every patient?
A. I believe later on there may well have been. There were a lot of Lifepaks later on. Whether that was shared between two, I can't say.
Q. But certainly in the early stages?
A. In the early stages there weren't enough.
Q. May I ask about other pieces of equipment, just on that topic. Did you have fluids available?
A. They will have come with the paramedic crews.

Q. So not in the initial stages?
A. No, each road ambulance will have all its own equipment on board.
Q. Is that something you were involved in? Did you administer fluids yourself? Did you see them administered?
A. Fluids were used on some patients, but in bleeding patients crystalloid, ie normal intravenous fluids are not what we would give.
Q. What would you give?
A. Ideally blood, because if you give IV fluids, the risk is that you actually dilute the blood and the blood is less likely to clot.
Q. So some fluid available, certainly later in the CCS. What about blood, was there any blood available?
A. No. We only began carrying pre-hospital blood a few years ago in the north-west.
MR JAMIESON: Thank you. I think that completes the questions I need to ask about the day. I don't know if there's anything else that you had, sir.
SIR JOHN SAUNDERS: No, thank you.
MR JAMIESON: May I ask you then about debriefs, please. I would like to ask you about a debrief that I know that you didn't attend but it touches upon the MERIT response so I would like to see if you can help us whether you

agree or don't, frankly.
Mr Lopez, it's {INQ021289/1}, please, starting at the first page.
It's the overall NWAS structured debrief report. The participants are listed in general rather than particular, but I understand that you've confirmed through your representatives that you did not attend this debrief.
A. I didn't.
Q. And I'm not suggesting there's anything that arises from that. Could we go, please, to {INQ021289/3}.
The third box indicates something that we've touched on already in your particular debrief:
"Lack of understanding of what roles were in place and who was doing them and what they entailed, especially around the MERIT/BASIC doctors."
And if we look to the right we can see there seems to be quite a number of participants who recognised this as an issue.
Is there anything you would like to add? Firstly, do you agree with that observation?
A. Yes, we recognised at that time that there wasn't much of an understanding of MERIT throughout NWAS. Since then there has been kind of a publicity within NWAS about MERIT, its roles and capabilities, and more

specifically what it's not capable of, because there was a misunderstanding that we were a pre-hospital service, which in the north-west it is not. I think this has been addressed since this debrief has come up.
SIR JOHN SAUNDERS: The comment on the right-hand side almost seems to say it's almost been addressed beforehand?
A. Because MERIT is so infrequently called out there's just a general lack of visual awareness that we exist.
SIR JOHN SAUNDERS: Right. And perhaps that's a message which needs to go out not just after an incident like this but on a regular basis?
A. Yes, that is why it is mentioned here the e-learning, so it part of the mandatory training, it is part of that now.
SIR JOHN SAUNDERS: Thank you.
MR JAMIESON: May we have {INQ021289/5}, please. The penultimate entry, again you're not present, but your view seems to be widespread or shared by others:
"Misinterpretation of where MERIT doctors should have been deployed to (TCG)."
So it goes back to assuming that tactical command group and goes back to the point we were talking about earlier: where is the best place for the MERIT doctor? And I asked you --

A. By policy I should have gone to Silver/tactical.
Q. I understand that and I asked you and I hope it was clear from the questions that I did, the suggestion that you were right to go to the incident rather than tactical.
A. I think there's a big element of luck that I lived so close to the incident and that's why it made sense to --
SIR JOHN SAUNDERS: I should take the credit for it, if I were you, the rational decision rather than luck!
A. Thank you.
MR JAMIESON: We know in fact the other MERIT doctor, the one who was actually on call, Dr Gleeson, lived somewhere near Penrith.
A. Sorry, I think that's where they thought he was, but he wasn't, he lives in Manchester.
Q. He didn't arrive until some time after midnight?
A. Yes.
Q. 00.20, I believe.
Could we go to {INQ021289/10} --
SIR JOHN SAUNDERS: Before we do, we've had so many acronyms, and I have no doubt been told about this one at some point, but NACC, the one in red in the middle?
MR JAMIESON: National Ambulance Coordination Centre.
A. It says is there but I don't actually know what that is.
SIR JOHN SAUNDERS: Okay -- are you guessing?

MR JAMIESON: No, it's there on the left. If you go across to the left and up --
SIR JOHN SAUNDERS: Ah yes, thank you very much.
A. I don't actually know what that role is, though.
SIR JOHN SAUNDERS: Okay. At least I know now what it means now.
MR JAMIESON: I am glad that you thought I was guessing.
SIR JOHN SAUNDERS: If you were, you were right.
MR JAMIESON: {INQ021289/10}. We've got, four down:
"MERIT/BASIC doctor self-activation as call never came from EOC."
I think you've given us the particular circumstances in relation to that.
But again, if you look six up from the bottom:
"No kit for enhanced pre-hospital care."
A. Again that goes back to MERIT not being a pre-hospital service in the north-west.
Q. There seems to be expectation on at least --
A. That's possibly because in various parts of the country it is a pre-hospital service, MERIT and the pre-hospital care are actually one and the same. And I think some of the participants on this especially are from different regions which offered mutual aid on that night.
We did feed it back, I think it was discussed whether we should have some sort of kit, but it's also

where would we store that kit, how do we access it out of hours, and then I think ultimately it was decided that we would not use -- have our own pre-hospital kit because not everyone is trained to use it who's on the MERIT rota.
Q. What about a vehicle allocated to the MERIT doctor with kit?
A. That's something that could be explored, yes.
SIR JOHN SAUNDERS: If you're on duty, do you have to be based somewhere specifically or can you just be going around --
A. No, the MERIT doctors live all over the north-west.
SIR JOHN SAUNDERS: And you wouldn't necessarily be at home anyway? You can be out?
A. Yes, you can be out.
MR JAMIESON: May we go to {INQ021289/11}. It's the triage and treatment aspect that I would like to look at, please, four down, one respondent has identified inappropriate or incorrect use of tourniquet technique. Is that something you observed?
A. That could mean different things. That could mean that a tourniquet has been applied to a limb when it wasn't necessary and that did happen later on in the evening and tourniquets that weren't needed were removed. It's very important that tourniquets are released as soon as

is practicable.
Incorrect use could be that they were placed too high, too low, not tight enough, the usual thing, because they are extremely painful to apply to a patient.
Q. I agree it could mean many things, which is why I asked if it was something that you'd observed on the night.
A. Yes.
Q. Which of those categories that you mention, or all of them, are you talking about?
A. It's more a tourniquet being applied and it was no longer needed or wasn't necessary to start with.
Q. We can see also, if we look two more boxes down -- three more boxes down:
"Short of IV fluids, drugs, TXA."
TXA, is that a clotting drug?
A. It is tranexamic acid, which is --
Q. I wasn't brave enough to say it.
A. It's a pro-coagulant drug.
Q. So it assists with?
A. With bleeding -- sorry, stemming bleeding. It's been proven to improve survival in trauma patients.
Q. Was it in short supply?
A. I don't recall it being in short supply. Whenever I administered it that night it was available to me.

Q. The bottom piece of feedback here is really something that I was asking you about earlier in relation to the patients that came down the stairs and at least one respondent believed that:
"Although the patients were triaged into P1/P2/P3, there was no clear understanding of which were next in priority in the P1 section."
A. I disagree with that because I know for a fact that I was directing ambulance crews to the P1 patients that I was most concerned about at first.
Q. We've agreed that there was at least a period of time when you were overwhelmed by the flow of patients?
A. Yes, by the time all the crews arrived to start removing them from the station and taking them to the trauma centres, I had a much better understanding of those patients -- not all of them, but most of them.
Q. So by that later stage, you'd been able to (overspeaking) --
A. Prioritise within the P1 cohort, yes.
Q. But there was a period of time, and I'm very deliberately not trying to pick or ask you to estimate that because you've said what you have said about your general memory of time, but there was certainly a period of time when there were patients coming downstairs when it was not possible for you to get that overview?

A. Immediately.
Q. Thank you very much.
SIR JOHN SAUNDERS: Before it goes, the first one under "Triage/treatment":
"Lack of understanding from operation crews in regards to triage/SMART triage packs."
Was that your experience on the CCS that night or not?
A. They're a bit fiddly to use because they fold over in lots of different ways and then to get the information on them you have to completely unfold them. It can be a bit difficult and one thing I found -- it kind of goes with the too small on write on, my pen wouldn't actually write on them, so unless you had just a biro, any other pen wouldn't write on them.
SIR JOHN SAUNDERS: Right. In general, on the casualty clearing station, was the skill of the paramedics generally good? Did you think they did a good job on the CCS?
A. Yes. Because what there was -- what I expect them to do on the casualty clearing station is to do another top-to-toe assessment of the patient and try and identify and deal with any immediate problems, stabilise them to the best they could, and get them ready to be transported. Their aim is not to start doing major

treatment. It's just to get them ready and stable enough to transfer to the trauma centres.
SIR JOHN SAUNDERS: Those tasks were completed well in your view?
A. I believe so, yes. A lot of the paramedics have very little exposure to major trauma while they are on the road and I think they all did very, very well.
SIR JOHN SAUNDERS: Did they triage accurately by and large? Were you coming back and thinking, "That shouldn't be a 2, that should be a 1", or vice versa?
A. So I think there was me and a couple of other paramedics who were doing the actual triaging, but even then we were still going round and revisiting the patients and some patients we escalated from P2 to P1 because they had deteriorated and some patients clinically improved and so we were able to downgrade those.
SIR JOHN SAUNDERS: So a limited number of paramedics were actually doing the triaging?
A. Yes.
SIR JOHN SAUNDERS: And how did you decide on who would be doing that?
A. That was ——
SIR JOHN SAUNDERS: (Overspeaking) primary triaging officer?
A. That was —— sorry, I've forgotten their names. Was it Joanne and...

SIR JOHN SAUNDERS: There was a primary or secondary one, wasn't there?
A. We were doing it as a team. And then if they had concerns they were coming to me and asking me to review the patient and ——
SIR JOHN SAUNDERS: Right.
A. —— take it from there.
SIR JOHN SAUNDERS: Was that because the others were not skilled enough to do the triaging or should you only have a limited number of people doing the triaging?
A. They can do the triaging but by the time all the other paramedics arrived most of the patients had been triaged, so it was about then pushing the care forward of those patients.
SIR JOHN SAUNDERS: Right.
A. By all means they were encouraged to do another assessment and that also by default does re—triage them. But it's not triaging in a word, it's what we call an ABC assessment of the patient.
SIR JOHN SAUNDERS: Thank you.
MR JAMIESON: Just to pick up on one thing you that said in answer to the chairman about people's priority changing, I think you had some experience on the night of at least one person, and I'm not going to ask you to identify them or give any details ——

A. I think I know who you mean.
Q. But one person who deteriorated very quickly from a P2 to a P1; is that right?
A. If it's who I think you're talking about, yes.
Q. The final document, please, is one that you've been taken to already, it's the MERIT debrief. It is {INQ020623/1}. I won't repeat the bits you've already been asked to look at, but we will look at some slightly different ones. This is the MERIT debrief. Is it the one that you did attend?
A. Yes.
Q. {INQ020623/4}. The first one, lack of awareness of role you have dealt with already and I don't ask that we do so again. But the third up from the bottom:
"BASIC NW doctors feel there was some near misses in [what's called] the P3 pile due to children triage. Children seem to compensate and then deteriorate rapidly. BASIC NW doctors feel that the triage tape used for paediatrics in the SMART triage packs are not that effective but are also not aware of any other alternatives."
Did you experience a particular difficulty in the triaging of paediatric patients?
A. So that entire cohort were the P3s, the walking wounded, they were sent out and they were placed —— well, asked

to stay opposite Victoria Station where Chetham's School of Music is. When we had finished or mostly dealt with all the P1s and P2s, we then went over to the P3s and then we split into two teams and started at either end and worked our way through.
During that time we discovered two patients —— I believe it was two —— who had deteriorated. One was a teenage girl who had been taken out by her friend. She wasn't a P2. She couldn't walk at the time but she had been taken out by her friends early on. The other was a young guy who had walked out, had some wounds, and then must have had internal bleeding and deteriorated then. Those patients were immediately escalated to P1 and were very rapidly taken to hospital.
Q. Until you were able to do that, until your other duties had released you ——
SIR JOHN SAUNDERS: Sorry, that doesn't appear to meet what is being said here. Because it seems from what's being said here that they've gone through a triage process, but because children perhaps don't exhibit the symptoms quite so readily or they can deteriorate very rapidly ——
A. The physiological reserve of children is far greater than particularly elderly adults. So they compensate, their body can adjust to trauma ——
SIR JOHN SAUNDERS: So they seem to be much better than they

actually are?
A. They appear to be far healthier than they actually are, but then they have a tendency to get to a cliff edge where their body can no longer compensate, they decompensate very, very rapidly and deteriorate really quickly.
SIR JOHN SAUNDERS: But were people mis-triaging them because of their age, because they didn't have enough experience of it?
A. No, the roughest way that we initiate triage is we ask everyone who can walk to get out. I think that had already actually occurred before I arrived or anyone else arrived and anyone who was able to had already gone.
SIR JOHN SAUNDERS: So they are automatically triaged as P3 ——
A. P3, yes ——
SIR JOHN SAUNDERS: —— if they say they can walk, but that may not pick up some people ——
A. No, which is why you do have to go back to ——
SIR JOHN SAUNDERS: Is there anything that can be done about that?
A. Unless you rewrite the triage system, which I think is agreed both internationally and nationally.
SIR JOHN SAUNDERS: One way is to say walking wounded out

but children stay for a quick check over before they are sent out.
A. That's a difficult question for me to answer. Children do compensate but there are physiological parameters you can still observe and look at. But grossly, if they can walk out, they are what we would say is grossly intact: they are talking, they are breathing, their heart and blood pressure and sufficient to enable them to function and their neurological condition enables them to walk.
SIR JOHN SAUNDERS: But fortunately you did a review of the walking wounded who were over by Chetham's.
A. Yes, that had always been planned.
SIR JOHN SAUNDERS: Were they told to stay there or were they allowed to go off?
A. I think —— I didn't tell them to stay there but I believe they had been told to stay there because plans were put in place to transport them to some of the hospitals for them to be assessed there.
SIR JOHN SAUNDERS: At least it's something that can be thought about even if it's impossible to deal with.
MR JAMIESON: You've explored precisely the issue I was going to. Thank you very much.
The final page, please, is the next one, {INQ020623/5}. It's just this, the second box, which perhaps encapsulates some of the difficulty that we've

been having here:
"One of the responders believed that also there was no CCS at scene as not agreed" ——
A. I think this box is an error. I don't think this has been worded correctly. So I think the CCP and CCS were actually synonymous on that night. They were brought down —— I've heard suggestions that the bridge going over to the City Room should have been used as a CCP, whereas, looking back, that would have been a completely inappropriate place to put patients: it's too narrow, it's largely quite inaccessible and difficult to get to.
Q. I think the general suggestion is that there could have been some triage in the City Room.
A. This isn't about the City Room, this is about the CCP and CCS; am I right?
Q. Well ——
SIR JOHN SAUNDERS: Okay, well, let's forget about the bridge for a moment and forget about the City Room. You just say this comment is just misconceived, really?
A. Yes.
MR JAMIESON: Thank you. That's the only thing I wanted your comments on. Thank you for answering my questions and your efforts on the night.
SIR JOHN SAUNDERS: Thank you.
MR DE LA POER: Before I turn to Ms Roberts an issue has

arisen in relation to the evidence that Dr Daley has given about speaking to a firearms officer at the foot of the stairs. We are, as ever, greatly assisted by the Operation Manteline team and Mr Horwell has been in contact with us on their behalf. We hope we may be able to get a relevant still, but it is derived from the station footage, not the footage operated by the arena, and that is just being a little complicated. Can I invite you to rise for 5 minutes or so to see if we can sort that out? I think in fairness to Ms Roberts, we should resolve that before she asks her questions.
SIR JOHN SAUNDERS: Okay.
(11.58 am)
(A short break)
(12.17 pm)
SIR JOHN SAUNDERS: I think it's remarkable what is achieved in such a short time and I'm very grateful for the Operation Manteline team for doing that. Was the delay in converting a Word document to a pdf or vice versa?
Further questions from Mr de la Poer
MR DE LA POER: Yes, we have we had to convert it into a format that's compatible with the electronic presentation of evidence system and also we wanted Dr Daley and other people with a direct interest to have

had an opportunity to see it before we resumed.
I have been asked, given the very high standards that Inspector Russell, in particular, holds himself to to indicate that that has not been through the quality assurance process that is usually the case, but that does permit us to elicit questions if there's any inaccuracy, he just wanted that to be known.
Mr Lopez, this document will be given an INQ reference in due course, but can you please display the second page. We'll just set this in the context to see ...
The first still, we've already seen, this is at 22.59.57, and is of you and Dan Smith entering the war memorial entrance; is that correct?
A. Yes.
Q. Over the page we'll have our first new still. Captured seconds later, this is a view from the area of the pub on the station concourse of the two of you walking in the direction of the staircase; is that correct?
A. Yes.
Q. And at the bottom we can see, circled in red, a firearms officer who is furthest from the camera wearing what appears to be a ballistic helmet with his arm raised and pointing in the direction of the staircase and the City Room; is that right?

A. Yes.
Q. And Mr Smith, I think, is on the left of the red circle with that kit bag. That is timed at 23.00.07.
Could we go to the next still, please. The top one is 6 seconds later, not zoomed in.
Then at 23.00.12, we can see that huddle of people is still where they were.
Then over the page, please, we can see a cropped—in image of the bottom image on the previous page timed at 23.00.12.
We know from the sequence of events that after that shot is taken, you move back towards the war memorial entrance where we see you in that huddle with those three paramedics who are briefly there and that is followed by you speaking to Mr Ennis.
Does that all fit together ——
A. Yes.
Q. —— in the timeline of what we've looked at?
Can we just pause for a moment. I have received a message suggesting that we can't be seen. I think Mr Suter, you're on copy to that. Could we pause for a moment? I don't think we need to rise.
SIR JOHN SAUNDERS: If I may say so, I think the quality is extremely high of those. It certainly doesn't need to be quality controlled any more.

MR DE LA POER: I'm told whatever issue there may have been has now been resolved.
Dr Daley, you hadn't seen those stills before today; is that right?
A. I hadn't.
Q. I just want to give you an opportunity to tell us what you believe was occurring in the stills that we can see.
A. This is where myself and Dan Smith had just met up outside and then proceeded inside the station. As I've said earlier, we started walking towards the steps because we knew that the City Room was where the incident had happened.
SIR JOHN SAUNDERS: How had you got that information?
A. I think someone outside had told us.
SIR JOHN SAUNDERS: The City Room?
A. Certainly not on the station concourse.
SIR JOHN SAUNDERS: But you knew to get to it you would need to go up the stairs?
A. Over the bridge yes. So we proceeded towards the bridge and that's where we encountered the police and were told we couldn't proceed.
MR DE LA POER: So your recollection is that in the conversation that we can see, which takes place a couple of seconds after 11 o'clock exactly, you were told by a GMP firearms officer you could not go up the stairs?

A. That's right.
MR DE LA POER: I don't propose to ask you any further questions about that or indeed anything else, Dr Daley. Can I just check with Mr Jamieson, firstly, whether he has anything arising?
MR JAMIESON: No, thank you. Can I also offer my thanks to the Operation Manteline team and say also, if there exists any audio recording of that conversation, it would obviously be very ——
SIR JOHN SAUNDERS: Yes. We will obviously make further enquiries surrounding it, but it was absolutely right that the doctor, seeing as the doctor is here, gets the opportunity to see it and comment on it.
MR JAMIESON: Absolutely, I entirely agree.
MR DE LA POER: I understand one of those enquiries is seeking to identify the firearms officer in question. Thank you, Mr Jamieson.
Ms Roberts, do you have any questions?
MS ROBERTS: I have no questions, thank you very much.
SIR JOHN SAUNDERS: Thank you very much indeed.
Just before you leave —— and obviously I will allow anybody to come back after these questions —— I'm grateful for the insights you've given me and you obviously thought carefully in the debrief procedures about what can be improved. Hopefully you're one of the

very few doctors who will have had to experience anything like that and you've now reviewed it extensively, I have no doubt, before you came to give evidence.

Is there anything else you think could help in saying actually it would have been -- might have been better if we'd done this with the benefit of hindsight? I'm not asking or expecting criticism of people or anything like that. Is there anything now, looking back this time, that you think could be done which hasn't been done?

A. I think the speed of deployment could have been improved on in relation to getting hold of MERIT doctors and also sending out a group message. There was discussion of setting up a WhatsApp group so that all the MERIT doctors could be notified and anyone available could offer their assistance as need be. That's certainly something that should be put forward.

Better communications. Communications in any major incident always seems to be a problem. I believe that --

SIR JOHN SAUNDERS: I think we've gathered that so far.

A. Radio channels can be swamped very easily, but it would have been beneficial -- it wasn't necessarily important on that night but I can see for another major incident

it would be extremely beneficial for us to have our own radio.

SIR JOHN SAUNDERS: MERIT doctors have their own radio?

A. I think so.

SIR JOHN SAUNDERS: That's under consideration, did you say?

A. I believe it is.

SIR JOHN SAUNDERS: Okay.

A. And also I think just when it comes to treating this many patients with complex trauma injuries, a pre-hospital service would have been beneficial to have had available on that evening.

SIR JOHN SAUNDERS: A pre-hospital?

A. Service.

SIR JOHN SAUNDERS: That means kit?

A. Kit and doctors with a certain level of expertise.

SIR JOHN SAUNDERS: Right. You were asked about the question of you might want a particular expertise there on the night. Would it be better to have some sort of system whereby if you decide very rapidly you want a particular sort of doctor at the scene, and it's life-saving to do that --

A. There is that availability in the north-west now but certainly it is only operational through the hours of 8 am to 8 pm. I'm one of those doctors.

SIR JOHN SAUNDERS: Because of your particular skills?

A. Yes. In addition to my current job as consultant anaesthetist, I'm a doctor in the North-west Air Ambulance. Our operational hours currently are only 8 until 8.

SIR JOHN SAUNDERS: Would it be helpful to have something similar on the MERIT doctor system or is it just too complicated.

A. When I was leaving they were looking at developing, upscaling some of the doctors on the rota as a kind of forward doctor role so they could start doing certain procedures. I don't know where that's up to at the moment.

SIR JOHN SAUNDERS: Potentially, presumably, if you could get a doctor with a certain skill on the scene within a reasonable amount of time, that could actually save lives?

A. Yes. It's not just skill, it's also the drugs and also a trained paramedic. So the paramedics that we work with have a very specific skill set, different to HART, different to the road paramedics. We need those to be our assistants for certain procedures and they're better at anticipating requirements in the clinical course and helping out with patient care.

SIR JOHN SAUNDERS: Right. There has been talk about whether better pain relief can be given at scene. Is

there anything that can be done about this? I understand the problems with it.

A. Morphine is a good analgesic, but it also has its negative effects, primarily on respiratory drive and depression, which in these sort of patients we were very cautious with. I think it came up in one of the debrief points from the NWAS one, which I didn't go to, which was about the administration of ketamine. Since then, more NWAS paramedics, the advanced paramedics, are capable of giving ketamine as are some of the paramedics who work on the air ambulance who are teamed up with the doctor.

SIR JOHN SAUNDERS: Right. So I get from your evidence that a number of things which maybe could have been done better on the night have been dealt with, but it may be there are still things that can be improved?

A. A number of things were under development at the time of the arena attack, primarily the development of pre-hospital care within the north-west, but since then we've now started carrying blood and MERIT is actually evolving to provide its own doctors with the skills and, I believe, equipment to be able to function at a higher level.

SIR JOHN SAUNDERS: Would it have made any difference if you'd had blood on the night?

A. I think this might be coming up in a later chapter ——
SIR JOHN SAUNDERS: All right, we'll leave that. Is there any reason why you shouldn't have had blood on the night?
A. Logistically, it's hard to arrange to carry. There's also a large clinical governance aspect to it in terms of patient safety, traceability, accountability.
SIR JOHN SAUNDERS: It's not straightforward?
A. It's not easy.
SIR JOHN SAUNDERS: But not impossible?
A. No.
SIR JOHN SAUNDERS: Anything else you want to add?
A. No, thank you.
SIR JOHN SAUNDERS: Can I thank you for what you did on the night. You weren't even on duty when you went and did it and I'm very grateful for the insights you have given me today.
A. Thank you.
SIR JOHN SAUNDERS: Would you like me to rise for a moment so the doctor can go?

Housekeeping

MR GREANEY: What I'm going to propose, to avoid you having to rise, I'm going to give an update about two matters and I wonder if the doctor would bear with us. I don't anticipate it will take more than 5 minutes.

SIR JOHN SAUNDERS: Otherwise just walk out!
MR GREANEY: Sir, can I begin by indicating that the reason we are finishing early today is because we have completed all of the evidence that was scheduled for the period between Easter and the half—term break. May I add that we are grateful to all core participants for helping us to achieve that. It is a considerable achievement. That leads to the first matter of update, which is as follows.

In the next 24 hours, we will be circulating to all core participants a timetable that will take us to the summer break, by which I mean a timetable for witnesses. I believe there were something that you wished to indicate in relation to ——

SIR JOHN SAUNDERS: There is. I am grateful we've got through on time. There is a long way to go still and we are all aware of that. For me, and I may be being naive about this, but for me the issues relating to the emergency response are really narrowing down, and I think we can all see that. So please could all CPs looking at it just refocus on where we can cut down what we're doing so we can get through this as expeditiously as possible while not, of course, leaving anything out. If I was looking at the list, I'd be certainly readjusting my focus and I hope that everyone can do

that and cooperate with that.
MR GREANEY: We are certain that everyone will have heard those observations and we will have discussions with the core participants.
SIR JOHN SAUNDERS: I'm grateful. There has been a lot of cooperation for which I'm obviously very grateful.
MR GREANEY: There has, sir.

The second update is as follows. Late last year, we announced that your intention was to publish your report in three volumes, and that given the importance of the issues concerned, you would not wait until the conclusion of the oral evidence hearings before starting to do so. We indicated that volume 1 of the report would address the security at the arena. We are now in a position to inform all core participants, and indeed the public, that volume 1 will be published at 2 pm on 17 June this year.

Moreover, later today, core participants will be provided with further information by email about the arrangements concerning publication. That is the update.

SIR JOHN SAUNDERS: Thank you. Can I just indicate that one of the reasons for getting the report out at this stage is for me to have considered whether to make recommendations which can feed into the consultation on

the Protect duty.

I have made recommendations in the report, as you will see when it comes out, as to the Protect duty, but in order to avoid people having unduly optimistic views about what I'm going to deal with, I am only dealing with recommendations as to the Protect duty as it applies to similar areas to the arena, so places where public performances are being carried on and where they are large arenas.

The reason for that is that there are different problems which arise with smaller areas and the Protect duty is intended to cover any public area of any sort, and there are obviously concerns with some of them, and I have seen them in the press as well, about which I've heard nothing.

So it seems to me it would be quite wrong for me to extend the recommendations to the Protect duty generally when I have not heard from people who either are promoting them in certain areas or have concerns about how it will operate. So I just want to limit expectations as to that. I will deal, and I hope I've dealt in some detail, with the sort of recommendations of the Protect duty which I think are appropriate for places like the arena, but I have not gone on to consider everywhere. I hope everyone understands the

reasons for it, because I just haven't heard the evidence relating to it.

MR GREANEY: Sir, thank you very much indeed. That's as far as we can take it today.

SIR JOHN SAUNDERS: We now have just over a week off. I am very grateful for everyone's hard work. Preparing volume 1 of the report and continuing hearings has been a considerable effort and I'm very grateful for all the lawyers on my team who have worked very, very hard to do that, and I hope you don't mind that I say that publicly. But I'm also very grateful to the other CPs for the efforts that they have put in to make sure we keep to the timetable. I'm very grateful for the level of cooperation which there has been between the CPs.

We are not all going to agree about everything all the time, but there have been discussions about everything, and the number of things about which I've had to make a ruling have been remarkably small. So we won't all agree all the time about the way I should approach this inquiry, but when we can agree, I think we have agreed. And I think we can all understand, and I hope understand better, that actually we are all aiming for the same thing. So we are all aiming to give as much transparency and shed enough light as we can on what happened. That won't be possible in all areas, as

everybody knows, but we will certainly do our best to do that.

So thank you for the hard work of the CPs and thank you for the cooperation, and can I thank publicly as well all the people behind the scenes, who I know are giving a great deal of help to everyone. Thank you for your tolerance and help. So have a break.

MR GREANEY: And we will resume at 10.00, please, on 7 June.

SIR JOHN SAUNDERS: I will look forward to it. Thank you.

(12.35 pm)

(The inquiry adjourned until 10.00 on Monday, 7 June 2021)

I N D E X