

OPUS2

Manchester Arena Inquiry

Day 114

June 9, 2021

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Phone: +44 (0)20 3008 5900

Email: transcripts@opus2.com

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

Wednesday, 9 June 2021

2 (10.00 am)

(Delay in proceedings)

4 (10.05 am)

5 MS CARTWRIGHT: Good morning, sir.

6 SIR JOHN SAUNDERS: Good morning.

7 MS CARTWRIGHT: Firstly, may I apologise that we are a few minutes late starting. That's all my fault.

9 Could I ask the gentleman in the witness box,

10 Mr Birchenough, to be sworn, please.

11 SIR JOHN SAUNDERS: Are you already standing up to do this?

12 THE WITNESS: Yes.

13 MR JAMES BIRCHENOUGH (affirmed)

14 SIR JOHN SAUNDERS: Did you have to use your own ambulance?

15 A. No!

16 SIR JOHN SAUNDERS: If you need a break at any time, just tell me.

18 A. Thank you, sir.

19 Questions from MS CARTWRIGHT

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

22 A. James William Birchenough.

23 Q. Mr Birchenough, you provided a witness statement dated 1 April 2018. Are the contents of that witness statement true to the best of your knowledge and belief?

1

1 A. Yes.

2 Q. Mr Birchenough, I'm going to cover four main areas with you this morning: firstly, your current role and background; training; then your role on 22 May and your involvement that day and into 23 May; and finally deal with the debrief and lessons learning.

7 SIR JOHN SAUNDERS: Before we start -- I'm sorry, I should have said before we started, things have gone quicker than may have been expected this week. We've tried to bring other witnesses forward. That is actually a very difficult process because there's a good deal of preparation which goes into calling witnesses, including supplying them with material to read beforehand. So the result is that we haven't been able to bring other witnesses forward and so we only have this witness and one more to complete the witnesses this week. There is another witness who can't be here for perfectly good reasons.

19 So the result of all of that is that we won't be sitting tomorrow. So we thought that was better that I'm telling you now. As I said, we would have brought other witnesses forward if we could have done and obviously there are other things we will be doing, but we won't be doing them in a hearing. So I just wanted to give people notice of that as soon as possible.

2

1 MS CARTWRIGHT: Thank you.

2 Could I indicate before we start, the witness has in the witness box with him a document that was not on his evidence proposal but it is the summary of radio channels that has been used with other witnesses.

6 Just for those following and for core participants, bearing in mind it wasn't flagged, that document is {INQ040441/1}. So there is also a copy of that for you which I'll hand to you at the appropriate time.

9 SIR JOHN SAUNDERS: Thank you.

11 MS CARTWRIGHT: Mr Birchenough, could I ask you then first of all in terms of your current role?

13 A. In my current role, I'm an operations manager.

14 Q. And if we deal with then your time with North West Ambulance Service, I think it's correct, isn't it, that you joined the Ambulance Service in 2003?

17 A. Yes.

18 Q. You qualified as a paramedic in 2007?

19 A. Yes.

20 Q. In 2012 you were promoted to the role of assistant operations manager?

22 A. Yes.

23 Q. And you then took up a secondment to operations manager in November of 2016?

25 A. Yes.

3

1 Q. And at a high level could you give us an indication about what an operations manager role is, please?

3 A. An operations manager is involved, obviously, with all aspects of operations for a group of ambulance stations and a number of ambulance staff of all grades.

6 Q. I think it's correct that you were the operations manager for the area that included Manchester city centre at the time of the arena attack?

9 A. That's correct.

10 Q. Could we then move, please, to deal with training? I'm particularly focusing on your training in respect of commander training, first of all.

13 We have your records, but I think it's perhaps more helpful if you describe to the chairman, as of the night of the attack, what commander training you'd had, please.

17 A. The basic incident training that all staff would get as far as basic training. I had been to do the NARU course in the February of 2017.

20 Q. And it's correct, isn't it, that as an operational manager, does that then mean that you're also able to discharge and perform the role of an operational commander or a Bronze commander?

24 A. No, not at the time, no.

25 Q. And did you achieve the qualification of a Bronze

4

1 commander subsequent to this night?
 2 A. Yes.
 3 Q. Could you just tell us when that occurred, please?
 4 A. It was February 2018.
 5 Q. Thank you. So the reference to the 9 February 2017 NARU
 6 operational course that witness has just described is
 7 {INQ041299/1}.
 8 Could you assist us then in terms of what that NARU
 9 operational commander course trained you and equipped --
 10 the knowledge it equipped you with, please?
 11 A. It's the National Ambulance Resilience Unit. It's
 12 predominantly based around the JESIP principles.
 13 Q. Then, in terms of if we look at JESIP training, we can
 14 see from your records -- and if you wish them to be
 15 brought up, we can -- that you had undergone, firstly,
 16 major incident management training on 3 July 2013, but
 17 then you had had JESIP multi-agency command training on
 18 3 July 2014. Can you assist us as to what that training
 19 equipped you with in terms of knowledge of JESIP and
 20 JESIP principles and the like, please?
 21 A. The training to my recollection is a one-day joint
 22 agency course, so with the police and the fire. And
 23 it's a single day going over the principles, and
 24 potentially touching on an exercise, although not a live
 25 exercise, just a concept exercise to run through those

5

1 principles.
 2 Q. Are you able to give us some indication that on the
 3 night that you attended the incident, what was your
 4 knowledge of the JESIP marauding terrorist firearm
 5 attack guidance?
 6 A. I was aware of the MTFA plans, but I wouldn't have been
 7 able to tell you in detail. The concept of them I would
 8 be aware of.
 9 Q. Can I ask then, in terms of an operational Plato, what
 10 was the extent of your knowledge at the time around
 11 Plato?
 12 A. It was a term I was aware of.
 13 Q. When you say a term that you were aware of, can you give
 14 us any greater understanding as to the level of your
 15 knowledge and understanding in respect of that?
 16 A. I was aware that it affects the zoning that's -- that
 17 general staff are able to work in.
 18 Q. And then can I go on, because the inquiry has heard some
 19 evidence about the difference in zoning in terms of how
 20 NWAS dealt with the various zones, but also how zoning
 21 is dealt with within the JESIP MTFA guidance. So did
 22 you know that -- what the guidance was around zoning
 23 that was in the JESIP guidance as to what a hot zone
 24 was, a warm zone and a cold zone?
 25 A. In relation to MTFA?

6

1 Q. Yes.
 2 SIR JOHN SAUNDERS: We are talking about Plato; is that
 3 right?
 4 MS CARTWRIGHT: Yes.
 5 SIR JOHN SAUNDERS: The zoning in a Plato operation.
 6 A. Yes, I was aware that that would mean general staff were
 7 unable to operate in the warm zone and would pull out.
 8 MS CARTWRIGHT: And that was knowledge you had at the time?
 9 A. Yes.
 10 Q. Then in a non-Plato situation, what was your knowledge
 11 and understanding about zones?
 12 A. That we are able to operate within a warm zone.
 13 Q. Thank you. When you say "we", can you just --
 14 A. General staff would be able to operate in a warm zone,
 15 my apologies.
 16 Q. Thank you.
 17 I'm going to move now, please, to deal with your
 18 involvement on the night, please.
 19 I think it's correct that you'd worked throughout
 20 the day of 22 May?
 21 A. That's correct.
 22 Q. And what time were you due to go off duty?
 23 A. 22.00.
 24 Q. And you tell us in the witness statement that in fact
 25 you had been to attend at North Manchester

7

1 General Hospital?
 2 A. That's correct.
 3 Q. Can you describe what you were then doing at the time
 4 when you heard about the incident?
 5 A. I was at -- about 9.30 I was asked to attend North
 6 Manchester General Hospital due to a large number of
 7 ambulances queueing down the corridor and outside.
 8 Q. The 9.30 when you had that information, it's right,
 9 isn't it, that you were in your control, you are at
 10 base?
 11 A. Yes, at one of the ambulance stations, yes.
 12 Q. Just to clarify, is it right that at that time that you
 13 were with Mr Ennis that the inquiry has heard evidence
 14 from?
 15 A. That's correct.
 16 Q. You were going on to say about the call you received.
 17 A. So I went to North Manchester and there was a large
 18 number of ambulances there. Initially, it's to find out
 19 who the patients are, if they have been triaged, and
 20 I was able to release a number of ambulances initially
 21 when I got there. And then it's with liaison with the
 22 nursing staff to try and work through the rest and see
 23 if we can clear the ambulances. We had a large number
 24 of calls that day.
 25 Q. You tell us in the witness statement that on the night

8

1 you were effectively one of the operational Bronze
 2 commanders at the scene and had been tasked to act as
 3 a casualty clear officer. I'm going to come on to that.
 4 I just want to deal with, at this stage, in terms of
 5 identifying yourself as an operational Bronze commander
 6 that night --
 7 A. I think that is -- that should have been -- I took on
 8 a functional role, I think would be a better way of
 9 wording that.
 10 Q. We will come on to deal with that when we move a little
 11 further on into the chronology. But I think you have
 12 already clarified that you had not received training to
 13 act as a Bronze commander?
 14 A. Correct.
 15 Q. Can you detail the information then you received when
 16 you were at the hospital relating to the arena attack,
 17 please?
 18 A. The first thing we were aware of was I was told a female
 19 patient had self-presented, saying she'd been shot.
 20 I didn't see the patient, but the nurse in charge
 21 confirmed that the injuries she had were consistent and
 22 that she may have been shot.
 23 Q. And so when you had received that information, what did
 24 you do?
 25 A. In relation to -- over the course of the next few

9

1 minutes, various people that were within the ambulance
 2 corridor, patients and family members, etc, were getting
 3 some information, presumably via social media.
 4 I spoke to the -- there were some police within that
 5 corridor as well. I spoke to them. And at some point,
 6 I'm not sure of the time, possibly 22.50, they confirmed
 7 there had been -- they'd heard there had been an
 8 explosion at the arena.
 9 Q. Just pausing there, so when you were at the hospital,
 10 can I ask, first of all, did you have a radio with you?
 11 A. Yes.
 12 Q. And had heard any information over the Airwave Talk
 13 Group at that time as to whether or not there had been
 14 any sort of incident before that time?
 15 A. No.
 16 Q. And perhaps then before we move forward, if I could just
 17 ask you to confirm using the document that's -- it
 18 should be in the witness box, {INQ40441/2}, and it's
 19 page 2 of that document, please, Mr Birchenough.
 20 SIR JOHN SAUNDERS: If you happen to have a spare copy,
 21 I have been given one but I'm afraid I failed to bring
 22 it with me.
 23 MS CARTWRIGHT: That's for you. (Handed). I do apologise.
 24 SIR JOHN SAUNDERS: No, no, I have been given one; I failed
 25 to bring it with me.

10

1 MS CARTWRIGHT: Mr Birchenough, if we turn to {INQ40441/3}
 2 of the document, we can see that there's reference to
 3 a GM officers' Talk Group, and we are not revealing the
 4 Airwaves group as part of the evidence, but at that
 5 time, even before having knowledge of the incident,
 6 would you have been listening into that officers' Talk
 7 Group?
 8 A. Yes.
 9 Q. And so even if there wasn't -- hadn't been an incident
 10 that night, would that be the Airwave that you would
 11 ordinarily be listening to and operating from?
 12 A. Yes.
 13 Q. Thank you.
 14 We can see at 22.50 that you made a call -- sorry,
 15 you had a call from the -- to the health control desk.
 16 I'm going to ask Mr Lopez, please, can we display
 17 {INQ015397T/1}. Thank you, Mr Lopez.
 18 Mr Birchenough, we can see that you in fact called
 19 the health control desk at 22.50, and can I ask, first
 20 of all, then, what was the purpose of you contacting the
 21 health control desk at that time and the relevance of
 22 the health control desk, please?
 23 A. The health control desk had initially contacted me
 24 earlier in the evening to tell me the number of
 25 ambulances that were queueing at North Manchester. So

11

1 my call to them is to feed back with the information I
 2 had.
 3 Q. I think we can see that in the exchange where you set
 4 out:
 5 "I've got half your ambulances here, I think."
 6 A. Yes. Not literally.
 7 Q. No. And so was the purpose of the call to update about
 8 the information you'd heard about a potential shooting
 9 at the MEN or was it just to give an update on the
 10 progress of the ambulances that were queueing at North
 11 Manchester General Hospital?
 12 A. It's an update for the progress at North Manchester
 13 Hospital. I believe at that point I didn't really know
 14 there had been an incident. I knew a single patient had
 15 arrived.
 16 Q. We can see that the health control desk set out:
 17 "There's been reports of shootings at the MEN."
 18 And then the response:
 19 "Okey dokey."
 20 "Have you been made aware?"
 21 I think where it's attributed to the health control
 22 desk, I think that's in fact you, isn't it, rather than
 23 the health control desk?
 24 A. No, health control desk is them on the desk. I'm
 25 showing up as "NMH".

12

1 Q. Okay. So let's just work through — I just wonder in
2 fact whether it's you giving that information, rather
3 than them?
4 A. No, that's them telling me.
5 Q. So let's just work through the call. So we can see that
6 health control desk indicate:
7 "Chloe speaking."
8 "Hi Chloe, it's Jim Birchenough up at
9 North Manchester."
10 "Hiya, Jim. Are you all right?"
11 Yes, I've got half your ambulances here, I think."
12 Then you communicate:
13 "Yeah, there's been reports of shootings at the
14 MEN."
15 "Okey dokey."
16 "Have you been made aware?"
17 "I haven't, no, but I think technically on your
18 screen I probably finished at 10 so I don't know if they
19 even know that I am still here."
20 The response is:
21 "Right, okay, yes, it's all going off."
22 And then:
23 "So you are still at the North Manchester now?"
24 And then the response is:
25 "Yes, right, okay, no worries. Do you want — who's

13

1 going?"
2 And health control desk say:
3 "I'm unsure. You'd have to speak to Control. I'm
4 just in the middle of ringing all the hospitals."
5 "All right."
6 And then the response is:
7 "But I'm not 100% sure of the information at the
8 moment."
9 And then essentially the call ends.
10 So at that time did you think there was any
11 indication that you would need to attend at the arena?
12 A. I didn't know at the time. I believe I was aware of the
13 patient that had arrived. It was either shortly before
14 that or shortly after that conversation. I believe
15 after that conversation I spoke to the police officer
16 that was in the corridor. But I didn't actually know
17 there had been — at that point I didn't know there has
18 been an incident.
19 Q. Thank you. Then just so we are clear, what information
20 did the police give you by way of situational awareness
21 when you spoke to them in the corridor?
22 A. Very little. Obviously it was all quite new, but they
23 confirmed they'd been told over their channel that there
24 had been an explosion at the arena.
25 SIR JOHN SAUNDERS: So nothing had come over your radio Talk

14

1 Group?
2 A. No, but in fairness sometimes, within a hospital
3 building, they don't receive signals brilliantly.
4 SIR JOHN SAUNDERS: Thank you.
5 MS CARTWRIGHT: Can I ask then, with the training you'd
6 already had, bearing in mind that's been reference to
7 a shooting and then information from the police about an
8 explosion, did that trigger any thought in your mind
9 that there may be a Plato-type incident developing at
10 the arena?
11 A. It didn't, no.
12 Q. You say this in your witness statement:
13 "In light of this information and realising that if
14 it was accurate there would very quickly be a massive
15 demand upon the Ambulance Service, I spoke to the sister
16 in charge again and told her I needed the remaining
17 crews to be clear from the hospital within the next
18 5 minutes."
19 A. Yes.
20 Q. If we can please then look at the next call where we can
21 see your involvement, please, to track your involvement
22 that night. Mr Lopez, please could we display
23 {INQ015024T/1}, please. Thank you.
24 Mr Birchenough, before going through this call at
25 22.58, I think it's right that you were that night in

15

1 a vehicle that was known by the signal Romeo 310?
2 A. That's correct.
3 Q. Can you just describe what sort of a vehicle that is,
4 please?
5 A. It's a rapid-response car with normal "rapid-response
6 ambulance" on it, the same as every paramedic would do.
7 Q. When we look at this call, the reference to Romeo 310 is
8 your call sign effectively on that night?
9 A. That's the vehicle call sign, because I wasn't signed on
10 to the vehicle as an operational paramedic because I was
11 covering an operations manager's role. So the radio
12 I was using at the time was Charlie Romeo 02. So that
13 was the call sign I was using but the vehicle I was on,
14 so they would have needed to send job through to the
15 vehicle call sign.
16 Q. Can you just, before we move on, because it may be
17 relevant when we come on to look at some of the
18 information you gave as to information you fed into the
19 debrief, can you just explain then in terms of the
20 radios that ambulance paramedics have and how that
21 operates in terms of the link to the call sign for
22 vehicles and particularly what happens then when the
23 paramedics are off the vehicle?
24 A. So ambulance staff, road staff, have individual personal
25 radios or two radios connected to a vehicle and then

16

1 there's a handset within the vehicle and the vehicle has
 2 call sign and all those are linked.
 3 Q. So they are all linked on the same call sign?
 4 A. They are all linked on the same — on the same call sign
 5 into the same vehicle. So if a message gets sent
 6 through to the vehicle, that will trigger both their
 7 radios.
 8 Q. Is there any way that a member of crew assigned to
 9 a vehicle can then operate under a different call sign
 10 on the radios?
 11 A. They — potentially they could, but it's — I don't
 12 fully understand how the control service use it. But
 13 each radio has an individual number and that number is
 14 identified as being related to that vehicle. So quite
 15 how you would change that, I don't know.
 16 Q. Perhaps we will come on to deal with that when we are
 17 looking a little bit more at the patient dispatch on the
 18 night, as to how that may have had an impact.
 19 Then just dealing with this call, please, at 22.58,
 20 we can see that following on from this call effectively
 21 what's being discussed is, again, the information that's
 22 provided from North West Control is:
 23 "Roger, we are a bit busy at the moment. We've got
 24 this incident at the arena. The rendezvous point is at
 25 Hunts Bank. Paddy on scene has confirmed there is at

17

1 least 40 casualties."
 2 To which you respond:
 3 "Do you want me to attend?"
 4 Yes, roger, please, if you would. I'll show you
 5 attended, thank you."
 6 Then your response is:
 7 "Yeah, if you want to text the RV point to
 8 Romeo 310."
 9 And Control confirms that:
 10 "Roger, thank you, will do."
 11 So in terms of this call at 22.58, is this in
 12 reality your allocation to that incident?
 13 A. Yes.
 14 Q. And can I ask at that stage in terms of the information
 15 that you received in this call and the information you'd
 16 already had on the earlier call and that you'd received
 17 at the hospital, was it your understanding that there
 18 was likely to be a major incident taking place at the
 19 arena?
 20 A. It wasn't, no.
 21 Q. So can I just explore that a little further. What did
 22 you think when you were being told that there was at
 23 least 40 casualties at the arena?
 24 A. I don't recall that part of the conversation, whether
 25 that didn't register or I didn't hear it. I don't

18

1 recall that part of the information.
 2 My understanding, as I recall, was something had
 3 happened, an incident of some description. There was
 4 obviously a deal of confusion around that and my
 5 offer — I didn't know who was attending, who was able
 6 to attend, and my offer was if they want me to attend.
 7 Q. And so can I just ask, at that point in terms of being
 8 allocated to the — to go to the arena, would you have
 9 just continued to be operating on the Talk Group we
 10 looked at a moment ago?
 11 A. Yes.
 12 Q. The GM officers' Talk Group?
 13 A. That's correct, yes.
 14 Q. So at that stage no one — you had no information to
 15 switch to any form of major incident channel?
 16 A. No.
 17 Q. Can I ask you then, just in terms of your knowledge of
 18 the major incident plan, which we will look at at
 19 various times, in terms of the role you had when you
 20 were at the scene.
 21 Mr Lopez, please could we display {INQ013132/31},
 22 please. Thank you.
 23 So further to that call at 22.58, you've obviously
 24 given your answer about your knowledge and understanding
 25 about a major incident, but obviously Control had other

19

1 information. But we can see in the NWS major incident
 2 plan at paragraph 6.2:
 3 "The NWS EOC will designate the appropriate Airwave
 4 Talk Groups for use in the initial stage of the incident
 5 as well as the telephone number for inbound calls into
 6 the EOC (as per action card 21). The tactical commander
 7 will be designated a number for use in contacting the
 8 EOC."
 9 So we can also see in terms of Airwave capacity
 10 management in major incidents at 6.3, that:
 11 "NWS Control should nominate a major incident Talk
 12 Group for the incident and all responding vehicles
 13 should switch to Talk Group upon mobilisation (no other
 14 Talk Groups should be monitored by the responding
 15 vehicles) and the operational commander should liaise
 16 with the EOC to agree a communications plan."
 17 Can I ask then, did you have knowledge at the time
 18 of the detail of the NWS major incident plan in terms
 19 of what it required by way of Airwave management in
 20 a major incident?
 21 A. Yes, I had knowledge of the plan at the time, yes.
 22 Q. Can I ask then, was there any thought in your mind at
 23 22.58 about whether you should be asking as to what
 24 Airwave channel should be used in responding to that
 25 incident?

20

1 A. I wasn't aware at the time it was a major incident.
 2 Q. But you didn't even think to raise that bearing in mind
 3 you'd heard about an explosion from the police,
 4 information as to a shooting, and there's information
 5 about 40 casualties?
 6 A. I don't recall the 40 casualty part. I apologise for
 7 that. The other part we — we do respond to explosions
 8 and shootings, stabbings, various other types of
 9 incident, and sometimes they are not exactly as
 10 reported.
 11 SIR JOHN SAUNDERS: So if you had thought it a major
 12 incident, would you then have asked them for the channel
 13 to switch to?
 14 A. Yes, sir.
 15 SIR JOHN SAUNDERS: If they knew it was a major incident, as
 16 presumably they did, should they have been telling you
 17 to switch to a major incident channel?
 18 A. Yes.
 19 SIR JOHN SAUNDERS: Thank you.
 20 MS CARTWRIGHT: So just dealing with the point that the
 21 chairman's just raised, I appreciate from your
 22 perspective you didn't have in your mind a major
 23 incident at that time, but once you were allocated at,
 24 I think, 11.03 and made your way to the arena, would it
 25 be fair to say that had you been notified of a major

21

1 incident NWS channel, you could have been listening in
 2 to that as you made your way to the arena?
 3 A. That would be correct, yes.
 4 Q. And would it be accurate then to say that the benefit of
 5 that is that, even though at that stage you're on the
 6 move, you're able to listen in to get some form of
 7 situational awareness as to what's taking place at the
 8 incident?
 9 A. Absolutely.
 10 Q. And would you agree that that would have been of benefit
 11 to you as you progressed to the arena that night?
 12 A. Absolutely.
 13 Q. Could we please move to the next transcript of call that
 14 we have, please, Mr Lopez, it's {INQ015043T/1}.
 15 We can see that at 11.02 you were given the details
 16 of the rendezvous point at Hunts Bank at
 17 Victoria Station.
 18 A. Yes.
 19 Q. And did you know that location well, bearing in mind you
 20 were based in Manchester city centre?
 21 A. I knew the location well. I knew Victoria Station.
 22 I knew Hunts Bank, yes.
 23 SIR JOHN SAUNDERS: I think you'd already been given it
 24 actually in the previous call and you'd asked them to
 25 text it through to you.

22

1 A. Yes.
 2 SIR JOHN SAUNDERS: The texting through, does that have the
 3 effect of putting it automatically on to the satnav —
 4 A. Absolutely, correct.
 5 SIR JOHN SAUNDERS: — so you can go there?
 6 A. Yes.
 7 SIR JOHN SAUNDERS: Thank you.
 8 MS CARTWRIGHT: Can I ask then, in terms of you having
 9 knowledge that it was at Manchester Arena and the
 10 rendezvous was at Hunts Bank, was there any thought in
 11 your mind about the proximity of the rendezvous point to
 12 where the incident was occurring?
 13 A. No, ma'am.
 14 Q. Thank you. Mr Lopez, if we can please display
 15 {INQ040368/5}, please.
 16 If we could expand, please, around the
 17 R310/Jim Birchenough entry, please. Thank you.
 18 Mr Birchenough, just using the interrogation that's
 19 been done of the various data by North West Ambulance
 20 Service, we can see that you are mobile at 23.03.41,
 21 having been allocated at 23.03.16 and you arrive at the
 22 scene at 23.11.09.
 23 A. That's correct.
 24 Q. Thank you. Could I ask then, in terms of you already
 25 telling us that Romeo 310 was a rapid-response car, what

23

1 equipment you had with you when you arrived at the
 2 rendezvous point, please, at Hunts Bank?
 3 A. A rapid-response car carries the same medical equipment
 4 as an emergency ambulance with the exception of a
 5 stretcher and some of the mobilisation equipment.
 6 Q. And can I ask in terms of — we've heard reference to
 7 sort of commander-type equipment that individuals would
 8 have, would it be right that because you weren't
 9 technically an operational commander at the time, that
 10 you did not have that equipment available to you?
 11 A. Yes, ma'am, that's correct.
 12 Q. And so without that equipment, would it mean you
 13 wouldn't have the tabards that we've heard about?
 14 A. Yes, that's correct.
 15 Q. Would you have had any action cards with you?
 16 A. We had a small pocketbook, which I had in my coat
 17 pocket.
 18 Q. So when you're describing a small pocketbook, what is
 19 that, please?
 20 A. A major incident pocketbook which has the action cards
 21 in it, an NWS pocketbook.
 22 Q. Can you assist us then as to what medical equipment was
 23 on your rapid-response vehicle then, please?
 24 A. It has a basic life support bag, advanced life support,
 25 and the standard drug package that an ambulance would

24

1 carry.
 2 Q. Just for completeness, had you received any mobile
 3 telephone calls from any of the -- anyone from NAWAS as
 4 you made your way to the arena in?
 5 A. I don't recall receiving any other telephone calls,
 6 ma'am, no.
 7 Q. Thank you. Can you just tell us then what you did when
 8 you arrived at scene at 23.11.09?
 9 A. As I approached the arena coming down the side, there
 10 were various other vehicles travelling in the same
 11 direction. So a few of us arrived at Hunts Bank,
 12 effectively in a convoy.
 13 I tried to park out of the way at the bottom of
 14 Hunts Bank. As I got out of the car somebody in
 15 a fluorescent jacket was trying to take me towards
 16 a patient.
 17 Q. I am not going to go into the details of the extent of
 18 that encounter, but is it right the information that you
 19 were giving was that they couldn't stop a person from
 20 bleeding, couldn't stop the bleeding?
 21 A. I believe that was what I was told.
 22 Q. Can you just give us some idea as to the location of
 23 where that individual was?
 24 A. From where I had parked at the bottom of Hunts Bank, it
 25 was back towards the main road. I think there's

25

1 a service yard type access entrance underneath the
 2 arena. I believe that's there.
 3 Q. Is that underneath the railway bridges, towards that
 4 way?
 5 A. It was that direction. I don't actually know the
 6 location, but that's the direction I believed he was
 7 indicating.
 8 Q. Can I ask you then, at that stage, in terms of the
 9 information you did have at that stage, did that raise
 10 any concerns to you as to an individual being away from
 11 the railway station or the arena at that point with
 12 potentially serious injuries?
 13 A. I don't understand the question, ma'am, I'm sorry.
 14 Q. It's all right. We are going to look at casualty
 15 management and setting up the casualty clearing station
 16 and the casualty collection point. But it's right,
 17 isn't it, that part of a response to an incident
 18 requires the careful management of patients?
 19 A. Yes, ma'am.
 20 Q. And essentially the allocation of patients to certain
 21 areas to ensure that they are then appropriately
 22 assessed, triaged and treated in accordance with the
 23 severity of their injuries? So just so I can understand
 24 at the time when there's a patient effectively further
 25 away from the scene to which you were making, did that

26

1 raise any flags to you as to what was going on in terms
 2 of the management of patients at that time?
 3 A. There was other people who were visibly hurt making
 4 their way down Hunts Bank at the time as I arrived,
 5 people who had presumably been in and around the area,
 6 making their own way down with being able to walk or be
 7 assisted. So I -- in answer to your question, no, it
 8 didn't raise my concern. There weren't -- I was aware
 9 there were people scattered.
 10 Q. Just going back to the matter we have looked at already
 11 where I have asked you about the fact that you've
 12 identified yourself in your witness statement as an
 13 operational Bronze commander, can you just describe --
 14 you say in your witness statement that that role would
 15 be a gloves-off role, so can you just assist us as to
 16 when you arrive and an individual approaches you asking
 17 to give assistance to the patient, how that's relevant
 18 to what you then did and what you saw your potential
 19 role as you made your way to the scene?
 20 A. My intention at going to scene, not knowing anywhere
 21 near -- not knowing the scale of this incident, and
 22 certainly not knowing it was a major incident, was to go
 23 to get information, to be able to feed back as to what
 24 the particular incident was and the scale of it. So my
 25 intention was, if possible, not to get involved

27

1 specifically with dealing with patients because that
 2 would stop me doing anything else.
 3 As I say, we'd arrived in effectively a convoy.
 4 There was an ambulance parked next to me. So when the
 5 gentleman had asked could I come and help, I allocated
 6 a crew that had just arrived and they went with the
 7 gentleman, so there was no delay.
 8 SIR JOHN SAUNDERS: I well understand that you're going
 9 there in some sort of command role because that's what
 10 your position is, helping organising.
 11 As you're going towards there, without any real idea
 12 of how major an incident this was, as you're seeing
 13 people injured, as you are hearing this information, you
 14 must be becoming more aware that it was something
 15 serious?
 16 A. Yes, sir.
 17 SIR JOHN SAUNDERS: Does that mean you need to get to see
 18 someone to find out what to do as soon as possible?
 19 A. I wasn't actually aware there was anybody else there in
 20 any form of management role. I was --
 21 SIR JOHN SAUNDERS: So you had to get there in order to
 22 manage it if necessary?
 23 A. Just to get information. Obviously from parking up,
 24 I realised it was a much larger scale than...
 25 SIR JOHN SAUNDERS: Yes. Thank you.

28

1 MS CARTWRIGHT: Can I ask, in terms of the fact that you had
 2 been using the Greater Manchester officers' Talk Group,
 3 had any additional information — that you'd picked up
 4 as you had proceeded to the scene on that Talk Group?
 5 A. I don't recall any, ma'am.
 6 Q. So when you got out of your vehicle on Hunts Bank, did
 7 you know who the Gold commander was for North West
 8 Ambulance Service?
 9 A. No, ma'am.
 10 Q. Did you know who the Silver or tactical commander was
 11 for North West Ambulance Service?
 12 A. Who would have been on call that evening, I could have
 13 had that information very readily to hand when I was in
 14 my office. Whether I actually knew — I can't recall
 15 whether I actually knew.
 16 Q. Had you been made aware as to whether anyone had been
 17 allocated as the Bronze or operational commander?
 18 A. No, ma'am.
 19 Q. And you told us that you were the Bronze commander on
 20 call. Did you think there was any chance that you could
 21 be allocated as that role?
 22 A. I wasn't Bronze commander and I wasn't on call.
 23 Q. Sorry, of course, I apologise. So there was no way you
 24 could ever be the operational commander at scene?
 25 SIR JOHN SAUNDERS: Well, if there was no one else there who

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1 had that qualification, you would have taken over,
 2 wouldn't you, and did what you could until someone
 3 turned up?
 4 A. Absolutely correct, sir, yes.
 5 MS CARTWRIGHT: We know that you'd been with Paddy Ennis
 6 much earlier that night when you had been back at your
 7 base. Had you had any information that Paddy Ennis had
 8 been deployed and was at the scene?
 9 A. No, ma'am, I left — I left the station before he'd been
 10 contacted about anything.
 11 Q. Thank you. So other than the information you've already
 12 told us about the fact that you'd had some information
 13 about a shooting, information from the police that there
 14 had been an explosion, and talk that there was somewhere
 15 in the order of 40 casualties, had you any other
 16 information in your mind as you progressed up Hunts
 17 Bank?
 18 A. I had no more information other than the visual
 19 information I was getting from the people I could see.
 20 Q. Can you then tell us, as you then directed the ambulance
 21 top go to the patient that had been alerted to you from
 22 the man as you got out of your vehicle, what you then
 23 did, please.
 24 A. I then made my way up Hunts Bank towards Station
 25 Approach.

30

1 Q. And can you continue, please.
 2 A. And saw Dan Smith.
 3 Q. Did you know Dan Smith before that night?
 4 A. Yes, ma'am.
 5 Q. Just explain how — did you work with Mr Smith?
 6 A. Yes. Previously he'd — if I get this correct, he had
 7 been one of the advance paramedics and was based in and
 8 around the station group when I first moved into that
 9 group. So I had been aware of Dan for over several
 10 years of my career.
 11 Q. And when you spoke to Dan Smith, what information did he
 12 give you at that time, please?
 13 A. Dan told me it was a major incident. He told me it had
 14 been confirmed there had been an explosion, and of the
 15 nature of that explosion, and where it had happened.
 16 All the information I was to receive, everything —
 17 everything I got came from Dan Smith as I arrived.
 18 Q. And in him describing that there had been an explosion,
 19 did he give you more details about that and what had
 20 caused that?
 21 A. Yes, ma'am.
 22 Q. So were you clear after speaking to Mr Smith that there
 23 had been some form of terrorist attack?
 24 A. Yes, ma'am. He — I apologise, I was trying to be
 25 delicate with wording. He'd confirmed that the police

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1 had seen on camera the detonation of the suicide
 2 explosion.
 3 Q. So in having that conversation with Mr Smith, did he
 4 also tell you that he had been allocated the role of the
 5 operational commander?
 6 A. He will have done. I believe he was wearing a tabard at
 7 the time I arrived.
 8 Q. Did he allocate to you at that time a functional role?
 9 A. In and around that conversation, yes, ma'am.
 10 Q. So what was the functional role he asked you to perform?
 11 A. Casualty clearing officer.
 12 Q. And did you have an understanding as to what the role of
 13 the casualty clearing officer was?
 14 A. Yes, ma'am.
 15 Q. Mr Smith in his witness statement indicates that during
 16 that conversation with you, that he advised you to
 17 familiarise yourself with the relevant action cards and
 18 refer to them. Can you recall that that would have been
 19 something he said to you at that time?
 20 A. I don't specifically recall the details of the
 21 conversation, but that would have been reasonable.
 22 Q. Before we look at the action cards and the major
 23 incident plan, what was then your understanding as you
 24 were allocated that functional role as to what your
 25 responsibilities and tasks would be as the casualty

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1 clearing officer ?

2 A. There's various tasks, but fundamentally casualty

3 clearing officer is to manage and oversee the casualty

4 clearing station.

5 Q. So in the conversation that Mr Smith was having with

6 you, did he tell you first of all where the casualty

7 clearing station was?

8 A. Yes, ma'am.

9 Q. What did he tell you about that?

10 A. That it was within the station concourse and the -- I'm

11 unaware of how he worded it, but we weren't to go past

12 the stairs.

13 Q. Did he tell you why you weren't to go past the stairs?

14 A. Because of where the explosion had been and that was the

15 limit of our -- effectively my understanding of that,

16 and I apologise, I don't recall the conversation in

17 detail, but my understanding was that was the warm zone

18 and the stairs onwards would be hot.

19 Q. I think you have mentioned there limit of exploitation,

20 so was there a discussion with Mr Smith about zones?

21 A. I don't remember in detail the conversation, but yes,

22 ma'am, there will have been for me to have that

23 understanding and knowledge.

24 Q. Can you please give us as much clarity as possible as to

25 what information you were given at that time about what

33

1 the various zones were?

2 A. The -- my understanding was the hot zone was upstairs at

3 what we now know is the City Room, and to the stairs was

4 my understanding, to the bottom of the stairs, none of

5 us were to go past the stairs. So my understanding was

6 that was where the warm zone would then start.

7 Q. Just pausing there, before we move to look at other

8 zones, did Mr Smith have any discussion with you about

9 what sort of -- whether it was a Plato hot zone or

10 whether any form of Plato had been declared?

11 A. I don't recall any mention of Operation Plato, ma'am,

12 no.

13 Q. Can I ask, bearing in mind you had had information

14 provided to you at the hospital, that there had been

15 potentially a firearm or shooting, did you give that

16 information to Mr Smith that you had to query whether or

17 not this was an Operation Plato?

18 A. I don't recall querying whether it was an Operation

19 Plato. I may have mentioned that somebody had presented

20 with injuries that were consistent with a shooting.

21 Q. So was anything said about Plato to either confirm or

22 refute it at that time about...

23 A. I don't recall a discussion regarding Operation Plato.

24 SIR JOHN SAUNDERS: In real life are -- when you come along

25 and speak to Dan Smith, is he saying, "The casualty

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1 clearing station is there, only as far as the bottom of

2 the stairs, we are not going up the stairs", or is he

3 saying. "That's the warm zone, that's the hot zone,

4 that's the cold zone", or he is just telling you where

5 you can go?

6 A. The first one, sir.

7 SIR JOHN SAUNDERS: Thank you.

8 MS CARTWRIGHT: Just going back to the action cards, so in

9 the discussions you were having with Mr Smith, there was

10 no thought in your mind as to what the action cards

11 were, they would be the major incident action cards; is

12 that correct?

13 A. We have an NWS pocket guide. They are the action cards

14 I would refer to.

15 Q. Because I just want to be clear, there was no thought in

16 your mind as to whether you needed to check whether it

17 needed to be the Plato action cards rather than the

18 major incident action cards?

19 A. No.

20 SIR JOHN SAUNDERS: Did you ever know there were such things

21 as Plato action cards?

22 A. I was aware -- I'm aware the zoning is different for the

23 Plato. It wasn't something I was well-versed in.

24 SIR JOHN SAUNDERS: Are you aware there are Plato action

25 cards?

35

1 A. Yes.

2 SIR JOHN SAUNDERS: You are? Thank you.

3 MS CARTWRIGHT: Then going back to the zoning, when you're

4 telling us about when the hot zone was and it going to

5 the bottom of the stairs, we are not talking about a hot

6 zone in terms of a Plato hot zone?

7 A. Not to my mind, no, no.

8 Q. Was there any discussion or understanding about where

9 the warm zone was?

10 SIR JOHN SAUNDERS: I think he said from the bottom of the

11 stairs. I think he said that.

12 MS CARTWRIGHT: But as to where it went up to.

13 A. How far behind me the warm zone would have gone?

14 Q. Yes.

15 A. No. No, ma'am.

16 Q. And in terms of -- was there any thought or discussion

17 about where the cold zone was?

18 A. Not for me. Once I knew I had an allocated task, my

19 area that I would work in, the casualty clearing

20 station, and that's as far as I could get to -- it's --

21 it wouldn't really have made any difference to me if it

22 had gone to the bottom of Hunts Bank.

23 Q. Can we then please look at --

24 SIR JOHN SAUNDERS: I think I may have misunderstood the

25 question.

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1 MS CARTWRIGHT: I apologise, it wasn't clear.
 2 Could I look with you then, please, as to how the
 3 role of the casualty clearing officer is dealt with in
 4 NWS's major incident plan, please?
 5 Mr Lopez, it's {INQ013132/22}, please.
 6 If we could expand it to paragraph 4.6.5. We can
 7 see that casualty clearing officer is a role that has
 8 with it an action card 8?
 9 A. Yes, ma'am.
 10 Q. We will look at that in a moment. Did you have
 11 a knowledge at the time of this major incident plan in
 12 terms of how it described the role of the casualty
 13 clearing officer?
 14 A. Yes, I had knowledge of that.
 15 Q. So we can see this role is described as:
 16 "The primary responsibility of the casualty clearing
 17 officer is the management of all activities within the
 18 casualty clearing station, to include the triage and
 19 treatment of casualties in liaison with the casualty
 20 clearing station medical lead and NWS loading officer,
 21 to ensure that casualties are dispatched to hospital
 22 appropriate to their priority."
 23 Was that information within your knowledge at the
 24 time?
 25 A. Yes, ma'am.

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1 Q. So can I ask you who — were you told who the casualty
 2 clearing station medical lead was when you were
 3 allocated the role?
 4 A. No, ma'am.
 5 Q. Did you become aware of who the casualty clearing
 6 station medical lead was?
 7 A. I was aware we had doctors within — when I went into
 8 the CCS, I was aware there was doctors within there as
 9 well as two NWS personnel doing the...
 10 Q. So were you told as to who that casualty clearing
 11 station medical lead was or did there come a time when
 12 you decided in your own mind who was performing that
 13 role?
 14 A. I don't recall being told specifically, but if I had
 15 been told a name, I wouldn't have known them.
 16 Q. But who, as you progressed that night doing the role of
 17 the casualty clearing officer, was the casualty clearing
 18 station medical lead?
 19 A. I believe it was Dr Daley.
 20 Q. Dr?
 21 A. Dr Daley.
 22 Q. Thank you. Then we can see there's reference to the
 23 NWS loading officer. I think it's right that — that
 24 individual who was allocated the loading officer, was
 25 that Mr Calderbank?

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1 A. Yes.
 2 Q. Can I ask, we know that Mr Calderbank wasn't on scene at
 3 the time when you arrive, and so is it important as
 4 casualty clearing officer is set up — is that then for
 5 you to allocate the loading officer? How does that
 6 work?
 7 A. No, I don't believe it is for me to allocate a loading
 8 officer. I believe Mr Calderbank was there or
 9 thereabouts at a similar time to myself. I was outside
 10 with Dan for a period of time before I went into the
 11 station, during which time — my recollection is that
 12 Matt had already arrived and I knew he had been
 13 allocated the loading officer role.
 14 Q. We can move then back into the next aspect of the role:
 15 "The casualty clearing officer will provide regular
 16 updates to the North West Ambulance Service operational
 17 commander with regards to the numbers and status of
 18 casualties within the casualty clearing station and the
 19 numbers of casualties dispatched from the incident site
 20 to receiving hospitals. The casualty clearing officer
 21 is responsible for completing the correct documentation
 22 of patients moved from the CCS. This is done using the
 23 tear-off strip from the SMART triage cards."
 24 So we can see, I think, throughout the evening that
 25 you would liaise with Dan Smith as the operational

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1 commander?
 2 A. Yes, ma'am.
 3 Q. But did you appreciate that your key role was about the
 4 numbers and status of casualties within that casualty
 5 clearing station?
 6 A. My understanding of the role was that it was for me to
 7 be aware of those numbers and update the loading officer
 8 and the operational commander.
 9 SIR JOHN SAUNDERS: Can we just put this in real life?
 10 A. Yes.
 11 SIR JOHN SAUNDERS: So you get there. You're meant to talk
 12 to the lead doctor —
 13 A. Yes.
 14 SIR JOHN SAUNDERS: — and make sure the triaging is
 15 operating properly? And he, as the lead doctor, will
 16 say: the priorities to get to hospital are that, that,
 17 that and in this order; right?
 18 A. Yes.
 19 SIR JOHN SAUNDERS: You speak to the loading officer and you
 20 say, "These are the people to get out first, this is the
 21 order you are moving them", and you get the process
 22 going?
 23 A. Yes. It's — yes.
 24 SIR JOHN SAUNDERS: That's what that seems to say, isn't it,
 25 in practical terms?

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1 A. Yes, the bit I was unsure of was the correct
 2 documentation of patients. I would believe that would
 3 probably sit better with the loading officer with the
 4 final sense of that.
 5 SIR JOHN SAUNDERS: We will come to that in a moment. But
 6 if no one tells you who is the medical lead, which
 7 apparently you weren't told, don't you need to know
 8 that, just to get going? Or did he come over and start
 9 talking to you? How did it actually operate?
 10 A. My recollection of times within this period are -- it
 11 was all a little bit of a blur in that -- initially,
 12 when I went into the station area, I knew the two NWAS
 13 staff who were operating as triage.
 14 SIR JOHN SAUNDERS: The triage officers?
 15 A. The triage officers.
 16 SIR JOHN SAUNDERS: Yes.
 17 A. I gained some information from them. They may have told
 18 me there was a doctor within there as well. I'm not
 19 sure if at any point then we had advance paramedics
 20 coming in.
 21 My job is to assimilate that information I'm getting
 22 from them initially with being told there's a number of
 23 P1 patients, and it was -- as you correctly said, to
 24 prioritise those P1s in a particular order. So
 25 initially there was a great need to take out a number of

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1 patients as soon as possible. Once that process had
 2 happened, my understanding of the casualty clearing
 3 officer role is to kind of get a better overall
 4 management and make sure that every patient has somebody
 5 with them and that we have an idea of where we are and
 6 to try and manage.
 7 They weren't -- they weren't in a group of P1s here
 8 and P2s there; there were people everywhere.
 9 SIR JOHN SAUNDERS: They were spread around, were they?
 10 There weren't P1s here and P2s there?
 11 A. No, sir.
 12 SIR JOHN SAUNDERS: Is that because of the numbers really
 13 involved?
 14 A. I would imagine so. When I have walked into the
 15 station, there was an awful lot of people there.
 16 SIR JOHN SAUNDERS: Okay. And then as you get going, you're
 17 then updating Dan Smith on how you are going and how
 18 many you've got out and how many P1s are left? So it
 19 sounds as if the information about how the priority is
 20 getting people out is not coming out of the medical lead
 21 but is coming from the triage officers?
 22 A. Both. Both, and equally, because of the numbers
 23 involved, I was talking to staff as I'm walking round,
 24 just a very quick, "What priority patient have you
 25 got?", and if they were telling me a P1, I would ask

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1 a little more detail to try and prioritise those
 2 patients, but if the doctor came to me immediately and
 3 said, "That patient needs to go", then that patient
 4 needed to go.
 5 SIR JOHN SAUNDERS: Okay. I'm sorry, Ms Cartwright.
 6 MS CARTWRIGHT: No, that's helpful.
 7 Can I just then seek clarity as to Mr Calderbank.
 8 So Mr Calderbank, we know, makes a call at 23.28 to
 9 indicate that he's on scene and is then told to make his
 10 way up to the front of the station. So I think you
 11 mentioned you thought Mr Calderbank was already there.
 12 We know you arrive at 23.11. And it seems that
 13 Mr Calderbank hasn't actually arrived in front of the
 14 station. He's obviously making his way shortly after
 15 23.28.
 16 So can you assist us, was Mr Calderbank present when
 17 you were having the discussion with Mr Smith or did he
 18 come along later?
 19 A. My arrival at scene is -- I'm unsure whether I have
 20 pressed the button to arrive at scene or whether that's
 21 located me and tagged me to that area as an arrival
 22 time. There was obviously a brief conversation with
 23 somebody about a patient, allocation of a crew. When
 24 I made my way up, I started talking to Dan, perhaps 4 or
 25 5 minutes later, after the 11 minutes past arrival.

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1 At some time between quarter past and potentially
 2 23.35, I believe, when I might have gone into the
 3 casualty clearing area, I was aware that -- I believe at
 4 some point Matt Calderbank had arrived at some point
 5 I couldn't be specific that it was 10 past or...
 6 Q. Can I ask then, in terms of the questions the
 7 chairman has asked you, and the identification in the
 8 major incident plan that it's for the casualty clearing
 9 officer to be responsible for completing correct
 10 documentation, I think you indicated you thought that
 11 was more a role for the loading officer than yourself.
 12 A. Yes. Did it say that it was the distinction of the
 13 patients?
 14 Q. It says:
 15 "The casualty clearing officer is responsible for
 16 completing correct documentation of patients moved from
 17 the casualty clearing station. This is done using the
 18 tear-off strip from the SMART triage cards."
 19 Perhaps if we just deal with what the tear-off strip
 20 is. It's right, isn't it, that the triage cards are
 21 used to apply P1 to P3, that essentially becomes almost
 22 where the information is captured about the patient in
 23 terms of the triage assessment and their observations?
 24 A. Yes.
 25 Q. And so that would then travel with the patient to

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1 hospital when they were dispatched?
 2 A. Yes.
 3 Q. And then what was intended on the system is that when
 4 the patient is dispatched, this slip at the bottom is
 5 what's torn off, is that correct, and would be left at
 6 scene?
 7 A. Yes. Again, my understanding of that is that would be
 8 done by the loading officer so he would have a tally of
 9 where all those patients have gone. I believe there is
 10 a part on that that says about the destination.
 11 Q. Yes, so on the tear-off slip as to what would be
 12 intended to be left behind at the casualty clearing area
 13 would be the vehicle that the patient had been
 14 dispatched on, the transport time, the destination, and
 15 the priority of that patient?
 16 A. And I would have had none of those pieces of information
 17 within the casualty clearing station, but when I have
 18 allocated a patient out to the loading officer as the
 19 next patient to go, he dictates which hospital they will
 20 be travelling to, which ambulance will be taking them.
 21 So my understanding of that is that that would be
 22 the loading officer's role as he would have that
 23 information.
 24 Q. Thank you.
 25 Would it be right to say that in fact that system of

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1 tearing off the strip and leaving it at the scene as
 2 a tally as to the patients that had been dispatched, the
 3 timing of it, the name, and the priority, didn't take
 4 place on the night?
 5 A. It didn't take place by me within the casualty clearing
 6 station. I assume it was done when that information was
 7 available at the loading point where they knew which
 8 ambulance would take it, which hospital what patient
 9 would go to.
 10 Q. Just so I'm clear, so you didn't believe it was your
 11 role to complete that information and do that system as
 12 the plan would indicate?
 13 A. I would never have had that information. I wouldn't
 14 have been able to have -- I wouldn't have known which
 15 hospital a patient was travelling to.
 16 SIR JOHN SAUNDERS: Can we have the sheet back?
 17 MS CARTWRIGHT: Yes, {INQ013132/22}.
 18 SIR JOHN SAUNDERS: It does appear to give the job to the
 19 casualty clearing officer, but you are saying actually
 20 you are not in a position to do it?
 21 A. I wouldn't have been in a position to do that, sir.
 22 I was prioritising in which order they came out --
 23 SIR JOHN SAUNDERS: So perhaps it's appropriate for the
 24 loading officer to do it, not you?
 25 A. That's my understanding, yes, sir.

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1 SIR JOHN SAUNDERS: Okay.
 2 MS CARTWRIGHT: Just so in terms of your understanding, did
 3 you think that somebody was doing that system?
 4 A. Having not looked at this on the night, had I been
 5 asked, my understanding was that the loading officer who
 6 would have had access to that information -- that is the
 7 logical place for that piece of kit to have been done.
 8 As the last part before the patient goes, that
 9 information is done, and he keeps the strip to have that
 10 idea of numbers.
 11 Q. But in terms of even what you saw that night, did you
 12 see evidence of that system in operation?
 13 A. No, ma'am. I was in a different area.
 14 Q. Mr Lopez, if we could go over the page then to
 15 {INQ013132/23}. We can just see to complete the
 16 description of the role of casualty clearing officer in
 17 the plan:
 18 "In a dynamic multi-casualty incident, it may only
 19 be possible to maintain accurate details on the numbers
 20 and status of casualties who have undergone treatment
 21 and have left the scene for hospital. A best estimate
 22 may therefore be necessary for those casualties still
 23 within the casualty clearing station. The casualty
 24 clearing officer should take responsibility for liaison
 25 with the casualty clearing station medical lead, loading

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1 officer, and the NWS trauma cell to ensure the correct
 2 distribution of casualties to the most appropriate
 3 specialist units."
 4 So in terms of the latter information around liaison
 5 with the NWS trauma cell, were you aware that that was
 6 part of your role as well on the night?
 7 A. No, ma'am.
 8 Q. Are you able to assist us as to who in your
 9 understanding was performing the trauma cell role on the
 10 night?
 11 A. I had no contact with the trauma cell on the evening.
 12 Again, had I been asked before, I would have said that
 13 role would sit with the loading officer.
 14 Q. Can we then --
 15 SIR JOHN SAUNDERS: Before we do, it's worth looking perhaps
 16 at the loading officer down at 4.6.8. This may be
 17 something which needs to be looked at and perhaps
 18 amended. It doesn't say anything about the loading
 19 officer having to complete those details or indeed being
 20 in contact with the trauma cell and, as far as you are
 21 concerned, he is the logical person to be doing all
 22 that?
 23 A. Perhaps in this circumstance it was the geography that
 24 I was inside and obviously he was outside on the road,
 25 that that --

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1 SIR JOHN SAUNDERS: But if you're the loading officer and
 2 actually sending someone off to hospital, you're always
 3 going to be the person who may be in the best position
 4 to actually fill that form in, wouldn't you?
 5 A. I feel that would be true, sir, yes.
 6 MS CARTWRIGHT: If we could take that document down, please,
 7 Mr Lopez.
 8 Could we then look at the action card that was in
 9 place for the role you were given by Mr Smith. It's
 10 {INQ013422/14}.
 11 SIR JOHN SAUNDERS: While we are looking at it, or getting
 12 it up, Mr Smith suggested you had a look at it before
 13 you started. Did you?
 14 A. I believe I looked at it before I went in, sir, yes.
 15 Q. If we could please just work through the action card
 16 together, please.
 17 The first matter we have got is that:
 18 "Don high—visibility tabard inscribed 'casualty
 19 clearing officer' and protective helmet."
 20 I think in terms of protective helmet we will see an
 21 image in a moment which confirms you did have a helmet
 22 with you that night. But in terms of a tabard, is it
 23 right we don't see you at any point wearing a tabard?
 24 A. No, I had no tabard.
 25 Q. Did you make a request of anyone at scene to give you

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1 that tabard so it clearly identified the role that you
 2 were performing that night?
 3 A. No, ma'am.
 4 Q. And why didn't you?
 5 A. I didn't feel — if I'm honest, it didn't occur to me
 6 before I went in to the station area. I didn't feel it
 7 was necessary once I was in there. I knew —
 8 SIR JOHN SAUNDERS: The answer is it didn't occur to you.
 9 So a post justification may not be the best, but it
 10 never occurred to you on the evening you should be
 11 wearing one?
 12 A. It didn't occur to me before I went in I should wear
 13 one, and I wasn't aware there was a problem in being
 14 identified once I was in there, sir, no.
 15 SIR JOHN SAUNDERS: Thank you.
 16 MS CARTWRIGHT: We move then to number 2:
 17 "Check communications/radio Talk Group and start an
 18 incident log."
 19 Did you check with Mr Smith, or anyone else, what
 20 the radio Talk Group was that was being used?
 21 A. Yes, ma'am, I believe we changed to a particular Talk
 22 Group.
 23 Q. Is that the NWAS major incident channel?
 24 A. Yes, I believe it is.
 25 Q. And so did you at that time then switch on to that

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1 different radio channel?
 2 A. Yes, ma'am.
 3 Q. And we can see reference to starting an incident log.
 4 At any point did you commence an incident log?
 5 A. No, ma'am.
 6 Q. Why did you not?
 7 A. Because of the amount of work — when I went — no,
 8 there was just too much to do to stop and start writing
 9 a log, a paper version of a log. So no, no, ma'am,
 10 I didn't.
 11 Q. Can I ask then, when you switched on to the NWAS major
 12 incident channel, was it clear that it was being used by
 13 all relevant individuals?
 14 A. I was aware it was in use, ma'am, yes. I don't know how
 15 many people would have been on that channel, how many
 16 people were —
 17 SIR JOHN SAUNDERS: I think it would be quite difficult for
 18 you to answer that question, really.
 19 MS CARTWRIGHT: Next matter, please:
 20 "In liaison with the operational commander,
 21 establish an appropriate safe location for the casualty
 22 clearing station and ambulance loading point."
 23 I think you've already told us by the time you had
 24 arrived you were told by Mr Smith where the casualty
 25 clearing station was; is that correct?

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1 A. Yes, ma'am.
 2 Q. So when you did arrive, did you have any input in terms
 3 of whether or not that was an appropriate place for the
 4 casualty clearing area?
 5 A. It seemed a very appropriate place, yes. It was — it
 6 was relatively clean, dry, hard standing. It had good
 7 access. It seemed the perfect place.
 8 Q. Can I just ask, whilst we are looking at the casualty
 9 clearing station, could you just describe as to —
 10 I think we have seen reference to a casualty collection
 11 point and then a casualty clearing station. Where in
 12 your mind was the CCP?
 13 A. I wasn't aware there was a CCP, ma'am.
 14 SIR JOHN SAUNDERS: Okay. One of the benefits of having
 15 a CCP, if it was possible physically to separate them,
 16 was that when you're moving them from the CCP to the
 17 CCS, you can actually say to someone, "P1s in this area,
 18 P2s in this area", which would make loading much easier?
 19 A. Yes, sir. I believe in this many ways that's true.
 20 Patients' priorities, as I'm sure you are aware, of
 21 being P1/P2 casualties do change. Whether that would
 22 imply that they would then be moved around within the
 23 casualty clearing station, I think for — again, my
 24 understanding of that would be it would depend on the
 25 geography of an incident. And if all the patients were

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1 at the scene of an incident, and then were being
 2 specifically moved once we'd got those positions set up,
 3 yes, it's very logical to have a collection point for
 4 a triage and then a station.
 5 The scene that I saw when I walked into the station
 6 was more that's where people had stopped.
 7 SIR JOHN SAUNDERS: It wasn't something that you could do to
 8 say, "Let's put all the P1s in this bit ready to go", or
 9 was it just easier to move them out to the loading
 10 point?
 11 A. No, moving them into effectively separate areas -- at
 12 the time there were patients and people who were with
 13 them and medical staff and police. There appeared to be
 14 an awful lot of people within the station area when
 15 I went in.
 16 SIR JOHN SAUNDERS: Right.
 17 A. I was -- I'm not sure there was a space that I can
 18 recall that I could have necessarily started putting P1s
 19 in.
 20 Patients were being treated. I felt the numbers
 21 weren't excessive enough that I had no control and no
 22 idea, certainly with the help from the two NAWAS triage
 23 and the doctors that were in there, that I felt fairly
 24 quickly we'd got a good idea of who was where.
 25 The practicalities of moving them to a specific area

1 for neatness didn't seem relevant or a high priority,
 2 sir.
 3 SIR JOHN SAUNDERS: Thank you.
 4 MS CARTWRIGHT: Moving down, please. I think we've
 5 already -- we can see what we've already discussed about
 6 the gloves-off role:
 7 "Stay focused on your role. Do not attempt rescue
 8 or treatment of casualties."
 9 That was your understanding of your involvement that
 10 night?
 11 A. Yes, ma'am.
 12 Q. Then we can see the next matter identified by the action
 13 card is:
 14 "In liaison with the parking officer consider that
 15 the casualty clearing station is close to the ambulance
 16 circuit (access/egress) on hard standing, where
 17 possible, safe from hazards, making use of existing
 18 building or shelter."
 19 Did you liaise -- first of all, did you know who the
 20 parking officer was?
 21 A. I believe Derek was the parking officer.
 22 Q. That's Mr Poland?
 23 A. Yes.
 24 Q. Did you liaise with Mr Poland?
 25 A. I believe in the group where we were talking with Dan

1 and Derek and at the point where at some point Matt
 2 would have joined in, I was told the casualty
 3 clearing -- I don't recall having specific conversations
 4 in relation to those four points. But the area
 5 certainly seemed to -- with the possible exception of
 6 number 3, that certainly the other two -- the other
 7 three points were ticked by that and probably to the
 8 best of our knowledge, it's safe from hazards again,
 9 ma'am.
 10 Q. Thank you. I'm going to move down to 7 on the action
 11 card. It sets out that:
 12 "Request the appropriate medical assistance within
 13 the casualty clearing station and ensure that there is
 14 an appropriate level of healthcare professionals and
 15 equipment for the station."
 16 Specifically in terms of the equipment for the
 17 station, how did you satisfy yourself that there was
 18 sufficient healthcare equipment for the station?
 19 A. During the initial -- again, I apologise, I can't give
 20 you specific time frame, but certainly within the
 21 first -- within the first 30 minutes there were more
 22 people and more equipment coming into the station
 23 rapidly. It wasn't -- I never had a concern that we
 24 weren't -- I didn't request more people as I knew more
 25 people were coming. And everyone who came in seemed to

1 bring equipment. So we had -- I was aware we had
 2 plenty.
 3 Q. Can I ask you, in terms of the discussions you had with
 4 Mr Smith, and bearing in mind your role has
 5 a responsibility for appropriate equipment, had you
 6 asked any questions of Mr Smith about whether or not the
 7 mass casualty vehicle had been dispatched, bearing in
 8 mind you knew from before you attended the incident it
 9 was a large number of casualties and certainly from what
 10 you've described on arrival as you made your approach to
 11 the station, you witnessed that in terms of what you
 12 saw?
 13 So did you ask a question at any point as to whether
 14 or not the mass casualty vehicle had been dispatched?
 15 A. No, ma'am, I didn't.
 16 Q. Did you in give any thought that night that there might
 17 be a benefit to having that mass casualty vehicle
 18 present at the scene?
 19 A. No, ma'am.
 20 Q. We have heard evidence in the inquiry in respect of
 21 other sorts of vehicles that do also have a high volume
 22 of equipment to treat casualties. In particular, we
 23 have heard evidence of the PSUs or public support
 24 vehicles.
 25 Our understanding is that two of those vehicles were

1 brought to the scene by the Greater Manchester HART
 2 operatives.
 3 Firstly , were you aware that those vehicles were
 4 present at the scene?
 5 A. No, not at the time, ma'am, no.
 6 Q. Did you make any enquiry as to whether they should be
 7 brought to scene?
 8 A. Initially , I wasn't -- I didn't feel we were short of
 9 equipment. So no, it didn't occur to me.
 10 Logically I was aware of the equipment that HART had
 11 brought with them when they arrived. I didn't put the
 12 two together, that they'd come in a separate vehicle for
 13 that, but logically , yes, they must have done.
 14 Q. Particularly in terms of -- if I ask you about
 15 stretchers: when you were present in the casualty
 16 clearing station on arrival , we know that the dispatch
 17 of patients from within the City Room into the casualty
 18 clearing station had not completed and we're aware from
 19 the inquiry that in reality they were brought down on
 20 makeshift stretchers rather than any of the available
 21 stretcher-type equipment, whether it be stretchers,
 22 Skeds, sheets, were not used.
 23 In terms of what you saw when you arrived, did you
 24 give any thought about stretchers in terms of your role
 25 for equipment?

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1 A. I don't recall at the time I went into the station
 2 seeing people coming down the stairs. I concede people
 3 may have been coming down, certainly not in large
 4 numbers, but there was an awful lot of people already
 5 within that station area and I believe around 23.35-ish,
 6 as it would will be then, I believe most people were
 7 already down. I don't recall seeing numbers of people
 8 coming down and me being aware that we needed stretchers
 9 to transport people.
 10 Obviously -- I'm sorry -- I'm aware that people had
 11 been carried down because of what they were lying on at
 12 the time within the area.
 13 Q. And then can I ask you then as a follow-up question, not
 14 so much in terms of getting them into the casualty
 15 clearing station , but we know that the patients that
 16 were brought down were in that area, some in large
 17 (inaudible: distorted) for a number of hours. Was there
 18 any thought given by you to bring stretchers off
 19 ambulances into that casualty clearing station to so
 20 that patients could be placed on those stretchers rather
 21 than being treated or left on the floor?
 22 A. Yes, ma'am. It was what we were trying to do, to get
 23 equipment there --
 24 SIR JOHN SAUNDERS: We are talking about the trolleys,
 25 really , aren't we, off the ambulances?

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1 MS CARTWRIGHT: Yes, the ambulance stretcher trolleys.
 2 A. No, it never occurred to me to get the canvas-type
 3 stretchers to make beds. I'll be honest, that never
 4 occurred to me. Yes, sir , we were after the wheeled
 5 stretchers that you would carry on an ambulance. Not
 6 everybody could be put on to those straight away as they
 7 were being treated and, you know, various
 8 immobilisations made to make it safe for them to travel.
 9 So when we could get people in and they were able to be
 10 lifted and put on to stretchers and we had the
 11 stretchers , then that was done.
 12 SIR JOHN SAUNDERS: Is that just before departure, in
 13 reality ?
 14 A. Certainly at that end of their treatment process, sir ,
 15 absolutely , yes, because at the point where they are
 16 stable enough and --
 17 SIR JOHN SAUNDERS: They're going to be in the ambulance
 18 (overspeaking) --
 19 A. -- as soon as we can get them up, we weren't keeping
 20 hold of them, we were getting them -- once we'd got the
 21 stretcher -- it wasn't -- it was the process of getting
 22 the patients stable enough to be able to get to that
 23 point and then we could dispatch them.
 24 SIR JOHN SAUNDERS: Thank you.
 25 MS CARTWRIGHT: Can I ask in terms of identification of

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1 healthcare professionals and equipment, did you give any
 2 thought about actual pain relief medication and --
 3 A. Yes. I was aware on various occasions paramedics with
 4 patients had asked for pain relief because the
 5 higher-grade pain relief they carry would be on the
 6 vehicle they had come from and obviously they'd been
 7 separated from that.
 8 The doctors that were within that area had
 9 a different type of pain relief that we wouldn't carry
 10 normally. As soon as somebody let me know they wanted
 11 something, I would direct a doctor to them and they
 12 would give them pain relief in that way.
 13 Q. In terms of what you saw in the casualty clearing
 14 station that night, was there any issue about
 15 availability of pain relief medication from what you
 16 saw?
 17 A. No, ma'am. Other than that short delay from being asked
 18 for it and allocating a doctor to provide it .
 19 Q. Can we go back to the action card, please. We can see
 20 at action 8:
 21 "In liaison with the medical adviser, brief and
 22 manage the medical/ambulance staff in the casualty
 23 clearing station ."
 24 So we can see reference to medical adviser rather
 25 than medical lead. Who was the medical adviser in your

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1 mind that night?
 2 A. I didn't know there was one, ma'am.
 3 Q. And did you at any point brief and manage the
 4 medical/ambulance staff in the casualty clearing
 5 station?
 6 A. When staff came into the room, they were allocated to
 7 a patient if a patient didn't have anyone with them.
 8 I think to call that a brief by me would be a huge
 9 stretch of the imagination. What they've been told they
 10 actually entered the station, I don't know. It became
 11 quite an encapsulated area.
 12 Q. We move next, please, to point 9 on the action card:
 13 "Ensure that adequate protection exists. Liaise
 14 with safety officer."
 15 We know that there was no safety officer on the
 16 night allocated, but did you, when you considered the
 17 action card, ask who was the safety officer?
 18 A. No. No, ma'am, I didn't. I'm aware that in the absence
 19 of a safety officer that within the CCS the safety of
 20 everybody within that would fall under me.
 21 Q. But did you at any point go to Dan Smith and say, "Who
 22 is the safety officer?", or, "We need a safety officer
 23 because it's an important part of my role that I liaise
 24 and work with the safety officer?"
 25 A. No, ma'am, I didn't.

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1 Q. In the next bullet point, we can see:
 2 "[A] separate triage area is marked out."
 3 We've been provided with a plan of the — where the
 4 patients that were brought from the casualty clearing
 5 station — from the City Room into the casualty clearing
 6 station were positioned. I'm not going to ask for it to
 7 be displayed, but, sir, for your reference it's
 8 {INQ041266/1}. I think you have had an opportunity as
 9 part of today to consider that.
 10 Certainly in terms of where the patients had been
 11 placed, we can see that P1 patients were with P2
 12 patients and I appreciate also that a patient's status
 13 can change from a P2 to a P1. But what did you do to
 14 allocate where the P1 patients would be placed and where
 15 the P2 patients were to be?
 16 A. No patients were moved as a result of their triage
 17 grade. As I said, I didn't — I felt very quickly that
 18 between the doctors that were in there, myself, and the
 19 triage, that we had a good overview of the patients that
 20 were in there and what their categories were. They were
 21 being treated.
 22 I didn't — I didn't see the logic to physically
 23 move people and stop that process for the element of
 24 neatness. And I understand that on paper that would be
 25 a very logical system to do, but, as you can see from

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1 that particular layout, there were patients everywhere.
 2 Initially, once we'd got the poorest of those patients
 3 away, the process seemed — I felt the process that we
 4 had worked — was working. I didn't feel that we were
 5 losing track of the grading of those patients.
 6 Q. We are aware that what has been described as P3 patients
 7 were placed on the other side of the road in the walled
 8 area that almost directly opposite the Victoria Station,
 9 near to the Chetham School of Music. So was there any
 10 discussion or thought around where the P3 patients had
 11 been placed?
 12 A. I don't feel the P3 patients, once they were out of the
 13 station area, would fall under my remit. They were —
 14 I believe the area on the opposite side of the road was
 15 a reasonable distance away from the incident and a place
 16 they could — a place they could collect and then be
 17 treated there, although I didn't feel like it was within
 18 my role.
 19 Q. So whose role was it to have responsibility for the P3
 20 patients?
 21 A. Because they were in a different geographical area to
 22 where I was, I know at various points various staff had
 23 been allocated to the role of overseeing that. As
 24 operational commander, I feel that would sit with Dan to
 25 make sure that someone was there, whether that was

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1 managing the area or managing the patients.
 2 Q. We went through the description of the role of the
 3 casualty clearing officer as defined in the major
 4 incident plan, and in terms of what is envisaged as your
 5 responsibility, it's the triage and treatment of all
 6 casualties. But just so we're clear, how you operated
 7 on the night is you saw your responsibility in reality
 8 as just for the P1 and P2 patients in the station
 9 itself?
 10 A. Yes. But geographically because of the area, because
 11 the P3s weren't within that area, I was allocated the
 12 casualty clearing station of the station.
 13 SIR JOHN SAUNDERS: It is just a matter of concern as to
 14 what thought was given to the P3 patients and the reason
 15 for that is, as we've seen, and as you know better than
 16 I do, their status can change pretty rapidly, and indeed
 17 certainly in relation to one person, it did. And what
 18 provision — and they might need to be got to hospital
 19 very quickly. Did you give any thought to that? Did
 20 you think — did you know who was coping with that? Did
 21 you know what was going to happen if someone did
 22 deteriorate very quickly?
 23 A. Initially I was aware that P3 patients were on the
 24 opposite side of the road. As I had walked up, I was
 25 aware that it was happening. I had asked a member of

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1 staff, I believe in my statement, that -- to be over
2 there with them.

3 SIR JOHN SAUNDERS: So you did ensure someone was there with
4 them?

5 A. Initially, and then once allocated the casualty clearing
6 station and being within that particular area within the
7 station, they weren't within the area, so no, sir --

8 SIR JOHN SAUNDERS: But you had asked someone to go there,
9 so you were relying on them to deal with the problem if
10 someone did deteriorate?

11 A. I think that's -- initially, before I had spoken to Dan
12 on my way up with another member of staff who was coming
13 up, I was aware there was a collection of people being
14 put against (overspeaking) on the far side of the road.

15 SIR JOHN SAUNDERS: I mean, there is a concern that the P3
16 patients may not have been treated as well as they
17 should have been on that night; do you think that's
18 justified?

19 A. Yes, sir.

20 SIR JOHN SAUNDERS: Thank you.

21 MS CARTWRIGHT: You tell us in the witness statement that:
22 "Lots of casualties had been designated as priority
23 P3 or walking wounded. Some of these people appeared to
24 have penetrating shrapnel wounds and broken bones, but
25 in light of the scale of what we were faced with, this

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1 assessment of P3 status was entirely correct. At some
2 point prior to going into the station I recall asking
3 one of the EMTs called Gareth Smith to stay outside with
4 the P3 patients who were on the far side of the road to
5 the station, to stay with them and continually talk to
6 them to ensure there had been no change in anyone's
7 condition that would require more urgent medical
8 intervention and treatment."

9 So when we read your statement it does seem to
10 suggest that you did see your role as having
11 a responsibility for the P3 patients.

12 A. That is out of context. I didn't have a role at the
13 point when that happened. That was before I'd spoken to
14 Dan. That was as I was walking up to the -- from
15 recollection, that was as I was walking up Hunts Bank
16 before I'd spoken to Dan.

17 SIR JOHN SAUNDERS: My impression is that once you got into
18 the CCS, then you are focused on that and that takes all
19 your attention.

20 A. Very much, sir, yes.

21 MS CARTWRIGHT: So then just going back to a later period of
22 time, when you are established and looking after the P1s
23 and P2s, was any information fed back to you about how
24 the P3 patients were being managed?

25 A. No, ma'am.

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1 Q. We have heard some evidence also from Dr Burke about how
2 his daughter and his family were placed in that P3 area,
3 and passed straight through the casualty clearing
4 station itself without any assessment before being
5 placed there. And so did you -- were you equipped at
6 any point with information like that, that there are
7 some patients who had simply been placed in that area,
8 rather than there having been a thorough assessment
9 before they were allocated to that particular area?

10 A. The triage system or P1, P2 and P3s, as I know you're
11 all aware, is a relatively brutal and simplistic system,
12 and P3 patients who are able to mobilise allocate
13 themselves a P3 with no further checking. So if they
14 are able to walk and move, they would have been advised
15 to have kept moving to a particular area.

16 Q. Particularly, just in terms of the example I have just
17 given, we know that Dr Burke's daughter wasn't able to
18 walk, she was carried into that area.

19 A. I don't recall any specific -- I don't recall any
20 interactions with patients for me to designate them as
21 a P3. I don't recall witnessing that happening. But
22 no, my understanding of the triage system is that they
23 are supposed to be able to self-mobilise. They need to
24 be walking rather than being physically moved by
25 somebody else.

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1 Q. Mr Lopez, if we could display again please, the action
2 card. I'm, sir, going to finish the number 9 and then
3 I suggest we take the morning break.
4 We can see:
5 "Ensure that transportation needs are prioritised."
6 I think you understand that that fell within your
7 role?

8 A. Yes. I was inside a building. I didn't have any --
9 that to me would fall within -- within the loading
10 officer's role because I was physically within
11 a building. So transportation fits with the parking
12 officer to make sure there's enough there and the
13 loading officer to make sure there are specific vehicles
14 available. That is how I feel it would have worked
15 better in this particular scenario. There were no
16 vehicles obviously accessed inside.

17 Q. I think we've already discussed to some extent the final
18 bullet point for 9:
19 "Records/patient ID are kept on patient movements.
20 Casualty clearing log by the loading officer."
21 Is this where you are saying you understood it was
22 more for the loading officer, Mr Calderbank, than for
23 you to keep the records?

24 A. Yes, ma'am.
25 Just going back to your previous point,

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1 transportation needs are prioritised , if that is the
 2 priority , the patients needing transportation, then yes,
 3 that very much sits within the role that I was doing.
 4 But physically sorting out which ambulance would take
 5 them I feel would sit with the loading officer .
 6 Q. Can I ask then in terms of that, what you were seeing of
 7 the P1 and P2 patients, how were you then identifying
 8 who had to be the next to get out, to get on to an
 9 ambulance? How did that operate in practice?
 10 A. That came in combination with talking to the doctors
 11 that were in there, the two NWS triage officers, and
 12 myself talking to ambulance staff as I'm walking round
 13 who tell me they've got a P1 patient. A quick detail of
 14 the patient's observations prioritises which ones become
 15 a higher priority P1. Not --
 16 SIR JOHN SAUNDERS: Is that the end of the action card?
 17 MS CARTWRIGHT: It's not, sir. It's whether you want me to
 18 continue to complete the action card and then take the
 19 break. But I'm conscious there are a number of bullet
 20 points.
 21 I think having performed this exercise, it should
 22 shorten the rest of the evidence of this witness, but
 23 I'm wondering if we take a short break now and then we
 24 continue just to complete the card.
 25 SIR JOHN SAUNDERS: Okay. Quarter of an hour?

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1 MS CARTWRIGHT: Thank you.
 2 (11.33 am)
 3 (A short break)
 4 (11.49 am)
 5 MS CARTWRIGHT: Mr Lopez, could we have back on the screen,
 6 please, {INQ013422/14}. Thank you.
 7 Mr Birchenough, we can see on the action card at
 8 point 10 reference to the primary triage officer and
 9 turning over the page {INQ013422/15}, please, Mr Lopez,
 10 the need to appoint a secondary triage officer to
 11 coordinate the triage sort and re--triage each patient
 12 every 15 minutes within the casualty clearing station.
 13 I think it's right by the time you had arrived, is
 14 it correct, that the triage officers had already been
 15 appointed?
 16 A. Yes, ma'am.
 17 Q. And they were Helen Mottram and Jo Hedges who the
 18 inquiry has already heard from?
 19 A. Yes, ma'am.
 20 Q. So did you identify who was the primary triage officer
 21 and who was the secondary triage officer between the two
 22 of them?
 23 A. I believe Jo Hedges was primary, Helen was secondary.
 24 Q. In terms of what was taking place within the casualty
 25 clearing station, was there a re--triage of those

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1 patients every 15 minutes?
 2 A. By the point I went in, many had paramedics or medics
 3 with them. It was an ongoing process. I couldn't say
 4 it was a diligent every 15 minutes as I walked round,
 5 but it seemed to be more of an ongoing process while
 6 treatment was in place.
 7 Q. Did you, once you went into the casualty clearing
 8 station, establish from Joanne Hedges and Helen Mottram
 9 the number of casualties that were in the casualty
 10 clearing station at that time?
 11 A. Yes, ma'am.
 12 Q. Then if we could go back to the action card, please, we
 13 can see at point 13 a topic we've already covered in
 14 terms of the available medical supplies. But we see
 15 specific reference at point 13 to:
 16 "Ensure medical supplies are available from the
 17 incident support units and from the mass casualty
 18 vehicle ... "
 19 So when you reviewed the action cards that night,
 20 did that not flag the need to query where those vehicles
 21 were?
 22 A. The action card I looked at before I went in to the
 23 station -- I didn't re--refer to the action card
 24 throughout the night. I wasn't -- I didn't feel there
 25 was any equipment shortage other than towards the end we

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1 were starting to get low with oxygen and, obviously as
 2 you mentioned before, the request for pain relief .
 3 Q. Moving down to point 14, again we've already addressed
 4 the categorisation of areas.
 5 SIR JOHN SAUNDERS: Sorry, an equipment officer? Did you
 6 allocate an equipment officer?
 7 A. No, sir.
 8 SIR JOHN SAUNDERS: I'm just asking that because in the
 9 feedback one of the HART teams which came from
 10 a different area, he did actually indicate that there
 11 were shortages of two particular things. I just wonder
 12 whether if you've got an equipment officer, then he or
 13 she can actually be going round and just checking that
 14 they've got everything, whereas you're doing lots of
 15 other things as well.
 16 A. I wouldn't disagree with that statement, sir .
 17 SIR JOHN SAUNDERS: Thank you.
 18 MS CARTWRIGHT: Look at point 14 then. We've already
 19 discussed about the separate areas for the P1, P2 and P3
 20 patients. The action plan indicates that it should have
 21 clear red, yellow, green and a different zone for those
 22 deceased. But how would you effect a red, yellow and
 23 green area? Would something be placed down or would it
 24 be how the area was described if it was capable of
 25 separating off the patients?

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1 A. I wouldn't have had any ability to — if I'd have
 2 separated the patients to have designated colour zones
 3 to those particular areas. I believe some of the
 4 incident vehicles may carry that. I think HART carry
 5 that.
 6 Q. I was going to ask, we've heard evidence from the HART
 7 team leader about placing a tarpaulin on the ground
 8 outside of the station. Did you see that?
 9 A. Yes, ma'am.
 10 Q. And bearing in mind your responsibility for the
 11 operation of the casualty clearing station, what was
 12 your understanding about what was operating there and
 13 how that fitted between your responsibilities?
 14 A. That — I don't — I couldn't tell you the time that
 15 that happened. That felt to me like it was becoming
 16 part of the casualty clearing area and we actually
 17 developed a system whereby, as we discussed before, we
 18 were unable to separate P1s, P2s and P3s there, but as
 19 we'd prioritised inside, we then effectively decanted
 20 patients from inside to those particular areas where
 21 they could continue their treatment being before loaded
 22 and put on to an ambulance, so it facilitated that role
 23 of the separation, as you describe it.
 24 Q. But in terms of that being set up and how it was
 25 separating, that sounds like it was something that was

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1 operating quite separate to what you were doing inside?
 2 A. It was separate, it was independent, but it was
 3 literally outside the doors. It was a few feet away
 4 from where I was.
 5 SIR JOHN SAUNDERS: Was it just being operated by a HART
 6 team?
 7 A. My liaison was with one of the HART operatives. To be
 8 honest, if there were doctors allocated to that area,
 9 I don't know.
 10 SIR JOHN SAUNDERS: How much use was it?
 11 A. I felt it was brilliant.
 12 SIR JOHN SAUNDERS: Right, okay.
 13 A. Because it did allow us to — initially, when I'm being
 14 told we have a number of patients who need to
 15 immediately, my job is to try and facilitate that,
 16 obviously in liaison with the loading officer, to get
 17 that number of stretchers and that number of vehicles
 18 available. So I tell him what I need, he provides it,
 19 we do that.
 20 What that particular area helps me do was I could
 21 ask them how much space they had, if they had room for
 22 another two or three P1s, whatever it may be. I didn't
 23 have to wait for a vehicle for available, I could decant
 24 them straight from that.
 25 SIR JOHN SAUNDERS: So it's a sort of staging point from the

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1 CCS to getting on the ambulances?
 2 A. That's better wording than mine. They also have a sort
 3 of a mass casualty oxygen system, which obviously, as it
 4 became later on, we were becoming a bit short of that,
 5 and I felt the system that we adopted worked well.
 6 SIR JOHN SAUNDERS: Thank you.
 7 MS CARTWRIGHT: Point 15, please, Mr Lopez. We can see
 8 there, Mr Birchenough:
 9 "As patients arrive from the forward incident site
 10 to the casualty clearing station, ensure that they have
 11 been triage sieved and have a triage label attached to
 12 them."
 13 We know that a number of the patients that came down
 14 from the City Room did not have triage labels attached
 15 to them, and so were you aware of that?
 16 A. No. No, ma'am. As the majority of patients, if not
 17 almost all of the patients, were already within the
 18 station as I arrived and had medics and were being
 19 re-triaged. So no, I wasn't aware that some didn't have
 20 labels, ma'am, no.
 21 Q. So then for the later time, for the time when the
 22 patients were in the casualty clearing station to their
 23 time of being dispatched to the hospital, there's been
 24 some information provided that for some patients there
 25 wasn't a triage card. Some paramedics had used the

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1 patient report form rather than the action card — the
 2 triage card, sorry, not action card.
 3 Were you aware of different documentation being
 4 completed by different paramedics who were treating the
 5 casualties?
 6 A. I don't recall being aware there was — I know — at
 7 that point everyone should have been getting a patient
 8 report form. By the time they had an individual medic
 9 looking after them, they should have all been — whilst
 10 we were treating them if they had the opportunity,
 11 those — the triage cards work well obviously for mass
 12 casualties, but they're a slightly more prolonged
 13 treatment which — they were having to be made safe and
 14 able to be transported, when people could do a PRF,
 15 I felt that was better.
 16 Q. Just in terms of the system, were the patients then,
 17 once they were in the casualty clearing station, as well
 18 as the triage card itself, also had a separate patient
 19 report forms during the time that they were in the
 20 casualty clearing station?
 21 A. I would imagine that was true, ma'am, yes.
 22 Q. I'm not asking you to imagine. I want, bearing in mind
 23 you had a responsibility for this area, to understand
 24 what in fact was taking place and what the system was.
 25 A. I don't recall. I can't recall a specific incident that

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1 they would have had both.

2 Q. And so you mentioned about the use of patient report

3 forms. So what was — what did you witness about how

4 that was being used?

5 A. If — once every patient had somebody with them, and

6 they are treating the patient, they have to, you know,

7 log as much detail on that as to the treatment they have

8 given and the injuries from the patient, etc. I was

9 aware patient report forms were being used.

10 Q. Mr Birchenough, I'm not going to go through each of the

11 final matters on the action card, but to summarise we

12 can see that as well as the tasks we have already been

13 through, there is the need within the role for:

14 "Effective handover of patients to the loading

15 officer for allocation of transportation to hospital."

16 But also:

17 "Ensuring the correct distribution of casualties to

18 appropriate treatment centres."

19 In terms of a correct distribution of casualties to

20 hospitals, I think in fact you did become involved in

21 a discussion, or you were privy to a discussion,

22 Mr Smith had with Annemarie Rooney; is that correct?

23 A. Before entering the CCS, yes, we were — for the

24 confirmation of the mass casualty plan numbers.

25 Q. Can we then move to look at that, please,

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1 Mr Birchenough.

2 Sir, I don't — unless there's anything else on the

3 action card, I'm going to move on to that now.

4 Mr Lopez, could I ask — perhaps before I put this

5 image on the screen, this is an image from just within

6 the doorway of the station itself. There are no

7 casualties that can be seen, but I just want to indicate

8 that I'm about to display a still on the screen timed

9 from 23.37.54 in case anyone who is observing or present

10 in court wishes to withdraw just while we deal with this

11 short topic, and I envisage this will take no more than

12 10 minutes.

13 Mr Lopez, just whilst we give a moment for those to

14 decide whether they wish to withdraw, could we have

15 displayed {INQ035632/60}. Could I ask now for that

16 image to be displayed.

17 Mr Birchenough, is it correct that we can see

18 Dan Smith with his tabard, checkered tabard, with his

19 back effectively to the — on the still and next to

20 that, is that you with the — what's described as the

21 lopsided hat?

22 A. That's correct.

23 Q. And we can see that this image is timed at 23.37.54. We

24 can see that reference to:

25 "Dr Daley talking to another NAWAS employee believed

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1 to be James Birchenough."

2 I think in fact we can see it's Mr Smith that you're

3 stood with at that time?

4 A. I'm facing, yes, Mr Smith.

5 Q. Thank you. So is this image that we see at 23.37 is the

6 first time that you've entered into the station itself?

7 A. Yes, ma'am, I believe it is.

8 Q. We have a log of a call. It's not a call directly

9 involving you, but we know that at 23.35.42 — and, sir,

10 just for your records, the transcript of that call from

11 Mr Smith to Annemarie Rooney is {INQ034302/1}. I'm not

12 going to be asked for the call to be played or the

13 transcript to be displayed.

14 At 23.34.41, first of all, on that call log the

15 tactical commander, Ms Rooney, and the operational

16 commander, Mr Smith, had a discussion about the number

17 of patients and within that call it described that there

18 was a large number of patients. There was a scene

19 outside with another large number of patients, and the

20 current estimate is around 40 P1 patients, 40 P1

21 patients and multiple walking wounded, that there was

22 a discussion about having to start moving them as there

23 was some very critical on scene, and also — and

24 Mr Smith was asking for confirmation from

25 Annemarie Rooney that the major incident plan, in terms

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1 of mass casualty, was up and ready, and was requesting

2 from her that — to read out to him the...

3 "... so that the casualty clearing officer can hear

4 and then he can start allocating casualties to

5 hospitals", he says.

6 So do you recall being alongside Mr Smith, bearing

7 in mind that there's reference to casualties and you

8 being present as the casualty clearing officer,

9 overhearing that conversation?

10 A. I remember the conversation, not in detail, ma'am, but

11 yes, I do remember the conversation.

12 Q. So we can see you on the image a little after that time,

13 23.37. Was that conversation also taking place in the

14 station itself or was it just outside the station?

15 A. My recollection is it was outside of the station.

16 Q. And just then to follow up as to the timings that were

17 discussed, I think Annemarie Rooney wasn't able to give

18 Mr Smith the immediate information about the hospitals,

19 but at 23.35.42, again there was a discussion between

20 Annemarie Rooney and Dan Smith where again Mr Smith

21 confirms:

22 "Sorry, just the mass casualty numbers, you know,

23 the mass casualty plan for Greater Manchester. Just the

24 numbers for each hospital. I've got the casualty

25 clearing officer with me here. He will note them down

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1 and then we will start allocating hospitals.”
 2 Then just to complete the timings, again
 3 Annemarie Rooney contacts Mr Smith at a later time,
 4 slightly after that, at 23.39.27, and is then able to
 5 give the details of the hospitals and the number of
 6 casualties to hospital, and so again for your reference,
 7 I’m not going to ask for it to be displayed, it’s
 8 {INQ034333/1}.

9 So can I just ask you then about the allocation of
 10 casualties to hospital? Were you aware of the
 11 casualty — about the position about casualty
 12 distribution to hospital?

13 A. I was aware of the mass casualty plan, yes.

14 Q. In terms of the hospitals where patients were to be
 15 allocated, was it right that the plan itself was in
 16 draft at the time or was it your understanding it was
 17 a completed plan?

18 A. I know it was relatively new. I couldn’t say whether
 19 I knew it was only a draft or whether it had been — but
 20 I knew it was very new.

21 Q. Had you seen that mass casualty plan?

22 A. Yes, I had seen a copy of it.

23 Q. But in terms of the document itself, that actually
 24 allocates the hospitals that can receive the P1
 25 patients, the P2, and the P3, as well as the numbers,

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1 doesn’t it?

2 A. Yes, in my understanding it’s a sort of pre-agreed
 3 capability of each hospital and what they would be able
 4 to take in in the event of a major incident, and that
 5 certain hospitals are capable or are in a much better
 6 position to take the very poorest of patients.

7 And it’s a designation of their sort of pre-agreed
 8 numbers that they are — they have agreed they would be
 9 able to take.

10 Q. So can you assist as to why it needed confirmation from
 11 Annemarie Rooney about the numbers of casualties to go
 12 to which hospital?

13 A. I would be surmising that whilst it’s a pre-agreed plan,
 14 should there be a particular incident going on within
 15 a hospital that we weren’t aware of, that that may
 16 affect the numbers, whether that’s volume or, you know,
 17 should there have been a loss of —

18 SIR JOHN SAUNDERS: But you wouldn’t have had a copy of this
 19 plan with you, would you?

20 A. No, absolutely not.

21 SIR JOHN SAUNDERS: So it may be it has to be a phone call
 22 to find out what the numbers are on the plan, and as you
 23 say, it may be that a preliminary call is necessary to
 24 make sure that people are actually in a position to do
 25 what they’ve signed up for?

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1 A. Yes.

2 MS CARTWRIGHT: We know that when the information is given
 3 as to the hospitals where patients can be dispatched to,
 4 it’s at 23.39, so an hour after the bomb had been
 5 detonated. So would you not have expected it to have
 6 been well known before that time as to which hospitals
 7 could receive the P1, P2 and P3 patients?

8 A. I believe in principle that would have been known, but
 9 it seems reasonable that they would have confirmed that
 10 with each hospital to make sure they haven’t got power
 11 failures or any other reasons that may affect them from
 12 taking —

13 SIR JOHN SAUNDERS: I think the point is being made is:
 14 wouldn’t you expect that check to have been done rather
 15 earlier?

16 A. I don’t feel I am in a position to — I don’t know how
 17 long that would take from after a major incident was
 18 declared, how far down the list of action cards that
 19 would be.

20 MS CARTWRIGHT: From what you understood from when you
 21 arrived at the scene and the discussions you were
 22 having, with Mr Smith in close proximity, with
 23 Annemarie Rooney over the Airwaves, had the absence of
 24 that information at that point delayed the
 25 transportation of the patients to hospital?

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1 A. I believe patients had already been transported to
 2 hospital before that conversation, so I would say no.

3 Q. Can you assist then as to you then knowing at 23.39 the
 4 hospitals the patients could go to, did you write down
 5 that information?

6 A. I did write down that information, yes.

7 Q. And I think you indicate you then provided those numbers
 8 and the hospitals for each of the various patient
 9 categorisations to Mr Calderbank; is that right?

10 A. Yes, ma’am.

11 Q. So at this stage now we know from the plan that has been
 12 provided, and again I’m not going to display it, which
 13 is {INQ041266/1}, as to where the various casualties
 14 were and where they were located.

15 We know that by 23.39, when the information is
 16 provided Annemarie Rooney as to hospitals, patients 1 to
 17 34, who have been identified to that map, were down in
 18 the casualty clearing station, and then a further four
 19 patients were brought down after that time.

20 But we also know from the timings as to when the
 21 patients were dispatched to hospital, a large number of
 22 patients were waiting a lengthy period of time before
 23 dispatch to hospital. And certainly it looks that in
 24 terms of those P1 and P2 patients, only one patient was
 25 dispatched to hospital before midnight, at 23.42.

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1 Between midnight and 1 o'clock in the morning, a further
 2 12 patients were dispatched. Between 1 and 2 in the
 3 morning, a further 11. But it was after 2 am before 14
 4 of those patients were dispatched to hospital.
 5 So can you assist us as to what was delaying the
 6 transportation of the patients to hospital?
 7 A. A combination of resources, of treatment for those
 8 patients. I'm not sure at the time that the detail
 9 about the casualty plan came through we -- I don't know
 10 how much resource we had on scene, whether we had enough
 11 people initially for every patient, so initially they
 12 were involved in treatment rather than transportation.
 13 Some of the treatments that patients got were quite
 14 extensive to make them stable enough to be transported.
 15 A combination of reasons, I would imagine, as to why
 16 there would be -- I don't recall -- I don't recall
 17 a specific reason that caused a delay of those -- of any
 18 patient being transferred.
 19 Q. Can I ask then about the P3 patients, just to complete
 20 about their transportation to hospital. Were you
 21 involved at all in the request and the attendance of the
 22 buses that were then brought to scene to take them to
 23 hospital?
 24 A. No, ma'am.
 25 Q. So can you provide any assistance as to the

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1 decision-making around that?
 2 A. No, ma'am.
 3 Q. At any point was there any discussion with Mr Smith --
 4 no, actually, I'll leave that there. You have answered
 5 that.
 6 Can I ask you about your knowledge of the forward
 7 command point when you went into the station? Did you
 8 look or ask Mr Smith about where the forward command
 9 point was?
 10 A. No. No, I didn't.
 11 Q. Did you understand what a forward command point was?
 12 A. Yes.
 13 Q. And the benefit of a forward command post where the
 14 three tri commanders would locate, co-locate?
 15 A. Yes, ma'am.
 16 Q. Did you see any evidence of presence of the Fire Service
 17 when you were at the scene?
 18 A. I don't recall being aware or being conscious that there
 19 weren't Fire Service at scene until -- I think the first
 20 fire people I saw were bringing stretchers into the
 21 casualty clearing station, but I couldn't tell you what
 22 time that was.
 23 Q. Would it be fair to say that that would be at a later
 24 time?
 25 A. It was after I had gone into the casualty clearing

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1 station, yes.
 2 Q. But did you not at any point have a discussion with
 3 Mr Smith, or anyone else, about the benefit and the
 4 assistance that the Fire Service could provide by way of
 5 their role and their knowledge as well in respect of
 6 trauma training, but also in helping move the patients?
 7 A. (Inaudible: distorted) have a conversation with Mr Smith
 8 regarding that.
 9 Q. And can I ask as well, just to understand information
 10 that you may have captured as you went into the
 11 situation that night, did Mr Smith give you any
 12 information about who had actually, by way of the NWAS
 13 personnel, been deployed into the City Room and operated
 14 in there?
 15 A. I believe I knew Paddy was there.
 16 Q. Did you get any other information about who else had
 17 been working in that area?
 18 A. I don't recall any information being given to me about
 19 that, no.
 20 Q. You tell us in the witness statement that you got to the
 21 point where you had cleared all the P1 and P2 patients
 22 and you were constantly feeding information to various
 23 people, including Francis Dreniw, who is one of the
 24 senior managers?
 25 A. Yes, I was aware he was at scene some time later.

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1 Q. And what role was Francis Dreniw carrying out at the
 2 scene?
 3 A. I'm not aware he had a specific role allocated to him.
 4 Q. You indicate that:
 5 "[You] wanted to start standing crews down, but
 6 realised we had split crews up during the course of the
 7 night and people were on vehicles assigned to different
 8 locations than their home stations, and that there was
 9 a massive amount of kit and equipment that needed to be
 10 repatriated to the right vehicles and crews."
 11 So I alluded to this very early on in your evidence
 12 about the allocation of ambulance staff to particular
 13 radios and the vehicles. Could you assist us as to what
 14 that issue was that you're describing in the witness
 15 statement around split crews, please?
 16 A. Yes, just going back to the start of what you said,
 17 I believe a conversation that I had with Francis Dreniw
 18 was he asked could we start standing any crews down to
 19 which the reply was I believe we have split some crews
 20 and that they are separated from the vehicles and that
 21 might not be physically possible but beneficial to stand
 22 a crew down, bearing in mind they're not a complete
 23 unit.
 24 Could you repeat the final part of your question,
 25 sorry?

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1 Q. I'm asking if you can explain -- there's reference to
 2 split crews and I wanted to just to understand about
 3 the -- how that impacts upon them and their radios.
 4 A. So at the start of a shift an ambulance would have
 5 a particular call sign, will have two handsets with it.
 6 A single-manned vehicle such as the RRV that I would
 7 have been on would have one handset.
 8 Those handsets are related to that's vehicle
 9 specifically. Every member of crew on that vehicle
 10 would then have their own handset that relates to that
 11 vehicle. So consequently they would all be under the
 12 same call sign as the vehicle. So both crew and that
 13 ambulance would have that call sign and they would
 14 answer that.
 15 One of the things I had become aware of was that
 16 because we didn't have an infinite amount of resource,
 17 we were sometimes sending a paramedic with a patient on
 18 a vehicle that may have a driver from somewhere else and
 19 how that situation had snowballed in so much as we had
 20 many crew who weren't with their crew mate and weren't
 21 with the necessary vehicle. I couldn't give you
 22 specific numbers, but I was just aware that that was an
 23 issue.
 24 At the point where we had the conversation with
 25 Francis Dreniw about standing crews down, I was

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1 conscious that wasn't very feasible because everybody
 2 was mixed up and actually at some point we needed to get
 3 everybody back together and move crews back to their
 4 relevant vehicles --
 5 SIR JOHN SAUNDERS: I think at the end Steve Hynes, having
 6 a made a speech, said you would be sorting it all out.
 7 A. That's how I recall.
 8 SIR JOHN SAUNDERS: I don't think I need a huge amount of
 9 detail about this. Thank you.
 10 MS CARTWRIGHT: Can I ask another question, please, in terms
 11 of whether your role changed with Mr Hynes taking on the
 12 role of the operational commander. I don't think we
 13 need to display the image, but there is an image where
 14 we can see, captured shortly after Mr Hynes took on the
 15 role of operational commander from Dan Smith, an image
 16 at 00.20. Sir, again for your records it is
 17 {INQ035612/445}.
 18 Within Mr Hynes' log itself, and again, sir, I'm not
 19 going to ask for it to be displayed, it's {INQ014785/2},
 20 he, within the role allocation list in his notes and his
 21 book, identifies that you were performing the role of
 22 the ambulance loading officer and has recorded that the
 23 casualty clearing officer was Daniel Smith.
 24 So did there come a time when you were allocated
 25 a new role?

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1 A. Not to my knowledge, ma'am, no. I was allocated
 2 casualty clearing officer from Dan Smith and maintained
 3 that role until the casualty clearing area was cleared.
 4 Q. Just to complete that topic, Mr Hynes, when he was
 5 operational commander, didn't task you in a different
 6 way to perform the role differently?
 7 A. No, ma'am.
 8 Q. Thank you.
 9 You tell us within your witness statement two
 10 further matters, out of fairness to you, to complete the
 11 matters I want to ask you about to complete your
 12 involvement on the night, that what you experienced that
 13 night was a dynamic and stressful situation with some
 14 very poorly patients. You witnessed genuine care being
 15 administered, not just emergency trauma treatment. And
 16 you indicate that what you saw was staff ensuring people
 17 were reassured, as comfortable as possible, taking the
 18 time to talk to them and reduce their anxiety as well as
 19 administer life-saving treatments, dressings and drugs.
 20 A. Yes, ma'am. I should say not just NWAS staff, but the
 21 police that were in there and other staff that were in
 22 there, yes, genuine care.
 23 Q. You also have set out within your witness statement that
 24 your assessment was that:
 25 "We are well trained and had good plans in place,

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1 but unfortunately we are not well experienced with this
 2 type of event. There's always the feeling after the
 3 event of should I have done something different, could
 4 we have done better, and this is right to be able to
 5 improve. But I have to say I'm immensely proud of how
 6 we as a service and others as individuals responded and
 7 dealt with this incident."
 8 A. Yes, ma'am.
 9 Q. Mr Birchenough, I'm going to next move then, because you
 10 do set out in your witness statement other things that
 11 you did, but those are the topics I want to cover,
 12 and I would like to finally move with you just to look
 13 at the feedback that you gave as part of the debrief
 14 process that took place on 15 June 2017, where you have
 15 identified matters that perhaps are of assistance to the
 16 inquiry, particularly with your unique perspective of
 17 having carried out a functional role at the scene that
 18 night.
 19 So, Mr Lopez, please could we first of all display
 20 {INQ022370/75}. So this is the first of two forms that
 21 you completed as part of that debrief; is that is
 22 correct?
 23 A. Yes, ma'am.
 24 Q. And this debrief is specifically looking at how well
 25 prepared you were for the incident. So I just want to

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1 work through the feedback you provided and see if you
 2 can assist, please.
 3 Under "command and control" we can see:
 4 "Control did not know I was on shift. No
 5 communication between HCD [healthcare desk] and EOC.
 6 Lucky Paddy/Dan/me available on shift. Derek..."
 7 Is that Derek Cartwright?
 8 A. Derek Poland.
 9 Q. "Derek and Matt Calderbank quick to respond."
 10 So what was the matter you were seeking to flag
 11 there in identifying that?
 12 A. As managers, we have a computer system that we would log
 13 on and put our finish time, call sign, phone number, etc
 14 into that so it's available to everybody.
 15 I would have signed on to that at 1 o'clock-ish,
 16 whenever I had started my shift, and I had put in that
 17 that I was due to finish at 22.00. I think the fact
 18 that I was still on shift, I may well -- I wasn't
 19 physically signed on to a vehicle, although I had the
 20 use of Romeo 310 because I was on a different command
 21 channel, and potentially I don't know how long they stay
 22 on at the end of your shift, but I should have finished
 23 at 22.00.
 24 SIR JOHN SAUNDERS: But the point you are making isn't it,
 25 is, "I was still on duty, I hadn't signed off, so

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1 somebody should have known that, and they should have
 2 been able to contact me"; is that right?
 3 A. Yes, sir.
 4 SIR JOHN SAUNDERS: And they didn't appear to know that?
 5 A. No, and that's uniquely to the fact that I was in an
 6 acting-up role and wasn't signed on. So had I logged on
 7 to a vehicle like an ambulance --
 8 SIR JOHN SAUNDERS: There may be an excuse for it, but the
 9 reality is you are a manager on duty still who was
 10 available and they didn't know that?
 11 A. Yes, sir.
 12 MS CARTWRIGHT: Moving next to safety, you highlighted:
 13 "Lack of kit for me. No major incident kit in
 14 manager's car, etc."
 15 Again, what were you highlighting as part of the
 16 debrief on safety there, please?
 17 A. There are particular parts of the kit that we get, the
 18 bit I was specifically getting at there was something
 19 like a dictaphone or some way of recording what was
 20 going on, ideally the body-worn cameras that the police
 21 have would be much more efficient and at the time I
 22 didn't have anything like that. I was aware I wasn't
 23 able to write anything, and had I been able to record
 24 something, that would probably been helpful.
 25 SIR JOHN SAUNDERS: You're supposed to start an incident log

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1 and you've got nothing to do it with?
 2 A. Yes, sir.
 3 MS CARTWRIGHT: Moving --
 4 SIR JOHN SAUNDERS: Has that changed now? Has that changed?
 5 A. Personally for me, sir, yes.
 6 SIR JOHN SAUNDERS: Okay.
 7 MS CARTWRIGHT: Under "communication" you have recorded:
 8 "Slow to set up MI channel. No pre-warnings
 9 over..."
 10 And what has been redacted, I think, is the GM
 11 managers' channel that we discussed earlier.
 12 A. I wasn't aware -- I didn't hear that a general message
 13 had gone out on the open managers' channel that we would
 14 have listened in to to say there was a major incident.
 15 I wasn't told that a major incident channel had been set
 16 up until later on when I was talking to Mr Smith.
 17 Yes, I didn't know it was a major incident until
 18 I arrived on scene and saw Mr Smith and had a message
 19 gone out over the open channel, I think I would have
 20 known more before I went.
 21 SIR JOHN SAUNDERS: And you would have had -- as you have
 22 already told us, you would have had a much better
 23 assessment of the scene and what was going on?
 24 A. Yes, sir.
 25 MS CARTWRIGHT: In terms of the major incident plan we

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1 looked at, the NAWA major incident plan, that actually
 2 envisages that once any vehicle is allocated to the
 3 major incident, that each allocated vehicle moves on to
 4 that major incident channel. So that would include the
 5 HART operatives?
 6 A. They have a separate channel as well, but yes, one of
 7 them, the team leader, I believe, would have a second
 8 radio --
 9 SIR JOHN SAUNDERS: That is not what we have actually heard.
 10 MS CARTWRIGHT: That's what I'm seeking to canvas, bearing
 11 in mind the policy itself says that all allocated
 12 vehicles should move on to the major incident channel.
 13 SIR JOHN SAUNDERS: I think we have heard now that it
 14 changed and they have two radios on a HART vehicle. But
 15 at the time they, as far as I knew, were on the HART
 16 channel and stayed on it.
 17 MS CARTWRIGHT: In terms of then assessment, we have got:
 18 "Good. Improved with communication on scene."
 19 A. Yes, I felt the assessment of patients was good and by
 20 the time I got into the CCS and was able to physically
 21 talk to people and witness for myself what was going on
 22 and ask people, yes, I felt the communication within
 23 that area was good. It was face-to-face communication,
 24 I have to say. It was not over a radio.
 25 SIR JOHN SAUNDERS: Is that what that means, assessment of

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1 patients? It just says "assessment".
 2 A. I believe that's what I have taken that to mean, the --
 3 I'm not sure if that was what was intended in the
 4 question, but that's not --
 5 SIR JOHN SAUNDERS: It's not immediately clear to me,
 6 reading the form.
 7 A. My response to that is to do with the assessment.
 8 I felt it was good and when we had face-to-face
 9 communications between us, I felt it improved.
 10 SIR JOHN SAUNDERS: Thank you.
 11 MS CARTWRIGHT: Over the page, {INQ022370/76}, please,
 12 Mr Lopez. Under "Resources" again, you have identified:
 13 "No [major incident] kit."
 14 But you do highlight that you're happy with
 15 training, Bronze, JESIP?
 16 A. Yes, ma'am.
 17 Q. "Triage not trained enough (general staff)."
 18 And then you identify that HART were excellent.
 19 So what further detail can you give us about the
 20 insufficient training for general staff triage?
 21 A. I don't imagine there's many road staff who don't --
 22 wouldn't like more training of every type. General road
 23 staff, and that to a certain degree includes some of the
 24 managers, are not -- we don't practise. We're not
 25 trained enough. We don't have time to do that sort of

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1 training.
 2 The HART team, which I had limited experience of at
 3 the time, I obviously work with them far more now, have
 4 specific training days and are very much more
 5 experienced in this and I felt at the time their general
 6 expertise in this situation was excellent and ours was
 7 good enough, but we could have been slicker because
 8 of --
 9 SIR JOHN SAUNDERS: Again, what the HART experts have said
 10 to us or the HART team said to us yesterday was because
 11 they deal with it in major incidents, that's what they
 12 do, they're trained, and they do the training for it,
 13 they can do it much more quickly, and in some ways much
 14 more brutally but more effectively because they are
 15 concentrating on speed and getting round people and
 16 getting people to hospital as soon as possible. Is that
 17 what you mean?
 18 A. Yes. The process of triage, as you said, is brutal.
 19 It's -- it doesn't take into account an awful lot of
 20 things. It is a very brutal process and, I have to say,
 21 it goes against every ethos of being a paramedic and of
 22 care. And that, I believe, stands for the managers when
 23 you are sort of making a conscious effort not to put
 24 gloves on to deal with a patient. That's kind of what
 25 we do and not to do that is difficult.

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1 MS CARTWRIGHT: You have identified that treatment was good,
 2 but then for transport you set out:
 3 "Standard response vehicle [and that's the vehicle
 4 you were driving], no major incident kit. First DMAs
 5 park out of the way and use kit."
 6 Can you explain what you mean by the "first DMAs"
 7 sentence, please.
 8 A. DMA is double-manned ambulance. So I have taken this
 9 question regarding transport that as I was on a standard
 10 RRV, again I have mentioned again that I didn't have MI
 11 kit which relates to the dictaphone. This was
 12 a suggestion, and it's kind of how it used to be, in
 13 a major incident, if you knew it was a major incident,
 14 your first ambulances that would turn up would park out
 15 of the way, strip all their kit off, take them in,
 16 create a kit dump, and start treating. You would have
 17 20 ambulance personnel and an awful large pile of kit to
 18 start treating and those ambulances would be parked out
 19 of the way so the next ambulances in could start
 20 transporting and coming in with stretchers and things.
 21 Is that practicable? In certain circumstances it
 22 may be. In this situation? I don't know. This was --
 23 this was asked on a debrief for how things may have been
 24 improved --
 25 SIR JOHN SAUNDERS: Has it been looked at?

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1 A. I don't know, sir.
 2 MS CARTWRIGHT: Then to the question:
 3 "The most important thing I have learned in my role
 4 has been."
 5 Your answer recorded was:
 6 "Poor/slow communications. Relied on knowing other
 7 staff and their roles."
 8 Are you able to just give a little bit more detail
 9 about that feedback, please?
 10 A. Communications always comes up as an issue, and I think
 11 probably to qualify that, it's in the initial stage it's
 12 lack of information. We all want as much information as
 13 possible. I would have liked an open channel and
 14 information to have been put out. The reality is they
 15 may not have known that information at the time. So
 16 communications for me incorporates the fact that within
 17 the first 30 minutes/an hour information is being
 18 gathered and assessed and if that information isn't
 19 given out, that sort of comes under the bracket of
 20 communications.
 21 I felt knowing a lot of the staff that were in there
 22 and their roles worked well for me. Had that not been
 23 the case and I had not known the staff because I don't
 24 recall that they were wearing tabards in the same way
 25 and they were identified in that same way.

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1 So for me, physically knowing a lot of the staff
2 that were in there and their roles helped.
3 Q. You then provide further comment:
4 "NWAS has many people acting into other roles
5 without full facilities and kit."
6 A. I think I'm just been repetitive.
7 SIR JOHN SAUNDERS: Yes, you are talking about yourself,
8 aren't you?
9 A. Yes, I apologise, yes.
10 MS CARTWRIGHT: Mr Lopez, can we then move please to the
11 second form that Mr Birchenough completed, which is
12 {INQ040654/31}, please. {INQ040654/31}. Thank you.
13 Mr Birchenough, this is the form you completed:
14 "Thinking of the incident response itself, identify
15 areas that went well or not so well or what you and your
16 team would do differently."
17 Under "command and control" you identified:
18 "Difficult to get hold of Control to volunteer. Not
19 requested by control. [Query] didn't know I was on.
20 [Query] Major incident message on channel."
21 And that's the Greater Manchester operatives'
22 channel:
23 "Requesting channel would enable managers on relief
24 to be aware."
25 SIR JOHN SAUNDERS: It's much the same as what you said

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1 before, I think?
2 A. Can I apologise, first, for my writing and, secondly,
3 for being very repetitive in that.
4 SIR JOHN SAUNDERS: I think if you saw most of our writings,
5 we would all be apologising, so I don't think you need
6 to do that.
7 MS CARTWRIGHT: I'll apologise now. Safety:
8 "Early announcement of suicide bomber by police. No
9 mention at scene of Plato. General discussion with Dan
10 re safety and awareness of +++ police."
11 So we can see reference to Plato and safety, and so
12 what specifically were you identifying there, please?
13 A. Obviously after the incident a lot of information is
14 passed, that there had been a declaration of Plato and
15 that there had been incidents reported in and around
16 Manchester, but for us at the time, as I arrived, when
17 Dan was briefing me, he said the police had confirmed
18 that it was a suicide bomber and that they'd seen it.
19 I recall him saying they had seen it on CCTV I believe
20 is what they told me. I don't recall any mention while
21 we were at scene of Plato, and we did have a brief
22 discussion that obviously the area that -- to use the
23 zoning, there's risks attached. We don't know if
24 there's not secondary -- there are elements of risk to
25 attending that scene.

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1 Q. What is the "+++ police" meant to indicate?
2 SIR JOHN SAUNDERS: Lots of policemen?
3 A. Lots of policemen, and that that would obviously not
4 help with the secondary device, but should there be
5 anything else, the fact that there's more police to
6 control an area and help us is -- is something we would
7 look at as a benefit to helping the safety.
8 MS CARTWRIGHT: Communication -- sir, I'm reading it because
9 I think it helps capture actually what Mr Birchenough
10 has written, but I think that a lot of this repeats what
11 you've already told us:
12 "Slow to set up major incident channel. Good verbal
13 face-to-face comms due to layout of incident."
14 Then you say:
15 "++ chat on major incident channel."
16 For the "++" here, what can does that indicate,
17 please?
18 A. I -- I recall when I went into the station that I had an
19 earpiece in from my radio. I recall there being a lot
20 of conversation on there, how much of that was
21 specifically relevant to me now that I had a task and
22 a role to complete. I also recall it being incredibly
23 noisy within the station and I couldn't focus on the
24 channel. That -- what I'm writing there is that I lost
25 communication with that specific channel because

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1 I couldn't hear it. There was a lot of chat that
2 probably wasn't specifically -- I don't know how many
3 people were on that channel.
4 SIR JOHN SAUNDERS: Okay. I can understand that a lot of
5 the chat would not be relevant to you, but was there
6 a lot of chat which shouldn't have been going on the
7 channel, ie is more discipline required among staff
8 about what they communicate on the channel?
9 A. I can't recall what was communicated on the channel,
10 sir, and I certainly know that the early part of it, it
11 was too noisy. I recall there being an alarm going off
12 and various other noises.
13 I think, yes, staff discipline and chat is a viable
14 point -- a valid point, my apologies.
15 SIR JOHN SAUNDERS: I just wondered what you meant, that was
16 all.
17 A. Yes. I also think, moving forward, possibly limiting
18 the number of people on particular channels and maybe,
19 to coin a terrible phrase that I'm sure you are sick of,
20 zoning the channels effectively, so not everybody would
21 be on -- you kind of relying on an infinite number of
22 staff as well to be able to perform all these roles, but
23 if you put every member of staff, if we had however many
24 ambulances we had and every one of them had two radios
25 and all the managers and everything else who is

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1 listening in, there's hundreds of people that channel,
 2 and it's open channel and you have to wait for somebody
 3 to finish talking before somebody starts. It's
 4 difficult. It wasn't a communications device that
 5 I used once I went in because I couldn't hear it and
 6 actually geographically we were quite close.

7 MS CARTWRIGHT: We then see at the bottom of the page:
 8 "Operationally we split crews up and separated them
 9 from vehicles. Could we better utilise Airwave call
 10 signs to allow this to avoid two A123 staff members and
 11 a separate location for A123?"

12 Again, I think we touched upon this topic, but could
 13 you give any other information relating to that
 14 feedback?

15 A. I apologise, that's very clumsily written.
 16 I think had we got a personal, you know, a collar
 17 number, PIN number type radio, it doesn't have to be
 18 a personal issue, but if that was signed on as
 19 a particular personal radio, rather than two people
 20 having the same radio and that being connected to
 21 a vehicle that may be driven by somebody else,
 22 potentially there would be three people answering that
 23 one radio call sign, and it could intentionally have
 24 been aimed at any of them.

25 Q. Over the page, please, Mr Lopez {INQ040654/32}. For

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1 "assessment" you have got:
 2 "Good. Got better in the first hour."
 3 Then for "resources":
 4 "Okay."
 5 But then you say this:
 6 "No incident support unit. Lack of meds truck."
 7 So did you still think when you completed the
 8 debrief that there had been no incident support units
 9 present at the scene?

10 A. I don't recall being informed that an incident support
 11 unit had arrived or that masses, large amounts of kit
 12 were being brought in to us.
 13 Towards the end, and I apologise, I don't recall
 14 time zones specifically, I was aware that oxygen was
 15 becoming an issue, and as we have discussed before, some
 16 of the pain relief. But there was alternatives
 17 available. I don't specifically recall us being --
 18 running short of kit, but I wasn't made aware that
 19 a huge pile of kit would have arrived in one of these
 20 vehicles.

21 Q. Can I just clarify though, would the PSU, the public
 22 support vehicles that HART brought to the scene, would
 23 they fall under the banner of what you describe as a ISU
 24 there?

25 A. An incident support unit is slightly different, is my

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1 understanding. So some of the -- there's -- there's
 2 a variety of vehicles that have a variety of uses,
 3 depending on the casualties that it's aimed for. So
 4 some of those would carry simplistic bandages, etc, that
 5 could be put within a P3 area where members of the
 6 public could do dressings and bandages for themselves.

7 Others would have more specific kit that would need
 8 trained personnel to use. It's a generic term,
 9 I believe, not specifically the ISU, but a generic term
 10 that...

11 Q. You recorded as well for "resources":
 12 "Atmosphere was calm, professional and caring."
 13 And for "triage" you set out:
 14 "All crews need to be made familiar with BASIC.
 15 More advanced assessment for P3s."
 16 Is there anything further you want to say about the
 17 more familiar with BASIC?

18 A. As I referred to before, I felt HART were very good in
 19 that sort of circumstance under the triage heading and
 20 general crews have an awareness of it, but I think
 21 that's probably all they have. It's certainly not
 22 something that's practised.

23 Q. Can you give us what extra feedback you would give
 24 relating to having identified the need for more advanced
 25 assessment for P3s and the evidence you've given us

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1 about you seeing P3s as being someone else's
 2 responsibility that night?

3 A. I think that's -- well, this is after the incident.
 4 This isn't what I would have felt initially on the
 5 morning --

6 Q. No, no, I appreciate that.

7 A. -- but obviously I had heard that there were some
 8 changes, as patients can do, changes to their priority
 9 status and it sounded like had there been more advanced
 10 assessment for those P3s, that may have been dealt with
 11 better. But this is post incident.

12 Q. I'm not going to ask for clarification regarding
 13 "treatment" and "transport" because I think you've
 14 identified already the matters they touch on. But just
 15 to identify for "treatment", you record:
 16 "Good. Need more major incident kit and controlled
 17 drugs."
 18 For "transport" you identified:
 19 "Difficult access and egress, narrow roads."
 20 Moving on then, the most important thing you learned
 21 in your role as being the casualty clearing officer was:
 22 "Flexibility and awareness of systems rather than
 23 rigid roles in initial stage."
 24 Could you just expand what you mean by that, please?

25 A. I think if you take a major incident plan very

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1 literally , how it's written in black and white, it would
2 be impossible to manage because of various reasons, but
3 not least the numbers of staff involved to take up
4 particular roles and set up particular areas.

5 I felt that an awareness of that overall system,
6 rather than it being somebody's tasked with that role,
7 somebody's tasked with that role, that if there's an
8 overall awareness in the initial stage when you haven't
9 got enough staff, that that would allow you to get some
10 of the crucial jobs done without it being specifically
11 allocated as a specific role.

12 Q. What did you mean by your final comment on this form of,
13 "Principles , not rules"?

14 A. I think probably, as I have repeated myself there, that
15 the concept of what we're trying to set up rather than
16 it being a specific role initially , they're just -- you
17 don't have enough staff to do -- to set up the major
18 incident plan as it's laid out. I don't feel you get
19 enough staff within an appropriate time frame to be able
20 to do that. I don't think that's probably realistic ,
21 but if there's enough people there who are aware of the
22 principles of it , rather than a specific role for
23 them -- and again, it's not ideal, you need a role to
24 make sure that's your job and you've done it, but if you
25 haven't got a safety officer and you haven't got an

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1 equipment officer, you can't just ignore those functions
2 that need doing just because somebody hasn't got
3 a specific role . There needs to be enough people there
4 who are aware that, you know, I haven't got an equipment
5 officer to ask, but I'm aware I need equipment, so I can
6 make that call myself. It's some flexibility within
7 that system.

8 MS CARTWRIGHT: Thank you, Mr Birchenough.

9 That concludes my questions. Sir, is there any
10 clarification you wish?

11 SIR JOHN SAUNDERS: No.

12 MS CARTWRIGHT: There is questioning next, please, from
13 Ms Ghahhary. Could I ask that she puts her questions to
14 Mr Birchenough now over the videolink, thank you.

15 Questions from MS GHAAHARY.

16 MS GHAAHARY: Good afternoon, Mr Birchenough. First of all,
17 may I thank you on behalf of the families for all of
18 your efforts that night. There will be no suggestion
19 from me that you did anything other than your very best
20 that evening.

21 I have four topics to cover and hopefully much of
22 the questions I have will simply be points of
23 clarification .

24 There's a little bit of feedback at my end. I just
25 want to check that you're able to hear me and you're not

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1 getting any echo in the room.

2 MS CARTWRIGHT: Certainly, Ms Ghahhary, there's no issue in
3 the room, thank you.

4 A. Yes, ma'am, I can hear.

5 MS GHAAHARY: First of all, then, Mr Birchenough, your role
6 and training. Your role within NWS at the time was
7 operational manager for the city centre. We don't need
8 to pull up your statement, but you describe your
9 function as being operationally in charge of a specific
10 area and all of the NWS staff and vehicles in that
11 area.

12 May I just clarify with you in terms of what you
13 were in charge of? Did that include specialist
14 equipment and vehicles such as the mass casualty
15 vehicle?

16 A. No, ma'am.

17 Q. Second question on this topic: you said in your
18 statement that one of the reasons you left behind your
19 kit was because you thought you would be holding an
20 operational command role, a gloves-off role. Can I just
21 clarify with you, on your way to the arena, what role
22 did you envisage you would play? Did you have
23 a particular role in mind?

24 A. En route to the arena, I wasn't aware this was a major
25 incident. My intention of going was to assess, get some

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1 information, and feed back. The incident had
2 progressed -- was far larger than I had imagined and had
3 progressed by the time I arrived. But en route to the
4 incident, I had no knowledge of it being a major
5 incident, nor had I given it any thought as to
6 a particular role. My intention was to gather
7 information, feed back, and move from there.

8 Q. Thank you. In terms of mobilisation, my second topic,
9 you've explained obviously that you learned of the
10 incident at the hospital. At that time your knowledge
11 and understanding was relatively limited. One of the
12 things that the record shows is that you were told there
13 were at least 40 casualties, but I think in your
14 evidence you said you don't recall receiving that
15 information at the time; is that right?

16 A. I don't recall receiving that. Whether I didn't
17 register it or whether I didn't hear it properly,
18 I don't recall the number. That -- had I received --
19 had I acknowledged that information consciously, I think
20 I would have thought slightly differently about the
21 process. But I don't recall knowing that information
22 en route.

23 Q. One of the things that you did at the hospital was you
24 asked the sister to ensure that all of the ambulances
25 were made available within the next 5 minutes and you

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1 said in your statement that's because you anticipated
 2 a massive demand for ambulances. Do you think that
 3 request was based on the information that there were at
 4 least 40 casualties?
 5 A. The information I had at the hospital — I should
 6 probably say at the time of going to the hospital, where
 7 there's a lot of ambulances being delayed, my usual
 8 approach is far more diplomatic and conciliatory with
 9 them to try and release ambulances.
 10 I was becoming aware, with confirmation from the
 11 police, that there had been an explosion. I don't
 12 specifically recall numbers, but the social media
 13 murmurings of people within the corridor sounded like
 14 something had occurred, an incident had occurred.
 15 I didn't — I don't recall knowing the scale of it. So
 16 my parting conversation to the nurse in charge was,
 17 "I need all the ambulances clearing", to which she
 18 wholeheartedly agreed and said she would.
 19 Q. Thank you. In any event, your knowledge was very
 20 limited and bearing in mind the role that you expected
 21 to play on scene, I think you have agreed that it would
 22 have been helpful to have received more information
 23 en route to the arena.
 24 In relation to that, can you help us with what the
 25 difficulty was at that particular stage, why you think

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1 you didn't receive more information than you could have
 2 hoped for?
 3 A. I wasn't aware it was a major incident whilst I was on
 4 a specific managers' channel. I don't recall or
 5 I didn't hear a general message to pass that
 6 information. I was aware something was happening. My
 7 intention was to go and gather some physical information
 8 as to what was actually happening, but the incident had
 9 progressed further than that.
 10 We always say we would like more information, but it
 11 comes in so fast, the information within the first
 12 30 minutes, an hour of an incident, that you don't have
 13 that information in the first 5 minutes, not in the
 14 detail that we would need.
 15 Q. Thank you. May I move on now to your arrival at the
 16 scene.
 17 When you arrived presumably the first thing you
 18 would have wanted to do is obtain all the details that
 19 you might need to perform any role that you had; would
 20 you agree with that?
 21 A. Not to perform any role I had. As I say, initially
 22 I was still unaware this was a major incident or there
 23 were any managers on scene.
 24 SIR JOHN SAUNDERS: Okay, but you did want to get all the
 25 information about what was going on?

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1 A. Yes, sir.
 2 MS GHAAHARY: Thank you. When you arrived at the entrance
 3 to the station, you met with Dan Smith and in your
 4 statement you say that you carried out a visual risk
 5 assessment with him. Can I just clarify, was that at
 6 the entrance that you carried out that assessment?
 7 A. Yes, ma'am.
 8 Q. And plainly he gave you some information. You've been
 9 through it, so I won't repeat it. But would you agree
 10 that at that stage you had some but not all details that
 11 were available at that time?
 12 A. Very much so.
 13 Q. You were asked about Patrick Ennis and whether you knew
 14 that he was in the City Room. You said you did. When
 15 you arrived at Victoria and spoke to Dan Smith, by then
 16 he had already spoken with Mr Ennis around 5 minutes
 17 beforehand. Did he give you any of the details that he
 18 had received from Mr Ennis about the City Room, the
 19 numbers of casualties and the seriousness of the
 20 injuries?
 21 A. Yes, ma'am, he did.
 22 Q. And did he tell you that the casualties had begun
 23 arriving at the casualty clearing station?
 24 A. I was aware that there were many casualties already
 25 within the casualty clearing area, so yes.

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1 Q. And so before you entered the station you knew that
 2 there were many P1 and P2 casualties and that they were
 3 already being brought down on to the concourse; is that
 4 the state of affairs?
 5 A. I don't know if it was worded — worded like that, but
 6 I was aware that, yes, people were being moved.
 7 Q. Thank you. Can I move on now to your role as casualty
 8 clearing officer.
 9 One of the things that you're required to do as part
 10 of that role is to liaise with other key roles. I think
 11 you said earlier that you didn't ask or discuss
 12 specifically who was playing which role, to use that
 13 phrase. Did I understand your evidence correctly?
 14 A. I can't recall specific details that — the conversation
 15 with Dan asked me would I take on the role of casualty
 16 clearing officer. He would have told me who —
 17 I certainly know he told me about the primary and
 18 secondary triage officers with inside. What information
 19 he told me is what information I had. I don't recall
 20 specifically detailing other roles and asking were they
 21 fulfilled.
 22 Q. One of the things that Dan Smith said in his statement
 23 was that he asked you to familiarise yourself with the
 24 relevant action card and refer to it. You said you
 25 don't recall Mr Smith saying that to you, but in any

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1 event you looked at the action card.
 2 Can I just ask, did you look at the action card once
 3 at that point or were you looking at the action card
 4 throughout the entirety of the incident or was it just
 5 a few times? How often did you use the action card, is
 6 my question?
 7 A. I looked at the action card once before I went into the
 8 station.
 9 SIR JOHN SAUNDERS: Okay. I just want to take you up on
 10 that slightly. We have read through it. It's quite
 11 a long document. There's quite a lot of detail in it.
 12 Is it a document that you were familiar with before?
 13 A. In principle, not in detail.
 14 SIR JOHN SAUNDERS: Right. So actually remembering the
 15 detail through the incident would be impossible?
 16 A. Yes, sir.
 17 SIR JOHN SAUNDERS: Would it have helped you to have looked
 18 at that or do you think, as you were saying, "I had got
 19 the principles and that is what really matters"?
 20 A. I think that's a fair comment, sir.
 21 SIR JOHN SAUNDERS: Okay. It's in a booklet. Would it help
 22 if it's actually on a card? Would it be more easy to
 23 refer to during an incident?
 24 A. I think in a prolonged incident that wasn't as fast
 25 paced as that particular incident, the format it's in is

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1 reasonable.
 2 SIR JOHN SAUNDERS: Okay.
 3 A. I wasn't mentally prepared for dealing with what we saw
 4 and dealing with what we dealt with.
 5 So —
 6 SIR JOHN SAUNDERS: You got on and did the job as best you
 7 could within the principles you'd read about?
 8 A. Yes, sir. Referring to the book seemed low on the
 9 priorities.
 10 SIR JOHN SAUNDERS: Okay. Ms Ghahhary?
 11 MS GHAAHARY: Just exploring that point a little further,
 12 Mr Lopez, please may we have up on the action card.
 13 It's {INQ019219/2}. If we can move to the next page,
 14 please.
 15 Earlier you were asked about starting a log at the
 16 scene and you didn't start a log because you had too
 17 much to do, which is understandable, if I may say so.
 18 But looking at this action card, you can see the
 19 last two columns enable you to put a tick and a time.
 20 Do you think, looking at that card now and bearing in
 21 mind you didn't have any time to start and keep a log,
 22 it would have been useful and easy, relatively speaking,
 23 to use the action card as a form of log by ticking the
 24 box and adding the time?
 25 A. No, I don't feel that would have been at all practicable

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1 for the circumstances we were in. This particular one
 2 is a NARU action card which is slightly different than
 3 the NAWAS one that we carry in a pocketbook.
 4 I understand the significance of starting a log and
 5 had I had a dictaphone or some camera or something,
 6 I would have certainly activated that so I could have
 7 started making some notes. But to have physically got
 8 a book out and started writing was much lower down on my
 9 list of what I was presented with and felt needed doing
 10 at the time.
 11 Q. May I press on you this a little, Mr Birchenough.
 12 I understand that getting out a booklet and starting
 13 to write a log might not have been possible or easy in
 14 the circumstances. But this action card is a prepared
 15 document. It doesn't require you to write anything.
 16 You are required to read it. And so please could you
 17 help me understand what the difficulty would be in
 18 simply ticking it off as you go along the checkpoints?
 19 SIR JOHN SAUNDERS: Sorry to interrupt. My understanding of
 20 the evidence is you didn't have these cards, did you?
 21 You had them in the booklet.
 22 A. I had a version of these cards in a small booklet, and
 23 whilst absolutely I could have ticked the box to say
 24 I've started a log, I physically wouldn't have started
 25 a log because of the reasons I've explained before.

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1 SIR JOHN SAUNDERS: I can't remember for myself at the
 2 moment whether the booklet has the same things. Does it
 3 have the tick and the time in it? It does. Someone is
 4 nodding. Okay, thank you.
 5 Anyway, your decision was not to do it on the day?
 6 A. I don't feel that — whilst you're correct, it's very
 7 simple to tick to say, "Yes, I've done that",
 8 I physically wouldn't have done it or couldn't do it.
 9 I physically couldn't start a log. I could have made
 10 a tick to say I had, but I physically couldn't do the
 11 log.
 12 MS GHAAHARY: Perhaps it was the way I phrased the question,
 13 Mr Birchenough.
 14 I accept that you had difficulty starting and
 15 keeping a log, but what I'm asking you is whether this
 16 action card could have in effect provided some form of
 17 a log. So not just the tick—box in relation to a log,
 18 but the tick—box in relation to everything could have
 19 been used as a record during the evening.
 20 I don't know if you'd understood that was my point.
 21 A. My apologies, no, I did not understand that as the
 22 point.
 23 My understanding of a log and the action card are
 24 they are two separate things.
 25 Q. Yes.

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1 SIR JOHN SAUNDERS: The question is: could you have just got
2 this out and done a tick --
3 MS GHAAHARY: In circumstances where you can't --
4 SIR JOHN SAUNDERS: -- to indicate that you'd checked
5 communications and the radio Talk Group, for example?
6 A. Yes, sir, I could have done.
7 MS GHAAHARY: Thank you, sir.
8 Looking at point 1 on the action card, you discussed
9 the use of a tabard. You didn't have a tabard on that
10 evening. Did you carry a tabard with you?
11 A. No, ma'am.
12 Q. Is that because you weren't provided with a tabard or is
13 it because it just wasn't in your vehicle?
14 A. We weren't provided with tabards at the time. I wasn't
15 an operational manager and therefore I wouldn't have had
16 that kit.
17 MS CARTWRIGHT: I apologise for interrupting. I'm conscious
18 we're shortly after 1 o'clock. Could I make an enquiry
19 at this stage as to how much longer you think you may be
20 so we can determine whether we complete your questioning
21 or whether we'll need to pause for lunch?
22 MS GHAAHARY: I estimate around another 15 minutes.
23 MS CARTWRIGHT: Sir, are you content for us to continue on?
24 SIR JOHN SAUNDERS: How many more people are due to ask
25 questions after that?

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1 MS CARTWRIGHT: There are no requests under the Rule 10
2 process and I'm grateful that Ms Roberts has indicated
3 she has two short topics.
4 SIR JOHN SAUNDERS: Right. We will make it 10 minutes,
5 shall we, rather than 15 minutes. Just cut down your
6 estimate a bit. Ten minutes, is that satisfactory for
7 everyone to wait? I know it makes difficulties for
8 lunch.
9 Sorry, Ms Roberts?
10 MS ROBERTS: I can deal with the two points that I have very
11 briefly. I'll probably lead on them, which won't
12 surprise you. It's simply to just give you two key
13 references. So I can deal with my points, I would
14 imagine, in 2 minutes.
15 SIR JOHN SAUNDERS: Okay. Are people happy to carry on?
16 I would just like to finish this witness before lunch if
17 possible.
18 MS CARTWRIGHT: I apologise for interrupting, sir. Thank
19 you.
20 SIR JOHN SAUNDERS: Right, Ms Ghahary.
21 MS GHAAHARY: Thank you, sir.
22 Moving on, and cutting through the action card, most
23 of which has been covered in detail, to point 12.
24 Mr Lopez, I think it might be on the next page
25 {INQ019219/3}.

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1 Point 12 required you to have regular communication
2 with the OC, who was Dan Smith and then subsequently
3 Mr Hynes; the medical adviser who had not been
4 officially appointed but the role was in some respects
5 being performed by Dr Daley; and a secondary triage
6 officer.
7 You didn't know that there was a medical adviser
8 appointed and no secondary triage officer had been
9 appointed, and so is it right that in relation to
10 point 12 the only person that you were having regular
11 communication with is Dan Smith and the two triage
12 officers?
13 A. No, I would say that my understanding was we had
14 a primary and a secondary triage officer, and medical
15 adviser, whilst it's highlighted as a specific role,
16 I took that to be the lead doctor within the area.
17 Operational commander, as you say, was Dan Smith. So to
18 my understanding I was in regular communication with all
19 of those, and a primary triage officer.
20 Q. Thank you. And point 13 on the action card relates to
21 medical supplies and the allocation of an equipment
22 officer. You've already dealt with the equipment
23 officer point, but can I revisit two issues in relation
24 to equipment.
25 First of all, the use of stretchers. On entering

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1 the station you said that you could see casualties were
2 being brought down on makeshift stretchers, and
3 evidently it was the police that had initiated
4 extrication in this way.
5 Can I ask Mr Lopez for document {INQ023487/3} to be
6 brought up, please.
7 Under the heading "Recollections", about five points
8 down, you say there:
9 "Police - 1 x pre stretchers arriving I asked them
10 to find things to carry patients on (tables etc)."
11 Can you see that?
12 A. Yes, ma'am, I can see that.
13 Q. Is that right? Did you ask the police to use tables and
14 other items?
15 A. I have no recollection of that statement at all.
16 I don't believe it would be to -- it certainly isn't in
17 relation to carrying people downstairs with them. The
18 majority of people, by the time I went into the casualty
19 clearing area, were downstairs. I don't recall seeing
20 people coming down the stairs. I don't actually know
21 what I meant by writing that, whether that's -- I don't
22 know, ma'am.
23 Q. Okay. In your statement you said that at one point you
24 asked police officers to keep a path clear to the exit.
25 The impression I got from that is that officers were

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1 putting casualties into the pathway between the CCS and
 2 the loading point outside. We can pull up that part of
 3 the statement if it helps, but do you recall that issue?
 4 A. I don't believe it's in connection with placing patients
 5 or casualties there. But that was the main door that
 6 people were coming in and out of. So it was for people
 7 not to have conversations and be in groups within that
 8 sort of pathway and to try and stand to one side so
 9 we could get patients in and out.
 10 I don't recall patients being brought down or put in
 11 that room. So no, it doesn't indicate that, no, ma'am.
 12 Q. Thank you for that clarification.
 13 The next point in relation to equipment is other
 14 medical supplies. In his evidence Dr Daley said that
 15 there was initially a shortage of equipment. He had
 16 some life packs available, but it really wasn't until
 17 the paramedics started to attend the CCS with their
 18 equipment that supplies increased.
 19 You said earlier that as far as you were aware there
 20 was no need for any more medical equipment. Can you
 21 just explain what that understanding was based on at the
 22 time?
 23 A. My understanding from listening to Dr Daley's evidence
 24 was that was earlier in the evening, and that at the
 25 point where I had gone in, certainly within half an hour

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1 of that, very many more staff had arrived bringing kit
 2 with them. And the kit that I believe we were short of
 3 later on I've mentioned to do with cylinders and some
 4 pain relief medication.
 5 Q. So bearing in mind you arrived around 11.10, the first
 6 casualties were beginning to be brought down a few
 7 minutes before that. Are you saying your understanding
 8 is it's at that stage that Dr Daley is referring to when
 9 he talks of a shortage in supply?
 10 A. Possibly even before I arrived. I don't know
 11 specifically. My understanding was it was before
 12 I arrived. At the point around 11.35, when I went into
 13 the CCS, I wasn't aware or certainly within the next
 14 half hour from there that there was a very — we needed
 15 more staff to come in. Every staff that came in seemed
 16 to bring kit.
 17 Q. Thank you. My final point on the action card is,
 18 looking at it now, do you feel that there are too many
 19 jobs for a casualty clearing officer?
 20 A. Yes, ma'am. I believe the action cards, particularly in
 21 the incident that we had, are unrealistic in various
 22 ways.
 23 Q. Thank you. My final point relates to role change.
 24 Mr Lopez, please can we have up {INQ014785/2}.
 25 This is Mr Hynes' incident log. You've already been

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1 asked about your role and whether it changed at any
 2 point, and you've confirmed that, as far as you're
 3 concerned, it did not, but can I ask you about other
 4 roles. As far as you were aware, did Matt Calderbank's
 5 role change at any point?
 6 A. Not as far as I'm aware, ma'am, no.
 7 Q. So although he has become the parking officer on this
 8 sheet, as far as you're concerned, he remained in the
 9 role of loading officer?
 10 A. Yes, ma'am.
 11 Q. In relation to the role of parking officer, you will be
 12 aware that once Mr Hynes arrived, Mr Poland became his
 13 loggist. Do you know who became the parking officer?
 14 A. No, ma'am.
 15 MS GHAAHARY: Thank you. Those are all my questions.
 16 SIR JOHN SAUNDERS: Thank you very much. Just before you
 17 ask your two brief questions, I just want to raise one
 18 thing.
 19 The overwhelming concern that the public would feel
 20 about the response from the Ambulance Service relates to
 21 delays. It relates to delays in getting people out of
 22 the City Room and then delays getting them from the CCS
 23 to the ambulance. And you've heard the times read out,
 24 and read out starkly like that they do sound like a very
 25 long time. Do you agree?

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1 A. Yes, sir.
 2 SIR JOHN SAUNDERS: So you're nothing to do with any delays
 3 getting from City Room, but let's deal with, if we can,
 4 a bit more detail about delays getting them from the
 5 casualty clearing station to the hospitals.
 6 We've got the plan, the hospitals who are saying
 7 what numbers they can take, and they guarantee in that
 8 plan too to get the relevant staff in who are off-duty
 9 to do that. So there was no problem, was there, with
 10 having hospitals available to take people from your
 11 point of view?
 12 A. Not to my knowledge, sir, no.
 13 SIR JOHN SAUNDERS: What about having sufficient ambulances
 14 there? Did that cause a delay, that there just weren't
 15 enough to take the people once they were identified as
 16 priorities to get to hospital?
 17 A. Potentially. I'm not aware of all the ambulances'
 18 arrival times. But potentially — the delay for me,
 19 I would say initially, as far as the area that I was
 20 working in, sir, is — is down to treatment, is down to
 21 stabilising of patients.
 22 SIR JOHN SAUNDERS: Stabilising of people in order to get
 23 them away?
 24 A. Yes, not just the life-saving treatment, but also, you
 25 know, any limb injuries or anything, you know, to be

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1 made capable that you can physically move a patient
 2 without causing them any more pain and distress.
 3 The prioritising of those patients that was ongoing
 4 during that time, you know, and then physically having
 5 a patient ready, getting a stretcher, an ambulance in.
 6 It was just the logistics of doing all that as opposed
 7 to just putting a patient in the back of an ambulance
 8 and sending them to hospital.
 9 SIR JOHN SAUNDERS: As soon as an ambulance arrives, there's
 10 no reason why you don't get the trolley off there into
 11 the area where you are or on the outside where the HART
 12 team are?
 13 A. No. Initially, sort of probably slightly before the
 14 HART team area was set up, there seemed to be an awful
 15 lot of people. So it was -- as required, we brought
 16 stretchers in rather than having them lined up. There
 17 just seemed to be an awful lot of people.
 18 SIR JOHN SAUNDERS: So you said, "We've got one to go now,
 19 get me a stretcher?"
 20 A. And it came in immediately. It was literally, you know,
 21 the distance that you and I are apart from the door.
 22 SIR JOHN SAUNDERS: Were they being stabilised as quickly as
 23 they should be, the patients?
 24 A. I can't speak specifically on any patient. Once every
 25 patient had -- once every -- yes, every patient had

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1 a paramedic with them or a doctor or whatever, I -- the
 2 treatment I witnessed was exemplary. It was focused.
 3 Each -- it was easier for the paramedics to focus with
 4 a specific patient. They weren't dealing with the
 5 scene. They were dealing with one patient.
 6 It takes some time to assess, treat, dress, you
 7 know, cannulate, give the relevant drugs and pain relief
 8 and stabilise that patient. It's not a process that can
 9 be done --
 10 SIR JOHN SAUNDERS: Well, I'm obviously, as you're aware,
 11 looking at recommendations. You are the expert, not me.
 12 You know about these things.
 13 As far as you are concerned, as from the casualty
 14 clearing station, from them getting there, was there
 15 anything that could have been done to get those
 16 patients, the PIs in particular, to hospital quicker
 17 than they got there?
 18 A. Yes, I'm sure they could. I'm sure -- I'm not aware
 19 that there were delays caused after stabilising of
 20 patients. Once patients were ready to go, there is
 21 obviously the physical logistics of getting them lifted
 22 on to a stretcher and taken outside, and obviously the
 23 priority of some patients, as you rightly said earlier
 24 on, sir, does change.
 25 Yes, I'm sure had we had a bigger area, had we had

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1 more staff on scene, had various other things been
 2 slicker, those times would have been shorter. I'm sure
 3 they could, sir.
 4 SIR JOHN SAUNDERS: Okay. One of the things you identified
 5 before as a problem maybe was resources and I gathered
 6 that you were concerned about actually the ambulances
 7 coming, but from what you said you don't think there was
 8 any delay caused by a lack of ambulances?
 9 A. I'm not aware that there was a specific -- I know we
 10 didn't have 60 ambulances arrive in the first half hour.
 11 SIR JOHN SAUNDERS: No. We can ask the loading officer who
 12 will have a better knowledge of that.
 13 A. As -- once the HART -- the area was set up outside and
 14 we -- I felt the system that we adopted meant the area
 15 inside was much easier to decant and probably made it
 16 much more systematic and logical outside. So
 17 potentially we got quicker.
 18 SIR JOHN SAUNDERS: Did it need HART officers to set out
 19 that area outside?
 20 A. They carried that equipment. We don't carry that
 21 equipment.
 22 SIR JOHN SAUNDERS: So it is equipment that is on their
 23 ambulances?
 24 A. I imagine the vehicle they went back to collect the --
 25 SIR JOHN SAUNDERS: Okay, the PSU vehicle?

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1 A. They have separate vehicles, yes.
 2 SIR JOHN SAUNDERS: Is there any reason why that shouldn't
 3 have been decanted from those vehicles and put in that
 4 area? Did it need HART officers to do that?
 5 A. They are the ones who are trained how to set that up.
 6 It's not a general training for staff. I wouldn't --
 7 I'm not a SORT trained officer, so I don't know if
 8 that's anything SORT would deal with as well. I don't
 9 believe it is, but it's HART.
 10 SIR JOHN SAUNDERS: Right. Okay.
 11 MS CARTWRIGHT: Mr Birchenough, can you assist as to whether
 12 when Mr Poland was allocated to the loggist from being
 13 the parking officer, was anyone else allocated the
 14 parking officer role, please?
 15 A. I wasn't aware that -- at what time that happened. I'm
 16 not aware anyone else took up the parking officer role.
 17 I certainly wasn't told.
 18 SIR JOHN SAUNDERS: Sorry, you have been left with very
 19 little time, Ms Roberts.
 20 Questions from MS ROBERTS
 21 MS CARTWRIGHT: I think we can probably get an answer to
 22 that last question.
 23 SIR JOHN SAUNDERS: I'm sure we can.
 24 MS CARTWRIGHT: I think I know who it is, but I think
 25 a timing as to which that person took over that role

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1 would be helpful. So we can just give that information
 2 this afternoon. Thank you.
 3 Just a couple of points then very briefly. As
 4 I say, if I take you through these, that will expedite
 5 matters.
 6 As I understand it, you were due to finish your
 7 shift at 10 o'clock that night?
 8 A. Yes, ma'am.
 9 Q. You were still at the North Manchester General Hospital,
 10 as we know, shortly before 11.00 pm when you learned
 11 about this incident and deployed to the arena; correct?
 12 A. Yes, ma'am.
 13 Q. So although you were still working, those who perhaps
 14 were looking at a screen and trying to work out who was
 15 and who wasn't working would have formed the impression
 16 that you had finished for the night and were probably at
 17 home?
 18 A. Yes, ma'am.
 19 SIR JOHN SAUNDERS: But don't you sign off?
 20 A. No, sir. That system, particularly at the time, not
 21 being on a vehicle, no. You would sign off a vehicle,
 22 but the log (inaudible: distorted), no.
 23 SIR JOHN SAUNDERS: Thank you.
 24 MS ROBERTS: I think in answer to one of the questions that
 25 the chairman raised earlier, would it help, do you

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1 think, if there were a signing on and a signing off?
 2 Because if that had been the situation, you hadn't
 3 actually signed off, then others might have known sooner
 4 that you were in fact still available to work?
 5 A. Yes, ma'am.
 6 Q. All right.
 7 A. Thank you.
 8 Q. You have talked about the ambulances, the number of
 9 ambulances that there were at North Manchester
 10 General Hospital. And had you in effect, my phrase,
 11 been sent to the hospital to troubleshoot, in other
 12 words to free up those ambulances and to free up the
 13 paramedics?
 14 A. Yes, ma'am.
 15 Q. All right. You told us that ordinarily you would be
 16 very polite and very circumspect in the way that you
 17 dealt with the staff there, and nobody doubts that. But
 18 can we take it from that that once you learned that
 19 there was an incident which required NWS staff and
 20 required paramedics at the scene, that you were direct
 21 in your instructions to the staff at North Manchester
 22 General to release those paramedics and release those
 23 ambulances as soon as they could?
 24 A. Yes, ma'am.
 25 Q. Thank you. Just so that everybody understands, once the

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1 ambulances are at a particular hospital with
 2 a particular patient that they have collected, they
 3 can't simply deposit that patient in a hospital
 4 corridor. They have to wait with that patient until
 5 there are nurses or doctors or a theatre, should surgery
 6 be required, to deal with that particular person.
 7 That's right, isn't it?
 8 A. Yes, ma'am. A patient needs to be handed over to
 9 a hospital and they have to accept that patient to
 10 a particular form of care. The responsibility would sit
 11 with the hospital, but yes.
 12 Q. All right. And until that happened they are not
 13 allowed, as I understand it, to leave that particular
 14 patient?
 15 A. That's correct, ma'am.
 16 Q. So up to North Manchester you had gone to free up some
 17 of your ambulances.
 18 Sir, the reference for you and for those who are
 19 interested, it doesn't need to go on the screen, it's
 20 the ambulance history analysis, and it's {INQ040368/1}.
 21 Within that document at {INQ040368/5-8}, there are six
 22 ambulances that you've freed up from North Manchester
 23 General when you realised the imperative of getting them
 24 to the arena and they arrived at scene between 23.11 and
 25 23.17.

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1 Mr Birchenough, of those six ambulances that you
 2 freed up from North Manchester General and that made
 3 their way to the arena, of the six, four had been at the
 4 North Manchester General with what are listed as red 2
 5 patients. What are red 2 patients?
 6 A. It could be all sorts of medical criteria, but patients
 7 that require needing to be seen rather than put into
 8 a waiting room at a hospital. They would need to be
 9 seen sooner rather than later.
 10 MS ROBERTS: All right. Thank you very much.
 11 SIR JOHN SAUNDERS: Thank you very much.
 12 MS CARTWRIGHT: Can I thank the stenographers in particular
 13 for sitting late to complete the evidence —
 14 SIR JOHN SAUNDERS: We always forget the stenographers who
 15 do a fantastic job, so we're really grateful. I'm also
 16 very sorry for those who are having their lunch delayed.
 17 I hope it doesn't cause too many problems with that.
 18 MS CARTWRIGHT: Sir, I still think if we take the usual hour
 19 we will conclude the next witness this afternoon in
 20 terms of the evidence to be addressed, but also the
 21 number of requests under the Rule 10 process.
 22 SIR JOHN SAUNDERS: Okay. That's fine. I mean, sometimes,
 23 as we know, estimates tend to get it wrong and we were
 24 going to finish this morning comfortably by lunchtime as
 25 I recall. So perhaps that's me asking too many

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1 questions.
 2 Thank you very much. I'm really grateful, not only,
 3 as you have heard, for efforts you made on that night,
 4 but also the insights you have given me into what went
 5 right and what went wrong. Thank you very much.
 6 So we will say an hour then. Thank you.
 7 (1.25 pm)
 8 (The lunch adjournment)
 9 (2.25 pm)
 10 (Proceedings delayed)
 11 (2.33 pm)
 12 MS CARTWRIGHT: Good afternoon, sir. The gentleman in the
 13 witness box is Mr Calderbank. Could I ask now that he
 14 be sworn.
 15 MR MATT CALDERBANK (affirmed)
 16 Questions from MS CARTWRIGHT
 17 MS CARTWRIGHT: Good afternoon. Please could you tell the
 18 inquiry your full name.
 19 A. Matthew Stuart Calderbank.
 20 Q. Mr Calderbank, you provided two witness statements to
 21 the inquiry. The first is dated 13 February 2018.
 22 Can I ask, first of all, are the contents of that
 23 statement true to the best of your knowledge and belief?
 24 A. They are.
 25 Q. And secondly, you provided a further witness statement

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1 to the inquiry dated 1 November 2019.
 2 A. That's correct.
 3 Q. And similarly, are the contents of that statement true
 4 to the best of your knowledge and belief?
 5 A. Yes, they are.
 6 Q. Mr Calderbank, in terms of your evidence this afternoon,
 7 I'm going to first of all deal with your role at NWS at
 8 the time and now, briefly dealing with your training for
 9 command and incidents, major incidents, and then move to
 10 deal with your involvement on 22 to 23 May, and finally
 11 we will deal with the debriefs that you completed,
 12 performed, I should say.
 13 A. Okay.
 14 Q. So it's correct, isn't it, that you are currently
 15 a permanent sector manager for Cheshire and Merseyside
 16 East?
 17 A. That's correct.
 18 Q. Let's just track through then your time with NWS. It's
 19 right, isn't it, that you have worked for North West
 20 Ambulance Service since 1994?
 21 A. Correct.
 22 Q. You joined as an ambulance technician?
 23 A. That's correct, yes.
 24 Q. You then became a paramedic and worked as a paramedic
 25 from 1996 to 2002?

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1 A. That is correct, yes.
 2 Q. You then progressed to becoming assistant operational
 3 manager from 2002 to 2013?
 4 A. Yes.
 5 Q. And then you became, as of the time of the incident, the
 6 operations manager for Greater Manchester West?
 7 A. That's right, yes.
 8 Q. And that was the role in which you were working on the
 9 night of the incident?
 10 A. Yes.
 11 Q. Could you give us an overview as to what the role of the
 12 operational manager for Greater Manchester West
 13 involved?
 14 A. An operational manager will work within a group of
 15 stations, managing the emergency response of a number of
 16 ambulances as part of a — as part of a sector. So it
 17 was my responsibility to ensure that ambulances were
 18 available and responding to emergency calls within
 19 that — within that area.
 20 Q. I think the area, that's principally — it wasn't
 21 Central Manchester but it was the Wigan area?
 22 A. That's correct, yes.
 23 Q. Did you have a good knowledge of the hospitals in the
 24 Manchester area?
 25 A. Yes, and Wigan falls within the Greater Manchester

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1 region, so as a responding paramedic within that area,
 2 a lot of the travelling with patients would be outside
 3 of the Wigan area and into the Greater Manchester
 4 network of hospitals, so yes.
 5 Q. Thank you. I think it's right at the time in May of
 6 2017 in any 24-hour period, is it correct that there
 7 would be two operational commanders on call for the
 8 Greater Manchester area?
 9 A. That's correct, yes.
 10 Q. And Greater Manchester West would obviously fall into
 11 that?
 12 A. That's correct, yes.
 13 Q. And you were working the shift, I think, from 8 o'clock
 14 in the morning on the Monday through to the following
 15 day?
 16 A. Yes.
 17 Q. So you were in fact on call?
 18 A. Yes.
 19 Q. Could we then deal please with your training and
 20 understanding of the command role? I'm not going to go
 21 through your training records. The inquiry have had
 22 them provided to them which sets out in detail the
 23 training you have had both in command, but also in
 24 respect to JESIP matters.
 25 Could I ask you to deal with it in this way at

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1 a high level? It's right, isn't it, that at the time of
 2 the incident you had undergone specific training,
 3 including attendance at the National Ambulance
 4 Resilience Unit operational commander training course --
 5 A. Yes.
 6 Q. -- which you completed in November of 2015? I think
 7 it's correct, isn't it, that you in fact could perform
 8 the role of an on-scene operational commander, a Bronze
 9 commander, at a major incident?
 10 A. Yes, that's correct.
 11 Q. It's right, isn't it, that you had also, at the time of
 12 the incident, been in attendance at the annual NWAS
 13 commander training courses since December of 2013?
 14 A. Yes, that's correct.
 15 Q. And you had also, as a commander, been expected to and
 16 did maintain your national occupational standards
 17 portfolio?
 18 A. Yes.
 19 Q. Which ensured that you had the knowledge, experience and
 20 training in respect of incident command?
 21 A. Yes.
 22 Q. And so on 22 May 2017 would you say that you were
 23 confident and more than competent to perform the role of
 24 a Bronze on-scene commander?
 25 A. I believe so. I believe at that point I met the

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1 requirements in regards to training and the national
 2 operating standards. So yes, I would say so.
 3 Q. And following on from that, can I then just, having got
 4 a general understanding of the training you had and the
 5 authorisation to be an operational commander, can you
 6 assist as to what your general knowledge was about JESIP
 7 and JESIP principles at the time, please?
 8 A. Yes, I would say that I had a good knowledge of JESIP
 9 and the JESIP principles. I think as an operational
 10 manager then there's a lot of opportunity to work with
 11 colleagues from police and fire, other blue light
 12 services. That is the opportunity to test those JESIP
 13 principles.
 14 I think having had experience at the likes of
 15 sporting events or incidents that had occurred within
 16 the region that I worked in, then that would be on the
 17 basis -- you would operate with the basis of the JESIP
 18 principles in mind.
 19 Q. Can I ask then, had you also -- would you have had
 20 a good understanding of what an Operation Plato incident
 21 was?
 22 A. Yes, I believe so.
 23 Q. And also an understanding about what it meant when
 24 something became a marauding terrorist firearm attack?
 25 A. Yes, I believe that has formed part of the annual

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1 commander training prior to 2017, so yes.
 2 Q. Thank you. You've already told us that you were on
 3 call, but you first were made aware of the incident at
 4 the arena when you were at home; is that correct?
 5 A. That's correct, yes.
 6 Q. And we have the call that notified you of the incident.
 7 So there is a transcript of the call which is -- I'm
 8 going to give the INQ, but Mr Lopez, I'm not asking for
 9 the transcript to be displayed. But for the record or
 10 those who wish to follow it, it's {INQ015337T/1}.
 11 It's correct, isn't it, that at 22.42 Greater
 12 Manchester Control contacted you and I think you even
 13 were able to identify the individual from Control who
 14 was on the call?
 15 A. Yes, I think -- I think she identified herself to me,
 16 but I'm familiar with that individual, yes.
 17 Q. We can see from the transcript that she was an
 18 individual called Julia, and she told you this:
 19 "Sorry to disturb you, but we have got an incident
 20 at the Manchester Arena. It's a possible bomb gone off
 21 or it is a shooting incident with possibly
 22 30 casualties."
 23 She then tells you that Annemarie knows:
 24 "I have told Annemarie. Donald (sic) Poland is
 25 going to Thompson Street Fire Station. Can you start

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1 making your way there as well?"
 2 Then we can see that there's a discussion about what
 3 the event was at the arena and Control indicated that it
 4 was a Brian Cox event, and the radio operator was able
 5 to tell you that they believed that the incident was in
 6 the reception area, that one of the jobs was saying, but
 7 she wasn't sure.
 8 It was then you asked the question:
 9 "Thompson Street Fire Station?"
 10 And she responds:
 11 "Yes, please."
 12 So you've had an opportunity, I think, before today
 13 to consider that transcript; is that correct?
 14 A. Yes, I have, yes.
 15 Q. And so with the information provided in that call did
 16 you have in your mind that it could be a Plato incident,
 17 bearing in mind the reference to a shooting incident?
 18 A. I think -- I think at the time it was particularly early
 19 in the incident. I think that I was still trying to
 20 assess what information people had and what they knew.
 21 I initially didn't think this could be a Plato. I don't
 22 recall thinking that. I think initially my thoughts
 23 were this sounds like it could be a large-scale
 24 incident. I think that early on, for me as an
 25 operational commander, it's about trying to get some

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1 more information if it's available.
 2 And obviously at that point I'm at home and starting
 3 to make preparations to mobilise towards the RVP.
 4 Q. Can I ask, as one of the on-call operational commanders,
 5 when the information that we've just had summarised was
 6 given to you on the call, would you have to at that
 7 point start to seek more information from Control?
 8 A. I think -- I think I would expect that as more
 9 information was -- became available, then that
 10 information would be passed to me as the -- as an
 11 attending operational commander or as an on-call
 12 commander. I think if a period of time has passed, then
 13 generally people would request an update if there was an
 14 available update from scene, but you would expect that
 15 there would be a flow of communication as and when that
 16 information is available to be passed.
 17 Q. The call identified that Annemarie was aware.
 18 A. Yes.
 19 Q. Was it clear to you that that was Annemarie Rooney?
 20 A. Yes, it was, yes.
 21 Q. And did you also know at that time that she was the
 22 on-call Silver/tactical commander for NWAS?
 23 A. Yes, I did.
 24 Q. So when the radio controller Julia was telling you that
 25 Annemarie knows, would that have been clear in your mind

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1 that she would be responding as NWAS's Silver commander
 2 to the incident?
 3 A. So I would expect that the Silver/tactical commander
 4 generally wouldn't respond to scene but would respond to
 5 an agreed location.
 6 Q. Sorry, I didn't mean that she had to physically go, but
 7 she would be the Silver commander?
 8 A. Yes, she had been made aware and would be mobilising or
 9 starting to make those -- develop those tactical
 10 relationships.
 11 Q. In terms of your knowledge of the command structure, was
 12 it in your mind that you then would be the operational
 13 commander?
 14 A. I think -- I think the reality of it is that I was aware
 15 of my location and the distance that I would be
 16 travelling to the incident, and I was aware of
 17 Derek Poland, my colleague who was the second Bronze
 18 officer, of his location, and aware that his travelling
 19 time would be less than mine.
 20 I believe I will have made an assumption that it was
 21 unlikely that I would be the operational commander when
 22 I arrived as there would have already been an
 23 operational commander there. However, it would always
 24 have been a possibility, so I won't have discounted it.
 25 However, I would have been relatively assured that there

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1 would have been somebody else arrived in that
 2 competent -- qualified competent position to do the
 3 role.
 4 Q. Thank you. We will move on to deal in a minute with the
 5 telephone call that you made to Mr Calderbank (sic).
 6 But can I ask, before that, was there any -- did you
 7 make any effort to make any contact with
 8 Annemarie Rooney as the Silver commander?
 9 A. No, I did not.
 10 Q. Was there any reason why you didn't contact her?
 11 A. No, I think at that particular point in the early
 12 stages, I probably felt that information would be passed
 13 to me as it was -- as it became available rather than me
 14 having to request it and creating another line of
 15 enquiry, perhaps, from -- into our control room.
 16 Q. At the stage when you were contacted, did you ask -- did
 17 you seek any information as to which Talk Group would be
 18 being used in respect of the commanders responding to
 19 the incident?
 20 A. Not at the point of being contacted, no.
 21 Q. The major incident plan that NWAS had at the time
 22 essentially cautions about the use of mobile phones in
 23 responding to major incidents. Would you agree with
 24 that?
 25 A. Yes.

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1 SIR JOHN SAUNDERS: Sorry, are you agreeing it's in the
 2 major incident plan or are you agreeing it's a good
 3 idea?
 4 A. I'm agreeing that it's in the major incident plan,
 5 I believe.
 6 MS CARTWRIGHT: I don't think we need to draw it up, but for
 7 your references it's {INQ013132/32}.
 8 SIR JOHN SAUNDERS: Do you see the sense of it too?
 9 A. Sorry, sir?
 10 SIR JOHN SAUNDERS: Not using a mobile phone?
 11 A. I can understand that it adds -- that mobile phone
 12 networks may be overloaded and it wouldn't be
 13 potentially the most reliable means of communication.
 14 So absolutely, yes.
 15 MS CARTWRIGHT: Would you also agree that if there are calls
 16 on mobile phones, it also means that it -- it means
 17 there's not a capture of exactly what was said in the
 18 discussions between the individuals at the relevant
 19 time?
 20 A. I would agree with that, yes.
 21 Q. And certainly for processes like this, that becomes
 22 a disadvantage to piece together what did or didn't
 23 happen?
 24 A. Yes.
 25 Q. We can see in your logbook -- please, Mr Lopez, could

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1 you put up on screen {INQ014790/2}, please. You in your
 2 notebook have recorded:
 3 "Phone update, 23.15."
 4 Is that to record the discussion you had with
 5 Mr Poland?
 6 A. Yes. So the phone update was an update -- was an
 7 update -- I made a phone call to Mr Poland on -- whilst
 8 I was travelling to the -- whilst I was travelling to
 9 the RVP. I -- the vehicle that I respond in doesn't
 10 have a secondary means of communication, so using
 11 a mobile phone would have been the only means of --
 12 without picking up a radio handset and using that whilst
 13 travelling with blue lights and sirens on, which I would
 14 be reluctant to do, so the mobile phone was my means of
 15 conversation via the hands-free.
 16 I have made the note after that event as a note to
 17 say that I have had had that mobile phone conversation.
 18 Q. Can you just give us the detail or recollection you have
 19 about that conversation with Mr Poland, please?
 20 A. My recollection is that I rang Derek, Mr Poland, to let
 21 him know that I was en route, to see if he had any
 22 awareness of the event and whether -- whether he had
 23 arrived at scene yet.
 24 I believe he informed me that he had, confirmed that
 25 the initial report -- there was a degree of accuracy in

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1 the initial report, that there were confirmed fatalities
 2 and a large number of injured patients.
 3 Q. Was there any discussion with Mr Poland as the other
 4 operational commander during that telephone call as to
 5 who would be the operational commander?
 6 A. Not at that point, no.
 7 Q. Was there any discussion about who was likely to get to
 8 I think what was the rendezvous point first; is that
 9 correct?
 10 A. So Mr Poland had confirmed that he was -- he was at
 11 scene. I'm not sure whether the initial rendezvous
 12 point changed for me from the initial information.
 13 I think originally I was heading to Thompson Street Fire
 14 Station and was updated en route that travel to Hunts Bank
 15 at Victoria Station --
 16 Q. We can see that in your pocket log that's still
 17 displayed on the screen. I think it's right that you
 18 have indicated in the witness statement you have
 19 provided that you believe that came over the Airwaves
 20 radio as you were making your way to the scene.
 21 A. That's correct.
 22 Q. So was the radio then on the handset you had in the car
 23 just playing as you travelled to the scene?
 24 A. Yes, and I think -- I think my response is a one-word
 25 response in terms of just let -- acknowledging that

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1 communication with the control room.
 2 Q. Thank you.
 3 We can see also in your logbook that at 23.20 you've
 4 recorded about the Airwaves and there's a channel number
 5 alongside that. You should have in front of you
 6 a document that records how we are referring to those
 7 channels. But it's correct, isn't it, that underneath
 8 the redaction that is a reference to the major incident
 9 channel at 23.20?
 10 A. That's correct.
 11 Q. And does that note therefore indicate that you'd been
 12 told that that was now the channel you had to move on
 13 to?
 14 A. I believe so, yes.
 15 Q. Would you have been able to, whilst you were making your
 16 way to the scene, to change your radio on to that
 17 channel?
 18 A. Not whilst travelling, no.
 19 Q. So would it be fair to say that before you arrived at
 20 the revised rendezvous at Hunts Bank, you'd not been
 21 able to listen to the revised radio channel as you were
 22 making your way to the scene?
 23 A. That's correct.
 24 SIR JOHN SAUNDERS: Is that what's called the major incident
 25 Talk Group?

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1 MS CARTWRIGHT: Yes, thank you, sir.
 2 You indicate in the witness statement, as you
 3 approach Manchester city centre, you're aware of lots of
 4 people out to the streets, and you noticed a number of
 5 people that were upset and distressed. And you also
 6 witnessed walking wounded patients and persons being
 7 assisted by others.
 8 A. That's correct, yes.
 9 Q. In terms of just so we can identify the timing, you were
 10 in -- is it vehicle BX2985?
 11 A. That's correct, yes.
 12 Q. And from the timings that have been collated from North
 13 West Ambulance Service, you were dispatched or allocated
 14 to the incident at 22.45.17, and having travelled from
 15 your home area, you arrived on scene at 23.29.29?
 16 A. That's correct.
 17 SIR JOHN SAUNDERS: That's right, is it? The statement says
 18 23.20.
 19 MS CARTWRIGHT: The witness has clarified. I couldn't find
 20 it in the information we were given from NWSA. We
 21 checked the document the witness has and that is the
 22 timing.
 23 SIR JOHN SAUNDERS: So about 23.30?
 24 A. I think at the time of making my statement, I believed
 25 it was 23.20. I think the time stamp that's taken from

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1 the Airwaves radio handset indicates that I was at Hunts
2 Bank at 23.28.
3 SIR JOHN SAUNDERS: Okay. That's fine.
4 MS CARTWRIGHT: And in fact we have a call that confirms
5 that, and Mr Lopez, could we please display
6 {INQ041282/3}. So that call from you is:
7 "Just letting you know that I'm on the scene now."
8 If we -- I don't need to display the other calls,
9 but we can see that Derek Poland then confirms on
10 {INQ041282/4} at 23.28.19:
11 "Roger. If you come to the front near the end of
12 the vehicles, that's where we are."
13 A. That would be correct, yes.
14 SIR JOHN SAUNDERS: Thank you.
15 MS CARTWRIGHT: Thank you.
16 You tell us in your witness statement that as you
17 approached the railway bridge on Victoria Street, you
18 noticed an ambulance parked up on the corner and you
19 pulled up behind that vehicle.
20 A. Yes, I did.
21 Q. And you then exited your vehicle and approached the
22 ambulance and in fact spoke to the crew in there at the
23 time?
24 A. That's correct.
25 Q. And in fact the ambulance that was there already had

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1 a patient with it; is that correct?
2 A. Yes, it is, yes.
3 Q. And that patient was then -- I think you approved the
4 dispatch of that patient, who you had identified as a P2
5 patient, to hospital?
6 A. I think the reality of it is that the crew -- so
7 I pulled behind the ambulance as I was -- as I believed
8 I was arriving at the rendezvous point and would have
9 expected to see ambulances at an RVP, and got out of
10 the -- of my own vehicle and knocked on the ambulance
11 door to get a sitrep, some awareness from the crew of:
12 is this the correct RVP? I was probably aware that one
13 ambulance at this point would signify that it probably
14 wasn't, and they were dealing with a patient.
15 The conversation that I had with them -- they were
16 asking: do you know where we need to go with this
17 patient, which hospital can we utilise? I believe that
18 I told them that I'd only just arrived on scene, I would
19 try and get that information for them and let them know.
20 I then proceeded to continue under the railway
21 bridge and started to make my way up Hunts Bank,
22 expecting to be able to either radio or return with the
23 information that they required.
24 I didn't return with the information that they
25 required, but they were informed by a member of the team

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1 or EOC that they were to attend MRI, and I have made
2 a note subsequently that they went to Manchester Royal
3 Infirmary.
4 Q. I'm not asking for the page of your logbook we have
5 already looked at to be redisplayed, but we see
6 reference to the ambulance, A570, the fact that it was
7 a patient with blast injuries, P2, requiring hospital,
8 and destination MRI?
9 A. Yes.
10 Q. So that evidences that contact you had on arrival?
11 A. Yes.
12 Q. You tell us in your witness statement that what you'd
13 also had confirmed to you as you made your way to the
14 scene was that this was a major incident?
15 A. I believe so, yes.
16 Q. And was there any other additional information, beyond
17 that that you had on the call with Mr Poland and the
18 initial call and the change of the rendezvous point,
19 that you're able to gather or listen to as you made your
20 way to the scene that we have not already addressed?
21 A. I'm not aware or I don't recall there being any other
22 information, no. There may have been -- there may have
23 been radio chatter before people have changed to the
24 radio channel, but I don't recall specifically.
25 Q. You tell us in your first witness statement that at the

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1 time when you arrived, you were still under the
2 impression that you were heading to the rendezvous
3 point, that the area where you had parked was relatively
4 quiet, and you approached an officer and asked him where
5 the forward incident point was, and you tell us in the
6 first witness statement that:
7 "The forward incident point is the area where
8 I would expect the commanding officers from each
9 emergency service to be. I was directed to Victoria
10 Station. As I was walking up Hunts Bank, I was thinking
11 how quiet it was, but when I got to the top it was
12 absolute mayhem. There were a few ambulances parked up
13 on the right--hand side of Hunts Bank and a couple at the
14 top."
15 A. That's my recollection, yes.
16 Q. Thank you. So as you left your vehicle it was first in
17 your mind to identify where the forward command point
18 was; is that correct?
19 A. That's correct, yes.
20 Q. And again, the inquiry has heard lots of evidence about
21 a forward command point, but why was it important for
22 you to identify where that forward command point was?
23 A. As I was attending in -- as an on-call commander with
24 a potentially -- a command position, I was aware that
25 that would be where Derek, my colleague, as the opposite

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1 on-call commander would be.
 2 Generally liaising with the other services and that
 3 would be the -- for me as a commander, that would be the
 4 point that I would look towards to identify, to first
 5 approach to be able to get that initial situational
 6 awareness of what was happening and what the needs were
 7 for the incident.
 8 Q. Thank you. In terms of that being a place where you
 9 needed to speak to the NWS commanders, was it
 10 correct -- is it correct that you also would have
 11 expected the other emergency blue light service
 12 commanders also to be co-locating at that point?
 13 A. At that point, as in that point of location, then yes.
 14 Potentially not at that point in time, perhaps. But
 15 I would -- there would be an expectation that other
 16 emergency services would be located at a forward command
 17 point.
 18 Q. And so you would -- you expected, as you made your way
 19 up Hunts Bank, there to be a physical place that was
 20 clear to everyone that was the forward command point?
 21 A. Not in so much as a physical -- as a physical --
 22 I expected there to be a place where I could identify
 23 where the commanders at scene were located and to be
 24 able to -- be able to infer almost: this is the forward
 25 command point and I will mobilise to where those

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1 commanders are and then establish this is the forward
 2 command point as we move forward, if that's the
 3 information I need.
 4 Q. Was it a Greater Manchester police officer that you
 5 approached?
 6 A. I believe it was -- well, it would have been, yes. It
 7 was somebody on the cordon at the bottom of Hunts Bank,
 8 I believe.
 9 Q. Thank you. You tell us in the witness statement that as
 10 you approached that you then saw your colleagues
 11 Dan Smith and Derek Poland outside of the station and
 12 you headed to meet them?
 13 A. Yes, I believe so.
 14 Q. So having very shortly before asked the officer where
 15 the forward command or forward incident point is, did
 16 you confirm with Mr Poland and Mr Smith at that time,
 17 "Is this the command point"?
 18 A. No. I think the -- I think the police officer just
 19 directed me in terms of, "Everybody is up there", as
 20 opposed to specifying, "This is a forward command
 21 point", which is understandable as they would have been
 22 on a cordoned area and wouldn't necessarily have had
 23 that information.
 24 I think my -- I met with Derek Poland and Dan Smith
 25 and that -- at that point Dan Smith was able to brief me

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1 on what the situation was at that point.
 2 But I don't think -- I don't think that it was
 3 a designated forward command point at that point. There
 4 was no other services there. It was just the first
 5 place that I located Derek Poland and Dan Smith,
 6 I believe.
 7 Q. You also tell us in the witness statement that as well
 8 as approaching Mr Smith and Mr Poland, you also recall
 9 that in the vicinity at the time was Mr Birchenough and
 10 Simon Beswick from the HART team; is that correct?
 11 A. That's correct, yes.
 12 Q. Can you then please tell us as to the information you
 13 received from Mr Smith when you approached him, please,
 14 outside the station.
 15 A. My recollection is that Dan Smith was able to brief me
 16 and my colleagues at that point. He informed me --
 17 I recall a conversation including that the belief was
 18 that it was an explosion, that it was a suicide bombing
 19 incident, and that there was one perpetrator. I believe
 20 that it was in that conversation that Mr Smith allocated
 21 the functional roles and it was my understanding that
 22 through that process of Dan Smith briefing us and
 23 allocating functional roles, that he would have assumed
 24 the operational command position.
 25 SIR JOHN SAUNDERS: Just before we go on, I'm sorry, was

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1 Mr Birchenough there at the time? You led it that -- on
 2 the statement that he was in the vicinity. It's no
 3 doubt my fault. I can't find it in the statement.
 4 MS CARTWRIGHT: It's the second statement, paragraph 18.
 5 SIR JOHN SAUNDERS: The second statement, thank you.
 6 Thank you. The first statement doesn't mention him.
 7 It mentions everybody else, but not him.
 8 MS CARTWRIGHT: Thank you.
 9 In terms of the functional role you were given, it
 10 was the ambulance loading officer?
 11 A. That's correct.
 12 Q. And what was your -- was there any discussion bearing in
 13 mind that you were the on-call operational commander, as
 14 was Mr Poland, and that Mr Smith wasn't in fact an
 15 on-call commander that night and I think in fact had --
 16 I think had -- was there any discussion, apologies,
 17 about whether in fact you or Mr Poland in fact would be
 18 more appropriate to be acting in the role of on-scene
 19 operational commander?
 20 A. No, there wasn't. But I don't think that I would expect
 21 that there would -- that there would be. As I was the
 22 last to arrive out of -- out of the three of us, then it
 23 would naturally fall to somebody else to do the
 24 operational command bit.
 25 If Mr Smith had already assumed that role prior to

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1 my arrival or Mr Poland's arrival, then it's my belief
 2 that he's more than competent to continue within that
 3 role, and I think it would be -- it would be a normal
 4 expectation for me to then take one of the functional
 5 roles and fall into what had already started to be
 6 established, that command and control structure.
 7 SIR JOHN SAUNDERS: Let me just stop there for a moment.
 8 Dan Smith is senior to you; is that right?
 9 A. Dan Smith at the time would have been a rank senior.
 10 However, as Dan Smith would have been a consultant
 11 paramedic at the time, so had more clinical
 12 responsibility whereas an operational manager has more
 13 operational responsibility. But yes, he would have been
 14 a rank senior, yes.
 15 SIR JOHN SAUNDERS: So you and Mr Poland are qualified
 16 operational commanders?
 17 A. Yes.
 18 SIR JOHN SAUNDERS: We have heard Mr Smith wasn't.
 19 A. And --
 20 SIR JOHN SAUNDERS: And we know it's not rank, it's job that
 21 counts.
 22 A. Yes. So I wouldn't have been aware of Mr Smith not
 23 being a qualified operational commander. I was aware
 24 that he was a qualified tactical commander, Silver
 25 commander, and aware that if he had been on scene for

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1 a longer period of time than myself or Derek, then
 2 I would have felt that he was able to take up that
 3 operational command role.
 4 SIR JOHN SAUNDERS: I'm not suggesting he didn't have the
 5 capacity. I'm just trying to work out how it worked,
 6 and I hope I'm correct in saying he didn't have the
 7 qualifications of operational commander. That's
 8 certainly my recollection of what he said.
 9 A. Sorry, sir, that may well be information that you have.
 10 That wouldn't be information that I had at the time.
 11 SIR JOHN SAUNDERS: Okay.
 12 A. But I can -- I think I can provide some assurance that
 13 it wasn't a decision that was made in relation to
 14 Mr Smith's operational rank, as you would.
 15 SIR JOHN SAUNDERS: Thank you.
 16 MS CARTWRIGHT: Can I just explore the matter further just
 17 a little bit?
 18 We know that at a later stage the operational
 19 commander role was changed from Mr Smith to Mr Hynes
 20 when he arrived. In that scenario would you expect
 21 there to be any discussion about, well, what training
 22 qualification do you have and actually is it more
 23 appropriate that you take on this role, or is that just
 24 not practical in practice?
 25 A. I don't think it would have ever occurred that in terms

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1 of questioning someone's qualification to do a role as
 2 such.
 3 I think perhaps that -- so the tactical commander
 4 position is a NARU-based course also, which generally
 5 people have covered a NARU operational commander course
 6 prior to that, but not necessarily all of the time, and
 7 the -- some of the attributes do work across both of the
 8 roles.
 9 So it's probably an assumption that he's qualified
 10 as such, but I certainly felt like he's competent to
 11 take that operational command position.
 12 Q. Can I ask you then if -- would you have been asking
 13 Mr Smith at that point who is the police operational
 14 commander, who is the fire operational commander, with
 15 your knowledge around JESIP and the importance of
 16 co-location of operational commanders?
 17 A. So I think that had -- almost immediately on my arrival,
 18 then I was -- I was tasked with a functional role as
 19 part of the major incident plan. And I think that had
 20 that functional role required that information, then
 21 absolutely I would have asked. But I don't think
 22 that -- at the time I clearly didn't feel that it did,
 23 and haven't explored that.
 24 I think at that point it was -- there was a large
 25 amount of -- there was a large amount of casualties,

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1 a large amount of particularly poorly and unwell
 2 patients that we needed to deal with, and there was
 3 a degree of urgency around setting up the structures to
 4 adequately move people from scene to hospital.
 5 Q. The first contact that you'd had from Control had
 6 indicated the potential for it to be a shooting
 7 incident. Did you in that first exchange with Mr Smith
 8 seek to get confirmation about whether this was an
 9 Operation Plato situation?
 10 A. I don't recall Operation Plato being words that had been
 11 discussed in those terms. However, it did make us aware
 12 that the understanding was that it was a lone individual
 13 and therefore who had exploded an IED device and
 14 therefore was -- there was no indication of any second
 15 suspect or any marauding aspect to the incident.
 16 Q. But would you, having been told originally that it could
 17 have been a shooting incident, not have wanted to
 18 satisfy yourself that that had been completely ruled out
 19 from the information that you sought from Mr Smith at
 20 the time?
 21 A. I think I was satisfied by the information that he gave
 22 that it was a lone individual who was now deceased, that
 23 it would not have fallen into Operation Plato based on
 24 the information that we had at that point. So I don't
 25 think I needed to -- I didn't feel at the time that

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1 I needed to ask specifically due to the information he'd
2 passed.
3 Q. Thank you. You also tell us in the witness statement
4 that as well as being allocated to the role of loading
5 officer, you were also briefed regarding the mass
6 casualty distribution plan which you understood at the
7 time was a new plan, recently agreed with hospitals
8 across Greater Manchester to determine their capacity to
9 treat casualties in a mass casualty situation and it was
10 important as loading officer for you to understand the
11 manner in which patients were to be distributed to
12 hospital.

13 So was that discussed at the same time as you were
14 being given the role, the functional role of loading
15 officer?

16 A. I think as -- either immediately after that initial
17 brief or as part of that brief we were informed that we
18 were looking at the mass casualty plan. My
19 understanding, I believe, at the time was that it was
20 a draft plan that had been either recently signed off or
21 was about to be signed off, but the hospitals had
22 engaged in the development of it and in principle there
23 was an agreement about it.

24 I'm aware that -- I wouldn't have been aware of
25 those things prior to my arrival, so unless briefed by

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1 Mr Smith at the time, then I wouldn't have been aware.
2 So I believe it was during that briefing.

3 Q. Thank you.

4 We know that the information as to hospitals and
5 number of patients reaching the hospitals was provided
6 by Annemarie Rooney to Mr Smith at 23.39 and so the
7 reference for that is {INQ034333/1}.

8 You tell us in your witness statement that you had
9 been handed over to you by Mr Smith what you believe
10 a sheet of paper containing the information. You do
11 qualify it by saying you can't specifically recall.

12 A. Yes, and I would -- I would agree with that aspect of my
13 statement, that I can't specifically recall how the --
14 having seen the mass casualty plan which details
15 particular hospitals with particular numbers of -- and
16 their ability to receive P1, P2, P3, patients, then
17 I can't specifically recall whether that was verbalised,
18 passed to me verbally by Mr Smith and I wrote it on
19 a gloved hand or whether it was on a piece of paper
20 I wrote down. I can't recall how I retained that
21 information as such.

22 Q. Can I ask you, would you have expected that before 23.39
23 there would have been greater clarity about the
24 distribution hospitals for patients?

25 A. I think at 23.39 there was probably still a degree of

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1 finding out the numbers of patients that were on scene
2 and what those priorities were. I believe at that time
3 then the movement from the City Room into the casualty
4 clearing station had come to an end or almost come to an
5 end anyway and some establishment of the command and
6 control.

7 The liaison with the hospitals, for me, would fall
8 under the sort of tactical command remit which would
9 probably be something that was -- which would be
10 something -- conversations which would be happening away
11 from the scene and off-site, as you will. So it may
12 well be -- I'm not aware that it was happening or wasn't
13 happening beforehand.

14 Q. We know there's -- in your pack there's the plan that's
15 been created of where the patients were and when they
16 were brought down. We know that casualties were in that
17 casualty clearing station area from 23.07, and we know
18 that those patients included P1, priority 1 patients.
19 So when you have patients in an area from 23.07, is it
20 not necessary that as that happens, it's equally known
21 where they can be taken to allow speed of extrication
22 and speed of treatment of patients in hospital?

23 A. I don't think it necessarily follows that knowing the
24 hospital capability would have dictated the speed of
25 extrication from the casualty clearing. I don't --

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1 I don't agree that those two are necessarily in line
2 with each other as such.

3 In normal working practice there's a trauma network
4 of hospitals anyway where we're able to take people with
5 different degrees of injury based on what that traumatic
6 injury is. So it wasn't a case that we were waiting --
7 anyone was waiting to -- for conversations with
8 receiving hospitals to say, "Are you ready to take these
9 patients?", as such.

10 Q. Can we please now look at the action card for ambulance
11 loading officer. Mr Lopez, could we display, please,
12 {INQ013422/32}. Thank you.

13 Just whilst that's coming on screen, I'm not going
14 to ask for the major incident plan to be displayed, but
15 we looked at it this morning with Mr Birchenough and
16 sir, for your reference again, it's {INQ013132/23}. In
17 the major incident plan the loading officer, card 16, at
18 paragraph 6.4.8 is described in this way:

19 "In liaison with the casualty clearing officer, the
20 loading officer is responsible for ensuring the
21 appropriate and effective loading of casualties from the
22 casualty clearing station on to the next available
23 appropriate vehicle."

24 Would you have had knowledge about that prior to
25 attending that night, about that role?

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1 A. I believe so, yes.
 2 Q. And we see now the action card on screen. Would you
 3 have had a copy of that action card with you that night?
 4 A. Yes, I have a pocketbook which contains -- which is the
 5 major incident and CBRNE pocketbook, which is an
 6 aide-memoire as such.
 7 Q. So when Mr Smith gave you the functional role of loading
 8 officer, would you have needed to have a look at that
 9 action card and what it required of you?
 10 A. I didn't have a look at the action card. The action
 11 card was available to me to look at. However, it wasn't
 12 my first instinct to review it, but it was available to
 13 me had it occurred to me to review it at that point.
 14 Q. We see the first matter identified on the action card
 15 is:
 16 "Don high-visibility tabard inscribed with 'loading
 17 officer' and protective helmet."
 18 You didn't have your commander tabards with you
 19 because I think you describe in your witness statement
 20 you'd left them in the car?
 21 A. Yes. So at the time, I believe, a commander tabard
 22 would be more accurate as I'm issued with an operational
 23 commander or Bronze, as it was referred to then, tabard,
 24 but not issued with functional role tabards.
 25 Q. But having then been given loading officer, would you

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1 not have thought then to obtain from somebody on the
 2 scene the loading officer tabard so there's complete
 3 clarity both for NWAS personnel deployed, but also the
 4 other services and personnel who had been dispatched as
 5 to who you were and that you were having a command role
 6 on scene?
 7 A. Yes, absolutely. That is what I should have done. On
 8 this occasion I didn't request a loading officer tabard.
 9 Q. Can you help, who could have had those tabards on scene
 10 from your knowledge of who was there as to where you
 11 could have got them from?
 12 A. I can't answer that. I'm not sure who would have had
 13 them. I'm aware that now they are issued to ambulances
 14 and the sliding sleeves are on ambulances. I'm not
 15 aware that that was the case at the time.
 16 Q. Move, please, to item 22 on the action card:
 17 "Check communications/radio Talk Group and start an
 18 incident log."
 19 You've told us already on the way to scene that you
 20 were on the major incident channel for North West
 21 Ambulance Service. Did you have your radio with you
 22 throughout that evening on that major incident channel
 23 for NWAS?
 24 A. Yes, I did.
 25 Q. We can see also that you have continued to make entries

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1 in your notebook. Where there's a reference to an
 2 incident log, would it have been expected that you
 3 started a separate sort of log beyond what you put in
 4 your notebook?
 5 A. It wouldn't be my expectation of that being
 6 a requirement, no. It's my understanding that that is
 7 my incident log.
 8 SIR JOHN SAUNDERS: And you were making notes at the time or
 9 later?
 10 A. At the time.
 11 MS CARTWRIGHT: We will look at those notes a minute.
 12 You have already confirmed that you understood that
 13 the loading officer would be responsible for the
 14 management of the vehicles and the controlled onward
 15 transportation of patients from the casualty clearing
 16 station to definitive care.
 17 If we just perhaps work through the rest of them:
 18 "Establish a loading point with consideration to
 19 access."
 20 Where was the loading point?
 21 A. The loading point will have been on Station Approach,
 22 opposite the memorial entrance to Victoria.
 23 SIR JOHN SAUNDERS: But the closest place people for people
 24 to be brought out from the CCS?
 25 A. That's correct.

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1 MS CARTWRIGHT: Next we can see that it was also required
 2 that:
 3 "In liaison with the Emergency Operations Centre and
 4 parking officer, ensure an adequate supply of ambulances
 5 and equipment to the loading point."
 6 A. Correct, yes.
 7 Q. I think you tell us in the witness statement that you
 8 didn't in fact need to contact Control to request more
 9 ambulances on the night?
 10 A. No, I didn't make any -- I don't recall making any
 11 contact with emergency -- EOC, Emergency Operations
 12 Control, around requiring more vehicles. I'm assuming
 13 that somebody clearly did, as more vehicles were
 14 dispatched as and when they were available, but it
 15 wasn't -- it wasn't on my request.
 16 Q. And were you well aware that Mr Poland was the parking
 17 officer?
 18 A. Yes, I believe Mr -- Derek Poland was the parking
 19 officer at the beginning stages of the incident and then
 20 in the subsequent stages I believe it was Fran Dreniw.
 21 Q. Thank you for qualifying that. Would that be after
 22 Mr Hynes arrived on scene?
 23 A. That would be correct, yes.
 24 Q. Next we see at point 6:
 25 "In liaison with the casualty clearing officer/CCS

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1 medical lead organise the packaging, loading and
 2 dispatch of casualties in priority order.”
 3 You were aware that Mr Birchenough was the casualty
 4 clearing officer ?
 5 A. Yes, I was.
 6 Q. But who did you believe was the CCS medical lead?
 7 A. I don't recall being made aware of a specific CCS
 8 medical lead, although I was aware of MERIT doctors and
 9 doctors who were working within that CCS. I wasn't made
 10 aware of who was the lead as such. However, I had
 11 conversations with several members of that team.
 12 Q. Did you at any point seek to ask from Mr Smith who he'd
 13 allocated that functional role to?
 14 A. No, I did not.
 15 Q. We can then see at point 7:
 16 "In liaison with the CCS medical lead, identify the
 17 suitable patients for evacuation by air assets."
 18 But that didn't apply here, is that not correct,
 19 because air assets weren't to be used?
 20 A. That's correct, yes. There was no air asset
 21 availability .
 22 Q. We can see 8:
 23 "Ensure that all patients have been triaged and
 24 labelled prior to leaving scene."
 25 Did that take place on the night?

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1 A. I believe so, yes.
 2 Q. 9:
 3 "To ensure a record of patients leaving the casualty
 4 clearing station is maintained, use the loading point
 5 log and triage tags."
 6 I think you have fairly accepted in your witness
 7 statement that that didn't take place?
 8 A. What didn't take place would be the -- so I would say
 9 that a record of patients leaving the casualty clearing
 10 station was maintained and that's displayed in the log
 11 that I kept. But what I didn't do was use the specified
 12 loading point log and some aspect of the triage tags.
 13 But I believe that the majority of the information
 14 that's required in the loading point log is the
 15 information that I recorded in my pocket log at the
 16 time.
 17 Q. We will look at that log in a minute.
 18 You tell us about the slips:
 19 "I'm aware that the triage categorisation card had
 20 a tear-off slip that should be collected and retained
 21 prior to patients leaving the scene for hospital.
 22 I accept that as the loading officer the responsibility
 23 for collecting these slips would fall to me. However,
 24 at no time during this incident did I ask for nor was
 25 I passed any of these slips such that the details could

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1 be retained. I do however accept that this should have
 2 been done.”
 3 A. Yes, I think that is -- that remains reasonably
 4 accurate. I think I may have requested the major
 5 incident number, which is what is recorded on the slip
 6 from the initial ambulances that were leaving, but
 7 the -- due to the nature of the injuries of the patients
 8 that were leaving in the first two ambulances, the
 9 ambulance crews didn't have immediate access to that.
 10 From that point on, I don't require -- I don't
 11 recall asking again for that information. However,
 12 I think in my log there is -- there is a detail at some
 13 point where an ambulance crew has volunteered that
 14 information to me as I have recorded it in my log.
 15 Q. Thank you. We will work through your notes in a minute
 16 that record patients and patient dispatch.
 17 But if the slips had been used and if the system
 18 envisaged had worked in practice on the night, where
 19 would those slips have gone and what would have happened
 20 to them?
 21 A. So in -- the way it's envisaged or the way it's written
 22 is that the slips are taken and placed into a folder
 23 which has a number of poly pockets and is collected and
 24 saved as and when you're going along, and then referred
 25 to afterwards.

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1 I believe that the purpose will be to maintain
 2 a record of who is leaving, when they are leaving, and
 3 be able to track patients afterwards.
 4 Q. Just to complete then the action card 16, we can see at
 5 10 that part of your role was also:
 6 "To collect ambulance and medical equipment used on
 7 site and to return it to source."
 8 And finally there's an identification for incident
 9 logs.
 10 Let's please now look at your -- the notes that you
 11 did make that evidence the dispatch of patients to
 12 hospital.
 13 Mr Lopez, please can we display {INQ023259/3}.
 14 I appreciate -- I think I'm just taking it -- I think
 15 it's the same document we looked at a moment ago, but
 16 I have gone to a different reference, sir, so it's not
 17 a different logbook.
 18 I'm not going to work through this with you, but is
 19 this the record that you kept of the dispatch of
 20 patients, their prioritisation when they left, and the
 21 ambulances that they were dispatched on and the
 22 hospitals they went to?
 23 A. That's correct, yes, it is.
 24 Q. Perhaps, Mr Lopez, if we move through the next two
 25 pages, so that can be --

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1 SIR JOHN SAUNDERS: Just help me with the fourth entry,
2 "Jim B".
3 A. So that is referring to Jim Birchenough --
4 SIR JOHN SAUNDERS: Yes.
5 A. -- who had placed a patient into the ambulance
6 Alpha 486, but I was aware that he had -- either he made
7 me aware that he hadn't recorded the time or I hadn't
8 noted the time, but I made a note that it was Jim.
9 SIR JOHN SAUNDERS: I was just interested to know why that
10 was there.
11 MS CARTWRIGHT: You describe that in the witness statement
12 you provided as one example of where you were bypassed
13 for a dispatch of an ambulance, and I think you give
14 another example where something similar had happened
15 where a patient had been placed in an ambulance without
16 your knowledge.
17 A. That's correct. And I think the reason that
18 I highlighted it is around the loading officer role
19 being part of the command and control of patients being
20 moved from site and if there isn't that degree of
21 control, that's when there's the danger that people who
22 are classed as -- not classed at priority 1 patients are
23 potentially, for want of a better phrase, jump the
24 queue, are removed to a hospital without the details
25 being recorded and making it difficult for us to track

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1 movement later on.
2 Q. In terms of the notes that you completed, perhaps if we
3 work through the pages so it's displayed on screen, so
4 the recording that you did create is identified. If we
5 can just move through {INQ023259/4}, please. And then
6 on to {INQ023259/5} also just to evidence the records
7 you kept on the night, but also the notes you made.
8 If that please could be removed from the scene.
9 I want to ask you, please, the -- we have dealt with
10 now the briefing you were given by Mr Smith and we have
11 dealt with your roles as the loading officer and what
12 that involves and what happened on the night. But
13 I want to just move, as you went forward, after meeting
14 Mr Smith and being given that functional role, you tell
15 us in the witness statement about what you saw at the
16 time and also what you had assessed in your first
17 witness statement to be the casualty clearing point --
18 sorry, casualty collection point, but also what was the
19 casualty clearing station.
20 Can I seek to confirm, because in the second witness
21 statement there seems to be -- it seems to be slightly
22 different as to what you're saying about the different
23 areas.
24 But if we look at the first in time account you
25 gave, you set out that:

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1 "A casualty collection point had been set up in
2 Victoria Station when I arrived. This is where the
3 patients received an initial basic triage via a triage
4 sieve. The aim of the sieve is to give the patient
5 a priority."
6 Then you went on to tell us a little later that:
7 "The casualty clearing station was located at the
8 front of the station, to the left-hand side, slightly
9 away from the majority of the casualties. It was set up
10 by the HART team and is an area which contains equipment
11 and is manned by HART team members."
12 You tell us that:
13 "Casualties were moved from the CCP into the CCS as
14 and when transport away from the scene is available."
15 So is that your understanding of the CCP and the CCS
16 on the night?
17 A. I think initially my understanding -- when I initially
18 arrived, it was indicated that the HART team were
19 setting up the CCS and I could see the HART team setting
20 up an area outside the memorial entrance to Victoria
21 Station which I'll have seen them doing that, and with
22 that information, assumed that this is the CCS, that
23 area.
24 I don't remember anyone providing any definition or
25 any label of this is -- an indication that, "This is the

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1 CCP, this is the CCS".
2 I think from the time that I spent at the incident,
3 it appeared to me that initially the patients that were
4 in the concourse of the -- of Victoria Station, that may
5 have started as a CCP, but quickly became the CCS. The
6 area outside, which is where the HART team had been
7 setting up, that was used as an extension of the CCS and
8 was -- it was in fact really the loading point almost
9 for the patients that were coming out of the CCS and
10 being moved into -- into ambulances.
11 The external area was the area, I believe, where the
12 doctors, medical team, were stabilising patients
13 immediately prior to them being able to be allocated
14 into an ambulance and moved to the hospital.
15 Q. Thank you. Just going back to the discussions we had
16 earlier about what Mr Smith told you, what was your
17 understanding then as to the zones that were in
18 operation both in the station but also within the
19 City Room and the area down the stairs, the concourse?
20 A. I don't -- I don't recall there being any conversation
21 that I was involved in which dictated what the zones
22 were and where they were.
23 However, on the initial conversation, the initial
24 briefing with Mr Smith provided us with a limit of
25 exploitation which for me would have indicated that

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1 ambulance staff would not have proceeded past that
 2 point. That would have been at the bottom of the stairs
 3 leading up the stairs into the foyer/City Room, which
 4 I believe that might then -- and it would have been my
 5 own rationalisation of what -- if we were utilising
 6 zones, what they would have been, that would have
 7 created that area as a hot zone.

8 Q. Is that the area beyond --
 9 A. Beyond the steps into the City Room as the -- would have
 10 been the hot zone. But I think again that is -- that's
 11 my rationalisation as a commander at scene, not
 12 something that was articulated in any briefing.

13 Q. But you're not describing that then as a Plato hot?
 14 A. No. I would be utilising the -- so NWAS use inner and
 15 outer cordon if it's a major incident, which you
 16 would -- so, for instance, a rail incident or any mass
 17 casualty. However, if it's a chemical, biological,
 18 radiological, nuclear explosion, CR explosion, CBRNE,
 19 then we would refer to the hot, warm and cold zones,
 20 I believe.

21 Q. So in terms of the area, whether it's a CCP or a CCS,
 22 that's in the station concourse area, that was a warm
 23 area where non-specialist NWAS personnel were fine to be
 24 operating?
 25 A. So I think utilising any of the zone -- the major

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1 incident plans where we talk about zones, then it's
 2 about -- it's about having appropriate PPE to -- in
 3 a particular area. So if -- in those terms, a warm zone
 4 requires somebody with the appropriate PPE to reduce
 5 that risk in that warm zone. If we're talking about an
 6 Operation Plato warm zone, then it would be -- because
 7 it's ballistic PPE, then that would be specialist and
 8 responders who go in there.

9 If it's a CBRNE, and the risk is perhaps, you know,
 10 more structural or is unknown, then perhaps the --
 11 provided that risk is assessed and looked at whether we
 12 can do anything about reducing it or eliminating it,
 13 then that appropriate PPE could be worn.

14 Q. Just to complete the zoning, you tell us in the second
 15 witness statement that during the course of your
 16 attendance at the scene, you permanently considered the
 17 City Room and beyond to be a hot zone, the concourse and
 18 areas immediately outside the station to be a warm zone,
 19 and anything beyond the police cordon a cold zone.

20 A. Yes, I believe that would fit with my thinking at the
 21 time, yes.

22 Q. What role did you take in particular in terms of then
 23 prioritisation of how you were going to get the P1s, the
 24 P2s and the P3s to hospital? How did it work in
 25 practice?

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1 A. In practice we were -- we were faced with a large number
 2 of casualties within -- within the concourse area, and
 3 initially didn't -- initially the ambulance response
 4 didn't have the number of resources that was required.
 5 It would be normal practice for an ambulance to arrive
 6 and where there's more than one casualty, the two
 7 occupants of the ambulance would naturally split and
 8 each would deliver one-to-one care to each of the
 9 patients.

10 If there were -- if there were 38 casualties within
 11 that concourse, then the first 19 ambulances that
 12 arrived would have been tied up, providing that initial
 13 one to one care. So the difficulty at first was very
 14 much providing clinicians to look after these people
 15 with devastating injuries and to provide them the
 16 much-needed clinical interventions on that concourse.

17 The subsequent vehicles that arrived after the
 18 19th vehicle, for example, after they arrived, those
 19 were the vehicles that could then start to provide the
 20 transportation.

21 So my role initially was around working with the
 22 casualty clearing officer and working with the HART team
 23 leader at that point to provide clinicians into the
 24 casualty clearing who could assist patients there, and
 25 also there was the immediate priority patients who were

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1 the first to be transported out there, and to physically
 2 have a vehicle with a stretcher, a trolley stretcher, in
 3 it to transport those patients.

4 SIR JOHN SAUNDERS: Okay. So the first -- you are saying
 5 really the first 19 ambulances are completely tied up
 6 and out of commission for getting people to hospital to
 7 start with?

8 A. Realistically, and so I think that -- I think that the
 9 reality of it is that it wouldn't have been the first 19
 10 because I think we moved a couple of -- the first two
 11 patients that moved prior to midnight will have been
 12 moved when potentially other patients in the CCS didn't
 13 have one-to-one clinicians with them. So it wasn't
 14 a case of 19 must arrive before we do anything. So
 15 there was -- there was a matter of urgency to remove the
 16 first two patients that left who were critically unwell.

17 SIR JOHN SAUNDERS: Right. Apart from the first two -- I'm
 18 just trying to work out whether the delay could have
 19 been avoided.

20 So you do -- you've got one clinician to each
 21 injured person?

22 A. Yes.

23 SIR JOHN SAUNDERS: They have come in ambulances with two
 24 people in them?
 25 A. Yes.

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1 SIR JOHN SAUNDERS: You require two people to go back with
 2 them?
 3 A. Yes.
 4 SIR JOHN SAUNDERS: Was there any other way of organising
 5 your resources? For example, did the P2 patients need
 6 someone with them all the time or could you have doubled
 7 them up so you could get the P1s out quickly?
 8 A. Under the circumstances -- and I believe that is -- the
 9 likelihood is that that is what happened, as I believe
 10 that I have recorded the P1s as leaving first, the
 11 majority of them. So I believe there would have been
 12 decisions made within the casualty clearing station
 13 around whether a clinician is allocated to an individual
 14 patient or whether they're allocated to move a P1.
 15 But you're absolutely correct, the difficulty is
 16 that the transportation of the patients requires two
 17 clinicians, one to drive, one to look after patients in
 18 the back, and whilst the -- whilst -- the first stages
 19 of those -- we didn't have the -- we didn't have the
 20 resources to provide transportation and -- without
 21 potentially leaving behind people.
 22 In reference to your P2 -- your query around P2,
 23 many of the P2s also had devastating injuries --
 24 SIR JOHN SAUNDERS: I'm simply looking at possibilities.
 25 A. No, absolutely.

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1 SIR JOHN SAUNDERS: It seems a delay of getting people to
 2 hospital was caused -- you've got enough ambulances, you
 3 just don't have enough people to man them.
 4 A. That would be -- yes. That would be -- with physical
 5 vehicles, then yes, we would have potentially had enough
 6 of those, but people to transport them and be able to
 7 maintain clinical care to the patients that we left
 8 behind, then we wouldn't.
 9 So the people within the -- the medical team within
 10 casualty clearing station will have been having
 11 conversations around, "This priority 1 needs to go now
 12 and that priority 1 can perhaps wait for the next
 13 ambulance to come along", to provide some care and they
 14 will flit between.
 15 So those were the difficult decisions, I suppose,
 16 that that team were making.
 17 SIR JOHN SAUNDERS: Were you making them or --
 18 A. No, my role was more to -- once an ambulance was
 19 available which had two physical persons who were able
 20 to -- if an ambulance arrived and had two people they
 21 would be able to go over to the -- they were dispatched
 22 over to the loading point area, the external CCS, where
 23 there would be a clinician with a patient and they would
 24 then take that patient with that new ambulance person
 25 who had arrived and into an ambulance. My role was to

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1 then provide them details of which hospital they were
 2 going to.
 3 SIR JOHN SAUNDERS: Okay. But we are not talking here about
 4 ambulances which arrived in the early stages. We're
 5 talking about new ambulances turning up. You've got
 6 a whole load of ambulances queued down there but all
 7 their clinicians and the drivers are out treating
 8 patients. So you're waiting for the next one to come
 9 along with a crew of two in order to take someone out.
 10 A. I would perhaps clarify the whole load of ambulances.
 11 There were a number of ambulances as they came along.
 12 But yes, in principle I would agree with you.
 13 SIR JOHN SAUNDERS: I'm talking about a load because I'm
 14 talking about roughly 19 because you've got your 38
 15 clinicians inside which have come from them. That's
 16 where the load comes from, the 19 down the road.
 17 A. I may have misled you there, sir --
 18 SIR JOHN SAUNDERS: How many about were parked down the
 19 road?
 20 A. There were a number that were at an RVP and they were
 21 dispatched in batches of five or six. There was
 22 a degree of the CCS team looking at who they were going
 23 to move next. But I think what I was trying to
 24 illustrate was that to move all of those people in a --
 25 with a degree of haste, more so than we did, would have

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1 required that 19 ambulances at least to provide that
 2 clinical care and then subsequent ambulances were moving
 3 patients.
 4 SIR JOHN SAUNDERS: Okay. And there was no other way of
 5 managing so far as you were concerned?
 6 A. Not that I'm aware. I'm sure that there may have been
 7 options that haven't -- that I haven't considered. I'm
 8 more than happy to listen to those.
 9 SIR JOHN SAUNDERS: Well, I am not going to give them
 10 because you are the expert. But are there -- is
 11 anything said in the major incident plan, "This is
 12 something which can happen"? So has it been foreseen or
 13 forecast in the major incident plan as to how you deal
 14 with it?
 15 A. I think the major incident plan talks about the
 16 structures that are put in place and how we do that.
 17 Part of that structure being in place is the control --
 18 the controlled release of patients from an area, not
 19 wanting to -- not wanting to overload hospitals by six
 20 ambulances arriving at the front door all at the same
 21 time, which would be detrimental to the patients'
 22 treatment when they do arrive.
 23 So I think there's -- there's a number of things,
 24 and it's down to that team within that CCS who worked
 25 really hard to direct their attentions to where it was

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1 needed.

2 SIR JOHN SAUNDERS: I am absolutely not thinking that anyone

3 wasn't working hard and doing their absolute best. What

4 we are thinking about here is systems, whether there

5 are — there may be just no way of improving the system,

6 no way of getting people quicker, but we need to look at

7 that possibility and how to do it.

8 A. I absolutely agree.

9 SIR JOHN SAUNDERS: You've got MERIT doctors, you've got

10 other types of doctors who I'm going to forget the names

11 of, you have other doctors who have come off the street,

12 so you do have other medically qualified people on there

13 apart from the paramedics, don't you —

14 A. Yes.

15 SIR JOHN SAUNDERS: — who would be able to be looking after

16 or being with a patient?

17 A. Yes, and I believe that is what was occurring at the

18 time.

19 SIR JOHN SAUNDERS: Okay.

20 A. Right, thank you.

21 MS CARTWRIGHT: I just want to be clear then: you obviously

22 are recording who is going out on the ambulance and

23 directing which hospital they are to go to in accordance

24 with the plan. But whose role would it have been on the

25 night then to say, "Which ambulance have you come off

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1 and, actually, I may need move you off that patient to

2 get you back to your ambulance to get things moving?"

3 Who was doing the tracking of who was where and then the

4 allocation of ambulances to move things along?

5 A. So I don't believe there was a necessity as such to

6 track which ambulance somebody had arrived on and —

7 there was no need to ensure that if you arrived on one

8 ambulance you left on the same ambulance.

9 Q. We have seen that. But particularly where crews are to

10 be split, and if there's a crew member that is inside

11 treating a patient, wouldn't there need to be someone

12 who see how things could be moved along as to the

13 ambulance resource and the paramedics that have come off

14 those ambulances?

15 A. I'm sorry, I'm not sure I understand your question.

16 Q. You've told us that when the crews split, then the

17 ambulance couldn't be dispatched because it needed to be

18 double-crewed for the ambulance then to go to hospital.

19 A. Yes.

20 Q. And so the double crew has come on an ambulance?

21 A. Yes.

22 Q. They are linked to that by way of their radios?

23 A. Yes.

24 Q. So even if they stay at the scene, the information they

25 will get on their radio is still linked to the vehicle

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1 that's outside?

2 A. No. So there's no necessity for someone to — once you

3 can change ambulance, you could work on — they could

4 move any ambulance, and that's in effect what happened.

5 So you would arrive — an ambulance crew may arrive

6 as a pair and split and go and look after two patients.

7 Another ambulance may arrive from somewhere else, split,

8 and team up with the two previous, take an ambulance

9 that belonged to a different area that they hadn't —

10 none of the four of them had arrived in.

11 Sorry, if I'm confusing —

12 Q. No, I'm sure it's my question. But then when the

13 ambulances are stacked in a way on Station Approach

14 where there's a one-way system, who then is making sure

15 that there's two paramedics on that ambulance that's at

16 the front of the queue?

17 A. So I believe I'm making sure that there's two paramedics

18 that are able to move the ambulance and that are

19 transporting people.

20 Q. And in terms of you being the person outside the

21 station, operating the system, was there any delay that

22 night due to the splitting of the crews and the crews

23 not being able then to move off together?

24 A. The delay was — so there will have been delays due to

25 splitting crews so that they could provide clinical care

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1 to patients that didn't have clinical care yet.

2 So the offset was that — of that would be that you

3 would need to — you would need to dispatch an ambulance

4 and move a patient and then leave a patient with no care

5 behind, potentially.

6 Q. And who was then managing getting the new person to the

7 patient in the station still?

8 A. That would have been via the CCS team. They would

9 arrive. I would dispatch them to CCS. CCS would then

10 say, "Look after — this is the patient that you need to

11 look after". I would then liaise with the HART team

12 leader in the external CCS/ambulance loading point if

13 they had someone who was available and ready to be

14 transported to the hospital, then I would facilitate

15 provision of an ambulance and ambulance crew if they

16 were available to then move them or let them know how

17 long it was, you know, potentially before we had

18 somebody to transport a patient.

19 Q. Thank you.

20 You tell us in your first witness statement that you

21 gave Jim Birchenough direction that no one was to move

22 until you had spoken with him to direct them as to which

23 hospital to go.

24 A. To yes.

25 Q. Did that specifically occur after Jim Birchenough had

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1 put someone on an ambulance that been dispatched and we
 2 see on your notebook or it had it occurred before that?
 3 A. It occurred after that incident.
 4 Q. And you say:
 5 "There was a problem in that people were flagging
 6 ambulances down. Therefore I couldn't document every
 7 patient and which hospitals they'd gone to."
 8 A. So yes, that would have been -- would have been the
 9 concern that if I'm keeping a log and trying to control
 10 in terms of priority of movement out, if ambulances that
 11 are just arriving or are the way are being flagged down
 12 or utilising patients or putting patients in them, then
 13 that -- there's a potential that would have been outside
 14 of that priority of movement for the patients.
 15 Q. Thank you. We know that there were ambulances that were
 16 at the RVP at Thompson Street. And so who was then
 17 looking at what was happening on the scene outside the
 18 station and then making sure that there continued be the
 19 flow of ambulances from Thompson Street Fire Station to
 20 the arena?
 21 A. I feel that would be a parking officer role who would
 22 have that information and that --
 23 SIR JOHN SAUNDERS: I think we have heard that it was the
 24 parking officer.
 25 MS CARTWRIGHT: You've told us in the witness statement also

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1 that primarily where you based yourself that night was
 2 outside of the station.
 3 A. Yes, that's correct, primarily.
 4 Q. Can you assist us to the P3 patients? Who was looking
 5 after them?
 6 A. In terms of clinically, I believe there was a period
 7 where student paramedics, perhaps, were looking after
 8 them. I know there was a period where we had dispatched
 9 some urgent care staff who wouldn't normally respond to
 10 emergency calls, and asked EOC to increase the numbers
 11 of transporting vehicles had -- had dispatched some
 12 urgent care staff. I believe they were -- were looking
 13 after or monitoring the walking wounded patients.
 14 Q. Understandably your priority had to be those P1 and P2
 15 patients, but had you been formulating, whilst you were
 16 loading, as to how it was moving forward that the P3
 17 patients would be transported to hospital?
 18 A. No, I hadn't. I think that for me that would be -- the
 19 movement of P3 patients generally wouldn't involve the
 20 use of emergency vehicles and would be something that
 21 the tactical commander would liaise with perhaps the
 22 local authority or our patient transport service to
 23 provide a different means of transportation. So my
 24 understanding is that that would be something that would
 25 be organising -- organised away from scene which would

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1 allow us to continue with the task in hand of moving
 2 patients from the scene.
 3 SIR JOHN SAUNDERS: It sounds a bit haphazard. In fact we
 4 know Chief Inspector Dexter got the bus to turn up.
 5 A. Yes, I would agree that for me one of the learning
 6 points for me is around how we managed P3s and the
 7 amount of -- whether it was necessary that they were --
 8 that they remained on scene and witness to these
 9 particularly difficult events for longer than was
 10 necessary had there been more focus on it. But I feel
 11 that it's probably -- those are the sort of tactical
 12 decisions that are made away from the actual operational
 13 site as such.
 14 SIR JOHN SAUNDERS: I'm not suggesting you didn't have
 15 enough to do.
 16 A. I appreciate that, sir.
 17 MS CARTWRIGHT: Mr Calderbank, can you assist us also, just
 18 so there can be clarity as to how the system operated,
 19 that once you knew the hospitals and what specialities
 20 they had, because I think they have different centres
 21 where they can specialise for the injuries a patient
 22 has, but when was it identified as to which hospital the
 23 patient was going to? Was it simply when they were
 24 brought out to you or was it established long before
 25 that?

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1 A. No, so the way the process worked on the evening is that
 2 I had been provided with the numbers of patients of --
 3 particular designations of priority patients each
 4 hospital could accept without -- without overloading
 5 them. I then made the decisions around which hospital
 6 the patient was going to be dispatched to from the site.
 7 That decision was made based on the local knowledge
 8 of the -- of what type of injuries that particular
 9 hospital may specialise in. I had a conversation with
 10 Derek Poland at the time just around which hospital was
 11 potentially the nearer. A lot of the hospitals within
 12 the Manchester area, there's a mile or 2 miles, half
 13 a mile between them, so just to clarify that hospital A
 14 was closer than B, and then they were dispatched to the
 15 hospital with a view of not overloading the hospitals to
 16 make sure that they were able to treat the patients as
 17 and when they arrived and that an ambulance wasn't
 18 arriving with a particularly unwell patient when all of
 19 the hospital resource were already dealing with
 20 a particularly unwell patient.
 21 Q. Thank you.
 22 You tell us in your second witness statement that:
 23 "As the night progressed there were occasions where
 24 different teams of clinicians looking after patients
 25 found themselves naturally competing with regard to the

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1 movement of their patient and it was [your] role to act
 2 as a conduit between the clinical teams to determine
 3 which patients were the most severely unwell in order to
 4 ensure the patients were moved in order of priority ."

5 A. Yes, I think that's --- I think what I'm referring to
 6 there is around the clinicians , the medical teams that
 7 were there, they were obviously keen to move patients
 8 that they were looking after who were priority 1
 9 patients may not have been aware that there was another
 10 priority 1 patient who had similar needs, and it was
 11 around having --- facilitating those conversations
 12 between perhaps those doctors or advanced paramedics to
 13 make a decision of which --- which of these priority
 14 patients ---

15 SIR JOHN SAUNDERS: I hope there wasn't too much discussion
 16 and a fairly quick decision was made.

17 A. Yes, absolutely , sir .

18 MS CARTWRIGHT: Mr Calderbank, finally in terms of your
 19 involvement on the night before moving to your debrief,
 20 you tell us in your witness statement that you recall
 21 the Fire Service were not immediately on scene and
 22 arrived in the early hours of 23 May, but you remember
 23 the vehicles driving down Station Approach and pulling
 24 over, and you advised them that they were not to park
 25 their vehicles in that location and they subsequently

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1 moved them further down the road.

2 Did then the arrival of the pumps outside Station
 3 Approach, did that disrupt in any way the distribution
 4 of patients?

5 A. No. As --- as they came down Station Approach, I asked
 6 them to --- that was part of our access and egress and
 7 part of the loading area of the process that we had in
 8 place, so I asked them to move, which they did
 9 immediately.

10 Q. Thank you. Can we move now, please, to look at your
 11 debrief documents that you've completed?

12 SIR JOHN SAUNDERS: While they are coming up, by all means
 13 give the reference.

14 MS CARTWRIGHT: The first one will be {INQ022370/17}, thank
 15 you, Mr Lopez.

16 SIR JOHN SAUNDERS: While you are doing this job and you are
 17 outside and located outside, did Dan Smith come and see
 18 you to see how things were going?

19 A. Yes, there was a --- there was regular conversations.

20 SIR JOHN SAUNDERS: So you had an ongoing dialogue?

21 A. Yes, there was ongoing dialogue through the functional
 22 roles throughout the incident. Just to --- around
 23 numbers of patients remaining ---

24 SIR JOHN SAUNDERS: You were making it work smoothly?

25 A. Yes, as smoothly as we could.

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1 MS CARTWRIGHT: Mr Lopez, could we please --- thank you.

2 Mr Calderbank, this is the first of the forms you
 3 completed from the debrief relating to preparedness and
 4 this debrief form deals with what went well and what
 5 prepared you well, but also areas for improvement.

6 So I'm going to quickly move through the entries
 7 you've made because I think a lot of them are
 8 self-explanatory, and then we will deal with the
 9 response itself .

10 So for "command and control", under that box we have
 11 got:

12 "Trained and qualified but not on each functional
 13 role. On-call structure robust enough?"

14 A. That's correct.

15 Q. So what does the question mark mean there?

16 A. So I suppose I'm questioning whether the on-call
 17 structure is robust enough, whether the --- whether --- as
 18 I'm qualified and trained as an operational commander,
 19 but at the time there was no training qualification
 20 around functional roles . There is around --- now around
 21 some of the functional roles . I think I'm querying
 22 whether that means that the on-call structure is robust
 23 enough in terms of do we need trained functional roles
 24 and do they need to be on an on-call structure for this
 25 sort of incident .

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1 SIR JOHN SAUNDERS: And do they?

2 A. I think ideally --- I think that would be --- that would
 3 be excellent. How often they were called into use and
 4 how well---practised, risk versus cost , are all course
 5 considerations for an NHS organisation. However ---

6 SIR JOHN SAUNDERS: Okay.

7 A. --- in an ideal world ---

8 SIR JOHN SAUNDERS: Clearly this job, rather than being
 9 thrown into doing it at an emergency like this, and
 10 dealing with seriously ill patients, if you'd had some
 11 training beforehand in how to do it, you wouldn't have
 12 required very much training to do it, would you?

13 A. Sorry ---

14 SIR JOHN SAUNDERS: To do this job that you were doing of
 15 moving, getting the patients out, being the loading
 16 officer .

17 A. I think that --- I think the annual commander training
 18 does --- does cover the main roles, and it gives a nod to
 19 the functional roles . And there's an expectation as
 20 a commander that you familiarise yourself and, you know,
 21 work to have that understanding.

22 It would be --- it would be great to arrive at an
 23 incident with people who are absolutely versed in each
 24 of the functional roles and we know who they are and
 25 they know what is expected of them each and every time

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1 to the Nth degree.
 2 SIR JOHN SAUNDERS: But you would be better at doing it now
 3 having done it once than you might have been this time?
 4 A. Absolutely.
 5 MS CARTWRIGHT: Concluding the comments for "command and
 6 control":
 7 "Met with commanders on scene and roles allocated.
 8 Aware of what individuals were doing. Well-organised
 9 initial command structure."
 10 A. Yes.
 11 Q. Moving to "safety", you set out how you were made aware
 12 of the incident nature immediately:
 13 "Limitation set early."
 14 And when you say "limitation set early", does that
 15 mean the limit of exploitation you've told us about?
 16 A. It does, yes.
 17 Q. "Large police presence. Staff used PPE. Occasional
 18 crew with no" --
 19 A. Helmet.
 20 Q. "... helmet. Left to drive vehicle and remained in
 21 safer area. Secondary devices considered but later."
 22 A. That's correct, thank you, sir.
 23 Q. You've highlighted under "communication":
 24 "Airwaves. Provided details of commander. Improved
 25 when Talk Group"?

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1 A. "Changed."
 2 Q. "... changed."
 3 And you used your mobile en route. So again, were
 4 you identifying that plainly having that major incident
 5 Talk Group up and running, the sooner that can take
 6 place the better?
 7 A. Yes. I think that's fair to say, yes.
 8 Q. For "assessment" you identify:
 9 "Overall assessment of incident, access and egress
 10 routes communicated. Numbers of casualties and hospital
 11 ability to accept provided early on. Some local?"
 12 A. "System knowledge."
 13 SIR JOHN SAUNDERS: I'm not sure why everyone thinks
 14 capitals are easier to read than ordinary writing.
 15 A. I can only apologise.
 16 SIR JOHN SAUNDERS: No, no need.
 17 MS CARTWRIGHT: So were you seeking to identify any issue
 18 around assessment in that feedback?
 19 A. I am -- no, I think I'm just providing feedback around
 20 my assessment of what happened.
 21 Q. Thank you. Mr Lopez, can we go over the page
 22 {INQ022370/18}, please. For "resources" we can see
 23 under that column:
 24 "Local knowledge of trauma unit greatly helped.
 25 What if wasn't available!"

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1 A. That might be a question mark, apologies.
 2 Q. Sorry. And so is that just a query, if there was
 3 a major incident and that wasn't available?
 4 A. Yes, but I think the reality of it -- of -- the reality
 5 of where we are now is that the -- things like trauma
 6 networks within the Greater Manchester area are
 7 well-embedded across all of our paramedics and
 8 technicians, so it is something that -- local knowledge
 9 of trauma units is available. So I think the question
 10 is almost redundant at this point.
 11 Q. Thank you. We can see in the notes in the margin:
 12 "No hospital ALO [ambulance liaison officer] on-call
 13 structure."
 14 A. That's correct.
 15 Q. Can you just expand on that information, please?
 16 A. The ambulance liaison officer will work with -- in
 17 general day-to-day working, works with hospitals on
 18 pressures that they may have, liaises with the Ambulance
 19 Service. It's a member of NWS who will liaise with
 20 individual control rooms or individual areas to talk
 21 about the demands that are happening at the hospital.
 22 In terms of a major incident, then having a -- I felt
 23 that having that liaison with hospitals would provide
 24 real-time information either back to our control room
 25 or, if required, control room, tactical/operational

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1 commander sort of feedback.
 2 There isn't an ALO on-call structure, and currently
 3 I think the ALO position works until different times
 4 across different areas, but 10 o'clock, midnight,
 5 2.00 am.
 6 Q. Under "triage" you have identified:
 7 "Large numbers of P1 and P2 but no definition in
 8 group."
 9 Would it have assisted if there had been
 10 a separation of the P1 and P2 patients?
 11 A. I think we have discussed or I referred to some of those
 12 conversations between clinicians around making decisions
 13 around which P1 was going to go -- was going to be moved
 14 first. So I think if there's -- a system of definition
 15 within that, if transportation to hospital isn't
 16 immediately available, then it may have assisted.
 17 Q. You have written under "treatment" that:
 18 "Clinicians were available throughout."
 19 For "transport":
 20 "Vehicles were provided throughout. Required
 21 managing for moving patients."
 22 We have also covered that in your evidence. You
 23 also set out:
 24 "Hospital details were provided early."
 25 A. Yes, that's correct.

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1 Q. And:
 2 "Updates" -- is that "available"?
 3 A. It is, yes.
 4 Q. Then for the most important thing you learned in the
 5 role of loading officer that night was:
 6 "It does not adequately fit the role required in
 7 terms of the title. It is a multifaceted role."
 8 Sorry, the next bit, "by people"?
 9 A. Sorry, that's:
 10 "Pulled by people with own requirements."
 11 Q. "Will use staff member as support and logging..."
 12 A. Logging.
 13 Q. "... next time?!"
 14 Is that saying that you would have been assisted by
 15 having a loggist with you?
 16 A. I felt so. I felt so at the time. I think on -- on
 17 reflection had that meant that you were removing
 18 somebody from something else that they can do, and
 19 perhaps if rather -- if -- I'm not sure now whether in
 20 that loading officer role, whether a loggist would
 21 assist me or moving forward or whether it would mean
 22 that I had another conversation to explain what
 23 I required logging to them, which would create another
 24 job to do, if that makes any sense.
 25 Q. Thank you. Then finally under "other", you have set

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1 out:
 2 "Hospital preparedness. Liaison on site at time at
 3 the hospital site. Reduce comms traffic into scene."
 4 A. Yes, so I think this is around thoughts for any
 5 structured learning, so learning about how prepared the
 6 hospitals would be and what liaison on site at what time
 7 for these hospital sites, how we could reduce the comms
 8 traffic, the communication traffic, apologies, into the
 9 scene at the time.
 10 Q. Is that not achievable by the Airwave -- use of the
 11 Airwave Talk Groups?
 12 A. I think that it would be achievable by use of an
 13 understanding of discipline when using the Airwaves Talk
 14 Groups and limiting the -- potentially limiting the
 15 conversation/chatting, perhaps, that goes across them.
 16 I think funnelling all conversation into one Talk Group
 17 whilst useful for that situational awareness, there's
 18 the risk, unless it's disciplined conversation, and
 19 actually required, that it becomes overloading and just
 20 noise in the background, perhaps.
 21 Q. Can we look then at your form by way of the debrief for
 22 the response itself on the night.
 23 Mr Lopez, it's {INQ040655/27}, please. That's
 24 {INQ040655/27}.
 25 So following the structure again of the responses

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1 you gave. For "command and control" you have recorded:
 2 "Initial info re officers clear, first responding
 3 officers met and briefed. Roles allocated. Scene
 4 dynamics did not allow checking of action card. Aware
 5 of relationships while on scene. Strong structure at
 6 scene."
 7 Just to be clear about the scene dynamics not
 8 allowing checking of action card, is that just the
 9 reality of what you're being tasked to do once you get
 10 to scene at a major incident?
 11 A. Yes, it is, yes.
 12 Q. But would it not be important, particularly where the
 13 action cards are clear about the structure of that role,
 14 that actually taking 5 or 10 minutes to read and
 15 consider the action card as and when required during an
 16 incident could actually in the long run save time?
 17 A. I think when applying -- when applying that to this
 18 particular incident, then I don't think that would have
 19 been the case. I think for me at the time I felt that
 20 any delay in not moving forward with setting up
 21 structure and starting to -- starting to allow,
 22 facilitate that movement from scene would be detrimental
 23 to the patients.
 24 I believe I did look at the action card much later
 25 on in the course of the evening when prompted by one of

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1 the -- my resilience team colleagues, and I can see as
 2 an aide-memoire that those action cards are absolutely
 3 valuable. The reality of it for me at the time was that
 4 I didn't feel that there was the -- that there was the
 5 space to do it within the time constraints and the
 6 criticality of the incident as such.
 7 Q. Thank you. Moving to "communication", you have
 8 recorded:
 9 "On-scene communication between officers and staff
 10 was good. Took a long time to establish a major
 11 incident channel? Several enquiries via phone re
 12 incident specifics, distracting, eg EOC needing to know
 13 info for hospital. Debriefed later."
 14 That's self-explanatory. If we move over the page
 15 {INQ040655/28}, please, to "assessment". We can see:
 16 "Scene and assessment information provided through
 17 command structure for resources."
 18 You've recorded:
 19 "Initial crews separated and away from vehicles.
 20 Soaked up first attendees."
 21 That's what you've already described to the
 22 chairman, isn't it?
 23 A. That's correct.
 24 Q. Then you go on:
 25 "Subsequent staff vehicles used to move patients.

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1 Crews split and using any vehicle. Limited stretchers
 2 at times. Walking wounded looked after by UCS..."
 3 Is that urgent care service?
 4 A. That's correct.
 5 Q. "... and students."
 6 Again, that's what you've told us about today. But
 7 as to the limited stretchers at times, how did you
 8 facilitate provision of stretchers?
 9 A. In terms of stretchers, I'll be talking about -- I'll be
 10 referring to the trolley stretchers that are fixed or
 11 blocked into the ambulances and then removed from the
 12 ambulances. We facilitated that by the provision of
 13 more vehicles as more vehicles arrived, then we had the
 14 function to unmount the stretchers from a vehicle and
 15 take them into move people.
 16 Q. Move then down, please, to "triage". In the first
 17 column you have indicated that:
 18 "The major incident packs were difficult to use in
 19 practice."
 20 A. Yes.
 21 Q. Can you explain that, please?
 22 A. That would be from a personal point of view, from the
 23 role that I was -- that I was undertaking. As we've
 24 discussed, I didn't take the slips from the major
 25 incident cards which are part of the pack

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1 and I documented it rather -- rather documented it in my
 2 logbook. I think my experience was that they were -- it
 3 was distracting initially for -- in the first instance
 4 to ask ambulance crews who are busy resuscitating
 5 patients to stop and provide something, and I think post
 6 that, then it wasn't something that was offered to me.
 7 But nor was it something that I requested either. So
 8 from my -- on this occasion then I felt that for me the
 9 major incident packs, that aspect of it, was difficult
 10 to use in reality, in practice.
 11 Q. I think the rest of the information you provided under
 12 triage you've already dealt with in your evidence, but
 13 just for completeness as to your recording:
 14 "Patients split into P1/P2/P3. Difficult to triage
 15 within these groups. Clinicians wanting own patient
 16 moving but unaware of other patients' conditions. Had
 17 to control movement to vehicles."
 18 Under "treatment" you have identified:
 19 "Not specifically part of role. Injury descriptions
 20 provided by clinicians to assist with priority and
 21 destination."
 22 What does it -- and this is you just confirming that
 23 you're a gloves-off role. So treatment really wouldn't
 24 be part of your role on the night; is that correct?
 25 A. Yes, so not specifically part of my role, absolutely.

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1 I was aware of some of the injury descriptions which
 2 were provided which assisted with which hospitals
 3 patients were going to be moved to.
 4 Q. Then under "transport":
 5 "Vehicles available, but not clinicians until later
 6 in incident."
 7 And then:
 8 "Good distribution of patients to hospitals."
 9 And that:
 10 "The crews did anything asked."
 11 A. Absolutely. That's correct.
 12 Q. Then finally under your summary as to the most important
 13 thing you learned from the role of loading officer in
 14 the night is:
 15 "Communication is key. Knowing how command works
 16 meant the scene could be managed. Operation clinicians
 17 could be directed efficiently without them requiring
 18 full understanding of process."
 19 A. Yes.
 20 Q. And finally under "other" we can see wording that we saw
 21 a little earlier today from Mr Birchenough:
 22 "Plan may not fit an incident and this should not
 23 affect decisions. Should be principles of a plan rather
 24 than roles. Not all roles available throughout and
 25 a role may take on actions of several others."

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1 So what did you intend to mean by "principles of
 2 a plan rather than rules"?
 3 A. I think I felt that the -- that the major incident plan
 4 should be seen as not so much guidelines, perhaps more
 5 than guidelines, but more specifically these are the
 6 roles that you must and must not step in and step out
 7 of, and that they should form part of your consideration
 8 around the planning, and I believe that they do.
 9 I believe that the joint decision-making model that we
 10 use refers to consideration around policies and
 11 procedures and where they fit into risk on scene and
 12 that situational awareness.
 13 I feel that the major incident plan may not -- it
 14 shouldn't be considered a one-size-fits-all and "This is
 15 how it's going to work", but we should be making
 16 decisions around what's happening in reality at any
 17 particular incident and using that as a basic -- basis
 18 to make those informed decisions.
 19 MS CARTWRIGHT: Thank you. That concludes my questions.
 20 I know from having canvassed with those who have made a
 21 bid under the Rule 10 process that if we take a short
 22 break now, we will conclude this witness today. So
 23 I wonder if we --
 24 SIR JOHN SAUNDERS: Today goes up to midnight. What did you
 25 have in mind?

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1 MS CARTWRIGHT: If we could take --
 2 SIR JOHN SAUNDERS: We will take a ten-minute break.
 3 MS CARTWRIGHT: Perhaps if I could ask Mr Welch how long he
 4 envisages his questioning will take.
 5 MR WELCH: If we have a ten-minute break, I anticipate I'll
 6 be done within 20 minutes.
 7 SIR JOHN SAUNDERS: So we are talking about 5 o'clock
 8 basically?
 9 MS ROBERTS: Two minutes again.
 10 MS CARTWRIGHT: Sir, it's not quite midnight but could I ask
 11 for a break now for the stenographers, please?
 12 SIR JOHN SAUNDERS: Sorry. Obviously we take the time it
 13 needs, so it's just predictions of time sometimes --
 14 I want to ask you this question of priorities, the
 15 clinical teams saying, "My patient goes first", "Not
 16 yours, mine is worse than yours", is -- surely that's
 17 a decision for the medical adviser, the senior medic on
 18 the adviser, the doctors to be saying, isn't it?
 19 A. Yes, it would have been at the time. It wouldn't have
 20 been -- it wouldn't have been me making those decisions
 21 when confronted. It would have been me directing
 22 a clinician or a doctor to another doctor and pointing
 23 out that perhaps you're not aware of this patient that
 24 I have -- that we're already working towards moving, and
 25 facilitating those discussions. But yes, they were --

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1 between that cadre of clinicians, they would be making
 2 those decisions, absolutely, sir.
 3 SIR JOHN SAUNDERS: Thank you. Half past?
 4 MS CARTWRIGHT: Thank you, sir.
 5 (4.21 pm)
 6 (A short break)
 7 (4.32 pm)
 8 MS CARTWRIGHT: Thank you, sir. Before Mr Welch asks his
 9 questions, can I just correct a timing error? When
 10 I gave you the allocation of mobile, the time I gave
 11 was, I think, 23.45.17. That was the time allocated and
 12 then mobile at 23.55.27 and at scene was correct as
 13 23.29.29. Just for the reference, it's {INQ040368/3}.
 14 SIR JOHN SAUNDERS: Thank you very much.
 15 MS CARTWRIGHT: Could I ask Mr Welch now to ask his
 16 questions, please.
 17 Questions from MR WELCH
 18 MR WELCH: Mr Calderbank, the first question I want to ask
 19 you about is the allocation of roles in respect of
 20 operational commander, please.
 21 I would first of all like to put just a few
 22 propositions to you. Generally in a major incident you
 23 would agree that for the allocation of roles its
 24 essential to have the most appropriate and qualified
 25 person allocated to a particular role; yes?

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1 A. I would agree that the most appropriate, yes.
 2 Q. And that would be based on their experience, training
 3 and knowledge, won't it?
 4 A. I would say that was right, yes.
 5 Q. And it's not meant to be about rank at all, is it?
 6 A. No.
 7 Q. Did you know of the agreement between Dan Smith and
 8 Annemarie Rooney in relation to his attendance at any
 9 event, any incident in the city centre prior to 22 May?
 10 A. No, sir, I did not.
 11 Q. So when you got there to the arena around about 11.30
 12 and you saw Mr Smith there, did you speak to him or to
 13 Mr Poland and say, "Why are you acting as the
 14 operational commander"?
 15 A. No, I did not, but I think the reason for that would be
 16 that I wouldn't have -- it wouldn't have surprised me.
 17 I would have assumed that Mr Smith had arrived to the
 18 scene prior to myself and Mr Poland and that's why, as
 19 that initial responder, he had taken that role, and
 20 I was comfortable with him acting in that position.
 21 Q. Why would it not have surprised you that he was there?
 22 A. Because he was -- because he works for North West
 23 Ambulance Service and he's a consultant paramedic and
 24 there was a large-scale incident on.
 25 Q. Okay. But why would it not have surprised you that he

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1 took the role of operational commander seeing as you're
 2 the on-call operational commander and Mr Poland is also
 3 the on-call operational commander?
 4 A. The way that we -- that I would expect it to work would
 5 be that in the absence of an on-call operational
 6 commander, then a suitable clinician or trained
 7 commander would assume that role until the next
 8 appropriate person and there would be a conversation
 9 about whether it was required to be -- they would be
 10 relieved from it or it would be handed over. Often
 11 there's some travelling involved for the on-call
 12 commander and so it's quite normal that it would be
 13 somebody else doing that in the interim stages before
 14 arrival.
 15 Just to answer why I wasn't surprised, then I would
 16 imagine that that would be because I would have assumed
 17 that Dan Smith had arrived before myself and Derek and
 18 had taken up that role which would seem -- which would
 19 be correct in his actions if that been the case.
 20 Q. Making that assumption, as you did, was there never any
 21 thought between any of you, and particularly you and
 22 Mr Poland, as to discussing at that time: okay, Mr Smith
 23 is here, we know that the first ambulance on scene
 24 assumes the role of Bronze commander under the action
 25 cards? It might be that that is the case. But there

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1 doesn't seem to have been any discussion at all as to
 2 why Dan Smith was the operational commander or whether
 3 it was appropriate for him to continue as the
 4 operational commander when the two on-call operational
 5 commanders are there. Do you see?
 6 A. If you're asking was there a conversation about it or
 7 discussion about it, no, you're absolutely right, there
 8 wasn't that. However, both Derek Poland and myself will
 9 be aware that Dan Smith's on-call role is a tactical
 10 commander role and it would therefore -- in my
 11 experience, it would therefore follow that he was -- he
 12 would have been trained at an operational command --
 13 Q. The chair has heard evidence from Mr Smith in relation
 14 to his training, so we don't need to repeat that. But
 15 can I ask you this -- and it's in a sense a constructive
 16 question: was there any sense of relief amongst you and
 17 Mr Poland that Dan Smith was there at the time and had
 18 assumed this operational command?
 19 A. I think relief in terms of knowing that Dan Smith is an
 20 excellent experienced clinician and has experience
 21 within the Ambulance Service and is also a familiar
 22 face, so then I suppose there was relief.
 23 If the question is, "Was I relieved that he was the
 24 operational commander and I wasn't", then no, I don't
 25 think relief is the -- is the correct sort of word to

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1 use. I think that what it meant was that there were
 2 more people there who could fill those functional roles
 3 and work to establish that command structure who I knew
 4 were familiar with it and had -- I had the knowledge
 5 that they would be able to do it competently.
 6 Q. Very well. I'll move on to the next topic which is the
 7 allocation of roles in terms of the loading officer --
 8 SIR JOHN SAUNDERS: Okay. Can I just say this about
 9 Steve Hynes.
 10 So Steve Hynes comes along and he takes over
 11 Dan Smith's job, and his reasoning for doing that is to
 12 say: well, then I can do what I am good at and Dan Smith
 13 can do what he's good at, which is actually treating
 14 people.
 15 In a way, didn't the same apply to you? That in
 16 a way he would have been better off doing the treating
 17 and you, who'd had the experience as operational
 18 commander, as indeed had Mr Poland, and the training
 19 which Mr Smith did not have, would be better off doing
 20 that role?
 21 A. I think that's a fair comment, sir. Absolutely.
 22 SIR JOHN SAUNDERS: Okay. I'm not suggesting by this that
 23 Mr Smith did not do a perfectly good job and it's not to
 24 be taken the wrong way. It's just a matter of principle
 25 when we're being told -- which I'm sure is correct --

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1 that actually it's not rank, it's role, and then when we
 2 look at it in those two incidents, it looks rather like
 3 it is rank rather than role.
 4 A. Yes, I can see that. I think it may be fair to say that
 5 the inquiry has more information than I had at the time
 6 in and around certain aspects of that.
 7 SIR JOHN SAUNDERS: No, I understand that.
 8 A. But --
 9 SIR JOHN SAUNDERS: And by the way, by the time you came,
 10 the deal had been done, and we do know Mr Smith and
 11 Mr Poland had spoken --
 12 A. I think from my own point of view, yes, that structure
 13 had already been established and was potentially 40 --
 14 40-plus minutes post event when I have arrived. So it
 15 would have seemed -- I wasn't aware that there would be
 16 a reason to change anything around.
 17 SIR JOHN SAUNDERS: And we have also heard that changing
 18 commanders is not a great idea because you need
 19 a handover.
 20 A. And I absolutely accept your point.
 21 SIR JOHN SAUNDERS: We will leave that issue now.
 22 MR WELCH: Thank you, sir.
 23 Allocation of roles in terms of the loading officer .
 24 Had you ever acted as a loading officer before?
 25 A. No, sir.

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1 Q. You didn't read the action card on the night. Do you
 2 know when you had last familiarised yourself with it
 3 before the attack?
 4 A. I think it will -- no, I can't put a date on when that
 5 will have been, but it will have been something that was
 6 not necessarily covered, but the major incident plan
 7 will have formed part of my annual commander training
 8 and will have been something that we had looked at
 9 regularly throughout each of those annual commander
 10 training days.
 11 Q. As part of that, are you going through all of the action
 12 cards, of which I think there are about 30, aren't
 13 there, for the major incident plan, reading through them
 14 again -- would it not be just to see what has changed or
 15 are you really familiarising yourself with that role?
 16 A. No, I think that -- so the commander training will
 17 form -- there will be specifics which are around
 18 a specific type of training, whether that's MTA or
 19 flooding or familiarisation with some other event that
 20 may not occur regularly. But as part of that some of it
 21 is around completing -- often you complete a tabletop
 22 exercise with roles that were allocated. So there will
 23 have been other commanders who -- other participants in
 24 that who may have taken up functional roles as part of
 25 those tabletop learning training exercises.

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1 Q. Well, that brings me on to my next question.
 2 In any of those tabletop exercises had you ever
 3 undertaken the role of loading officer?
 4 A. No, sir.
 5 Q. But others might have or will have?
 6 A. Others on those training days, yes, sir. Whether others
 7 had at the arena incident, then I'm unaware.
 8 Q. Precisely. Because when the roles are being allocated,
 9 was there any discussion as to who was the most suitable
 10 for these roles, whether anyone had performed it before,
 11 either in a live incident or in any exercises?
 12 A. No, sir, there was not. I don't think that I would have
 13 expected that to be -- to -- generally I would expect
 14 the operational commander to allocate the roles.
 15 Had there been a reason why I felt that I wasn't
 16 capable to complete that role or more suited to do
 17 something else, then that would have been the
 18 opportunity to interject at that point and suggest that
 19 I did something else.
 20 Q. Well, I realise that this -- and accept that this is a
 21 dynamic incident that needs decisive actions. But it
 22 really doesn't take very long, does it, for someone to
 23 say, "Has anyone acted as loading officer before"?
 24 A. No, it wouldn't, no.
 25 Q. And that could be done and then we would have had

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1 someone, in the absence of any training in that role,
 2 who might have had the experience for it; do you agree
 3 with that?
 4 A. I agree that had that scenario occurred, then that is
 5 a possible outcome of that, yes.
 6 Q. Indeed, that could apply to any of the different roles
 7 that were allocated by Mr Smith, and it really doesn't
 8 take long to ask those questions, does it?
 9 A. No, sir, it doesn't.
 10 Q. Moving on, if I can, to your actions as a loading
 11 officer. Ms Cartwright said that you could have spent 5
 12 to 10 minutes looking at the action card. If we just
 13 look at action card 16, which I'll get the reference
 14 for, it's only about one page long, isn't it? It has
 15 about ten entries, doesn't it?
 16 A. Ten or 11, sir, yes.
 17 Q. {INQ013442/32}, 11 entries. It's not going to take 5 or
 18 10 minutes to read that, is it? Let's be realistic.
 19 A. No, I don't think I suggested that it would.
 20 Q. No.
 21 A. But no, you're right, no.
 22 Q. And it is under the major incident plan a direction,
 23 isn't it, that the steps in the action cards should be
 24 followed in a structured order, isn't it?
 25 A. I'm not sure whether -- I think they are there to act as

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1 an aide-memoire, but these are the tasks that are
 2 expected of the loading -- the action cards are the
 3 steps that are expected. I don't believe that they are
 4 necessarily in order situation, and they generally,
 5 I believe, used as an aide-memoire. But those are the
 6 actions that you're expected to take and cover.
 7 Q. Okay. The reference for those who are interested is
 8 {INQ013132/52}, and it's section 12 of the major
 9 incident plan. The last sentence of the third
 10 paragraph:
 11 "It is essential that staff remain focused and
 12 follow the structured processes identified in the major
 13 incident response plan."
 14 That's under "action cards". So do you agree that
 15 it is important to follow these in the structure that it
 16 appears?
 17 A. I agree that it's important that those -- that those
 18 actions are completed. I don't necessarily agree that
 19 they need to be done in the order which is the only
 20 difference in ...
 21 Q. One of the actions in action card 16 is number 5:
 22 "In liaison with the Emergency Operation Centre and
 23 parking officer, ensure an adequate supply of ambulances
 24 and equipment to the loading point"; yes?
 25 A. Yes.

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1 Q. You were asked before about whether it would have been
 2 possible to have people -- patients move more quickly
 3 from the CCP on to the ambulances and I believe your
 4 answer was effectively, "We didn't have the resources
 5 there", was that right, partly?
 6 A. Yes, I think what I was trying to explain was that to be
 7 able to provide clinicians to provide a one-to-one or to
 8 make sure that all of the injured had a clinician with
 9 them that meant that the ambulances that would arrive
 10 then carrying two clinicians, those clinicians would
 11 naturally split and look after two patients.
 12 Q. Yes.
 13 A. Which then made it difficult to transport an individual
 14 patient because they would require two clinicians again.
 15 Q. There is a document that's been produced which is the
 16 ambulance history analysis that we've seen in the past.
 17 By my estimation on that, before you had arrived at
 18 23.30, 23 ambulances had already arrived and only one of
 19 them had left.
 20 Of those 23, only four left before midnight. So is
 21 it right that the chair was correct that there really
 22 were a load of ambulances lined up with all the
 23 clinicians from those ambulances inside treating
 24 patients and it's quite obvious that that's where they
 25 were?

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1 A. I have no reason to doubt the information that you have.
 2 My recollection is that perhaps in my line of sight,
 3 perhaps they were parked at the -- you know, under the
 4 care of their parking officer or they weren't directly
 5 in the area that I was in. I don't recall specifically
 6 there being 23 or slightly less ambulances around in
 7 that area at that point, but absolutely if that's the
 8 information that you have, then that will be correct,
 9 yes.

10 Q. Given that you have a situation where you have a large
 11 number of patients within -- on the concourse, you don't
 12 have a line, it would appear, of ambulances but you
 13 don't seem to have a number of ambulances going out, and
 14 you quite rightly have assumed that the clinicians have
 15 gone outside, would the obvious thing not have been to
 16 phone the -- contact the EOC and say, "We need more
 17 ambulances here because all the clinicians are inside"?

18 A. I believe that that was what was happening through the
 19 RVP point and through the parking officer, through the
 20 ops commander at site, because ambulances were arriving
 21 in batches and being released from the Thompson Street
 22 RVP point to site, I believe.

23 Q. But isn't it your responsibility under the action card
 24 to make sure there enough ambulances there? And part of
 25 that must be, mustn't it, to contact the EOC and say,

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1 "We need more, everyone is inside treating people, we
 2 simply need more ambulances so that we can get people to
 3 the hospitals more quickly"?

4 A. Yes, I think the action card refers to having those
 5 conversations with the parking officer, the loading
 6 officer, and EOC, I believe, in terms of making sure
 7 those ambulances are available, but yes, sir.

8 Q. Just one more point, if we can, on the action card
 9 before we leave that. If I could just bring it back up,
 10 please, it's not just this page actually, is it, because
 11 if we go to the next page, which is {INQ013422/33}, this
 12 is the loading point log that should have been completed
 13 under the action card. What you did was to complete
 14 a record in your pocket notebook, didn't you? One of
 15 the things that you didn't have in your pocket notebook
 16 and which is the first column in that document is the
 17 casualty name. And that can be important, can't it?

18 A. If there were no other means of tracking a patient, then
 19 the patient's name would be one way to do that. That
 20 can be important.

21 Q. It does create that log of where, who has gone out, what
 22 their state was when they had gone, and more
 23 importantly, which hospital they'd gone to, doesn't it?

24 A. I believe those are the details that I logged in my
 25 pocketbook in terms of who that patient -- which

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1 vehicle -- what priority it was, what time it was, what
 2 patient -- what vehicle it was, and what hospital they
 3 went to, which enabled us to track those patients.

4 Q. But it didn't have the names within the book?

5 A. No, it did not, sir.

6 Q. Two very brief further points I want to raise.
 7 Firstly, in relation to the casualty distribution
 8 plan, you were speaking with Mr Poland about the
 9 abilities of certain of the hospitals and what
 10 specialist services they offered, weren't you?

11 A. I recall conversations with Derek Poland around
 12 locations, geographically, in terms of mileages from
 13 the -- from the arena to individual hospitals, as he's
 14 more familiar with that. I don't specifying recall
 15 conversations around specialities. But it may have
 16 been. I may have asked him to confirm, "Does hospital A
 17 still do X, Y or Z?"

18 Q. You didn't have a copy of the casualty distribution
 19 plan, did you?

20 A. No, I don't believe that there was copies of the
 21 casualty -- it was a draft, so I don't believe they were
 22 in existence as such or they hadn't been circulated.

23 Q. Looking forward -- I don't want to ask you about the
 24 detail of it for obvious reasons -- it's a relatively
 25 short document, isn't it, in that it's about eight pages

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1 long and that covers the whole of the North West,
 2 doesn't it?

3 A. That's correct, yes.

4 Q. And the last page is a matrix, isn't it, that shows the
 5 different specialist capabilities of all of the
 6 hospitals under the casualty distribution plan, doesn't
 7 it?

8 A. To the best of my knowledge, if you're telling me that's
 9 what it does, then yes. I'm not overly familiar with it
 10 in terms of --

11 Q. Given your role, and you have to decide where an
 12 individual patient is going, to which of the three of
 13 the hospitals that were accepting P1s in the first
 14 instance, it would have assisted you to have this
 15 document on the night, wouldn't it?

16 A. I don't think -- again, I think it was a draft document.
 17 So I think it existed in -- in that same iteration that
 18 you are talking about.

19 I think it would assist -- it would assist somebody
 20 particularly if it was an area where you are completely
 21 unfamiliar with. I think that, as far as I'm aware,
 22 there were -- there were -- there was perhaps one onward
 23 hospital transfer after the original destination. So
 24 all of the patients that were dispatched in ambulances
 25 during that period, I believe, remained within the

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1 hospitals and were treated within the hospitals that
 2 they were transported to on that occasion, bar one who
 3 may have been onwardly transferred following further
 4 investigations, so what it may have done is reconfirmed
 5 or provided some reassurance that the decisions that we
 6 were making on scene at the time were the correct ones.
 7 Q. Very well.
 8 Final question, which is in relation to who was the
 9 parking officer after midnight because we have heard
 10 that it had been Mr Poland and then Mr Hynes took
 11 Mr Poland off and it's not clear at this time who it
 12 then became. There's a record actually that it was you.
 13 First of all, could you confirm whether or not you
 14 did act as the parking officer?
 15 A. No, I did not. It was — at no point did I act as the
 16 parking officer, no.
 17 Q. Do you know who took over from Mr Poland?
 18 A. Yes, I do: it was Fran Dreniw.
 19 Q. Was there any issue in relation to the handover between
 20 those two and did it create any issue in relation to the
 21 speed with which people were put on to the ambulances?
 22 A. I wouldn't have been present during any particular
 23 verbal, physical handover.
 24 SIR JOHN SAUNDERS: Okay, I don't think we are concerned
 25 with that. It did change who did it. Did it make any

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1 difference to the flow of ambulances or hold up your
 2 process? Sorry to cut across you.
 3 A. Not as far as I'm concerned, sir.
 4 SIR JOHN SAUNDERS: Thank you.
 5 MR WELCH: Thank you very much, Mr Calderbank, and thank you
 6 for your efforts on the night.
 7 Thank you, sir.
 8 MS CARTWRIGHT: I'm not seeking to suggest we need to look
 9 at it, but just so it sits within the transcript, the
 10 draft mass casualty distribution plan dated 9 February
 11 2017 is {INQ025532/1}.
 12 Could I ask Ms Roberts now please to ask her
 13 questions.
 14 SIR JOHN SAUNDERS: Ms Roberts?
 15 Questions from MS ROBERTS
 16 MS ROBERTS: Thank you very much.
 17 Three points of clarification. For your record,
 18 first of all, sir, the gentleman who took over, as you
 19 know now from what Mr Calderbank said, Fran, that's
 20 Francis, Dreniw, D-R-E-N-I-W. He's provided
 21 a feedback — sorry, a questionnaire which is
 22 {INQ019838/1} which gives the time that he took over as
 23 parking officer. There is some uncertainty about that,
 24 so we're going to clarify that for all core participants
 25 so we have, as I say, a final answer in relation to

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1 that.
 2 The second topic, again for your clarification, sir,
 3 because it arose during questions of Mr Calderbank, both
 4 in terms of those put by CTI, but also by my learned
 5 friend Mr Welch, and it's in relation to Dan Smith and
 6 his qualifications, his expertise and his training and
 7 so forth.
 8 I think, sir, you're quite right that there was
 9 a confusion because in his witness statement it tended
 10 to suggest that he'd had no training so far as
 11 operational commander is concerned. And it is
 12 presumably with that in mind that Mr Gozem began his
 13 questioning of Dan Smith on Day 110 which was 26 May at
 14 page 191 of the transcript {Day110/191:1} by asking
 15 Mr Smith as to whether he'd acted as an operational
 16 commander before.
 17 You clarified — he said:
 18 "Had I performed the role before?"
 19 You said:
 20 "Yes."
 21 And the answer from Mr Smith was:
 22 "Yes, I had, yes."
 23 Mr Gozem:
 24 "Because you hadn't undertaken any operational
 25 command training, had you?"

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1 And his answer was this:
 2 "Not recently. So when I did operational command,
 3 it backdated — it was before NARU... around... 2004
 4 through to 2009. So I was operational commander at that
 5 point for a large number of incidents because that was
 6 a role I undertook. It was a role we don't have any
 7 more in the Ambulance Service but it was clinical
 8 practice supervisor and then assistant operations
 9 manager. At that time that role responded to any
 10 incidents of note, really, as the operational
 11 commander."
 12 So as I say, it's not necessarily as binary as
 13 perhaps it has been hitherto suggested. So I just
 14 thought that might help everyone's understanding.
 15 The final point of clarification within my
 16 2 minutes, I hope, and it's something that you touched
 17 upon right at the end of your questioning from Mr Welch
 18 just now. I think you told us that of those 38 patients
 19 that we see were transferred to hospital, that only one
 20 of them required onward hospital transfer. That's
 21 right, isn't it?
 22 A. I believe so.
 23 Q. And I think you told us that so far as deciding which
 24 hospital a patient should go to, that there is
 25 a decision based, is it, presumably upon not only the

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1 needs of that particular patient presenting to you as
 2 either a P1 or a P2, but also the hospital having the
 3 appropriate expertise, the appropriate clinicians, and
 4 those clinicians being on site at the hospital and ready
 5 to receive that patient. And we know that many came off
 6 duty — put themselves on duty that night so that they
 7 could get to the hospitals and treat those patients and
 8 that would form part of your decision-making, would it?
 9 A. That's correct, ma'am, yes.
 10 Q. And as you say, it presumably, the need get the patient
 11 to the appropriate hospital to reduce to an absolute
 12 minimum, as the seen to be the case on this evening, so
 13 out of 38 only one, for onward transfer. So in other
 14 words to get the patient to the right hospital with the
 15 right clinicians treating them?
 16 A. Yes, ma'am.
 17 MS ROBERTS: Thank you very much.
 18 Thank you, sir.
 19 SIR JOHN SAUNDERS: Before you sit down, the matter which
 20 has arisen about the paramedics coming off their
 21 ambulances in order to come and treat and having one to
 22 treat, and therefore there being — not being possible
 23 to get those ambulances going again to take those people
 24 away, I understand the balancing requirements that there
 25 are in relation to that.

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1 MS ROBERTS: Yes.
 2 SIR JOHN SAUNDERS: On the face of it, it does sound like it
 3 may be possible to actually speed the process up and
 4 that is a concern which the inquiry has, the actual
 5 getting people to hospital.
 6 MS ROBERTS: Yes.
 7 SIR JOHN SAUNDERS: I would quite like some input, please,
 8 from NWS if at all possible on how they envisage that
 9 sort of situation being managed, whether it does appear
 10 anywhere how it should be managed, and if so, whether
 11 anyone has thought about whether there might be a better
 12 way of dealing with it.
 13 MS ROBERTS: Yes, absolutely.
 14 SIR JOHN SAUNDERS: Okay. Well, I would be grateful.
 15 MS CARTWRIGHT: Thank you, sir. I have no further
 16 questions.
 17 SIR JOHN SAUNDERS: When on Monday?
 18 MS CARTWRIGHT: So we will reconvene at 10 o'clock on Monday
 19 and we continue with North West Ambulance Service
 20 evidence with Mr Barnes.
 21 SIR JOHN SAUNDERS: Thank you very much to everyone for
 22 getting through this in a reasonable time. I hope
 23 everyone thinks we have looked at this evidence pretty
 24 thoroughly. I don't think there's much more we could
 25 have investigated. Thank you.

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1 (5.01 pm)
 2 (The hearing adjourned until
 3 Monday, 14 June 2021 at 10.00 am)

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