

OPUS2

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

1

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

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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,

3

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

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

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

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

7

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

8

1 page, please, {INQ019210/2}.

2 This is the role of medical adviser. It indicates

3 that there is a specific tabard for the role; do you see

4 that?

5 A. I do.

6 Q. Then it identifies a number of activities. We'll focus

7 on number 3 first:

8 "Liaise with the ambulance incident commander and

9 obtain a full briefing. Work in conjunction with the

10 ambulance incident commander for the triage, treatment

11 and transportation of all casualties. Open dialogue

12 with the receiving hospital or hospitals."

13 Then there is communication with the strategic

14 medical adviser. That's point 3.

15 We can see at 4:

16 "Co-locate with the ambulance incident commander or

17 operational commander throughout the incident.

18 Regularly brief the strategic medical adviser."

19 Number 5:

20 "Do not attempt rescue or treatment of casualties."

21 We'll go over the page {INQ019210/3} so that the

22 whole card is in evidence. We can see at number 7:

23 "Check all doctors' ID cards as bogus doctors are

24 not uncommon at incidents."

25 I'm not going to take you through the others beyond

1 number 8:

2 "Appoint doctors to designated operational areas.

3 Forward doctor to work with the operational commander,

4 casualty clearing stations and the body holding area."

5 Thank you very much, Mr Lopez, we can take that

6 down.

7 Was your role on the night of 22 May that of medical

8 adviser?

9 A. I was asked to attend, but I asked in what respect

10 because ordinarily there would be two doctors on call at

11 one time. The first doctor should ideally locate at

12 Silver or tactical command and then, if there is

13 a second doctor, they would then go to scene and be the

14 forward doctor. I think based on the proximity I was to

15 the arena, I was asked to go to the arena and that's

16 where I started -- met up with Dan Smith quite early on,

17 and then I began the process of taking on the role of,

18 I suppose, forward doctor from that respect.

19 Q. Forward doctor? So that's going to be the next one that

20 I turn to. Are we to understand from your answer that

21 you didn't see yourself in the role on the night of

22 medical adviser?

23 A. I think throughout the night the things that I was

24 expected to do, the roles that I took on evolved as the

25 night evolved and changed with that. It was very clear

1 from the start that things needed to be set up, we

2 needed to start putting wheels in motion to get the

3 resources to where they needed to be and plan for the

4 casualties to be brought out to us.

5 Then as the night progressed, more medical

6 assistance arrived, paramedics and then later on

7 doctors, and my role changed as that happened.

8 Q. It's important that nobody misunderstands me and thinks

9 that I'm suggesting to you that somehow you had to

10 occupy a straitjacketed set of positions. I think

11 we can see from at least one of those that's identified

12 there that you did undertake the role of checking

13 identification of doctors.

14 A. Yes.

15 Q. In that sense you were occupying that part of the role

16 of medical adviser. But we can also see from there that

17 the medical adviser is not supposed to treat casualties.

18 A. Which in the early stages I didn't.

19 Q. You didn't to start with, but later you did?

20 A. Yes.

21 Q. Let's have a look, as you have mentioned it, at forward

22 doctor. {INQ019224/2}. We can see the tabard at the

23 top:

24 "3. Liaise with the operational commander and

25 obtain a full briefing. Work in liaison with the

1 medical adviser for the triage, treatment and

2 transportation of all casualties in the sector

3 allocated. Ensure you have a method of communication

4 [number 5] between yourself, the medical adviser and

5 other medical assets on scene. You should be issued

6 with a radio by the Ambulance Service."

7 Were you issued with a radio?

8 A. No.

9 Q. Do you think the fact that you didn't have a radio made

10 any difference to the contribution you were able to

11 make?

12 A. It made communication with the other MERIT doctor very

13 difficult. I think that will be -- has been revealed in

14 some of the transcripts later on. But on scene it

15 didn't make a difference. I knew who I needed to ask

16 for certain equipment, et cetera, and that worked fine

17 on scene.

18 Q. We can see at 6:

19 "Work within the sector allocated by the operational

20 commander. Regularly brief the medical adviser."

21 And then:

22 "The forward doctor may be deployed to the casualty

23 clearing station, the body holding area or the incident

24 ground."

25 Of those I think that I'd be right in saying that

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

13

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

14

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

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

16

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

4 That will be a paramedic; is that right?

5 A. Yes.

6 Q. And loading officer, again a paramedic?

7 A. Yes.

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

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

12 A. Yes.

13 Q. We can see those there.

14 {INQ019220/3}, please. At 10 we can see:
 15 "Specialist guidance to support the ambulance
 16 clinicians ."

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

19 A. Further down, yes.

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

21 A. It's number 10.

22 Q. Where it says "guidance and support", that may
 23 involve --

24 A. Yes.

25 Q. -- hands-on treatment?

17

1 A. Yes.

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

6 A. Yes.

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

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

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

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

19 A. Yes.

20 Q. The strategic medical adviser?

21 A. Yes.

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

25 A. Yes.

18

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

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

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

16 A. Yes.

17 Q. As we have already alluded to, you had been on duty on
 18 22 May as the on-call MERIT doctor; is that right?

19 A. That's right.

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

22 A. At 8 pm.

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

25 A. No, you're not notified .

19

1 Q. So there's no handover?

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

5 Q. Your shift simply comes to an end?

6 A. Yes.

7 Q. And you're --

8 A. The next person is on call.

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

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

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

16 A. Yes.

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

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

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

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

25 Q. Did you encounter members of the public?

20

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

21

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

22

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

23

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

24

1 the Victoria Railway Station. Those who follow our
 2 proceedings will be familiar with them. You've had
 3 an opportunity to see them before you have come to give
 4 evidence today; is that right?
 5 A. I have.
 6 Q. So we will bring up, please, Mr Lopez, {INQ035612/169}.
 7 Those that have viewed this footage carefully have
 8 identified that you are in company with consultant
 9 paramedic Dan Smith. It is not immediately apparent
 10 from that still because I think his body position
 11 obscures yours, but if we go to {INQ035612/171}, please,
 12 we can see more clearly that you're in that shot;
 13 is that correct?
 14 A. That's right.
 15 Q. So that is timed at 22.59.49, the previous one was
 16 22.59.25. Essentially, does this still capture your
 17 arrival at the railway station complex?
 18 A. It does.
 19 Q. As is clear from the still, did you immediately see and
 20 speak to Dan Smith?
 21 A. I did.
 22 Q. At that stage, so far as you can remember, what was the
 23 conversation you had with Dan Smith?
 24 A. I don't remember much about that. I just know that we
 25 tried to get a brief understanding of what had actually

25

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

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

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

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

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

1 or --
 2 A. I saw the police on the concourse, I didn't see those
 3 unarmed police coming down the stairs, no.
 4 Q. I understand. At all events, once the conversation with
 5 Mr Ennis was over, did you speak to Dan Smith?
 6 A. We had several conversations about where we thought
 7 we were going with the incident in terms of planning, on
 8 where to locate the casualty clearing station, where to
 9 cohort the different patients, expected casualties, and
 10 then getting all the resources into the correct place.
 11 Q. Let's just show two stills shortly to get our timings.
 12 The first page is {INQ035612/192}, which is timed at
 13 23.03.17, which is the final still we have of Mr Ennis
 14 down on the concourse. He is there identified as
 15 speaking to you. Do you have a recollection of speaking
 16 to him on his own?
 17 A. I do remember speaking to him. It was, again, just
 18 another further update about the injuries of the
 19 patients upstairs and what we were going to do in terms
 20 of treating them.
 21 Q. And we know from the CCTV that he goes from this
 22 conversation straight back to the City Room. But that
 23 was not something, as I understand your evidence, that
 24 you heard him say to you?
 25 A. No.

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

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

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

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

1 City Room. You knew that HART weren't on scene. You
 2 hadn't seen any Fire and Rescue Service operatives on
 3 scene. You weren't expecting any paramedics to be
 4 in the City Room at this point, although at least
 5 20 minutes had passed since the detonation. What
 6 thought, if any, did you give to exactly who was going
 7 to move those patients so they could start getting some
 8 care?
 9 A. When it was decided that it was safe to send people in
 10 to get them out. At that point it hadn't been declared
 11 safe to us, and policy dictates that we do not enter
 12 unless it is safe for us to do so. And also, a lot of
 13 us have to be in the correct level of PPE in order to do
 14 that.
 15 Q. As an experienced and qualified doctor, did you
 16 understand that following a detonation of the type that
 17 had occurred, for some people time really may be of the
 18 essence in terms --
 19 A. Of course.
 20 Q. -- of life-saving? What was your thinking, if anything,
 21 around having that sense of, as you would understandably
 22 feel, the desire to give them treatment and the fact
 23 that the minutes were passing as you had to wait for
 24 people to be properly equipped to go and help them?
 25 A. I understood that there were very sick people up there,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 Firstly, the arrival of HART operatives. Were you
 2 aware of Mr Beswick, Ms Vaughan and Mr Hargreaves'
 3 arrival?
 4 A. Yes.
 5 Q. Were you aware of the deployment of Mr Hargreaves and
 6 Ms Vaughan to the City Room?
 7 A. I did see them going up, yes.
 8 Q. To your mind, was it your belief that that was the first
 9 time since Mr Ennis had come down that paramedics had
 10 gone up into the City Room?
 11 A. Yes.
 12 Q. Did you have any discussion with Mr Beswick about where
 13 he would position himself?
 14 A. No.
 15 Q. Based upon your experience, where would you expect the
 16 HART leader to position himself in an incident like
 17 this?
 18 A. I would expect him to be liaising with Dan Smith.
 19 Q. To liaise with Dan Smith?
 20 A. Mm-hm.
 21 Q. And once that liaison has happened, is that liaison
 22 going to determine where they position themselves or
 23 would you expect them to either be remote from the
 24 incident ground or at the incident ground?
 25 A. I would expect them to begin -- to be at the incident

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

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

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

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

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

1 discussion about whether we should be issued with
 2 personal radios, but I think that was being looked at
 3 when I left MERIT.
 4 Q. So I suppose your last answer probably answers this
 5 question. Members of the public watching this may want
 6 to be reassured that the important role that MERIT
 7 doctors can play at an incident is optimised and they
 8 know about it in a timely fashion. Are you able to say
 9 whether or not that area of improvement has been
 10 adequately addressed?
 11 A. I'm not. I left MERIT a few months ago and I think
 12 discussions about the radios were still ongoing.
 13 Q. When you say you left it a few months ago --
 14 A. Last autumn.
 15 Q. So in autumn 2020, that issue, so far as you were
 16 concerned, remained unresolved?
 17 A. It did. We were all issued with everyone's numbers so
 18 we should have been able to use phones which worked well
 19 on the night. And again, I think most hospitals and NHS
 20 organisations now use WhatsApp for major incidents.
 21 SIR JOHN SAUNDERS: It clearly didn't work very well on the
 22 night.
 23 A. No.
 24 SIR JOHN SAUNDERS: They rang you and asked you whether you
 25 were on call, where you'd expect them to know who was on

1 call.
 2 A. What came out in the debrief was that the lady who was
 3 on the trauma cell desk was actually just being seconded
 4 into this role from completely something different.
 5 When the call came through, she panicked a little, went
 6 through the day sheet, just saw my name as the first
 7 MERIT doctor that was listed, even though I had
 8 finished, and then called me, erroneously, but --
 9 SIR JOHN SAUNDERS: And then apparently didn't call
 10 Dr Gleeson it looks like.
 11 A. I looks like that, but I can't comment.
 12 SIR JOHN SAUNDERS: Just looking at what we're looking at,
 13 it appears that he was actually called to go into
 14 Salford Royal Hospital and help there and then he was
 15 concerned that he was on call as a MERIT doctor so
 16 refused to go there and then had to actually ring
 17 himself to the trauma cell to find out what was going
 18 on.
 19 A. That's right.
 20 MR DE LA POER: Page 4, please, at the top {INQ020623/4}:
 21 "The MERIT doctors feel there is a lack of awareness
 22 at commander level for MERIT and what their role
 23 entails."
 24 Was that feedback with which you agreed?
 25 A. Yes. It has also been addressed.

1 Q. That has been addressed?
 2 A. Yes.
 3 Q. What was the origin in terms of events on the night of
 4 that feedback?
 5 A. I think it was just felt that certain people didn't
 6 really know what we were going to be on scene for.
 7 There was an expectation from some people that we'd be
 8 very hands on and we had to say, no, it's more of
 9 a hands-off role, and that's time and time again. But
 10 now commanders are briefed better on the role of MERIT,
 11 the call-out process, and also I believe it's part of
 12 NWS mandatory training.
 13 Q. In terms of commanders at the scene, there were two
 14 officially, Mr Smith, Dan Smith, followed by Mr Hynes,
 15 although your understanding was it was Dr Eddie Tunn who
 16 was the relief commander. Is it one of those three
 17 people or more than one that that concern is being
 18 expressed about?
 19 SIR JOHN SAUNDERS: Not a criticism of them; it's
 20 a criticism of their training.
 21 A. There were a lot of senior NWS paramedics and officers
 22 on scene who I didn't know, and this comes out in one of
 23 the debrief points about lack of tabards. I didn't know
 24 who to speak to about specific points just by sight. It
 25 was only when I'd go up to someone and ask them for

1 something, but I was always told -- put in the right
 2 direction. I was always given assistance when it was
 3 asked for.
 4 MR DE LA POER: Speaking of tabards, I don't think you wore
 5 a tabard that night.
 6 A. No.
 7 Q. Had you been issued one or more of the three tabards
 8 that might involve you at the scene?
 9 A. No, we hadn't, but as a result of the debrief we were
 10 issued tabards with interchangeable badges depending on
 11 which role you were assuming.
 12 Q. Had you been more clearly labelled, if you'll forgive me
 13 describing it in that way, do you think that might have
 14 made any difference to what people were asking of you or
 15 expecting of you beyond what you thought you were there
 16 to do?
 17 A. I think so. It would have made me very, very visible.
 18 As I've already answered, the back of my NWS jacket
 19 didn't have any writing on it to identify who I was. It
 20 was only the epaulettes which from a distance are not
 21 legible.
 22 SIR JOHN SAUNDERS: But did Dan Smith on the night appear to
 23 know what your roles were?
 24 A. Yes.
 25 SIR JOHN SAUNDERS: So that wasn't a problem with him?

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

1 with. That arises out of the concern that you had that
 2 some people didn't understand your role?
 3 A. Yes.
 4 Q. And you have told us that that has been addressed.
 5 6:
 6 "An exercise testing the link between forward
 7 doctor, medical adviser, trauma cell and ROCC is needed
 8 to test this function."
 9 Can you help us with what that means?
 10 A. We do various training exercises throughout the year, we
 11 don't all attend each one because of our other jobs, so
 12 we're not always available. I didn't attend the job
 13 testing this function. It may well have occurred but
 14 I'm not the person to ask about it.
 15 Q. Finally 8, I think we have covered this already, this
 16 goes back to the communication issues.
 17 A. Yes.
 18 Q. So it came out of this debrief that there was a specific
 19 recommendation in relation to communication and, as
 20 you have told us, you can't tell us now in May of 2021
 21 whether that has been resolved because you left in the
 22 autumn of 2020?
 23 A. Yes.
 24 MR DE LA POER: Thank you very much indeed, Dr Daley. Those
 25 are the questions I have for you.

1 Sir, we have been going for just short of
 2 90 minutes. Would now be a good time for a break?
 3 SIR JOHN SAUNDERS: A quarter of an hour. Would that be all
 4 right for you?
 5 A. Please.
 6 SIR JOHN SAUNDERS: Thank you.
 7 (10.56 am)
 8 (A short break)
 9 (11.12 am)
 10 MR DE LA POER: Sir, can I invite Mr Jamieson who is taking
 11 the lead on behalf of the bereaved families, to ask his
 12 questions.
 13 Questions from MR JAMIESON
 14 MR JAMIESON: Good morning, doctor. I'm going to take the
 15 same structure with my questioning that Mr de la Poer
 16 Queen's Counsel did.
 17 Firstly, some questions about 22 May and the events
 18 and then finally just a few questions about debriefs.
 19 All right? Just so you can follow the process.
 20 A. Mm-hm.
 21 Q. I wonder could we have another document on screen,
 22 please? It's {INQ013152/1}. This is the emergency
 23 operations centre, the EOC's, the call centre for NAWAS,
 24 procedure on the deployment of MERIT doctors as you can
 25 see.

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

1 impossible if the particular MERIT doctor had no access
 2 to the equipment that would be necessary.
 3 A. More importantly, the doctors might not necessarily have
 4 the skills to do that.
 5 Q. Quite. Just thinking about the circumstances in
 6 which -- I think there were two particular
 7 circumstances, and it's repeated in this document, when
 8 a MERIT doctor might be called out: a mass casualty or
 9 a major incident, it speaks for itself, where there may
 10 be lots of casualties. The other circumstance was where
 11 somebody was trapped for an extended period of time,
 12 60 minutes or more, I think, is the figure. Is it also
 13 in that circumstance where advanced interventions might
 14 be particularly needed?
 15 A. They might well be, yes.
 16 Q. If this is the relevant and current document --
 17 A. Sorry, when is this document dated?
 18 Q. It is dated 2015?
 19 A. Okay.
 20 Q. Yes, were you a MERIT doctor in 2015?
 21 A. Yes.
 22 Q. All right. So it comes in the disclosure and it is
 23 dated in 2015 and I don't understand there to be
 24 a successor. If I'm wrong about that, I'll be
 25 corrected. It seems on the face of it that those

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 arisen in relation to the evidence that Dr Daley has
 2 given about speaking to a firearms officer at the foot
 3 of the stairs. We are, as ever, greatly assisted by the
 4 Operation Manteline team and Mr Horwell has been in
 5 contact with us on their behalf. We hope we may be able
 6 to get a relevant still, but it is derived from the
 7 station footage, not the footage operated by the arena,
 8 and that is just being a little complicated. Can
 9 I invite you to rise for 5 minutes or so to see if
 10 we can sort that out? I think in fairness to
 11 Ms Roberts, we should resolve that before she asks her
 12 questions.
 13 SIR JOHN SAUNDERS: Okay.
 14 (11.58 am)
 15 (A short break)
 16 (12.17 pm)
 17 SIR JOHN SAUNDERS: I think it's remarkable what is achieved
 18 in such a short time and I'm very grateful for the
 19 Operation Manteline team for doing that. Was the delay
 20 in converting a Word document to a pdf or vice versa?
 21 Further questions from Mr de la Poer
 22 MR DE LA POER: Yes, we have had to convert it into
 23 a format that's compatible with the electronic
 24 presentation of evidence system and also we wanted
 25 Dr Daley and other people with a direct interest to have

1 had an opportunity to see it before we resumed.
 2 I have been asked, given the very high standards
 3 that Inspector Russell, in particular, holds himself to
 4 to indicate that that has not been through the quality
 5 assurance process that is usually the case, but that
 6 does permit us to elicit questions if there's any
 7 inaccuracy, he just wanted that to be known.
 8 Mr Lopez, this document will be given an INQ
 9 reference in due course, but can you please display the
 10 second page. We'll just set this in the context to
 11 see ...
 12 The first still, we've already seen, this is at
 13 22.59.57, and is of you and Dan Smith entering the war
 14 memorial entrance; is that correct?
 15 A. Yes.
 16 Q. Over the page we'll have our first new still. Captured
 17 seconds later, this is a view from the area of the pub
 18 on the station concourse of the two of you walking
 19 in the direction of the staircase; is that correct?
 20 A. Yes.
 21 Q. And at the bottom we can see, circled in red, a firearms
 22 officer who is furthest from the camera wearing what
 23 appears to be a ballistic helmet with his arm raised and
 24 pointing in the direction of the staircase and the
 25 City Room; is that right?

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1 A. Yes.
 2 Q. And Mr Smith, I think, is on the left of the red circle
 3 with that kit bag. That is timed at 23.00.07.
 4 Could we go to the next still, please. The top one
 5 is 6 seconds later, not zoomed in.
 6 Then at 23.00.12, we can see that huddle of people
 7 is still where they were.
 8 Then over the page, please, we can see a cropped—in
 9 image of the bottom image on the previous page timed at
 10 23.00.12.
 11 We know from the sequence of events that after that
 12 shot is taken, you move back towards the war memorial
 13 entrance where we see you in that huddle with those
 14 three paramedics who are briefly there and that is
 15 followed by you speaking to Mr Ennis.
 16 Does that all fit together —
 17 A. Yes.
 18 Q. — in the timeline of what we've looked at?
 19 Can we just pause for a moment. I have received
 20 a message suggesting that we can't be seen. I think
 21 Mr Suter, you're on copy to that. Could we pause for
 22 a moment? I don't think we need to rise.
 23 SIR JOHN SAUNDERS: If I may say so, I think the quality is
 24 extremely high of those. It certainly doesn't need to
 25 be quality controlled any more.

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

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

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1 very few doctors who will have had to experience
 2 anything like that and you've now reviewed it
 3 extensively, I have no doubt, before you came to give
 4 evidence.
 5 Is there anything else you think could help in
 6 saying actually it would have been -- might have been
 7 better if we'd done this with the benefit of hindsight?
 8 I'm not asking or expecting criticism of people or
 9 anything like that. Is there anything now, looking back
 10 this time, that you think could be done which hasn't
 11 been done?
 12 A. I think the speed of deployment could have been improved
 13 on in relation to getting hold of MERIT doctors and also
 14 sending out a group message. There was discussion of
 15 setting up a WhatsApp group so that all the
 16 MERIT doctors could be notified and anyone available
 17 could offer their assistance as need be. That's
 18 certainly something that should be put forward.
 19 Better communications. Communications in any major
 20 incident always seems to be a problem. I believe
 21 that --
 22 SIR JOHN SAUNDERS: I think we've gathered that so far.
 23 A. Radio channels can be swamped very easily, but it would
 24 have been beneficial -- it wasn't necessarily important
 25 on that night but I can see for another major incident

1 it would be extremely beneficial for us to have our own
 2 radio.
 3 SIR JOHN SAUNDERS: MERIT doctors have their own radio?
 4 A. I think so.
 5 SIR JOHN SAUNDERS: That's under consideration, did you say?
 6 A. I believe it is.
 7 SIR JOHN SAUNDERS: Okay.
 8 A. And also I think just when it comes to treating this
 9 many patients with complex trauma injuries,
 10 a pre-hospital service would have been beneficial to
 11 have had available on that evening.
 12 SIR JOHN SAUNDERS: A pre-hospital?
 13 A. Service.
 14 SIR JOHN SAUNDERS: That means kit?
 15 A. Kit and doctors with a certain level of expertise.
 16 SIR JOHN SAUNDERS: Right. You were asked about the
 17 question of you might want a particular expertise there
 18 on the night. Would it be better to have some sort of
 19 system whereby if you decide very rapidly you want
 20 a particular sort of doctor at the scene, and it's
 21 life-saving to do that --
 22 A. There is that availability in the north-west now but
 23 certainly it is only operational through the hours of
 24 8 am to 8 pm. I'm one of those doctors.
 25 SIR JOHN SAUNDERS: Because of your particular skills?

1 A. Yes. In addition to my current job as consultant
 2 anaesthetist, I'm a doctor in the North-west Air
 3 Ambulance. Our operational hours currently are only 8
 4 until 8.
 5 SIR JOHN SAUNDERS: Would it be helpful to have something
 6 similar on the MERIT doctor system or is it just too
 7 complicated.
 8 A. When I was leaving they were looking at developing,
 9 upscaling some of the doctors on the rota as a kind of
 10 forward doctor role so they could start doing certain
 11 procedures. I don't know where that's up to at the
 12 moment.
 13 SIR JOHN SAUNDERS: Potentially, presumably, if you could
 14 get a doctor with a certain skill on the scene within
 15 a reasonable amount of time, that could actually save
 16 lives?
 17 A. Yes. It's not just skill, it's also the drugs and also
 18 a trained paramedic. So the paramedics that we work
 19 with have a very specific skill set, different to HART,
 20 different to the road paramedics. We need those to be
 21 our assistants for certain procedures and they're better
 22 at anticipating requirements in the clinical course and
 23 helping out with patient care.
 24 SIR JOHN SAUNDERS: Right. There has been talk about
 25 whether better pain relief can be given at scene. Is

1 there anything that can be done about this?
 2 I understand the problems with it.
 3 A. Morphine is a good analgesic, but it also has its
 4 negative effects, primarily on respiratory drive and
 5 depression, which in these sort of patients we were very
 6 cautious with. I think it came up in one of the debrief
 7 points from the NAWAS one, which I didn't go to, which
 8 was about the administration of ketamine. Since then,
 9 more NAWAS paramedics, the advanced paramedics, are
 10 capable of giving ketamine as are some of the paramedics
 11 who work on the air ambulance who are teamed up with the
 12 doctor.
 13 SIR JOHN SAUNDERS: Right. So I get from your evidence that
 14 a number of things which maybe could have been done
 15 better on the night have been dealt with, but it may be
 16 there are still things that can be improved?
 17 A. A number of things were under development at the time of
 18 the arena attack, primarily the development of
 19 pre-hospital care within the north-west, but since then
 20 we've now started carrying blood and MERIT is actually
 21 evolving to provide its own doctors with the skills and,
 22 I believe, equipment to be able to function at a higher
 23 level.
 24 SIR JOHN SAUNDERS: Would it have made any difference if
 25 you'd had blood on the night?

1 A. I think this might be coming up in a later chapter --
 2 SIR JOHN SAUNDERS: All right, we'll leave that. Is there
 3 any reason why you shouldn't have had blood on the
 4 night?
 5 A. Logistically, it's hard to arrange to carry. There's
 6 also a large clinical governance aspect to it in terms
 7 of patient safety, traceability, accountability.
 8 SIR JOHN SAUNDERS: It's not straightforward?
 9 A. It's not easy.
 10 SIR JOHN SAUNDERS: But not impossible?
 11 A. No.
 12 SIR JOHN SAUNDERS: Anything else you want to add?
 13 A. No, thank you.
 14 SIR JOHN SAUNDERS: Can I thank you for what you did on the
 15 night. You weren't even on duty when you went and did
 16 it and I'm very grateful for the insights you have given
 17 me today.
 18 A. Thank you.
 19 SIR JOHN SAUNDERS: Would you like me to rise for a moment
 20 so the doctor can go?
 21 Housekeeping
 22 MR GREANEY: What I'm going to propose, to avoid you having
 23 to rise, I'm going to give an update about two matters
 24 and I wonder if the doctor would bear with us. I don't
 25 anticipate it will take more than 5 minutes.

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1 SIR JOHN SAUNDERS: Otherwise just walk out!
 2 MR GREANEY: Sir, can I begin by indicating that the reason
 3 we are finishing early today is because we have
 4 completed all of the evidence that was scheduled for the
 5 period between Easter and the half-term break. May
 6 I add that we are grateful to all core participants for
 7 helping us to achieve that. It is a considerable
 8 achievement. That leads to the first matter of update,
 9 which is as follows.
 10 In the next 24 hours, we will be circulating to all
 11 core participants a timetable that will take us to the
 12 summer break, by which I mean a timetable for witnesses.
 13 I believe there were something that you wished to
 14 indicate in relation to --
 15 SIR JOHN SAUNDERS: There is. I am grateful we've got
 16 through on time. There is a long way to go still and
 17 we are all aware of that. For me, and I may be being
 18 naive about this, but for me the issues relating to the
 19 emergency response are really narrowing down, and
 20 I think we can all see that. So please could all CPs
 21 looking at it just refocus on where we can cut down what
 22 we're doing so we can get through this as expeditiously
 23 as possible while not, of course, leaving anything out.
 24 If I was looking at the list, I'd be certainly
 25 readjusting my focus and I hope that everyone can do

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1 that and cooperate with that.
 2 MR GREANEY: We are certain that everyone will have heard
 3 those observations and we will have discussions with the
 4 core participants.
 5 SIR JOHN SAUNDERS: I'm grateful. There has been a lot of
 6 cooperation for which I'm obviously very grateful.
 7 MR GREANEY: There has, sir.
 8 The second update is as follows. Late last year, we
 9 announced that your intention was to publish your report
 10 in three volumes, and that given the importance of the
 11 issues concerned, you would not wait until the
 12 conclusion of the oral evidence hearings before starting
 13 to do so. We indicated that volume 1 of the report
 14 would address the security at the arena. We are now in
 15 a position to inform all core participants, and indeed
 16 the public, that volume 1 will be published at 2 pm on
 17 17 June this year.
 18 Moreover, later today, core participants will be
 19 provided with further information by email about the
 20 arrangements concerning publication. That is the
 21 update.
 22 SIR JOHN SAUNDERS: Thank you. Can I just indicate that one
 23 of the reasons for getting the report out at this stage
 24 is for me to have considered whether to make
 25 recommendations which can feed into the consultation on

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1 the Protect duty.
 2 I have made recommendations in the report, as
 3 you will see when it comes out, as to the Protect duty,
 4 but in order to avoid people having unduly optimistic
 5 views about what I'm going to deal with, I am only
 6 dealing with recommendations as to the Protect duty as
 7 it applies to similar areas to the arena, so places
 8 where public performances are being carried on and where
 9 they are large arenas.
 10 The reason for that is that there are different
 11 problems which arise with smaller areas and the Protect
 12 duty is intended to cover any public area of any sort,
 13 and there are obviously concerns with some of them, and
 14 I have seen them in the press as well, about which I've
 15 heard nothing.
 16 So it seems to me it would be quite wrong for me to
 17 extend the recommendations to the Protect duty generally
 18 when I have not heard from people who either are
 19 promoting them in certain areas or have concerns about
 20 how it will operate. So I just want to limit
 21 expectations as to that. I will deal, and I hope I've
 22 dealt in some detail, with the sort of recommendations
 23 of the Protect duty which I think are appropriate for
 24 places like the arena, but I have not gone on to
 25 consider everywhere. I hope everyone understands the

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1 reasons for it, because I just haven't heard the
 2 evidence relating to it.
 3 MR GREANEY: Sir, thank you very much indeed. That's as far
 4 as we can take it today.
 5 SIR JOHN SAUNDERS: We now have just over a week off. I am
 6 very grateful for everyone's hard work. Preparing
 7 volume 1 of the report and continuing hearings has been
 8 a considerable effort and I'm very grateful for all the
 9 lawyers on my team who have worked very, very hard to do
 10 that, and I hope you don't mind that I say that
 11 publicly. But I'm also very grateful to the other CPs
 12 for the efforts that they have put in to make sure we
 13 keep to the timetable. I'm very grateful for the level
 14 of cooperation which there has been between the CPs.
 15 We are not all going to agree about everything all
 16 the time, but there have been discussions about
 17 everything, and the number of things about which I've
 18 had to make a ruling have been remarkably small. So we
 19 won't all agree all the time about the way I should
 20 approach this inquiry, but when we can agree, I think
 21 we have agreed. And I think we can all understand, and
 22 I hope understand better, that actually we are all
 23 aiming for the same thing. So we are all aiming to give
 24 as much transparency and shed enough light as we can on
 25 what happened. That won't be possible in all areas, as

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1 everybody knows, but we will certainly do our best to do
 2 that.
 3 So thank you for the hard work of the CPs and
 4 thank you for the cooperation, and can I thank publicly
 5 as well all the people behind the scenes, who I know are
 6 giving a great deal of help to everyone. Thank you for
 7 your tolerance and help. So have a break.
 8 MR GREANEY: And we will resume at 10.00, please, on 7 June.
 9 SIR JOHN SAUNDERS: I will look forward to it. Thank you.
 10 (12.35 pm)
 11 (The inquiry adjourned until 10.00 on
 12 Monday, 7 June 2021)
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