

OPUS2

Manchester Arena Inquiry

Day 144

September 10, 2021

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1 Friday, 10 September 2021
 2 (9.30 am)
 3 (Delay in proceedings)
 4 (9.47 am)
 5 MR GREANEY: Sir, good morning. As Mr de la Poer --
 6 SIR JOHN SAUNDERS: Can I say, I'm really sorry to be
 7 sitting late. As people knew from yesterday, I have
 8 been having some back pain. That is much better today,
 9 but there is another symptom which requires some
 10 investigation. As we're dealing with NWAS matters
 11 today, we couldn't be in better hands if I need any
 12 help. I will try to make sure that anything I need to
 13 have done does not interfere with the progress of the
 14 inquiry.
 15 MR GREANEY: Thank you very much for saying that. We know
 16 if at any stage if you need to take a break, you'll just
 17 walk out.
 18 As Mr de la Poer explained yesterday, we are going
 19 to turn now, as you just indicated, to the evidence of
 20 the Ambulance Service experts. They are, as everyone
 21 knows, Christian Cooper and Michael Herriot. Mr Cooper
 22 is in the witness box and Mr Herriot is in the position
 23 commonly occupied by Mr Atkinson and I'm going to asked
 24 if they could both be sworn at this stage, please.
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1 MR CHRISTIAN COOPER (affirmed)
 2 MR MICHAEL HERRIOT (affirmed)
 3 Questions from MR GREANEY
 4 MR GREANEY: I will begin by inviting each of you to
 5 identify yourself. Mr Cooper, first of all, tell us
 6 your full name, please.
 7 CHRISTIAN COOPER: Christian Paul Cooper.
 8 MICHAEL HERRIOT: Michael Francis Herriot.
 9 MR GREANEY: So that you and everyone else know, generally
 10 speaking, unless I indicate to the contrary, I will be
 11 directing my questions in the first instance to
 12 Mr Cooper and then seeking any contribution that
 13 Mr Herriot has to make. But if at any stage either of
 14 you wish to indicate that one or the other is better off
 15 dealing with a topic, please let me know.
 16 First of all, the scope of your instructions. This
 17 is a topic that is well-known, but in summary,
 18 Mr Cooper, have you been asked to assist the inquiry
 19 in relation to three connected issues? First of all,
 20 whether NWAS was adequately prepared for an event such
 21 as the attack at the Manchester Arena?
 22 CHRISTIAN COOPER: Yes.
 23 Q. Secondly, whether the response of NWAS to the attack was
 24 adequate?
 25 CHRISTIAN COOPER: Yes, that's correct.

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1 Q. And thirdly, with the lessons that are to be learned
 2 from the preparation for and response to the attack?
 3 CHRISTIAN COOPER: Yes.
 4 Q. Second topic. No one has, or indeed could, challenge
 5 the ability of either of you to provide expert evidence
 6 on those three issues. But we will set out briefly your
 7 qualifications and experience so that there can be
 8 public confidence in the views you are going to express.
 9 Mr Cooper, first of all. Have you had a long career
 10 in the Ambulance Service and NHS?
 11 CHRISTIAN COOPER: Yes, I have.
 12 Q. Having served as an ambulance officer and paramedic for
 13 Great Western Ambulance Service between 2000 and 2007?
 14 CHRISTIAN COOPER: That's correct.
 15 Q. As resilience manager for South West Strategic Health
 16 Authority from 2007 until 2009?
 17 CHRISTIAN COOPER: Yes.
 18 Q. As the HART and specialist operations manager for Great
 19 Western Ambulance Service NHS Trust between 2009 and
 20 2013?
 21 CHRISTIAN COOPER: Yes.
 22 Q. As the head of quality and improvement for the National
 23 Ambulance Resilience Unit or NARU between 2013 and 2021?
 24 CHRISTIAN COOPER: Yes.
 25 Q. And are you currently the national head of operations

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1 for the National Ambulance Resilience Unit?
 2 CHRISTIAN COOPER: Yes, that's correct.
 3 Q. What is the National Ambulance Resilience Unit, please?
 4 CHRISTIAN COOPER: It's a unit that operates on behalf of
 5 NHS England at the national level to coordinate and
 6 maintain a series of specialist -- we call them
 7 interoperable -- capabilities that are hosted by each
 8 regional ambulance trust.
 9 Q. What does your current role for NARU involve?
 10 CHRISTIAN COOPER: I am responsible for working within
 11 a team, but overseeing the development of national
 12 standards, contractual standards, that apply to
 13 ambulance trusts for developing and maintaining the
 14 arrangements at the national level for those ambulance
 15 trusts to respond effectively to major incidents and for
 16 undertaking various assurance and inspection activities
 17 that may be in support of regulators or at the request
 18 of commissioning bodies such as NHS England.
 19 Q. Have you received various public recognitions and awards
 20 relating to your work?
 21 CHRISTIAN COOPER: Yes.
 22 Q. Have you published extensively in relation to that work
 23 also?
 24 CHRISTIAN COOPER: Yes, I have.
 25 Q. Thank you, Mr Cooper.

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1 Mr Herriot next. Did you work as a nurse or at
 2 least in nursing between 1976 and 1980?
 3 MICHAEL HERRIOT: Yes.
 4 Q. Did you then enter the Ambulance Service?
 5 MICHAEL HERRIOT: Yes.
 6 Q. By 1995, were you the assistant chief ambulance officer
 7 of the Scottish Ambulance Service?
 8 MICHAEL HERRIOT: I was.
 9 Q. Then, between 1995 and 1997, did you work at the
 10 Home Office Emergency Planning College?
 11 MICHAEL HERRIOT: I did.
 12 Q. And since April of 1997, have you been the associate
 13 director of the Scottish Ambulance Service?
 14 MICHAEL HERRIOT: For special operations, emergency planning
 15 and other similar functions, yes.
 16 SIR JOHN SAUNDERS: Mr Herriot, because you're speaking
 17 through a plastic screen, for me it's quite difficult to
 18 hear and I think people at the back may have the same
 19 problem. I wonder if we could locate the mic
 20 slightly -- when you're talking to Mr Greaney, you're
 21 actually talking -- push it that way. If you can speak
 22 up as much as you can, I would be grateful.
 23 MR GREANEY: In summary for anyone that couldn't hear,
 24 Mr Herriot was dealing with his long and distinguished
 25 service in the Ambulance Service.

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1 Have you received various recognitions and public
 2 awards in respect of your work?
 3 MICHAEL HERRIOT: I have.
 4 Q. Including the Queen's Ambulance Service Medal for
 5 distinguished service?
 6 MICHAEL HERRIOT: Yes.
 7 Q. And are you also as a result of your work a member of
 8 the Order of the British Empire?
 9 MICHAEL HERRIOT: That's correct.
 10 Q. Next, please, can I seek to capture your views about the
 11 performance of the Ambulance Service in relation to the
 12 arena attack in summary so as to provide some context.
 13 Mr Cooper, first of all. Is it your view that NWAS
 14 did a good deal well, both in relation to its planning
 15 for an attack such as the events of 22 May and in its
 16 response to that attack?
 17 CHRISTIAN COOPER: Overall, yes.
 18 Q. And do you wish, moreover, to recognise the courage and
 19 resourcefulness of many of the NWAS staff on the ground
 20 on the night of the 22nd?
 21 CHRISTIAN COOPER: Yes, I absolutely do.
 22 Q. But do you nonetheless have concerns about the planning
 23 undertaken by NWAS and its response on the night?
 24 CHRISTIAN COOPER: Yes.
 25 Q. And would it be fair to say that those concerns are ones

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1 that are serious?
 2 CHRISTIAN COOPER: Yes.
 3 Q. Mr Herriot, do you agree?
 4 MICHAEL HERRIOT: I would concur with that, yes.
 5 Q. So gentlemen, against that background what I'm going to
 6 do is break your evidence down into two broad parts:
 7 first of all, planning and preparation for an attack
 8 such as that which occurred; and secondly, the response
 9 on the night.
 10 So first, planning and preparation. In 2017 was
 11 NWAS aware that the risk of a terrorist attack was
 12 severe?
 13 CHRISTIAN COOPER: Yes.
 14 Q. Was NWAS aware that that risk included a risk to crowded
 15 places?
 16 CHRISTIAN COOPER: Yes.
 17 Q. In general terms, was NWAS well prepared to respond to
 18 an attack such as that which occurred?
 19 CHRISTIAN COOPER: Yes, I believe it was.
 20 Q. Were its emergency plans, including its major incident
 21 response plan and its mass casualty dispersal plan, fit
 22 for purpose?
 23 CHRISTIAN COOPER: They were.
 24 Q. Had NWAS established training for its commanders?
 25 CHRISTIAN COOPER: Yes, it had.

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1 Q. Had it, moreover, engaged in extensive exercising for an
 2 attack such as that which occurred?
 3 CHRISTIAN COOPER: Yes.
 4 Q. And was JESIP, a set of principles that the inquiry is
 5 now very familiar with, well understood and apparently
 6 embraced by NWAS?
 7 CHRISTIAN COOPER: Yes, yes.
 8 Q. So do you agree that there would have been, on the
 9 afternoon of 22 May, grounds for believing that NWAS
 10 would have responded effectively to an attack such as
 11 that which occurred?
 12 CHRISTIAN COOPER: Yes, that was a reasonable expectation
 13 at the time, yes.
 14 Q. Mr Herriot, do you agree with those views?
 15 MICHAEL HERRIOT: I do. NWAS's planning was both
 16 comprehensive and compliant.
 17 Q. By compliant, do you mean compliant with the regulatory
 18 framework that existed --
 19 MICHAEL HERRIOT: With the standards in place at the time.
 20 Q. Having said all of that, Mr Cooper, are there aspects of
 21 planning and preparation about which you have concerns?
 22 CHRISTIAN COOPER: Some, yes.
 23 Q. First of all, was there a site-specific plan prepared by
 24 NWAS for the Manchester Arena?
 25 CHRISTIAN COOPER: No.

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1 Q. Was there any requirement under the regulatory framework
 2 under which NWS operated for there to be one?
 3 CHRISTIAN COOPER: No. The main standards that would have
 4 governed that at that time were the EPRR core standards
 5 produced by NHS England, and there was no specific
 6 obligation in those contract standards for
 7 a site-specific plan to be in place for particular
 8 locations.
 9 Q. Nonetheless, would you regard it as having been good
 10 practice in 2017 for NWS to have had a site-specific
 11 plan for the arena?
 12 CHRISTIAN COOPER: Yes, and it was commonplace, and still is
 13 today, for ambulance trusts to maintain site-specific
 14 plans for locations that they consider to be high risk.
 15 An example might be COMAH sites or sites that have
 16 hazardous materials on them. It would be for the
 17 ambulance trusts locally, through its local community
 18 risk assessment process, to identify sites that it felt
 19 would benefit from a particular set of plans or
 20 arrangements.
 21 Q. Putting yourself into Manchester in 2017, and bearing in
 22 mind what would have been good practice, would you have
 23 expected NWS to have had a site-specific plan for
 24 Manchester Arena?
 25 CHRISTIAN COOPER: Given its size, given its coterminous

1 location with a transport hub and other factors as well,
 2 yes, I would have expected a site-specific plan.
 3 SIR JOHN SAUNDERS: Similar questions were asked of GMFRS
 4 yesterday. Could we be looking at a joint plan by all
 5 the emergency services which would seem to be maybe
 6 sensible?
 7 CHRISTIAN COOPER: I think that would be more effective,
 8 yes, and probably produced through the LRF mechanism.
 9 MR GREANEY: So that is an important recommendation that the
 10 inquiry can take forward?
 11 CHRISTIAN COOPER: I would say so, yes.
 12 Q. Two issues flow from this. I'll identify them both at
 13 this stage, then we'll deal with them in turn. First,
 14 what should such a site-specific plan have dealt with
 15 and, secondly, what difference, if any, would the
 16 existence of such a plan have made to the NWS response
 17 on the night?
 18 Let's deal with those in turn. What should such
 19 a plan have involved?
 20 CHRISTIAN COOPER: There should be an assessment of risk
 21 that is specific to that location. The location itself
 22 will have unique access and egress points. There will
 23 be factors that relate to how that site is operated and
 24 how it functions. Sites such as that will probably have
 25 their own emergency preparedness and planning

1 arrangements associated with them, so it's important
 2 that the emergency services understand the content of
 3 those arrangements and are able to produce or augment
 4 their own generic major incident plan to deal
 5 specifically with the response at that location. As
 6 I say, that's fairly commonplace for certain specific
 7 sites within the geography of every ambulance trust.
 8 But there is no -- there is no specification
 9 nationally to identify sites. That is left to the
 10 ambulance trust to do, or indeed the LRF mechanism with
 11 the emergency planners from each of the emergency
 12 services coming together to look at the sites within
 13 that LRF area that would benefit from such an
 14 arrangement.
 15 Q. So there is no specification which indicates how sites
 16 are to be identified for the preparation of a plan. Is
 17 there any specification for what the content of
 18 a site-specific plan ought to be?
 19 CHRISTIAN COOPER: There is generic guidance in place that
 20 advises the emergency services, and indeed the
 21 Ambulance Service specifically, on how to write an
 22 emergency plan and the kinds of things that should be in
 23 it. That is necessarily generic to allow the
 24 Ambulance Service to look at whatever it's trying to
 25 deal with locally and tailor that plan to suit it. So

1 there are generic templates, well-established generic
 2 templates, for producing emergency plans. What we would
 3 expect is that would be the starting point for emergency
 4 planning professionals from each of the emergency
 5 services and members of the LRF when a site is
 6 identified, hopefully that site will have its own
 7 emergency planners, or somebody responsible at the site
 8 for producing that site's emergency arrangements, and
 9 they should all come together and produce their own plan
 10 that they think would be effective.
 11 So there isn't necessarily a set standard that
 12 we would judge that against, it would be for the LRF to
 13 satisfy itself that it had made suitable arrangements.
 14 Q. But in terms of the arena, you would expect
 15 a site-specific plan to set out the layout of the arena?
 16 CHRISTIAN COOPER: Yes.
 17 Q. By which I mean the arena complex or perhaps by
 18 reference to a floor plan or something of that sort?
 19 CHRISTIAN COOPER: Yes.
 20 Q. So that the various entrances and exits would be
 21 apparent?
 22 CHRISTIAN COOPER: Yes.
 23 Q. And things such as the telephone numbers of those
 24 directly concerned with the arena?
 25 CHRISTIAN COOPER: Yes.

1 Q. And moreover, I don't know whether you can help with
2 this, one of the things it might be thought didn't go at
3 all well on the night -- I don't just mean for N WAS,
4 I mean more generally -- was the identification of
5 a single or at least a consistent rendezvous point.
6 Would you expect a site-specific plan to have anything
7 to say about an RVP?

8 CHRISTIAN COOPER: That would be good practice and indeed
9 such plans for airports, key transport hubs usually do
10 include that. That will normally be protectively marked
11 and sensitive because obviously we do not want that
12 disclosed in advance, but it would be good practice to
13 include all of the factors that you have just listed.

14 Q. Obviously, anything can change in the event of an
15 incident which might make the identified RVP not
16 appropriate, but having an RVP identified that would
17 generally be the correct place to meet would seem
18 sensible, would it not?

19 CHRISTIAN COOPER: Yes.

20 Q. We're also very familiar with the concept of a forward
21 command point or post. Would you expect anything to be
22 said about such a location in a site-specific plan?

23 CHRISTIAN COOPER: If we're talking about the FCP that is
24 defined within the JESIP doctrine --

25 Q. I am.

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1 CHRISTIAN COOPER: -- that tends to be more dynamic. That
2 tends to be -- there's an expectation that the three
3 commanders will form up and create one of those.
4 It would not, I would suggest, be normal to pre-identify
5 a JESIP FCP.

6 Q. That's helpful. But an RVP, yes, an FCP --

7 CHRISTIAN COOPER: If you had a site-specific plan that
8 contained established RVPs, places that are already
9 known to be a suitable location for that, then of course
10 that would be a preferential point to locate an FCP.

11 Q. Next issue. The difference that having a site-specific
12 plan, if any, might have made on the night. It's
13 probably the case that you have identified one already.
14 Things didn't go well in relation to the identification
15 of an RVP; do you agree with that?

16 CHRISTIAN COOPER: I do agree.

17 Q. If there had been a pre-identified RVP, do you think
18 that that would have been a more straightforward issue
19 on the night?

20 CHRISTIAN COOPER: Yes, it's always an option available to
21 the commanders to say, "We don't think this is suitable
22 for our purposes given what's going on, we would need to
23 relocate", and then they can relocate together.

24 SIR JOHN SAUNDERS: Can we deal with the mechanics of that
25 for a moment? There are two things. First of all,

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1 obviously new issues will arise as we go through it.
2 Did we ask questions relating to this with those
3 witnesses who gave evidence about the activities of the
4 LRF?

5 MR GREANEY: Mr Argyle was the principal witness who gave
6 evidence about the LRF. Do you mean did we ask him
7 questions about site-specific plans?

8 SIR JOHN SAUNDERS: Yes.

9 MR GREANEY: I'm not sure we did, sir, no.

10 SIR JOHN SAUNDERS: It would be helpful, if we're going to
11 make recommendations, if we could ask them -- I'm just
12 saying this now because I'll forget otherwise -- to make
13 any comments they have in relation to it.

14 MR GREANEY: I entirely agree, sir, and you're quite right
15 that obviously if issues arise or a stronger focus rests
16 on issues as we go along, and I'm sure Mr Argyle will
17 understand why he wasn't asked about that, if he wasn't,
18 and that he will assist or one of his colleagues will.

19 SIR JOHN SAUNDERS: Thank you.

20 The nomination of the RVP, as we've heard, came from
21 Inspector Smith, who was the first police officer and
22 most senior police officer on the site to start with and
23 he did that really from his own local knowledge of where
24 may have been a suitable place to do that. Would you
25 expect a local inspector in that situation to know what

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1 would be the nominated RVP on the site plan or is that
2 something which would have to go through the force duty
3 officer?

4 CHRISTIAN COOPER: I think with site-specific plans, it's
5 probably unrealistic to expect every front line member
6 of staff within the emergency services to be fully
7 familiar with everything in that plan. The plan needs
8 to be available to commanders who might be expected to
9 adopt those roles, to tactical advisers, but of crucial
10 importance, it needs to be available to the control room
11 so that when a call comes in at that location, the
12 control room very quickly can make reference to that
13 plan. And usually, certainly all the site-specific
14 plans I've seen, they're very easy to navigate to the
15 key information you need early on, like where the key
16 RVPs are.

17 SIR JOHN SAUNDERS: Thank you.

18 MICHAEL HERRIOT: Sir, if I may, it's also fairly common for
19 there to be a summary of that plan, which may include an
20 action card or a summary of the type of response that
21 would be expected to be mounted.

22 SIR JOHN SAUNDERS: Thank you. And of course we do know as
23 well that BTP were actually on the site, so they no
24 doubt would have known that in any event.

25 MR GREANEY: Yes.

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1 So what we are having in mind, just looking to the
2 future, is a site-specific plan into which all three
3 emergency services have made a contribution, which is
4 available to each of them, is within the control room
5 for each of them and readily accessible, and which has
6 a pre-identified rendezvous point, which at the very
7 least provides a starting point?

8 CHRISTIAN COOPER: Yes.

9 Q. So on the night of the arena attack, when discussion
10 started about rendezvous points, that would have been
11 a difference if such a document had existed?

12 CHRISTIAN COOPER: It would have been enormously helpful to
13 have had at least a starting point for where those RVPs
14 should be. And in terms of the mechanism, I think it's
15 fair to say there is a national expectation at the
16 moment that the mechanism for this should be that the
17 Local Resilience Forum is best placed to understand the
18 risks across a particular geography. They are under
19 a statutory obligation to risk assess that geography
20 and, one would hope, that as part of that risk
21 assessment process, a site such as Manchester Arena
22 would be identified and then the LRF is best placed to
23 undertake the relevant planning activity and that would
24 include details such as the pre-identification of RVPs.

25 Q. So Manchester Arena, a location that can accommodate

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1 14,000 people, more than 14,000 people --

2 SIR JOHN SAUNDERS: 20,000, isn't it?

3 MR GREANEY: It's approaching 20,000 maximum, sir, you're
4 quite right, but about 14,500 on the night. In the city
5 centre, above a major transport hub. That is the kind
6 of location that you'd expect to be the subject of
7 a site-specific plan?

8 CHRISTIAN COOPER: Yes.

9 Q. You are anticipating something, the chairman's
10 suggestion, across the three emergency services,
11 prepared by the Local Resilience Forum?

12 CHRISTIAN COOPER: Yes.

13 Q. A number of the issues that we've identified have been
14 related to the resourcing of the Local Resilience Forum
15 and I have no doubt therefore that it will be your view
16 that the Local Resilience Forum would need to be
17 properly resourced for this purpose?

18 CHRISTIAN COOPER: Yes, and that is a particular challenge
19 for the Ambulance Service because ambulance services are
20 regional rather than local. Their geography is
21 considerably larger than police and Fire and Rescue
22 Services. So as a result, a single ambulance trust
23 needs to service multiple LRFs, which makes it a greater
24 resource challenge for an ambulance trust than a police
25 or Fire Service that is only usually resourcing one LRF.

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1 Q. So there are two sides to this. One, each of the
2 organisations needs to ensure that it has a proper level
3 of representation on each Local Resilience Forum?

4 CHRISTIAN COOPER: Yes.

5 Q. Secondly, the Local Resilience Forum itself needs to be
6 properly resourced so that it can produce what is needed
7 in the form of these site-specific plans?

8 CHRISTIAN COOPER: Yes, and as a category 1 responder under
9 the Civil Contingencies Act the Ambulance Service has an
10 obligation to do that.

11 Q. So difference 1, RVPs. Are there any other differences
12 that you consider a proper site-specific plan would have
13 made to the response of NWS on the night if it had
14 existed?

15 CHRISTIAN COOPER: For Manchester Arena?

16 Q. Yes.

17 CHRISTIAN COOPER: I think for an event of this nature --
18 and we may be straying into evidence around the
19 Purple Guide and event planning here, but it is
20 synonymous with the site-specific plan because the
21 site-specific plan should also contain details of what
22 that site intends to do in the event of emergency in the
23 very early phases which assists the emergency services
24 to dovetail their response against that. That, I think,
25 is probably one of the most important elements for the

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1 emergency services of a site-specific plan.

2 The situation is very likely to develop to a point
3 where that site-specific plan then gets superseded by
4 the emergency response arrangements of the responding
5 agencies, but certainly in the early phases, in addition
6 to the RVP, the access and egress routes to that
7 location, what steps that location may take in the early
8 phases -- and of course it may be different for
9 Manchester Arena to COMAH sites or other sites where
10 there might be very different arrangements that need to
11 take place early on. So I guess it's hard for me to say
12 because the very nature of a site-specific plan is that
13 it has to be very specific to that site.

14 Q. Yes.

15 CHRISTIAN COOPER: But what you're effectively doing with
16 a site-specific plan is taking what would otherwise be
17 a very generic set of major incident arrangements and
18 augmenting that with the extra detail that you would
19 need to make an effective response. The best major
20 incident plans I have seen within ambulance trusts have
21 a generic section and then they effectively have
22 appendices of all these additional site-specific
23 arrangements for the local airport, local hazardous
24 sites, local stadia, and so on and so forth.

25 SIR JOHN SAUNDERS: Whatever we are going to later say about

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1 what first aid facilities there were at the site, there
 2 were some, and might it be — it may have not been in
 3 this particular case but might it be of significance for
 4 NNAS for example to know where the actual first aid
 5 facilities are on the site?
 6 CHRISTIAN COOPER: Yes, sir. I think there's two things.
 7 I think there are some elements, no doubt at the
 8 Manchester Arena, that will be the same for every event
 9 that they put on: the location of the medical area, for
 10 example, where they envisage ambulances — if you only
 11 have one or two casualties, where they would envisage
 12 those being picked up, those are all things that would
 13 be absolutely appropriate in a site-specific plan.
 14 Where it's a bit more challenging is something like
 15 Manchester Arena that puts on multiple events of
 16 different types, different risk profiles, which means
 17 that there will be some things that I think it's
 18 probably unrealistic to expect to be in a site-specific
 19 plan because it needs to be flexible enough to allow for
 20 that variance in what is going on.
 21 But that should be picked up by elements that
 22 we will no doubt get into later from the Purple Guide
 23 and suitable specific event planning.
 24 MR GREANEY: Thank you. We are going to get into the issue
 25 of liaison between the medical provision in the course

1 of an event and NNAS in due course.
 2 What we were dealing with were the respects in which
 3 you think the planning and preparation of NNAS was
 4 lacking. First, absence of a site-specific plan.
 5 Secondly, I want to deal with something that you refer
 6 to in your reports as being a predetermined attendance
 7 or PDA. So first, what is a predetermined attendance?
 8 CHRISTIAN COOPER: It's a set of arrangements or a procedure
 9 that dictates the minimum number of assets that an
 10 Ambulance Service is going to send to a particular type
 11 of event or emergency.
 12 Now, similar to the site-specific plan, there is no
 13 specific contractual requirement or standard or
 14 regulatory provision that specifically requires an
 15 ambulance trust to have a predetermined attendance. But
 16 it is something that's seen as good practice and again
 17 it is something that most ambulance services have,
 18 though it is widely variable what they have them for.
 19 It's very common for an ambulance trust to have
 20 a predetermined attendance for their local airport, for
 21 example.
 22 Q. Can I ask you to pause for a moment? So just as with
 23 a site-specific plan, no regulatory requirement for
 24 there to be one. But in 2017, it would have been good
 25 practice?

1 CHRISTIAN COOPER: Yes.
 2 Q. And would you have expected the North West Ambulance
 3 Service to have had a predetermined attendance that was
 4 relevant to the events of 22 May?
 5 CHRISTIAN COOPER: It would have been good practice to have
 6 some form of predetermined attendance for a terrorist
 7 attack.
 8 Q. So that was really what I was concerned to know. Does
 9 a PDA relate to a location, for example an airport, or
 10 to an event, or to both?
 11 CHRISTIAN COOPER: They take many different forms. Because
 12 there's no prescribed specification or standard for what
 13 they are to contain, it is really a matter for the
 14 ambulance trust to determine what it needs to be. It
 15 can be as specific as saying, "For this type of incident
 16 you must send the following number of commanders, the
 17 following number of ambulances, the following number of
 18 specialist assets". It can be that specific or it can
 19 be far more generic than that and say, "If a major
 20 incident is declared, generally speaking, the following
 21 number of ambulances should be made available".
 22 Q. I don't want to get into specific numbers because that
 23 may be sensitive, but you would have expected NNAS to
 24 have had a predetermined attendance for a terrorist
 25 attack?

1 CHRISTIAN COOPER: Yes.
 2 Q. That would have been expected to have dealt with, at
 3 least in general terms, the number of ambulances that
 4 should attend?
 5 CHRISTIAN COOPER: Yes.
 6 Q. And whether specialist resources should or shouldn't
 7 attend?
 8 CHRISTIAN COOPER: Yes, and I think that's the key part.
 9 It's really quite difficult for an ambulance trust,
 10 given the amount of demand that they face on a daily
 11 basis, to immediately, let's say, make ambulances 20 and
 12 send 20 ambulances to an event that's happened before
 13 it's clear what's going on.
 14 Q. This is a fascinating and important issue and we do need
 15 to understand it. But let's just understand it in the
 16 context of Manchester. The public might imagine that
 17 there are ambulances waiting around at ambulance
 18 stations ready to be told to go to a particular
 19 emergency or to a particular event. Is that the reality
 20 of the Ambulance Service in the United Kingdom?
 21 CHRISTIAN COOPER: No, far from it.
 22 Q. What is the reality?
 23 CHRISTIAN COOPER: The majority of the time the
 24 Ambulance Service is in a position where it is what
 25 we would call all assets utilised and is stacking

1 emergency calls within its control room. Those are
 2 emergency calls that have been graded and are waiting
 3 for an ambulance to be sent.
 4 SIR JOHN SAUNDERS: So it's playing catch-up?
 5 CHRISTIAN COOPER: Yes. The Ambulance Service has very
 6 established procedures and very experienced people in
 7 its control rooms on a daily basis that prioritise those
 8 calls to ensure that the emergencies of the highest
 9 priority receive an ambulance as quickly as possible.
 10 But it's inescapable that there are so many calls within
 11 that system that the Ambulance Service is, as you say,
 12 sir, always playing catch-up in terms of the amount of
 13 vehicles it's got versus demand.

14 In the context of a PDA then, if you were to have
 15 a predetermined attendance for various different types
 16 of emergency that take 20 ambulances immediately out of
 17 that system, that is going to have a significant impact.
 18 It's not necessarily the wrong thing to do, but it needs
 19 to be recognised the impact that that will have.

20 But what is very commonplace in ambulance trusts is
 21 for jobs that are graded as requiring a hazardous area
 22 response or a potential terrorism or a potential bomb
 23 that may have gone off or anything of that nature, it is
 24 very common for the Ambulance Service to have
 25 arrangements to send its specialist assets without

25

1 delay, so mobilise its HART teams, if it's potentially
 2 terrorism with firearms, start to prepare its AIT
 3 responders, and prepare to deploy them, prepare to
 4 deploy certain key commanders in key roles. That is
 5 commonplace. That's certainly good practice and I would
 6 go further to suggest it's a national expectation that
 7 they have that.

8 The predetermined attendance of and how many
 9 ambulances you are going to send with it I think is
 10 perhaps less clear. There is no specification for that
 11 nationally, so we would deem it good practice to have
 12 that in place. And I think if we take the context of
 13 Manchester Arena, it would perhaps have been more
 14 helpful for a set number of ambulances to be sent and
 15 then stood down if not required, so at least you reach
 16 a critical mass of resources quickly rather than
 17 expecting commanders at various different points in
 18 those very early and quite chaotic stages to be trying
 19 to make decisions about what number of ambulances they
 20 think they need.

21 And when indeed you reach a point of realisation
 22 that you need a large number, it would have been more
 23 fortuitous if those had been mobilised automatically
 24 earlier. So it is perhaps an area that would benefit
 25 from a review.

26

1 SIR JOHN SAUNDERS: So predetermined attendance, we became
 2 very familiar with, with GMFRS and NWFC yesterday. And
 3 I don't know whether you did hear any of that evidence,
 4 but clearly there can be problems relating to that as
 5 well.

6 CHRISTIAN COOPER: Indeed.

7 SIR JOHN SAUNDERS: If you get action cards, that sort of
 8 thing, identifying which are the right ones, so I'm not
 9 saying it's a bad idea, but at least no doubt those sort
 10 of problems or potential problems need to be taken into
 11 account as well?

12 CHRISTIAN COOPER: Indeed, sir, and PDAs are very
 13 well-established in the Fire and Rescue Service, less so
 14 in the Ambulance Service, but the Ambulance Service is
 15 a little more flexible now with its arrangements. It
 16 tends to have them for its specialist assets rather than
 17 its day-to-day assets.

18 MICHAEL HERRIOT: I would suggest at the very least there
 19 should be a PDA for a generic major incident, so when
 20 a major incident is declared, a fixed number and type of
 21 asset would be sent. And the order of those assets
 22 would be specified also in that procedure.

23 SIR JOHN SAUNDERS: Thank you.

24 MR GREANEY: I just want to understand in a moment what
 25 difference this might have made on the night. But if in

27

1 your view there should be a review of the use by
 2 ambulance services of PDAs, whose responsibility should
 3 it be to carry out that review?

4 CHRISTIAN COOPER: There are a number of national groups
 5 established, national directors of operations group,
 6 there's an Emergency Response and Resilience Group.
 7 NARU itself is probably very well placed to do that.
 8 But it would need to be a collaboration of all ambulance
 9 trusts because what we would hopefully want to achieve
 10 is some standardisation.

11 Q. In terms of a difference on the night, and let's just
 12 envisage that there is a PDA for a terrorist attack,
 13 would you expect that a PDA relating to a terrorist
 14 attack would make provision for the attendance of
 15 specialist assets?

16 CHRISTIAN COOPER: Yes.

17 Q. And on the night, we know, we are not identifying where
 18 they were based, but we know on the night that one HART
 19 was at a factory fire in Stockport where in fact, not
 20 their fault, they were not able to provide any value.
 21 The other was based in Merseyside and they weren't
 22 mobilised for a period of, I think, about 40 minutes.

23 Are you envisaging a situation in which the PDA
 24 says: we need one team or two teams, specialist teams,
 25 at location of the terrorist attack as soon as possible?

28

1 CHRISTIAN COOPER: Yes. There's a risk, of course,
 2 particularly with a terrorist attack, that you don't
 3 know if it's going to be multi-sited, so there needs to
 4 be a caution about sending all specialist assets to
 5 a single location. But I would certainly expect a PDA
 6 to make those assets ready and potentially mobilise them
 7 to a strategic holding area or the equivalent. "Yes" is
 8 the answer, that is the optimal, with a note of caution
 9 and some form of provision in there to manage the risk
 10 of not sending all of your assets to a single point when
 11 it could be a multi-sited attack.
 12 Q. So there are some ifs and buts and I quite get that.
 13 But doing the best that you can, if there had been a PDA
 14 making that plan or provision in existence on the night,
 15 would you have expected HART to arrive quicker and/or in
 16 greater numbers than in fact occurred?
 17 CHRISTIAN COOPER: Yes, because the alternative is to wait
 18 for a commander to identify that they are needed, and
 19 that, in my view, is an unnecessary delay.
 20 SIR JOHN SAUNDERS: It may involve them looking through
 21 their action cards to find out what they're meant to be
 22 doing, which itself takes some time.
 23 CHRISTIAN COOPER: Indeed, sir, and what you're trying to
 24 achieve with a PDA is taking that thinking out of it.
 25 The resources are coming. If you don't want them or

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1 don't need them, the onus is on the commander to stand
 2 them down, but it takes quite a bit of pressure off the
 3 commander if they know that a critical mass of assets is
 4 already on its way.
 5 MR GREANEY: That deals with specialist resources. Just in
 6 terms of — I'm going to use the term "ordinary
 7 ambulances", I don't mean that in any critical or
 8 pejorative way. We know that at various stages,
 9 requests were made for different numbers of ambulances.
 10 So Advanced Paramedic Ennis, who was on the scene as you
 11 know, within 15 minutes asked, I think, for four
 12 ambulances to begin with and that number was increased
 13 over time. No ambulance arrives until, I think, about
 14 11 o'clock in the result — it is in fact exactly
 15 11 o'clock. If there had been a PDA providing for the
 16 attendance of a particular number or numbers of
 17 ambulances, would you have expected ambulances to have
 18 arrived at the scene sooner than in fact occurred?
 19 CHRISTIAN COOPER: Yes, but with the caveat that the
 20 Ambulance Service is always busy. There are busier than
 21 busy periods and regular periods where there simply are
 22 no ambulances that are available, they're all committed.
 23 So the PDA has the advantage of immediately identifying
 24 that you've got a problem because you don't have the
 25 resources to meet your PDA, so somebody should

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1 immediately start to manage that issue.
 2 I think it is the practice of most ambulance control
 3 rooms that when a major incident is declared, certainly,
 4 they immediately start to look at their resourcing map
 5 and what is committed where and start to try and
 6 identify assets that can be — that happens. But
 7 I think a more formal process for a major incident to
 8 expedite that would be helpful.
 9 SIR JOHN SAUNDERS: We ought to remember all the time, which
 10 we may forget, that when we're talking about ambulances
 11 coming with ambulances come the paramedics. So it's not
 12 just a vehicle which is coming, it's paramedics who are
 13 going to go in and do the treating.
 14 CHRISTIAN COOPER: That's quite right, sir: two paramedics
 15 or ambulance staff on every double-crewed vehicle.
 16 I think perhaps —
 17 MR GREANEY: (overspeaking) few weeks ago, a very important
 18 issue that I know the chairman is interested in that
 19 we'll look at in due course. But at the very least —
 20 MICHAEL HERRIOT: I think even if it didn't result in
 21 regular ambulances arriving sooner, it would certainly
 22 have resulted in a more comprehensive specialist
 23 response, and that involves each of the HART teams,
 24 early mobilisation, and also identification of other
 25 assets.

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1 SIR JOHN SAUNDERS: The equipment van?
 2 MICHAEL HERRIOT: The equipment, the Ambulance Intervention
 3 Team, Special operations Response Team possibly. All of
 4 those aspects would be very early mobilisations within
 5 a PDA and my belief is they would have created some
 6 benefit.
 7 SIR JOHN SAUNDERS: Thank you.
 8 MR GREANEY: I think what we're going to see by the end of
 9 your evidence is a lot of these individual benefits you
 10 consider would have worked together on the night to make
 11 a difference.
 12 CHRISTIAN COOPER: Yes.
 13 Q. So for example, and I am jumping ahead now, having the
 14 equipment van there would have had a number of
 15 advantages?
 16 CHRISTIAN COOPER: Yes.
 17 Q. Just on the PDA, and on the number of ambulances who get
 18 there, what I have understood from what you have said is
 19 that at the very least it would have communicated to
 20 those with responsibility for making arrangements:
 21 there's no option here, we've got to get five/10/20,
 22 whatever, ambulances to that scene, this is a priority?
 23 CHRISTIAN COOPER: Yes, and to start the process of
 24 identifying within the system what assets can be made
 25 available quickly. They have ways of doing that, they

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1 have ways of putting general messages out to say to
2 ambulance crews that may be clearing at a hospital,
3 "Can you clear quicker? We need you". There may be
4 ambulances that are on their way to a lower acuity call,
5 a lower grade of call that could potentially be
6 diverted.

7 I think the key thing about a PDA is it's not
8 waiting for somebody to proactively do that. It says
9 right from the start of a major incident declaration:
10 someone in the control room needs to start to be
11 prepared to make those assets available.

12 Q. Ultimately, and I do want to deal with this in more
13 detail in due course, ultimately you have a strategic
14 commander in post?

15 CHRISTIAN COOPER: Yes.

16 Q. It is his or her responsibility to make sure this works?

17 CHRISTIAN COOPER: Yes.

18 Q. And an option available to that person relates not just
19 to the resources of that individual Ambulance Service
20 but also the resources of other ambulance services? I'm
21 talking about mutual aid.

22 CHRISTIAN COOPER: Yes. It may be beneficial to explore it
23 further when we deal with command matters. But the
24 strategic commander is not necessarily responsible for
25 ensuring that that particular individual detailed

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1 activity is undertaken. It is certainly overall
2 responsible for looking at that resourcing picture, what
3 the impact of the major incident is having, and making
4 sure that both the other outstanding emergencies within
5 the stack can be dealt with and day-to-day business can
6 be dealt with as well as providing suitable resources to
7 the tactical and operational commander that are dealing
8 with the incident.

9 I mean, in simple terms, the tactical commander is
10 responsible for identifying what resources they need to
11 get this job done properly and a large part of that
12 could be done in advance in a PDA, I agree. Then the
13 strategic commander takes a step back and says, "What
14 impact is this having on my overall emergency responses
15 here? I need to manage that problem", whilst also
16 saying to the tactical commander, "You can have what you
17 need", because of course the strategic commander has
18 a position of authority within the organisation where
19 they can say that, "That incident needs to have the
20 resources it needs, let me worry about sorting out the
21 wider issues with our business", in effect.

22 And certainly the strategic commander is the one
23 that's in a place to make phone calls to neighbouring
24 ambulance trusts and say, "I need some help under mutual
25 aid, not necessarily for this specific incident but to

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1 backfill the wider emergencies I am dealing with", and
2 can take all of that responsibility away from the
3 tactical and operational commander, who are then free to
4 focus on resourcing for the specific incident.

5 Q. As you yourself have said, we're going to come on to
6 look at these issues when we look at the command
7 structure, but without giving too much away, it would be
8 fair to say that you don't consider that Mr Barnes, as
9 Gold commander, performed to a high standard on the
10 night of the arena attack?

11 CHRISTIAN COOPER: I think that's a fair assessment.

12 Q. I'm going to move on to the next aspect of planning and
13 preparation that in your view didn't go well, but I'm
14 just going to check with Mr Herriot. Is there anything
15 you want to add in relation to predetermined attendance
16 before we move on?

17 MICHAEL HERRIOT: No, sir.

18 Q. Next topic, exercising. As you have told us already,
19 in the years before the arena attack, NWAS engaged in
20 significant exercising and, moreover, in significant
21 multi-agency exercising.

22 CHRISTIAN COOPER: They did.

23 Q. But the issue I'm going to invite you to agree with
24 relates to a concern that we have encountered really
25 across chapter 10 of our oral evidence hearings, namely

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1 that exercising takes place, problems are identified,
2 including serious problems, but change is not
3 implemented to deal with those problems. Do you
4 recognise in the work that you have done that concern?

5 CHRISTIAN COOPER: I do.

6 Q. And do you share that concern, that exercising revealed
7 problems that did not result in change being implemented
8 so far as NWAS is concerned?

9 CHRISTIAN COOPER: Yes, and it's by no means exclusive to
10 NWAS or this incident.

11 Q. Quite right. I hope I made that plain. This is across
12 the emergency services. I'm going to ask you at the end
13 of this to ask you to help us with how this is to be put
14 right because what is the point in exercising, what is
15 the point in identifying problems unless you put them
16 right --

17 CHRISTIAN COOPER: Indeed.

18 Q. -- which is to do no more than state the obvious.

19 Let's pick up on some key aspects. It will help
20 you, and it may help others to follow this, if
21 I indicate, without asking it to be put on the screen,
22 that I'm at your second report, which is your divider 2,
23 I'm at page 58 of 226 pages. The INQ reference for
24 those who are following in that way is {INQ032665/58}.

25 I'm not putting this on the screen only because you

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1 identify a whole series of features. I'm just going to
 2 pick out the ones that seem to me to be the most
 3 relevant in light of the issues that now exist.
 4 First of all, did Exercise Dawn Vigil take place in
 5 July 2015?
 6 CHRISTIAN COOPER: Yes.
 7 Q. Was that a multi-agency exercise in which NWS played
 8 a part, including its commanders and specialist teams?
 9 CHRISTIAN COOPER: Yes.
 10 Q. Was the scenario a terrorist attack?
 11 CHRISTIAN COOPER: Yes.
 12 Q. Among other learning points, of which I recognise there
 13 were many, were there the following? First of all,
 14 during the course of that exercise, was there a delay in
 15 appointing a safety officer?
 16 CHRISTIAN COOPER: Yes.
 17 Q. We're going to get on to what a safety officer is in due
 18 course, although we probably know about it already.
 19 Would it be fair to say that that problem occurred,
 20 but even more acutely, in May of 2017?
 21 CHRISTIAN COOPER: Yes.
 22 Q. In fact, it wasn't a case of a delay in appointing
 23 a safety officer, no safety officer was appointed?
 24 CHRISTIAN COOPER: That's correct.
 25 Q. That was one learning point.

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1 Secondly, was there a delay on the occasion of that
 2 exercise in committing HART staff to triage and treat
 3 patients because they were used to, as it was put,
 4 construct other structures?
 5 CHRISTIAN COOPER: Yes.
 6 Q. So in 2015, in the exercise, they weren't being used for
 7 what they are designed to be used for, getting into
 8 a hazardous location, triaging and treating, they were
 9 given some other task to do?
 10 CHRISTIAN COOPER: Yes.
 11 Q. Did that repeat itself in May 2017?
 12 CHRISTIAN COOPER: It did.
 13 Q. So lessons that have been identified but change, at
 14 least no sufficient change, being implemented on the
 15 face of it?
 16 CHRISTIAN COOPER: I agree.
 17 Q. Now turning over the page {INQ032665/59}. I'm not going
 18 to deal with every exercise you've identified, although
 19 I will deal with them in general terms at the end.
 20 Did Exercise Lawman 2 take place in March 2016?
 21 CHRISTIAN COOPER: Yes.
 22 Q. Again, was that a multi-agency exercise in which NWS
 23 played an active part?
 24 CHRISTIAN COOPER: Yes.
 25 Q. And the Fire and Rescue Service also played a part,

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1 although GMFRS would want us to note that it was not
 2 GMFRS that took part but instead Merseyside Fire and
 3 Rescue Service?
 4 CHRISTIAN COOPER: Yes, that's my understanding.
 5 Q. Again, was the scenario for that exercise a terrorist
 6 attack?
 7 CHRISTIAN COOPER: It was, yes, a terrorist and mass
 8 casualty attack, yes.
 9 Q. Indeed. In fact, it was an MTFA mass casualty exercise?
 10 CHRISTIAN COOPER: Yes.
 11 Q. Among other learning points, were, on the occasion of
 12 that exercise, Airwave operational groups not used
 13 at the operational level?
 14 CHRISTIAN COOPER: Yes, that's correct.
 15 Q. Again, does that resonate with what occurred in May of
 16 2017?
 17 CHRISTIAN COOPER: It does.
 18 Q. And was the Fire and Rescue Service — bearing in mind
 19 it was not GMFRS of course, were the specialist
 20 responders of that Fire and Rescue Service held back
 21 from the warm zone whilst permissions were sought?
 22 CHRISTIAN COOPER: Yes.
 23 Q. Leaving the specialist resources of the
 24 Ambulance Service to go in effectively alone?
 25 CHRISTIAN COOPER: Yes.

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1 Q. And again, as everyone knows, that was something which
 2 also occurred on 22 May 2017.
 3 CHRISTIAN COOPER: Apologies, I think the Ambulance Service
 4 who were in that exercise went in with the police, but
 5 without fire.
 6 Q. You're quite right to make that qualification.
 7 As we know very well indeed, Exercise
 8 Winchester Accord took place in May 2016. Learning
 9 points for lots of organisations, but was a learning
 10 point for NWS that joint situational awareness was not
 11 achieved across the three emergency services?
 12 CHRISTIAN COOPER: Yes.
 13 Q. To say the least, that repeated itself on 22 May 2017?
 14 CHRISTIAN COOPER: It did.
 15 Q. We also know within the inquiry that Exercise Hawk River
 16 took place in March 2017 and again was that
 17 a multi-agency exercise in which NWS played an active
 18 part?
 19 CHRISTIAN COOPER: Yes.
 20 Q. The scenario was an MTFA mass casualty incident again?
 21 CHRISTIAN COOPER: Yes.
 22 Q. On the occasion of that exercise, were there conflicting
 23 views about the boundaries concerning warm zones?
 24 CHRISTIAN COOPER: Yes.
 25 Q. Which the exercise revealed in a real time situation

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1 would need to be clarified at the FCP?
 2 CHRISTIAN COOPER: Yes.
 3 Q. Was it also identified that the actual limits of a warm
 4 zone would be something that would need to be
 5 communicated effectively to staff on the ground?
 6 CHRISTIAN COOPER: Yes, absolutely.
 7 Q. Again, I'm not saying anything controversial by
 8 indicating that those were issues which came to light
 9 again on 22 May 2017.
 10 CHRISTIAN COOPER: Yes.
 11 Q. On the occasion of Exercise Hawk River, was an issue
 12 also identified regarding the lack of multi-agency Talk
 13 Groups being utilised so as to inform situational
 14 awareness?
 15 CHRISTIAN COOPER: Yes.
 16 Q. And again, something which was to feature in the events
 17 of 22 May?
 18 CHRISTIAN COOPER: Yes.
 19 Q. Conversely, there were exercises when JESIP worked well,
 20 were there not?
 21 CHRISTIAN COOPER: There were.
 22 Q. So on the one hand, over this period of exercising of
 23 2 years, we see things going wrong, often as a result of
 24 the principles in JESIP not being utilised?
 25 CHRISTIAN COOPER: Yes.

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1 Q. And conversely, we have exercises where JESIP is applied
 2 properly and things do go well?
 3 CHRISTIAN COOPER: Yes, and I would go further: where JESIP
 4 is applied, an important observation for the
 5 Ambulance Service is that casualties received care
 6 earlier.
 7 Q. So to draw these strands together, there were lessons to
 8 learn in these exercises going back to July of 2015?
 9 CHRISTIAN COOPER: Yes.
 10 Q. Lessons to learn about things which then went wrong on
 11 22 May 2017?
 12 CHRISTIAN COOPER: Yes.
 13 Q. So if those lessons were learned or at least identified,
 14 as appears to be the case, change was not implemented or
 15 not significantly, sufficiently?
 16 CHRISTIAN COOPER: Yes.
 17 Q. And in your view, obviously other emergency services
 18 will need to speak for themselves, does that represent
 19 a failure by NWS?
 20 CHRISTIAN COOPER: Yes.
 21 Q. And does it represent a significant failure by them?
 22 CHRISTIAN COOPER: Yes.
 23 SIR JOHN SAUNDERS: So some time, when we come to
 24 recommendations, one of the recommendations suggested to
 25 me by GMFRS and NWFC yesterday is: we need more

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1 training. That's not going to be welcomed by people
 2 administering the rescue services, maybe, but actually
 3 if we don't learn the lessons, there's not much point in
 4 having more training, so at some point you're going to
 5 have to tell me how we try and make sure the
 6 recommendations or learning is followed. I'm not asking
 7 you to do it this minute.
 8 CHRISTIAN COOPER: I agree, sir. I would take the
 9 opportunity to point out this is a well-known issue, and
 10 JESIP, I am aware, has made a number of attempts through
 11 the introduction of a joint organisational learning
 12 programme to encourage emergency services to share the
 13 lessons that are learned from these exercises so that
 14 everybody can see them, but also to try and put a bit
 15 more of a formal process around — it's one thing to
 16 identify lessons, it's something quite different to
 17 demonstrate that you have fixed the problem.
 18 And this JOL system, which is more mature now than
 19 it was in 2017, is seeking to do that, but I think
 20 we would welcome an opportunity to look further at how
 21 that can be made even more effective, because it is
 22 evident here that the problem is not a lack actually of
 23 multi-agency training, there was a lot of that, it was
 24 a failure to implement the really good learning that
 25 came out of those exercises.

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1 SIR JOHN SAUNDERS: Okay. I think it's fair to say
 2 in relation to GMFRS and NWFC, it was a specific joining
 3 of control rooms into exercises, so I make that clear.
 4 Thank you.
 5 MR GREANEY: You're quite right to do so, sir.
 6 I'm sure you appreciate and accept what I said
 7 earlier that this isn't an issue just for NWS, it's
 8 an issue across the emergency services, it would seem,
 9 that lessons are identified and change is not
 10 sufficiently implemented, and I expect that the chairman
 11 will be very interested in your views about how that
 12 situation is to be improved so we don't just identify
 13 lessons, we actually make the necessary changes.
 14 SIR JOHN SAUNDERS: And the roles of LRFs and whether they
 15 should be given compulsory powers to make sure that
 16 people actually do put in place the learning.
 17 MR GREANEY: So you have given us some evidence about how it
 18 has been improved so far, but is the position that you
 19 would welcome the opportunity to reflect and to put into
 20 writing what further can be done in order to improve
 21 this obviously important situation?
 22 CHRISTIAN COOPER: Yes.
 23 MICHAEL HERRIOT: I think we also accept that LRFs are, by
 24 their nature, local entities and, as has been explained,
 25 ambulance services are regional entities. So North West

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1 Ambulance Service, as you know, cover five areas, so
 2 consistency across LRFs is an issue.
 3 CHRISTIAN COOPER: It's perhaps something that could be
 4 explored in writing, but of course one of the dangers
 5 with an LRF having increased powers to mandate — one of
 6 the things that would make the Ambulance Service
 7 nervous, I would suggest, is if there were two LRFs that
 8 had conflicting views. That would place the
 9 Ambulance Service in an impossible position, so as long
 10 as there were safeguards to protect against that.
 11 SIR JOHN SAUNDERS: I see the problem.
 12 MR GREANEY: Sir, are you content that I should go on for,
 13 I expect, another 20 or 30 minutes?
 14 SIR JOHN SAUNDERS: I'm happy because of my causing of
 15 delay, we haven't actually done the amount of time we'd
 16 expect to do. So I'm perfectly happy to go on to 11 or
 17 just after, five past. This may be a convenient time to
 18 say, I said in your absence, but maybe you knew
 19 yesterday, about the importance of keeping to the
 20 timetable at this particular stage, dealing with the
 21 expert reports and the reasons for that, because of the
 22 timetable for chapter 12. I hope everyone knows about
 23 that: we're going to be much stricter about time. A
 24 result of that was we finished early yesterday, so it's
 25 to be highly commended. But it was Mr de la Poer at

1 that time rather than you. I'm not suggesting anything!
 2 MR GREANEY: I'm confident, sir, that we will, with
 3 everyone's cooperation, be able to manage this evidence
 4 as well within the timescale.
 5 I'm still dealing with planning and preparation, and
 6 I'm now going to move on to seek your assistance
 7 in relation to what I'm going to call the care gap. Can
 8 I explain to you what I mean by that?
 9 The public might expect that in the event that there
 10 is an incident such as the terrorist outrage as occurred
 11 on 22 May 2017, paramedics would be there within seconds
 12 or minutes treating the casualties. But what we now
 13 understand very well is that that is wholly unrealistic
 14 and there may be a period even of 30 minutes before
 15 paramedics are actually able to start treating
 16 casualties.
 17 CHRISTIAN COOPER: I think in any kind of significant
 18 number, yes.
 19 Q. So there is that care gap?
 20 CHRISTIAN COOPER: Yes.
 21 Q. The issue is how that care gap is to be bridged and
 22 bridged effectively. First of all, are you aware of the
 23 evidence that we received from Brigadier Hodgetts?
 24 CHRISTIAN COOPER: I am.
 25 Q. His general thesis was that the public need to be

1 educated about how to perform some basic life-saving
 2 measures, the application of tourniquets and perhaps
 3 also establishing or maintaining an airway. Do you
 4 agree with him?
 5 CHRISTIAN COOPER: I do. I agree with the principle of
 6 upskilling members of the public and there is evidence
 7 of — in other countries where children in schools are
 8 trained how to undertake CPR, and in some cases the use
 9 of a defibrillator as well from a very early age, and
 10 where that happens, there is a marked improvement in
 11 survivability from cardiac arrest pre-hospital before
 12 professionals arrive. So the principle of training and
 13 equipping large numbers of members of the public to do
 14 something meaningful, certainly in the early phases of
 15 a catastrophic and terrible event like a terrorist
 16 attack that leave people with catastrophic haemorrhage,
 17 for example, I think is a very positive thing to look
 18 at.
 19 Q. I think you have in mind in particular the experience of
 20 countries such as New Zealand and Canada, and in Canada
 21 where they've taught their children to perform CPR, they
 22 have actually seen meaningful evidence that lives are
 23 saved by doing that kind of thing?
 24 CHRISTIAN COOPER: Yes.
 25 Q. So what we're talking about is educating the public not

1 just about CPR and defibrillators but about the kind of
 2 things I'm speaking of: maintaining an airway and
 3 applying a tourniquet?
 4 CHRISTIAN COOPER: Yes.
 5 SIR JOHN SAUNDERS: Do you mind me interrupting? This is
 6 something that has concerned me.
 7 MR GREANEY: Not at all.
 8 SIR JOHN SAUNDERS: Is there now a generally accepted
 9 medical agreement as to the use of tourniquets and any
 10 safeguards which need to be put in place? I'm talking
 11 in particular about what, I have to say until I heard
 12 Brigadier Hodgetts, was always my belief that there was
 13 a necessity to release tourniquets on a fairly regular
 14 and rapid basis, which makes it quite difficult for
 15 members of the public. And indeed, we have heard that
 16 repeated from some people during the inquiry. Is there
 17 now general acceptance that the view expressed by
 18 Brigadier Hodgetts, who obviously is an extremely
 19 impressive witness, his view that really that is not
 20 a necessity any longer, is the correct one?
 21 CHRISTIAN COOPER: There are opposing views. I think, with
 22 respect, sir, that's probably evidence better elicited
 23 from a medical professional.
 24 SIR JOHN SAUNDERS: All I actually needed to know was
 25 whether there are opposing views or not.

1 CHRISTIAN COOPER: There certainly are. There are
 2 complexities to using a tourniquet that are known and
 3 that have come out in the evidence. It's those
 4 complexities that raise concerns about them being
 5 applied incorrectly and the consequences of doing so.
 6 That always has to be balanced against the consequences
 7 of not, which may, to be stark, be the loss of life
 8 versus the loss of a limb.

9 SIR JOHN SAUNDERS: So we will try and look at and get some
 10 agreed medical — at least accept what the position is.
 11 Can I say I'm not for a moment suggesting
 12 Brigadier Hodgetts was wrong. He has been generally
 13 accepted as being extremely impressive and helpful and
 14 the app is also accepted that way. Please don't think
 15 I'm criticising him.

16 MR GREANEY: You certainly did make plain at the end of the
 17 evidence to the brigadier that you wanted absolute
 18 clarity in relation to that particular issue and I know
 19 that people are dealing with that.

20 MICHAEL HERRIOT: In fairness, there is far greater
 21 consensus now than there has been previously, and the
 22 use of tourniquets is being taught on some first aid
 23 courses, which is I'm sure commendable. Some of the
 24 concerns have been rather than — not about the damage
 25 done by applying the tourniquet but of course it

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1 actually not being applied effectively .

2 SIR JOHN SAUNDERS: I may be getting myself into an
 3 extremely complex topic.

4 MR GREANEY: I hope this is capable of a yes—or—no answer.
 5 When you say there is greater consensus now, do you mean
 6 there is greater consensus that the view expressed by
 7 Brigadier Hodgetts is correct?

8 MICHAEL HERRIOT: About the value and efficacy of the use of
 9 a tourniquet, yes.

10 MR GREANEY: So the public need to be educated and the
 11 issue, I don't know if this is a matter for you, but you
 12 may have a view, is how that is to be achieved.
 13 Obviously there's the extraordinary work of
 14 Brigadier Hodgetts and citizenAID. Do you have any
 15 further ideas either to express now or in writing in due
 16 course about how we educate the public about what
 17 difference they can make?

18 CHRISTIAN COOPER: I think it's something I would like to
 19 give some thought to.

20 SIR JOHN SAUNDERS: On the face of it, doing it in schools
 21 sounds like a very good idea to me.

22 CHRISTIAN COOPER: Indeed, and there are a number of very
 23 well-established charities in this country who do
 24 similar work that could potentially be expanded, so yes.

25 MICHAEL HERRIOT: It's fair to say that there have been

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1 a great number of initiatives over the years. I was
 2 reflecting that there was an initiative called Save
 3 a Life back about 30 years ago with the aim of educating
 4 members of the public to ensure that if someone
 5 collapsed, they would be within view of someone who
 6 could do something effective. That thinking has
 7 continued to the current day, particularly through the
 8 voluntary societies, but they haven't been terribly
 9 effective getting that embedded. Perhaps that's the
 10 issue.

11 SIR JOHN SAUNDERS: It may be that we'll ask for comments
 12 from the Department of Education.

13 MR GREANEY: Indeed, sir, thank you.
 14 We were discussing bridging this care gap and
 15 educating the public. Secondly, as the events of the
 16 arena attack reveal, those likely to be on the scene
 17 very quickly will include police officers and an issue
 18 that has arisen is whether police officers should also
 19 be trained in the basic skills of life support,
 20 including the use of a tourniquet and maintaining an
 21 airway. Do you have a view about whether that is
 22 something which seems sensible?

23 CHRISTIAN COOPER: I think in general, yes. I think the key
 24 is basic skills because it is basic skills in the very
 25 early phases that will assist in saving life. I think

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1 there is a risk in potentially overtraining police
 2 officers in advanced trauma and the danger that creates
 3 in conflicting their role, and of course there are
 4 certain police officers in the early phases of incidents
 5 like this where there may still be a terrorist threat
 6 present where — it sounds callous but the best thing
 7 for all is they concentrate on neutralising that threat
 8 first to stop further injury and others being affected
 9 and we wouldn't want that process to be delayed by those
 10 particular officers feeling obligated to slow that
 11 response in relation to patient care. So there are some
 12 complexities to this, but in general, where there are
 13 a number of police officers that find themselves with
 14 casualties that have suffered potentially
 15 life-threatening injuries, equipping those police
 16 officers to be able to do something to buy some time
 17 I think has great value.

18 Q. In fact, the first police officers into the City Room
 19 were not the armed officers, they were officers of
 20 British Transport Police, so those are the kind of
 21 officers that I have in mind. And I believe you're
 22 saying that it's very sensible that those be equipped
 23 with those kind of techniques?

24 CHRISTIAN COOPER: Yes.

25 Q. So public, police. Thirdly, of course we're dealing

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1 with what happened at an event, a music concert, and
 2 medical services will generally be provided at such an
 3 event?
 4 CHRISTIAN COOPER: Yes.
 5 Q. The Purple Guide to which you have referred already. In
 6 terms of bridging the care gap, is it your view that
 7 such medical services have a critical role to play?
 8 CHRISTIAN COOPER: Yes.
 9 Q. And in particular, should they be expected to start the
 10 process of triage?
 11 CHRISTIAN COOPER: Yes.
 12 Q. And also to provide treatment if appropriate?
 13 CHRISTIAN COOPER: Yes.
 14 Q. Can they reasonably be expected to pass what we know is
 15 a METHANE message?
 16 CHRISTIAN COOPER: Yes.
 17 Q. So assisting with the gaining of situational awareness
 18 at a really early stage?
 19 CHRISTIAN COOPER: Yes, absolutely.
 20 Q. And can they also be expected then to liaise with the
 21 formal emergency services when they turn up?
 22 CHRISTIAN COOPER: Yes.
 23 Q. So these are all three ways or three parts of our
 24 community that can bridge that gap: public, police and
 25 the medical provider who is there for the event if it's

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1 an event?
 2 CHRISTIAN COOPER: Yes, I agree.
 3 MR GREANEY: That then leads us on to ETUK, and sir, that
 4 would be a convenient moment to take our break.
 5 SIR JOHN SAUNDERS: Right. Quarter of an hour, and we're on
 6 time, are we?
 7 MR GREANEY: We are, sir, yes.
 8 SIR JOHN SAUNDERS: Thank you.
 9 (11.00 am)
 10 (A short break)
 11 (11.20 am)
 12 MR GREANEY: We were still dealing with planning and
 13 preparation, so the first phase of my questions.
 14 We were turning to the provider of medical services on
 15 the occasion of the Ariana Grande concert, namely ETUK.
 16 First, is a handover of responsibility document good
 17 practice?
 18 CHRISTIAN COOPER: Yes.
 19 Q. What is a handover of responsibility document?
 20 CHRISTIAN COOPER: It is a formalised process where an
 21 existing contracted provider of medical services
 22 formally hands over responsibility for the medical
 23 provision and the subsequent events to an emergency
 24 responder attending a scene.
 25 Q. Let's be realistic about it. In the circumstances of

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1 the arena attack, are you suggesting that some document
 2 should have been created which Ian Parry handed over to
 3 Patrick Ennis or are we talking about something
 4 different and done ahead of that time?
 5 CHRISTIAN COOPER: This needs to be done ahead of time.
 6 They need to be clear about how they're going to do
 7 that. In practice it's normally a meeting or some
 8 communication between the person leading the events
 9 prior to the attendance of the Ambulance Service and
 10 then somebody in a formal command role within the
 11 Ambulance Service then takes over that responsibility.
 12 Q. So you would expect, I think you're telling us, there to
 13 be have some liaison between ETUK and NWS ahead of the
 14 Ariana Grande concert?
 15 CHRISTIAN COOPER: Yes.
 16 Q. And an agreement between the two of them about what?
 17 CHRISTIAN COOPER: Agreement between the two of them about,
 18 should there be an event at the arena that would require
 19 the attendance of — one's already in attendance, but an
 20 attendance of the other, how that then takes place.
 21 There can be smaller-scale versions of this. How would
 22 they hand over a single patient to the Ambulance Service
 23 that needed conveying to hospital? That's normally
 24 agreed in advance in some sort of arrangement. Then
 25 there's a broader issue of a large-scale incident. It's

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1 that practical handover of responsibility from what's
 2 been contracted from the service provider to something
 3 that is now way beyond their ability to deal with.
 4 Q. The agreed position is, I believe, that there was no
 5 such handover of responsibility document in existence
 6 between ETUK and NWS. Is it your view that there
 7 should have been one?
 8 CHRISTIAN COOPER: Yes.
 9 Q. Going forward, should there always be one?
 10 CHRISTIAN COOPER: If it's a contracted medical provider at
 11 a set location, yes.
 12 Q. And on the night of the arena attack, what advantage or
 13 advantages, if any, would the existence of such
 14 a document have given rise to?
 15 CHRISTIAN COOPER: It would have given clarity to both ETUK
 16 and NWS as to what to expect in that event.
 17 SIR JOHN SAUNDERS: Who should take the initiative? I'm
 18 going come to another general topic in a moment, but who
 19 should take the initiative in making sure that document
 20 is prepared?
 21 CHRISTIAN COOPER: I think it needs to be the medical
 22 provider, and the reason I say that is because NWS may
 23 not be aware of (overspeaking) event has taken place.
 24 SIR JOHN SAUNDERS: And that seemed to me to be the obvious
 25 point that it should be. It may be that people

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1 generally in the inquiry do understand that the Health
 2 and Safety Executive have responded to our enquiries
 3 about what should happen with health provision at arenas
 4 like the arena and what they are saying is that it
 5 doesn't come within their control, so they would not be
 6 the people who would be seeing whether it is adequate or
 7 not. What they say is it has to come under the
 8 licensing conditions for the facility. I'm sorry to
 9 revert yet again to licensing.

10 MR GREANEY: I'm all ears.

11 SIR JOHN SAUNDERS: So it's a matter of interest to me as to
 12 how much, and to what extent, licensing authorities are
 13 aware of this responsibility. It may be the
 14 Purple Guide provides everything that is necessary, but
 15 if at the end of this, when we come to recommendations,
 16 what I'm going to ask for you to do, if you'd be good
 17 enough, is to specify on a minimum basis — so not
 18 everything you can think of, the minimum basis — what
 19 conditions on the licence should require to ensure that
 20 medical providers do provide what is necessary. That
 21 would include, on what you have said, that they need to
 22 contact NWS in this case and ensure that they make
 23 provision for a handover document and that that is
 24 included in licensing conditions so it can be enforced
 25 in some way. Obviously it's a long way down the line

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1 until we get to recommendations but that is where I'm
 2 thinking at the moment and we are asking through
 3 contacts in the licensing trade to find out how much
 4 local authorities are actually aware of this necessity.

5 CHRISTIAN COOPER: Myself and Mike would welcome the
 6 opportunity to make recommendations.

7 SIR JOHN SAUNDERS: It is within the Home Office guidance
 8 that there should be some provision but I haven't looked
 9 at it in detail yet as to how prescriptive what the
 10 Home Office says in their guidance document is.

11 MR GREANEY: I have no doubt this is a really important
 12 issue, how private healthcare providers of this sort are
 13 to be regulated. I'm going to see if we can make
 14 a little progress this morning in relation to the issue.

15 SIR JOHN SAUNDERS: Of course. I just wanted everyone to
 16 know where we are going. I'm sure you are aware of what
 17 is going on, I just want everyone to be aware.

18 MICHAEL HERRIOT: I think it would perhaps just be worth
 19 mentioning that not all ambulance services agree that
 20 they should be taking responsibility for a private
 21 provider's staff in those circumstances. And whilst one
 22 would expect it would be advantageous to use everybody
 23 that had got some skill for the benefit of all, there
 24 are concerns that if an Ambulance Service isn't aware of
 25 the qualifications of those people, that they would be

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1 very reluctant to take on responsibility for them.

2 SIR JOHN SAUNDERS: Okay. Obviously, the detail is
 3 something we will need to look at.

4 MICHAEL HERRIOT: And certainly on the licensing point, just
 5 at this stage, in our experience the intervention of
 6 licensing authorities is a very light touch, if at all,
 7 in respect of medical provision and words like
 8 "adequate" come into this.

9 SIR JOHN SAUNDERS: So the condition would say something
 10 like: you are to provide adequate first aid cover?

11 MICHAEL HERRIOT: Exactly, but not stipulated exactly what
 12 that is, what standard, regulated by whom, et cetera.

13 SIR JOHN SAUNDERS: Thank you, Mr Herriot.

14 MR GREANEY: Mr Herriot, I am going to direct my next series
 15 of questions to you, so please keep your voice up.

16 On the night of the arena attack, in your view, were
 17 there an adequate number of ETUK first aiders?

18 MICHAEL HERRIOT: From my standpoint, no. But the
 19 counterargument to that is that there is guidance and it
 20 could be argued that the provision was in keeping with
 21 the guidance. My issue with that is more about skills
 22 mix, so it's not just about number, it's about what
 23 skills those individuals have.

24 Q. If we just pause for a moment because that was in fact
 25 my next question.

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1 So question 1: were there adequate numbers? Your
 2 expert view is no, but you can see how it might be
 3 argued to the contrary.

4 Question 2 is: those who were present as ETUK
 5 first aiders, did any have adequate skills and had they
 6 been trained to an appropriate standard for the job they
 7 had?

8 MICHAEL HERRIOT: They certainly did not meet the standards
 9 recommended in their industry code of practice, the
 10 Purple Guide.

11 Q. And in your expert view, leaving the Purple Guide to one
 12 side for a moment, did they have adequate skills for the
 13 task that they had?

14 MICHAEL HERRIOT: They had adequate skills to deal with
 15 minor first aid issues, which is what they seemed to
 16 expect their role to be. They couldn't be expected to
 17 manage a major incident clearly, but they should have
 18 been competent in managing those initial stages of the
 19 handover to the Ambulance Service, I would suggest.

20 SIR JOHN SAUNDERS: The industry code of practice is the
 21 Purple Guide. We have heard a suggestion in evidence
 22 just a couple of days ago that perhaps the Purple Guide
 23 is out of date and could be looked at again. Do you
 24 agree with that or not?

25 MICHAEL HERRIOT: I do. The genesis of the Purple Guide,

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1 of course, is that it originated in the early 1990s,
 2 first edition. There were issues with the first edition
 3 because when it looked at risk --
 4 SIR JOHN SAUNDERS: I'm really sorry, do you mind if I cut
 5 across you? What I'm going to ask you is if in due
 6 course you would specify for me in a written document
 7 where you see the Purple Guide could benefit from
 8 updating and improvement.
 9 MICHAEL HERRIOT: Yes, sir. It assessed risk at one level,
 10 which was numbers, and clearly we would wish to
 11 influence it. It included a wider number of factors and
 12 while that is in the text, it doesn't necessarily get
 13 applied as we would anticipate.
 14 SIR JOHN SAUNDERS: Thank you very much.
 15 MR GREANEY: That is your view, not adequate numbers, not
 16 adequately skilled. And there is a question at least as
 17 important as those first two questions: were those ETUK
 18 first aiders adequately managed in your view?
 19 MICHAEL HERRIOT: No. I think there was a deficit of
 20 leadership. There was certainly a number of plans, but
 21 they weren't followed on the night by the contractor.
 22 SIR JOHN SAUNDERS: Okay. Sorry to cut across you again.
 23 We have, as people will know, received a statement from
 24 a gentleman from the --
 25 MR GREANEY: Jeremy Cowen.

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1 SIR JOHN SAUNDERS: -- thank you very much -- who sets out
 2 the problems about management.
 3 MR GREANEY: It's a really important statement and in fact
 4 I was going to read it out at this stage and then ask
 5 the experts if they have a view about it. It's going to
 6 take a bit of time, but it's sufficiently important to
 7 warrant that in my opinion.
 8 I'm going to read the statement of Jeremy Cowen
 9 dated 19 August 2021. The INQ reference is
 10 {INQ041868/1}. Can I, before I read it, express the
 11 gratitude of the inquiry legal team to Mr Cowen for the
 12 work that he has done.
 13 SIR JOHN SAUNDERS: I would join with that. Thank you.
 14 MR GREANEY: I am going to start at paragraph 3. He states:
 15 "I am currently employed by the Northern Ireland
 16 Ambulance Service as an emergency planning officer,
 17 a role that I have held for 14 years. However, I make
 18 this statement in a personal capacity and not as
 19 a representative of NIAS. I am not providing expert
 20 evidence, rather to provide an informed perspective, but
 21 it is relevant for me to outline my history and
 22 experience with NIAS so that the inquiry can decide what
 23 weight to attach to my evidence.
 24 "I have worked for the Northern Ireland Ambulance
 25 Service for 24 years, following on from a previous

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1 career in broadcasting, originally starting in the
 2 Ambulance Service as a non-emergency ambulance person,
 3 through ambulance technician, station supervisor,
 4 paramedic supervisor, project officer, station officer
 5 and finally to the post that I hold now.
 6 "My current role is of the same rank as a station
 7 officer, although I report directly to an assistant
 8 director, whereas a station officer reports to an area
 9 manager, who in turn reports to an assistant director.
 10 "My duties involve all aspects of emergency
 11 preparedness and resilience and include working with all
 12 partner agencies, both public sector and private sector.
 13 I have a special interest in event and venue safety with
 14 the aim of ensuring safe delivery of events and
 15 minimising impact on the wider health and social care
 16 system, as well as the local communities.
 17 "I have been involved in a wide range of events and
 18 venue planning, ranging from small local events up to
 19 major international events such as the Tall Ships
 20 Festival of 2015, which had an overall attendance of
 21 about 500,000 over a four-day period. I sit on a number
 22 of safety advisory and other planning and preparedness
 23 groups locally, and was a member for the Department of
 24 Communities (NI) Safety Technical Group, which was
 25 a multi-agency team tasked with offering guidance and

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1 advice vis-a-vis venue and spectator safety to the
 2 department's regional stadia development project.
 3 "In addition, I have contributed locally on a number
 4 of guidance documents regarding venue and event safety,
 5 this included reviewing the section on medical provision
 6 in the Northern Ireland Red Guide. The Red Guide was
 7 originally Northern Ireland's guide to safety at sports
 8 grounds but this has now been replaced with the
 9 Green Guide which originated from England and Wales.
 10 "I have witnessed at first-hand the damage to
 11 individuals, to families and to entire communities, the
 12 aftermath of such incidents, and I want at the outset to
 13 offer my very deepest and dearest condolences to all
 14 that have been affected by this particular atrocity, and
 15 also to formally record my admiration to all those who
 16 responded to it, the statutory, the voluntary and the
 17 ad hoc for the amazing work they did during and in the
 18 aftermath of the bombing.
 19 "I am passionate about lessons learned and outcomes
 20 and have been taking a keen professional interest in the
 21 inquiry and I wish to assist it in offering this
 22 statement to the inquiry. I do not know the event, the
 23 venue or the medical or other providers at the venue, so
 24 this statement is based solely upon my own personal
 25 observations and experiences at events. It is not

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1 written to assess or comment upon the issues being
 2 investigated by this inquiry, nor the actions of any
 3 individual or organisation in any way. However, I do
 4 believe that there is a risk for a potential gap in the
 5 quality and assurance of medical management at venues,
 6 which this inquiry has a unique opportunity to consider.
 7 "Whilst there are a number of excellent pieces of
 8 guidance and some specific legislation, such as those
 9 for health, safety and welfare, there is no set national
 10 standard relating to qualifications or competencies in
 11 terms of those managing medical systems at venues.
 12 "I am sure, by reason of my experience and
 13 observations, that the vast number of providers do an
 14 excellent job and have competent persons fulfilling each
 15 role. However, there is no yardstick to measure or give
 16 assurance of their competency, and with changing threats
 17 and times, and how they keep up to speed with latest
 18 developments. In other words, there is no recognised
 19 standard against which those providing first aid cover
 20 at events and those managing them can be assessed. My
 21 view is that without any standard, there can be no
 22 assurance.
 23 "Such a standard exists for stewarding operations,
 24 the national occupational standard SKASS series of
 25 performance criteria, and these were recently reviewed

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1 and updated to include, for example, some basic
 2 life-saving interventions for stewards to take should
 3 an incident occur.
 4 "In terms of sports stadia, the Sports Ground Safety
 5 Authority have defined three layers of spectator safety
 6 qualification, levels 2, 3 and 4. Their corporate
 7 website contains the following quote:
 8 "'At the heart of a successful event is the safety
 9 and security of the spectators. At sports grounds this
 10 is achieved through a safety management team.
 11 A fundamental part of this is the education and training
 12 of everyone involved.'"
 13 "It is my firm belief that this ethos carries over
 14 to each and every event for each and every role,
 15 including that of medical manager.
 16 "I regard the position of medical manager as being
 17 of critical importance. By that I mean that they will
 18 have a critical role to play if an incident occurs,
 19 particularly so if the incident is a major incident.
 20 "There is no issue in terms of the medical
 21 qualifications or competencies of the individual medical
 22 professionals. These are adequately covered by the
 23 various qualification frameworks that exist for the
 24 role, eg paramedic, technician, doctor, nurse,
 25 first aider, et cetera, but there is no set standard or

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1 training for those who have to direct, plan and operate
 2 a medical system, and these folk are the key
 3 decision-makers.
 4 "The phrase 'medical management' can also be read as
 5 treatment of injury or condition, so for clarity when
 6 I refer here to medical management I am specifically
 7 discussing the operational management, not the clinical
 8 management.
 9 "The role of medical manager is a key one. It is
 10 not the same skill set as being a medic, nor is it
 11 simply a command role. Neither is it simply a
 12 slips/trips/falls type risk skill set. It is about
 13 being able to fundamentally understand medical and
 14 delivery/operational risks throughout the life cycle of
 15 an event and to pre-empt them to mitigate impacts on the
 16 patient, the event and the wider community accordingly.
 17 It is also, I believe, a bit of a hybrid
 18 operational/tactical role and thus requires perhaps
 19 a more bespoke approach.
 20 "The statutory ambulance services of the NHS do have
 21 a national occupational standard for the various
 22 incident command roles: operational, tactical and
 23 strategic.
 24 "The importance of a medical manager becomes obvious
 25 if, for example, a terrorist bombing occurs at an event.

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1 There may be, for good reason, a delay before the
 2 paramedics and specialist responders of the
 3 Ambulance Service physically arrive at the scene. Once
 4 they have arrived, treatment may not start immediately
 5 due to the need for triage to be initiated and
 6 established. This may well leave the event first aid
 7 provider as the first available source of emergency
 8 medical treatment as they may well be there immediately.
 9 "A medical manager should be expected to understand
 10 what a METHANE message is, and to pass it on to the
 11 emergency services at the earliest possible opportunity.
 12 The METHANE message and situational awareness of the
 13 medical manager will be invaluable to the emergency
 14 services.
 15 "A medical manager should also be expected to begin
 16 the process of triage. In the first instance, this may
 17 be as simple as instructing those patients who can walk
 18 to remove themselves from the immediate scene so that
 19 a focus could be put upon those unable to walk for
 20 whatever reason. This could happen quite quickly after
 21 an incident, so that by the time the Ambulance Service
 22 and partner agencies arrive at the scene, things are
 23 already moving forward.
 24 "However, in order for this to be achieved, a number
 25 of things will need to occur:

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1 "(a) There needs to be a standard to which medical
2 managers can be judged. The inquiry offers a unique
3 opportunity to explore this at a national level and
4 I would suggest that consideration be given to looking
5 at creating a formal national occupational standard or
6 similar framework for those who are required to operate
7 as a medical manager at an event. This will ensure that
8 they are able to perform this important role adequately.
9 I set out what that framework may look like in the next
10 paragraph of this statement;
11 "(b) Those who provide first aid capacity at an
12 event beneath the medical manager need to be properly
13 trained;
14 "(c) The organisations, medical managers and
15 first aid providers who represent first aid provision at
16 an event need to be regulated so that there can be
17 public assurance that a proper standard is being met.
18 It is not for me, of course, to say by whom that
19 regulation should be done.
20 "The proposed framework may include for example:
21 "Relevant legislation and guidance;
22 "Medical risk assessment, factoring in specifics
23 such as the venue, event and audience, and surrounding
24 supporting infrastructure ;
25 "Linking to other medical strategies such as the

1 resuscitation strategy, alternative care pathways;
2 "Resourcing options to reflect risk assessment,
3 understanding tool sets available in terms of skill
4 sets ;
5 "Major incident procedures and handover to statutory
6 services ;
7 "Working with statutory and non–statutory partners
8 (including JESIP awareness);
9 "Decision–making and rationale for those decisions;
10 "Resilience and business continuity arrangements to
11 support delivery ;
12 "Governance, including management of medicines,
13 infection prevention and control, indemnities required;
14 "Managing complaints;
15 "Counter–terrorism awareness and the part medical
16 services play in this ;
17 "Health, safety and welfare;
18 "Roles of other partners in a venue (what they can
19 do and cannot do for you);
20 "Testing and exercising of plans;
21 "Briefing, debriefing and lessons learned from
22 debriefs ;
23 "Equality, disability , dignity and safeguarding;
24 "Record keeping, including Caldecott, data
25 protection, and patient confidentiality ;

1 "Role of media and communications;
2 "Working with statutory ambulance liaison officers ;
3 "Understanding event phases and how medical systems
4 need to reflect the phases;
5 "Environmental and waste management.
6 "This is not to suggest that there are no courses or
7 training on offer , but against what standard are they
8 being delivered? For an event steward, the public know
9 exactly what it says on the tin. Same for a medic. But
10 for those charged with the running of the medical
11 system, there is no tin at all -- before we can even
12 imagine what the contents of the tin might be. The list
13 above does not contain anything new, rather it is
14 a composite of relevant areas from the Civil
15 Contingencies Act 2004, the National Ambulance
16 Resilience Unit command and control guidelines, the
17 Purple, Green and Pink Guides, as well as the basic
18 standards that apply in terms of assurance within the
19 Ambulance Service."
20 He is now moving on to deal with a separate albeit
21 connected issue:
22 "The presence of an ambulance liaison officer at
23 events where there has been an agreed risk threshold
24 reached is good practice. The liaison officer can then
25 facilitate the venue in terms of access to real time

1 informatics, such as delays or pressures on receiving
2 emergency departments, any diverts or alternative
3 pathways available for the care of patients.
4 "An ambulance liaison officer may also be able to
5 quickly initiate the trust major incident plan and could
6 be in a position to give a METHANE report and other
7 situational awareness directly to the ambulance control
8 room for dissemination to partner agencies relatively
9 quickly.
10 "The construction of an occupational standard should
11 give venues comfort and confidence that their provider
12 has all of the necessary skills and attributes to
13 competently manage and interface with all partners
14 involved in an event. For medical providers, they
15 should be able to draw similar confidence that they have
16 all of their key bases covered, and for the public they
17 too can be reassured that their individual unique
18 medical needs can be met. I do not see this as
19 a win/win, rather than a win/win/win scenario.
20 "As I have emphasised already, in the event of
21 a mass casualty event, there may well be a delay before
22 specifically the Ambulance Service arrives at the scene.
23 This creates a care gap that needs to be bridged.
24 I have commented on how, for example, early initiation
25 of triage would help, but the immediate needs of those

1 whose life is at risk simply cannot be ignored. The
 2 National Ambulance Resilience Unit (NARU) triage tool
 3 emphasises early on the need to deal with catastrophic
 4 bleeding of a patient. I see that potentially the use
 5 of tourniquets is a key tool for use by all in such
 6 a scenario. This means that members of the general
 7 public, as well as those who are employed in whatever
 8 capacity at an event, need to be better informed in how
 9 to, for example, apply a tourniquet.

10 "In addition, colleagues in the police and fire
 11 services need to have good quality life support skills
 12 to maximise the potential for saving lives. This would
 13 be consistent with the JESIP core aims in the joint
 14 decision model which are: working together, saving
 15 lives, reducing harm.

16 "Such an approach may also create an environment for
 17 a positive impact upon their obligations under the Human
 18 Rights Act, specifically Article 2, the right to life.

19 "Healthcare is a regulated environment and as such
 20 has benefited enormously in terms of maintaining and
 21 improving standards across the sector. As I have
 22 explained, I see the provision of first aid by private
 23 companies as being suitable for regulation so that the
 24 quality can be defined and suitable standards maintained
 25 and improved. However, as I have outlined in my

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1 statement, this is a personal view.

2 "Finally, I would like to thank the inquiry for
 3 accepting my submission to hopefully assist it in its
 4 task of recommending actions and, going forward, so that
 5 we can continue to develop our capabilities and
 6 competencies with the ultimate aim of ensuring that our
 7 wonderful events and venues remain safe and secure for
 8 all."

9 I appreciate that's taken a little time, but it's
 10 going --

11 SIR JOHN SAUNDERS: Having read it, it's again appropriate
 12 to express our thanks to Mr Cowen, or my thanks in
 13 particular, for going to the trouble to produce that
 14 document for us.

15 MR GREANEY: I entirely agree, it has been most valuable.

16 I'm going to ask you about some specific aspects of
 17 what Mr Cowen had to say in a moment. But first of all,
 18 I will ask you, Mr Cooper, is there anything that I have
 19 just read out that you disagree with?

20 CHRISTIAN COOPER: No.

21 Q. On the contrary, do you agree with it?

22 CHRISTIAN COOPER: I do.

23 Q. Mr Herriot, anything you disagree with?

24 MICHAEL HERRIOT: No, and it certainly expresses a view
 25 that's been common, certainly amongst ambulance

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1 personnel, for some time. I certainly support what he
 2 says.

3 Q. So does it follow, Mr Cooper, first of all, that you
 4 consider that there is a need generally for independent
 5 providers of medical care at events, including medical
 6 managers, to be regulated?

7 CHRISTIAN COOPER: Yes, I do.

8 Q. Whether by the HSE, the CQC, Licensing or some different
 9 regulator, do you agree that standards need to be set
 10 for the medical manager and enforced?

11 CHRISTIAN COOPER: Yes.

12 Q. And for staff also?

13 CHRISTIAN COOPER: Yes.

14 Q. Do you have a view about an ambulance liaison officer as
 15 described by Mr Cowen?

16 CHRISTIAN COOPER: I think that would be a benefit. The key
 17 to that is understanding what that thread is that
 18 warrants one. That would require some work. But in
 19 principle, yes, I absolutely agree with that
 20 observation.

21 Q. That might be an issue that you'd want to take away and
 22 set out some further views in writing about?

23 CHRISTIAN COOPER: Yes.

24 MICHAEL HERRIOT: Again, that was fairly common for a number
 25 of years, but for various reasons that has fallen by

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1 the wayside.

2 Q. There was a period when the use of an ambulance liaison
 3 officer was common?

4 MICHAEL HERRIOT: Yes, and that was reflected in guidance,
 5 so both the Green and Purple Guide describe having
 6 a professional ambulance officer at the event in order
 7 to carry out the tasks that have been described.

8 Q. And for various reasons, as you put it, that fell by
 9 the wayside?

10 MICHAEL HERRIOT: Yes, and again that was because of the
 11 pressure on resourcing from the Ambulance Service side
 12 but also the costs that would have been incurred for the
 13 promoter or venue operator.

14 Q. So essentially, it came down to the finances?

15 MICHAEL HERRIOT: Mm--hm.

16 Q. I believe, gentlemen, that what you are agreed about
 17 is that this is, on the face of it, a good idea but work
 18 needs to be done in order to identify the threshold at
 19 which an ambulance liaison officer would be involved?

20 CHRISTIAN COOPER: Yes.

21 Q. And presumably work also needs to be done in order to
 22 establish whether this is something which should be
 23 mandatory for those who operate venues or voluntary?

24 CHRISTIAN COOPER: Yes.

25 Q. Again, I'm sure we would welcome your views on these

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1 matters in writing.
 2 SIR JOHN SAUNDERS: Mr Greaney, I have no doubt we will get,
 3 and I look forward to having them, the views of NWAS on
 4 this, but all ambulance trusts will actually be
 5 interested in this topic. I wonder who would coordinate
 6 trying to get the views when something is formulated
 7 from the ambulance trusts.
 8 MR GREANEY: Would that be NARU?
 9 CHRISTIAN COOPER: NARU would be well placed to do that.
 10 There are several national groups that could do that for
 11 the Ambulance Service.
 12 SIR JOHN SAUNDERS: Thank you. And I look forward to the
 13 assistance of NWAS, if they will, coordinating with
 14 other trusts, as I'm sure they would. Thank you.
 15 MR GREANEY: I'm now going to move to the second phase of my
 16 questioning and deal with the response unless there's
 17 anything you would like to investigate.
 18 SIR JOHN SAUNDERS: No, thank you.
 19 MR GREANEY: We're turning now to the response on the night
 20 and are making very good progress.
 21 Mr Cooper, as you explained earlier, the importance
 22 of JESIP was well understood by NWAS, was it not?
 23 CHRISTIAN COOPER: Yes.
 24 Q. And indeed, we are not going to look at many documents
 25 for my questions, but we see this in the major incident

1 response plan, version 5, that was in force on the night
 2 of the attack.
 3 We'll put this on the screen so people can follow
 4 what I'm asking about. {INQ013132/1}, first of all, the
 5 bottom half of that page. This is the plan that was
 6 approved on 22 June 2016, version 5, and date of issue,
 7 18 October 2016. We've certainly been operating on the
 8 basis that this was the version in force at the time.
 9 {INQ013132/8}, please. This is a section headed:
 10 "Joint emergency services interoperability
 11 principles.
 12 "2.1, joint doctrine. Public inquiries and inquests
 13 from numerous major incidents have identified that
 14 emergency services should have worked better together
 15 and displayed greater cooperation and coordination, ie
 16 better interoperability. Launched in 2013, the Joint
 17 Emergency Services Interoperability Programme (JESIP),
 18 now referred to as the Joint Emergency Services
 19 Interoperability Principles, established principles for
 20 joint working via the 'Joint Doctrine: the
 21 Interoperability Framework 2013'.
 22 So we see there, do we not, that NWAS well
 23 understood JESIP?
 24 CHRISTIAN COOPER: Yes.
 25 Q. And understood, moreover, what was at stake if it was

1 not followed?
 2 CHRISTIAN COOPER: Yes.
 3 Q. Did JESIP work that night?
 4 CHRISTIAN COOPER: No, I don't believe it did.
 5 Q. I'm sure that you'll be the first to say that each
 6 emergency service must bear its share of the
 7 responsibility for that?
 8 CHRISTIAN COOPER: I do, yes.
 9 Q. But does NWAS bear some share of responsibility in your
 10 view?
 11 CHRISTIAN COOPER: Yes.
 12 Q. I'm confident that you won't want to be involved in
 13 being seen as blaming individuals but we do need to make
 14 reference to individuals. First of all, the NWAS
 15 Gold commander that night, Neil Barnes. Does he have
 16 any responsibility for the fact that JESIP failed?
 17 CHRISTIAN COOPER: Yes.
 18 Q. Why?
 19 CHRISTIAN COOPER: As the strategic commander, it was
 20 Mr Barnes' responsibility to be in overall command, and
 21 command under the JESIP principles is -- the JESIP
 22 principles form a really important and key aspect to
 23 command at all levels, including that of the strategic.
 24 Q. Annemarie Rooney was the tactical or Silver commander
 25 for NWAS that night. Does she bear any responsibility

1 for the fact that JESIP failed?
 2 CHRISTIAN COOPER: Yes. We have no need to get into the
 3 detail, but it was clear that on a number of occasions
 4 Annemarie Rooney did follow JESIP principles and attempt
 5 to apply JESIP working. But nonetheless, in that role
 6 as a tactical commander, that is a key role under JESIP,
 7 so that commander must bear some responsibility for any
 8 failures to apply JESIP effectively.
 9 Q. Dan Smith was the NWAS operational or Bronze commander
 10 during the period that was of principal relevance to
 11 treatment of casualties and movement of casualties.
 12 Does he bear any responsibility for the fact that JESIP
 13 failed on the night?
 14 CHRISTIAN COOPER: Yes.
 15 Q. Why?
 16 CHRISTIAN COOPER: As the operational commander it was
 17 perhaps most apparent to that individual that the
 18 consequences of JESIP not working effectively were
 19 manifesting themselves in relation to this incident. So
 20 perhaps the earliest of indicators that something was
 21 wrong in relation to JESIP would, and indeed should,
 22 have been apparent to the operational commander.
 23 Q. In expressing the view that JESIP failed on the night,
 24 I'm sure you're aware that you're not expressing that as
 25 a lone voice or indeed saying anything that is

1 unconventional. And the question I know the chairman
 2 will be interested in is: does the fact that JESIP
 3 failed that night, indeed not just that night but it
 4 failed in exercising and on other occasions, does that
 5 mean that JESIP is not fit for purpose?
 6 CHRISTIAN COOPER: Myself and Mike have given this
 7 considerable thought in relation to our analysis. In
 8 summary terms, we're of the view that there is not
 9 a problem with the JESIP principles. If you were to set
 10 about a process of rewriting them, it's highly likely
 11 you would produce exactly the same as what exists.
 12 I think the problem was the failure to apply those
 13 principles correctly. So a problem of embedding rather
 14 than a problem with the principles themselves.
 15 Q. In fact, others have said very much the same as you,
 16 that there isn't a problem with JESIP as an idea,
 17 concept, it's just that it wasn't put into effect by
 18 people on the night?
 19 CHRISTIAN COOPER: Yes.
 20 Q. The question, I suppose, is if on the night it didn't
 21 work and other occasions it didn't work, how are we to
 22 prefer that occurring again?
 23 CHRISTIAN COOPER: I think more work needs to be done
 24 in relation to embedding it within the emergency
 25 services. One of the attempts the Ambulance Service has

1 made since 2017, and NWAS have been actively involved in
 2 this, is the development of new command standards,
 3 a decent proportion of those contractual standards that
 4 are in place now directly relate to JESIP, so that
 5 places the Ambulance Service in a position where
 6 a failure to apply JESIP represents a contractual breach
 7 of their obligations within the NHS. That is something
 8 that has happened positively since the events of 2017.
 9 And it has helped as I think we've seen better use of
 10 JESIP and better embedding since.
 11 Something else that the JESIP team have done is
 12 produce the Joint Organisational Learning system with
 13 a view to formally reviewing how JESIP has worked at all
 14 of these major incident exercises that occur and indeed
 15 at live events that take place. I think that has
 16 helped. So there have been good, productive steps that
 17 have happened since 2017 to try and improve the use of
 18 JESIP. I think one of the key issues for me in
 19 reviewing the evidence in relation to this inquiry is
 20 this issue of JESIP not catering sufficiently within its
 21 doctrine or its principles for what happens if emergency
 22 service commanders disagree about something.
 23 Q. That's a really important issue that I do want to come
 24 on to in just one moment.
 25 SIR JOHN SAUNDERS: Do you mind? Just before you go

1 further, just let me take this up.
 2 MR GREANEY: Not at all.
 3 SIR JOHN SAUNDERS: I well understand that everyone has said
 4 that the JESIP principles are good, they just need to be
 5 used, and then why has that not happened, well it must
 6 be they're not embedded sufficiently. The training for
 7 JESIP has gone on for years. Everybody knows what JESIP
 8 is. Everybody knows what they are. But can you name
 9 for me any major, live emergency when JESIP has actually
 10 operated properly? Not a training event, a real live
 11 emergency.
 12 CHRISTIAN COOPER: I am aware of lots of smaller scale
 13 emergencies where it's used effectively all the time.
 14 We haven't had an attack of this magnitude since 2017,
 15 so hard to say. But I do think there is more work to be
 16 done. I don't think tinkering, changing, reviewing what
 17 are effectively fundamental principles that, whilst
 18 JESIP has codified them and promoted them and developed
 19 them, we mustn't forget that these are principles that
 20 have been used by the emergency services for decades.
 21 They represent common sense around emergency management
 22 and command.
 23 Where I think there is more work to be done is being
 24 clear about what to do if it looks like it's not working
 25 and recognition of that far earlier in an incident and

1 how that's managed. I think the disagreement issue is
 2 something we can explore in a moment, but I think
 3 there's a way forward with that.
 4 I'm expressing a personal view. It's drawn from
 5 experience, but a personal reflection as to where we are
 6 at the moment. I think the problem lies with individual
 7 organisations and agencies. I don't think they've done
 8 enough. I don't think it has been sufficiently
 9 prioritised.
 10 SIR JOHN SAUNDERS: Forget about commanders for a moment and
 11 tell me: do the average people working within — take
 12 NWAS as an example but it's not meant to be selecting
 13 them. Do the ordinary people working with NWAS believe
 14 in it?
 15 CHRISTIAN COOPER: Yes.
 16 SIR JOHN SAUNDERS: Right. It involves, apart from anything
 17 else, acting to an extent counter-intuitively in that it
 18 involves not just rushing in to help and doing what
 19 people are trained to do and want to do, which is to
 20 help people, it involves, at least for certain people,
 21 standing back and saying: right, I need to find somebody
 22 else so we can discuss it before we actually get on with
 23 it. That's counter-intuitive to most people. Can you
 24 overcome that?
 25 CHRISTIAN COOPER: I think you can because we train our

1 commanders in the three respective emergency services to
 2 stand back and manage an incident, we train our
 3 responders to follow command instructions and deploy
 4 according to set principles. All JESIP is seeking to do
 5 is co-locate those commanders and rather than the three
 6 of them doing an individual assessment of risk or an
 7 individual approach to decision-making, do it together.
 8 SIR JOHN SAUNDERS: Okay. You may not know the answer to
 9 this, but do you happen to know whether for Westminster
 10 and London Bridge JESIP was deemed to have worked
 11 satisfactorily?
 12 CHRISTIAN COOPER: I would prefer to review that in a bit
 13 more detail before I comment.
 14 SIR JOHN SAUNDERS: Thank you.
 15 MICHAEL HERRIOT: I think as a personal observation, sir, at
 16 incidents where there's a requirement for JESIP, I think
 17 it's not that frequently used at a higher level, it's
 18 used every day at operational level. But one observes
 19 people retreating into their silos because they're under
 20 pressure and they have their own imperatives and I think
 21 the more pressure they're under, the more they retreat
 22 into their silos. That's a personal observation.
 23 SIR JOHN SAUNDERS: Thank you.
 24 MR GREANEY: You began to deal with a situation which in
 25 fact existed in the circumstances of Manchester where

1 there is a disagreement between the emergency services
 2 about how to deal with a particular situation. One can
 3 postulate quite extreme examples. Let's imagine that
 4 there is an FCP identified, not that that happened here,
 5 the commanders to get together, so they've co-located.
 6 They are communicating, they are coordinating, but there
 7 is a fundamental disagreement in the context of a Plato
 8 incident about whether a particular location is hot,
 9 warm or cold. And what we've been exploring is whether
 10 one of the emergency services in that situation should
 11 have what I described as a trump card and be able to
 12 say, "All right, I've listened to what you have to say,
 13 I disagree, this is what we're all going to do".
 14 That was a rather long lead-in to a question.
 15 Is that a good idea and if it isn't, how are we to deal
 16 with the situation in which there is disagreement?
 17 CHRISTIAN COOPER: Before I assess whether it's a good idea
 18 I think there are certain things, like the allocation of
 19 an RVP, for example, where it is certainly accepted by
 20 the ambulance services -- I am not just talking about
 21 NWAS, I'm talking about all of them -- that the police
 22 are probably best placed to make that determination
 23 based on the access to intelligence that they've got,
 24 their ability to secure that area if necessary, their
 25 understanding of local geography in relation to sites

1 that are appropriate.
 2 It is very rare when there is a proper JESIP
 3 discussion and the police articulate a preference for
 4 an RVP for that to be disputed. It's far more likely to
 5 cause an issue when the conversation hasn't taken place
 6 properly and people are making judgements for
 7 themselves. So I think there are certain elements where
 8 primacy or making decisions in the event of there being
 9 a disagreement could work potentially. It creates
 10 difficulties when you place a responsibility and
 11 authority on one organisation to direct the actions of
 12 another. I think that's a complex area that needs some
 13 careful thought. But in terms of these disagreements
 14 that occur, JESIP may not be explicit about what to do
 15 if there is a disagreement, but it has in effect created
 16 the circumstance to resolve it. And if you can't
 17 resolve it, at the very least you have three
 18 commanders --
 19 Q. What do you mean, created the circumstance to resolve
 20 it? Do you mean because they're together?
 21 CHRISTIAN COOPER: Yes, they are co-located, they have
 22 a common understanding of risk, even if they disagree
 23 about that risk and what to do about it, they've shared
 24 what they each know and, in simple terms, if the outcome
 25 is, "We think an RVP should be there", "We disagree, we

1 thin an RVP should be there", at least if they're
 2 working together within the JESIP model that
 3 disagreement is well-known and understood. That doesn't
 4 mean that they are then fundamentally inhibited from
 5 continuing a joint emergency response, it simply means
 6 one agency will be using that RVP, another will be using
 7 that one, as long as everybody knows that, any
 8 difficulties arising from that can be overcome in that
 9 joint decision.
 10 I guess what I'm suggesting is that the model still
 11 works even if there is a disagreement among commanders
 12 and if there is going to be a disagreement between the
 13 agencies, better it's done within that JESIP framework
 14 than outside of it.
 15 SIR JOHN SAUNDERS: It's rather an awful idea that we're
 16 having a long discussion, or it could be a long
 17 discussion because we are disagreeing about the RVP, and
 18 eventually we have to work out, "Well, we are not going
 19 to agree it, we are all going to different ones", and
 20 now it is, "How are we going to manage to communicate?"
 21 By this time the emergency will be over, won't it?
 22 CHRISTIAN COOPER: I don't disagree, which is why I say
 23 in relation to the RVP I think it may be sensible for
 24 the police to have a trump card that says: okay, we've
 25 had a conversation about this, but in order to effect

1 this response properly, we're using this RVP, we all
2 need to use that RVP.

3 I think with RVPs that probably works. If you take
4 another example where the fundamental disagreement is,
5 "We cannot enter that inner cordon because there's
6 a hazardous material present", and one agency says
7 they're comfortable doing it, another doesn't, and you
8 place an agency in a position where they can effectively
9 direct another agency to go into that, I think that is
10 more problematic.

11 So I think it may be something that we can look at
12 and follow up for you, sir, but there are complexities
13 in relation to giving an organisation overall
14 responsibility for any disagreements that might occur
15 under JESIP.

16 SIR JOHN SAUNDERS: But the contrary, what actually happens
17 is you then get a situation where Inspector Smith, the
18 man for the police who is running the operation on the
19 ground at the time, is up there in the City Room and he
20 and all the other police officers are going round and
21 saying, "Don't worry, help is on the way, they're going
22 to be here, you can hear the sirens coming, the medics,
23 on their way, you're going to get help", and actually
24 they're not intending to do it at all. That doesn't
25 look like people working in coordination.

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1 CHRISTIAN COOPER: I agree, sir, and I think what the JESIP
2 principle would have envisaged in that circumstance
3 is that at an appropriate forward point within
4 Manchester Arena, you have a police commander, a fire
5 commander and an ambulance commander who have their own
6 situational awareness of what's going on and in this
7 particular circumstance, you have the Ambulance Service
8 who have put a paramedic in there very early and
9 understand what the patient requirement is, and is
10 actually comfortable to operate in that area. That is
11 known to the Ambulance Service. You have police
12 officers who have, to all intents and purposes, cleared
13 that area very quickly and whilst of course there will
14 always be residual risk and threats, there is isn't an
15 active gunman operating in that area. And the police
16 know what they're doing about those forward firearms.

17 I'm not for one minute suggesting that the most
18 appropriate person at the forward control point for the
19 police is the firearms commander. They've got a very
20 important job to do very quickly, but it needs a police
21 commander to understand what the police are doing, so
22 a very quick conversation should have taken place
23 in that JESIP huddle and then I think the disagreements
24 that we're talking about would be highly unusual, should
25 that happen.

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1 SIR JOHN SAUNDERS: It may be unusual but, I'm really sorry
2 to say, listening to the evidence of Mr Blezard — and
3 this is no criticism of his evidence in any way — he is
4 defending the position of saying, "No, we were right not
5 to go in, there was a risk of IEDs in there which had
6 not been got rid of", and I suppose his solution would
7 have been: we are there, we say, "No, we are not going
8 in, you tell Inspector Smith", and you just say, "You
9 carry on doing what you want in there, but we're not
10 going there, you'll just have to tell the members of the
11 public in there that the paramedics aren't coming".

12 CHRISTIAN COOPER: I think it's easier to come to that view
13 when you haven't had the benefit of a police officer
14 telling you, "We want you in that area, we've got armed
15 officers in there, there is no ongoing threat from
16 a terrorist, you can get in there and treat", versus
17 them having to go on their own individual assessment and
18 appreciation of risk.

19 I think the scenario you've just described is
20 foreseeable. There is a tendency for people to worry
21 about the what if and there are always any number of
22 what ifs. Of course there could always be a secondary
23 device. There could always be a number of things that
24 could happen. But the whole point of having specialist
25 emergency responders is that you're able to try and

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1 manage that risk. This isn't going to be risk-free.
2 SIR JOHN SAUNDERS: So do we have — sorry to cut across
3 this. You have a police view which is actually, when
4 you're dealing with secondary unexploded devices, you
5 still go in and you have an Ambulance Service view, if
6 there are unexploded devices in there, you don't go in.
7 So it's all very well having a huddle, but before you
8 started you actually have different views of what you're
9 going to do.

10 CHRISTIAN COOPER: That can happen.

11 SIR JOHN SAUNDERS: No, no, it did happen, sorry.

12 CHRISTIAN COOPER: It certainly did happen there.

13 SIR JOHN SAUNDERS: And it could happen again tomorrow?

14 CHRISTIAN COOPER: I think it could, almost certainly will.

15 I think the issue is: but is it better dealt with under
16 the JESIP model or without a JESIP model?

17 SIR JOHN SAUNDERS: What's the point of having a discussion
18 if you know beforehand you're not going to agree?

19 CHRISTIAN COOPER: I think in the majority of cases those
20 discussions resolve the disagreement. It's unusual that
21 they don't.

22 SIR JOHN SAUNDERS: Okay. Thank you.

23 MR GREANEY: Can I use a phrase I overuse and draw some of
24 these strands together. Is what you're saying that the
25 thing that went wrong in this case, the thing which went

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1 wrong in a big way and which caused all manner of
 2 consequences, was that there was never an FCP, there was
 3 therefore never co-location of the commanders and
 4 therefore never the discussion of the sort that you're
 5 speaking about?
 6 CHRISTIAN COOPER: Yes.
 7 Q. And in a sense, who knows, but your own view seems to be
 8 that if they had got together and they had exchanged
 9 views and communicated properly in that way,
 10 a resolution would have been achieved?
 11 CHRISTIAN COOPER: Yes.
 12 Q. That was the first thing.
 13 Secondly, the chairman has drawn your attention to
 14 the fact that there do seem to have been different
 15 approaches by different organisations to issues such as
 16 risk. Is there anything to be said for exploring
 17 whether there is any way in which the emergency services
 18 can assess risk in the same way and agree ahead of time
 19 about how they will deal with a particular risk if it
 20 eventuates?
 21 CHRISTIAN COOPER: I think there's a lot of merit in that.
 22 It's not an easy task because it's my belief that the
 23 perception and the appetite for risk is different and
 24 not just across the different emergency services, but
 25 across different individual commanders. So all the more

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1 reason I think for us to look at: can we plan in advance
 2 something that gives commanders a better understanding
 3 of a generic set of circumstances and what risk approach
 4 should be taken, what are we agreed is the right way?
 5 The fact that there may or may not be a secondary
 6 device, that inhibits one but not the other. That's
 7 work that could certainly be done in advance to say: we
 8 are all going to agree how we are going to approach
 9 a situation like that.
 10 Q. I believe what you're saying to us is, perhaps for
 11 historical reasons in part, perhaps for reasons
 12 connected with the day-to-day business of each emergency
 13 service, they don't necessarily have the same appetite
 14 for risk.
 15 CHRISTIAN COOPER: I think that's true.
 16 Q. And even within an emergency service, different
 17 commanders might have different attitudes and appetites
 18 for risk?
 19 CHRISTIAN COOPER: I think that's true as well, yes.
 20 Q. I'm not seeking to criticise any particular emergency
 21 service in saying that, but that is your perception
 22 based upon your many years of experience in the roles
 23 that you had?
 24 CHRISTIAN COOPER: That's correct, yes.
 25 Q. So there must surely be against that background, which

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1 potentially gives rise to danger, benefit for seeing
 2 whether or not there can be agreement as to an approach?
 3 CHRISTIAN COOPER: Yes, in the same way that there is
 4 a common acceptance now that a shared understanding of
 5 the situation, shared situational awareness helps.
 6 I think what we're talking about here is we also need
 7 a shared agreement about risk. That needs pre-work.
 8 You can't expect that to happen on the day, at the time,
 9 by the commanders. There are certain things that will
 10 play into their mind and affect that and I think that's
 11 where the work is. In advance of an incident, there are
 12 common and consistent risks that will materialise at
 13 a whole host of incidents and achieving that shared
 14 understanding of how we are going to deal with those
 15 risks in advance of the incident would be enormously
 16 helpful.
 17 Q. Whose responsibility should it be to do that work of
 18 seeing whether such a solution can be identified or
 19 is that something you'd like to think about and put into
 20 writing?
 21 CHRISTIAN COOPER: I think it's probably something we need
 22 to think about.
 23 Q. That's fair enough.
 24 SIR JOHN SAUNDERS: I'm sorry to sound unduly cynical but
 25 the public will view the results of this inquiry in the

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1 light of: well, haven't we heard all of this before? So
 2 we do actually have to try and come up with something
 3 different and you're telling me how important JESIP, and
 4 is I understand that, and the benefits of JESIP but when
 5 I see here that there was actually no hope -- no hope --
 6 on the night of the rescue services agreeing where it
 7 was safe to go into, what an acceptable risk was on what
 8 I have been told in this inquiry, I just think: what use
 9 is JESIP then on that particular occasion with those
 10 different attitudes?
 11 CHRISTIAN COOPER: If I may, sir, I'm not suggesting nothing
 12 needs to change, either within JESIP or otherwise.
 13 I agree, I think it absolutely does, and I share the
 14 frustration that we seem to be discussing these things
 15 at inquiry after inquiry, and so something decisive,
 16 I agree, needs to happen.
 17 It is -- the top level principles of JESIP are
 18 relatively straightforward, common sense principles that
 19 few take issue with. There is a lot more work to be
 20 done, I would suggest, underneath those principles,
 21 whether that be by JESIP or the emergency services
 22 collaboratively, whoever it is. We would certainly
 23 welcome giving some thought to that, but I think it's
 24 that gap underneath those principles about the practical
 25 application of them where more work could be beneficial.

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1 SIR JOHN SAUNDERS: Thank you.
 2 MR GREANEY: So shortly, I am going to move into an analysis
 3 of what happened once NAWAS do arrive at the scene.
 4 First, just to deal with a general topic and to get
 5 it out of the way, you have touched upon it already, is
 6 it your view that the NAWAS command structure did not
 7 function appropriately on the night of the arena attack?
 8 CHRISTIAN COOPER: Yes.
 9 Q. Is it also your view that what happened that night, and
 10 moreover what went wrong, was illustrative of a broader
 11 problem within command in the Ambulance Service at that
 12 time?
 13 CHRISTIAN COOPER: Yes.
 14 Q. You paused before answering yes to that question. It
 15 may be that you think I've expressed rather too broad
 16 a proposition. I'll give you an opportunity to explain
 17 what the concerns are or have developed about command at
 18 about this time.
 19 CHRISTIAN COOPER: I think the key thing for me, before
 20 blame is attributed, is that there has been a very
 21 fundamental change in the standards and expectations
 22 particularly of ambulance commanders since 2017. And
 23 knowing those standards as I do, and knowing the
 24 requirements of those standards, then by definition what
 25 was in place prior to that was substandard.

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1 Q. Again, you've expressly yourself carefully. Was the
 2 upshot of what you now know, bearing in mind your role
 3 as head of operations for NARU, that there was at the
 4 time a situation in which people who were not suitable
 5 for particular roles in the command structure were on
 6 rotas for those positions?
 7 CHRISTIAN COOPER: Yes.
 8 Q. I expressed that really badly but you know what I am
 9 getting at.
 10 CHRISTIAN COOPER: Yes. I am making a very wide
 11 generalisation here, but it was fairly common practice
 12 in the Ambulance Service for commanders to be appointed
 13 to command roles based on what their day-to-day level of
 14 management was rather than their ability to command.
 15 Q. To take quite a stark example, but I believe one that
 16 you actually experienced, the HR manager within an
 17 Ambulance Service -- I'm not suggesting this is an
 18 example deriving from NAWAS by the way -- but the human
 19 resources manager for an Ambulance Service is likely to
 20 have a senior position within the organisation?
 21 CHRISTIAN COOPER: Yes.
 22 Q. And the stark example involves that person being on the
 23 rota to be Gold commander --
 24 CHRISTIAN COOPER: Yes.
 25 Q. -- when in fact they don't have one iota of operational

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1 experience? And you actually came across that stark
 2 example, did you not?
 3 CHRISTIAN COOPER: I did.
 4 SIR JOHN SAUNDERS: When, just general year?
 5 CHRISTIAN COOPER: This was pre-2017.
 6 SIR JOHN SAUNDERS: By a long way?
 7 CHRISTIAN COOPER: 2016, so not a long way at all. And
 8 I must stress, that was not NAWAS.
 9 SIR JOHN SAUNDERS: No, no. All right. Clearly, all trusts
 10 do operate independently.
 11 CHRISTIAN COOPER: Yes.
 12 MR GREANEY: But this was not a stark example, this was not
 13 a single example. Did your work reveal that there was
 14 a problem with this more generally?
 15 CHRISTIAN COOPER: Yes. There were other pieces of work
 16 going on at the time. There was an HMIC inspection,
 17 I believe, of the level of embedding within JESIP.
 18 There were audits going on of ambulance trusts, in
 19 particular the specialist capabilities, and there were
 20 a number of other activities as well, that all started
 21 to indicate that there may be an issue with the level of
 22 competence of ambulance commanders and, as a result, a
 23 number of workstreams were commissioned nationally to
 24 try and address that and that is what I have described
 25 as being some improvements that have been made since.

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1 So there are now contractual standards on ambulance
 2 trusts for each level of command. Included within
 3 that is a much better standardised description of what
 4 competence those commanders are required to have.
 5 So to expand on the example we gave earlier, it may
 6 or may not be appropriate to have a human resources
 7 director operating as a strategic commander, but if they
 8 do that now under the current regime, they must have
 9 attended a strategic commander course, they must have
 10 maintained continual professional development, they must
 11 have attended exercises regularly and reflected on them,
 12 and performed that role either live or in exercises on
 13 regular occasions. That responsibility has to be
 14 written into their job description and role profile.
 15 None of that existed prior to 2017.
 16 Q. So would it be fair to summarise the position in this
 17 way: that in 2017 there was a problem, it has now, you
 18 consider, been resolved, but it had most certainly not
 19 been resolved by 22 May 2017?
 20 CHRISTIAN COOPER: Yes.
 21 MS ROBERTS: (Inaudible: no microphone) can we be absolutely
 22 clear, when the answers are given, whether they are
 23 references to the national picture or whether they are
 24 NAWAS specific.
 25 SIR JOHN SAUNDERS: We understand. I think they've so far

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1 been talking about nationally and I have no doubt that
 2 Mr Greaney will, if he is going to seek questions as to
 3 whether this affected what happened on the night, which
 4 would of course relate to NAWAS, I'm sure he'll make that
 5 clear. But I am clear that at the moment we are talking
 6 about a national picture and the extreme example is
 7 clearly nothing to do with NAWAS at all.
 8 MS ROBERTS: It would be helpful for our benefit if that
 9 were flagged beforehand that it's not NAWAS and
 10 a hypothetical example or something that relates to
 11 somebody else or relates to another organisation rather
 12 than this, because it's very easy to conflate the two.
 13 Thank you very much.
 14 MR GREANEY: It was made plain before the example was given
 15 and it wasn't hypothetical, it was real.
 16 At all events, let's move into the events of the
 17 night.
 18 SIR JOHN SAUNDERS: I think it's Friday, that could be the
 19 problem, if we're all going to fall out now.
 20 MR GREANEY: I'm not sure that was a falling-out, sir.
 21 MS ROBERTS: We never fall out; we just disagree.
 22 SIR JOHN SAUNDERS: Just a minor tiff, we will call it that.
 23 MR GREANEY: In all events I am going to move into the
 24 events of night and what I'm going to do is to seek to
 25 deal with things principally in themes but I'm going to

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1 deal with them chronologically to the extent that's
 2 possible.
 3 Sir, we can either take an early lunch or I can go
 4 on for another 15 minutes.
 5 SIR JOHN SAUNDERS: I don't mind. When is it easier to get
 6 lunch? I think we have actually got a time for lunch of
 7 1245.
 8 MR GREANEY: I will go on.
 9 What I'm going to do is start with Advanced
 10 Paramedic Patrick Ennis. Just to remind ourselves of
 11 some of the critical times, by 22.46, he was at the
 12 scene and, whilst outside, he declared a major incident
 13 standby. First of all, what is a major incident
 14 standby?
 15 CHRISTIAN COOPER: When it comes to a major incident
 16 declaration there are two options for any ambulance
 17 member of staff to make: a major incident standby, which
 18 is a warning in effect that a major incident may be
 19 about to be declared. It allows, effectively, a run-up
 20 or a warm-up period, it allows people to start to be
 21 moved into post or assets to be examined. It prepares
 22 people for what might be a major incident coming. That
 23 would be as opposed to a formal declaration of a major
 24 incident.
 25 Q. And bearing in mind what he knew at that stage, having

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1 not by that time gone into the City Room, was
 2 a declaration of major incident standby appropriate or
 3 inappropriate?
 4 CHRISTIAN COOPER: I think it was appropriate at that time.
 5 SIR JOHN SAUNDERS: We do actually know it was treated as
 6 being the actual event anyway.
 7 MR GREANEY: It was, absolutely, although as we know
 8 Mr Ennis did go on to formally declare a major
 9 incident --
 10 SIR JOHN SAUNDERS: It was being treated that way --
 11 (overspeaking).
 12 MR GREANEY: (Overspeaking) you're quite right, sir.
 13 I'm going to show on the screen some images now from
 14 the sequence of events, so I just give a warning that
 15 we are going to be looking at some images of the
 16 City Room. They have been redacted in the way that
 17 we are all now familiar with but I just pause for
 18 a moment to give anyone an opportunity to switch off the
 19 screen or who wants to leave this room to do so.
 20 (Pause)
 21 {INQ035612/142}, please. This is 22.52.48.
 22 Advanced paramedic Patrick Ennis is on the overbridge
 23 walking towards the City Room. If we go over the page
 24 to {INQ035612/143}, please. At 22.53.01, by now
 25 Mr Ennis is in the City Room and in company with

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1 Inspector Michael Smith. So as 22.52 ticks over to
 2 22.53, he enters the City Room.
 3 Then we know at 22.54, Mr Ennis made a call to the
 4 EOC whilst he was still in the City Room and he passed
 5 a message containing information about, for example, the
 6 number of casualties that he was aware of at that stage.
 7 Was that in your judgement a METHANE message?
 8 CHRISTIAN COOPER: Yes.
 9 Q. Was it an adequate METHANE message?
 10 CHRISTIAN COOPER: Yes.
 11 Q. {INQ035612/170}, please, at 23.00, or just shortly
 12 before, Mr Ennis has left the City Room. So he was
 13 within there for a period of round about 7 minutes.
 14 During that seven-minute period of time --
 15 SIR JOHN SAUNDERS: Sorry, do the DPAs there relate to the
 16 names of people? I think the indication is it does.
 17 Thank you.
 18 MR GREANEY: So we have Mr Ennis in the City Room for
 19 a period of round about 7 minutes. As the footage
 20 reveals, and indeed as Mr Ennis was to explain to us, he
 21 did not during that period treat any of the casualties
 22 who were within that room.
 23 At the time that Mr Ennis gave evidence, that
 24 resulted in a headline along the lines of:
 25 "First paramedic on scene does not treat

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1 casualties."

2 And in turn that generated a social media reaction.

3 So out of fairness to Mr Ennis, let me ask you a direct

4 question: are you in any way critical of the fact that

5 Mr Ennis did not during that period treat any casualty

6 or instead is that what you would have expected of him?

7 CHRISTIAN COOPER: It's what I would have expected and I am

8 in no way critical of him. I appreciate the sensitivity

9 of it and I should also express, having been a paramedic

10 myself, it's an extremely difficult thing to do when you

11 are highly trained to be able to help people, not to go

12 to that first patient and render care. But it is

13 absolutely necessary that the first ambulance person on

14 scene gains the relevant situational awareness and

15 passes the information necessary back to the control

16 room to enable the Ambulance Service to provide its full

17 and effective response.

18 What he did was difficult and entirely appropriate

19 and in line with major incident planning and doctrine.

20 Q. Mr Herriot, do you agree or disagree?

21 MICHAEL HERRIOT: I do. I think any criticism of him is

22 unfair and he was required to gain that situational

23 awareness. Had he not done so, it was more likely to

24 compromise what came after.

25 MR GREANEY: Dan Smith arrived at the scene at almost

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1 exactly 11 pm. By way of training, he was a tactical

2 commander, but as I recall it at any rate, not an

3 operational commander. Was it in those circumstances

4 appropriate for him to take up the role as operational

5 commander?

6 CHRISTIAN COOPER: I think it's right for that to be

7 examined. It's not uncommon for a person that is

8 a qualified tactical commander and an experienced

9 tactical commander to possess the necessary skills and

10 ability to function as an operational commander. But if

11 there is an on-call assigned operational commander

12 already on scene, then we would normally expect some

13 sort of reason or justification for that assigned

14 operational commander not to be the very person that

15 takes operational command.

16 It may be that Dan Smith felt that his level of

17 seniority, his experience, rendered him a more

18 appropriate person to take operational command, and as

19 a commander that is his prerogative.

20 SIR JOHN SAUNDERS: I'm afraid I can't remember the

21 evidence, whether he had gone through the necessary

22 training for an operational commander in the past and

23 had acted as that in the past. Ms Roberts is indicating

24 that that was the evidence.

25 MS ROBERTS: My recollection is that he had but it was

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1 pre-NARU.

2 CHRISTIAN COOPER: I think that's correct. At some point in

3 his career he had been trained as an operational

4 commander, he wasn't current or what we would class as

5 current ---

6 SIR JOHN SAUNDERS: You would still expect --- a current

7 operational commander, if they're on duty, your view

8 is that would be the appropriate person to do it, but

9 I'm just putting it within the further context that

10 Mr Smith had done it in the past.

11 MR GREANEY: Quite right, sir, thank you very much indeed

12 for that context.

13 In terms of Mr Smith, obviously we could go into

14 a huge amount of detail but it's probably more helpful

15 to deal with things in headline, I'm going to pose three

16 questions. You've answered the first.

17 First, did Mr Smith do sufficient in your judgement

18 to ensure JESIP worked?

19 CHRISTIAN COOPER: No.

20 Q. Second, in your judgement did he do sufficient to ensure

21 that there was adequate paramedic presence in the

22 City Room?

23 CHRISTIAN COOPER: No.

24 Q. Thirdly, did he do, in your view, sufficient to ensure

25 that adequate equipment and other physical resources

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1 were present at the scene?

2 CHRISTIAN COOPER: No.

3 Q. Mr Herriot, do you agree or disagree with those views?

4 MICHAEL HERRIOT: I agree.

5 Q. The police are the ones, and the only ones, who are able

6 to declare Operation Plato.

7 CHRISTIAN COOPER: That's correct.

8 Q. Then they must communicate that declaration?

9 CHRISTIAN COOPER: That's of critical importance, yes.

10 Q. And they need to do so as a matter of urgency, as we

11 know. Do you agree that a critical part of

12 Operation Plato is the designation of zones?

13 CHRISTIAN COOPER: I agree.

14 Q. Should the way in which particular zones or areas have

15 been designated be communicated to other emergency

16 services?

17 CHRISTIAN COOPER: Yes.

18 Q. Why is that important?

19 CHRISTIAN COOPER: It has direct implications to their

20 response. If it is a Plato hot zone, as has been

21 adduced in evidence, that then means it is not possible

22 for any ambulance responders to operate in that area.

23 If it's a Plato warm zone, or if it's indeed not being

24 treated as Plato, then certain ambulance resources can

25 deploy. So purely from a deployment perspective, if

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1 nothing else, it's of critical importance.
 2 Q. As you have said, if Dan Smith had been told the
 3 City Room is hot, that has consequences?
 4 CHRISTIAN COOPER: Yes.
 5 Q. If he'd been told it was warm, that has different
 6 consequences?
 7 CHRISTIAN COOPER: Yes.
 8 Q. And if cold, that has yet further different
 9 consequences?
 10 CHRISTIAN COOPER: Yes, and of course, it also needs to be
 11 kept in mind that with a Plato declaration it may be
 12 that the police are not the first on scene. It may be
 13 that a front line ambulance crew have already got there
 14 or are already dealing with a matter and then the police
 15 have evidence or intelligence to suggest there is
 16 a Plato hot zone where they are, the Ambulance Service
 17 need to take immediate steps to get those people out for
 18 their own safety.
 19 SIR JOHN SAUNDERS: Right. We know from the police experts
 20 that they take the view that after the armed police had
 21 been through and cleared the area, this was a cold zone,
 22 despite the risk that there might be IEDs there. The
 23 Ambulance Service do not take the view that it's a cold
 24 zone or the equivalent of it if there's still a risk of
 25 IEDs. How does that work? It's their job to declare

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1 the zones, the police.
 2 CHRISTIAN COOPER: It's the police's job to tell us what
 3 they think it is. If they declare it a cold zone under
 4 the Plato doctrine, certainly as was then, then the
 5 emergency services should treat that as a cold zone. If
 6 they form the view that in their mind it's not, if JESIP
 7 had occurred, that they were doing the joint
 8 understanding of risk, there would need to be some form
 9 of conversation about that and why there was that
 10 differing view, and as I've said before, hopefully it
 11 could be resolved at that stage. In the absence of it,
 12 though, you have this situation where you have different
 13 perception of what that zone is.
 14 SIR JOHN SAUNDERS: I think it's fair to say, though I am
 15 simplifying a situation which is less simple, a cold
 16 zone, when the police declare it a cold zone, they
 17 regard it as being a cold zone as to whether there is
 18 a marauding terrorist there. They are not taking into
 19 account when they declare that there could be an IED so
 20 it would be possible for paramedics to say: we're happy
 21 there are no marauding terrorists in there and you've
 22 declared it in a cold zone in those terms, but
 23 nevertheless until you can assure us there's no IED
 24 there we're still going in.
 25 CHRISTIAN COOPER: I'm not sure the description in the

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1 doctrine as was or the doctrine now is quite so specific
 2 about — in there a cold zone is a zone that is safe,
 3 a zone where you would be quite content for any
 4 responders to be operating, a zone where there may still
 5 be some very small residual risk but not one that can't
 6 be overcome with what any normal emergency responder
 7 would be able to deal with.
 8 SIR JOHN SAUNDERS: This actually comes from the evidence
 9 which we had from CT Police, the recent evidence from —
 10 MR GREANEY: Yes. Sir, your assessment of the evidence
 11 we've heard is entirely accurate. At the time we're
 12 concerned with a cold zone, as defined by JOPs 3, was an
 13 area where it has been assessed that there is no
 14 immediate threat to life, a hot zone was where the
 15 attackers are present and/or there is an immediate
 16 threat to life, and a warm zone was where the attackers
 17 are believed to have passed through but could
 18 enter/re-enter imminently and these areas could not be
 19 guaranteed as safe.
 20 SIR JOHN SAUNDERS: When we were asking questions about
 21 that, that was clarified as being safe in terms of
 22 whether there is a marauding terrorist.
 23 MR GREANEY: Exactly. At the time, a marauding terrorist
 24 with a firearm.
 25 CHRISTIAN COOPER: I think that's the difficulty because

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1 there's obviously a literal interpretation of that and
 2 the emergency services are taking a slightly different
 3 practical view of it.
 4 MR GREANEY: This is the problem and I'm going to explore it
 5 just a little bit before lunch and do so in stages.
 6 So given that the designation of zones is so
 7 important to the Ambulance Service because, as you're
 8 going to explain, that really determines or at any rate
 9 is of a high degree of relevance to whether your
 10 resources go in and, if so, which resources go in.
 11 CHRISTIAN COOPER: Yes.
 12 Q. Bearing in mind the importance of that designation, was
 13 it reasonable for Dan Smith effectively to be left to
 14 work it out for himself?
 15 CHRISTIAN COOPER: No.
 16 Q. What should have happened?
 17 CHRISTIAN COOPER: There should have been an FCP with
 18 co-located operational commanders who could have shared
 19 their understanding of exactly what these zones are, why
 20 they are what they are, and there's also a critical role
 21 within that joint command process of them regularly
 22 reviewing it. If you have a hot zone, you've got no
 23 ambulance paramedics operating in there, so I would
 24 expect the ambulance commander to be constantly pressing
 25 the police commander to say, "When can we get to a stage

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1 where this is not hot any more because I need to commit
 2 paramedics?"

3 So that can't happen unless there is good, effective
 4 joint working, either physical co-location, radio
 5 co-location, whatever it is, there needs to be that
 6 three-way approach to zoning to make sure that as soon
 7 as is possible, life-saving interventions can start
 8 taking place.

9 Q. I'm going to ask you a little more about the nature of
 10 zoning in a moment. But as you'll appreciate, obviously
 11 it's not for you to decide how the City Room should have
 12 been zoned from, say, 11 pm when Dan Smith arrived, I'm
 13 sure you'll accept that is for the policing experts to
 14 express a view about and the chairman to make his
 15 decision.

16 But certainly as we as CTI understand the evidence
 17 now, there is no sensible body of opinion that the
 18 City Room was a hot zone from 11 pm. So at worst, it
 19 was a hot zone and there is a body of opinion, as the
 20 chairman has alluded to, that it was in fact a cold
 21 zone.

22 SIR JOHN SAUNDERS: At worst a warm zone but and possibly a
 23 cold zone.

24 MR GREANEY: At worst a warm zone and on one body of opinion
 25 a cold zone.

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1 So does it follow from that that, at the very least
 2 HART would have gone into that area, the City Room?

3 CHRISTIAN COOPER: Yes.

4 Q. Indeed, as we're going to hear, I believe it's your
 5 opinion, by which I mean your opinion and Mr Herriot's,
 6 that at the very least you consider that the whole of
 7 the first HART should have gone in, all six?

8 CHRISTIAN COOPER: Yes.

9 Q. In terms of zoning, just before we finish for lunch, two
 10 aspects to this. Obviously we have Plato zoning, hot,
 11 warm and cold. Dan Smith's position was that his
 12 mindset at the time was he didn't believe that there was
 13 a discretion available for him. He thought: if it's
 14 hot, these are the consequences, if it's warm these are
 15 these consequences, if cold these are the consequences.

16 Do you consider that as of May 2017, there was
 17 a discretion (a) to deploy resources other than HART to
 18 a warm zone, and (b) do you consider that there was
 19 a discretion to deploy any resources in any
 20 circumstances into a hot zone?

21 CHRISTIAN COOPER: That depends entirely on whether or not
 22 Dan Smith considered it to be a Plato situation.

23 Q. That's what I'm asking you to focus on at the moment.

24 CHRISTIAN COOPER: If it was a Plato situation and he was
 25 treating it as a Plato incident under the principles in

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1 place at that time then he had no discretion if it was
 2 a hot zone.

3 If it was a warm zone, the only option he would have
 4 had for an Operation Plato event would have been to
 5 deploy specialists into that area. And by that I mean
 6 HART and AIT operatives.

7 Q. So the rule, my word, at the time would have prohibited
 8 him from deploying paramedics, standard paramedics, into
 9 a warm zone?

10 CHRISTIAN COOPER: Yes.

11 Q. I'm going to move on next -- I'll just deal with one
 12 topic before we do. That is Plato zoning, hot, warm and
 13 cold. At various stages during the evidence, confusion
 14 has developed, at least on my part, about the use of
 15 those terms by NWSA to mean something different from
 16 Plato zoning. Do you understand what I'm talking about?

17 CHRISTIAN COOPER: If you're referring to hot, warm and cold
 18 being used for a non-Plato event then that is also
 19 commonplace.

20 SIR JOHN SAUNDERS: In major incidents?

21 CHRISTIAN COOPER: In major incidents, absolutely, sir.

22 More often than not a major incident will still be zoned
 23 in that regard, hot, warm and cold.

24 MR GREANEY: My poor question, but this is what I was
 25 driving at.

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1 Will the consequences of a zone being hot in a major
 2 incident designation be the same necessarily as the
 3 designation of an area as hot in a Plato situation?

4 CHRISTIAN COOPER: No, they're quite different. If you have
 5 a non-Plato hot zone, the Ambulance Service still has
 6 resources it can deploy into a hot zone as long as it is
 7 not a Plato event.

8 Q. Obviously, that is or may be a massive difference.

9 CHRISTIAN COOPER: Yes. For a major incident where there is
 10 a hot zone, you would still only expect the deployment
 11 of very specialist responders; HART would be the main
 12 ones. There is some discretion for a commander to
 13 deploy other specialist assets into a general major
 14 incident hot zone based on their understanding of risk.

15 Q. Is the fact that hot zone is used in different ways and
 16 has very different consequences in the two different
 17 situations something that is or, rather, was in May 2017
 18 capable of causing confusion?

19 CHRISTIAN COOPER: Yes.

20 Q. Does that state of affairs still persist now? And
 21 obviously we need to be careful not to get into
 22 operationally sensitive issues, so bear that in mind in
 23 your answer.

24 CHRISTIAN COOPER: The situation has changed now and there
 25 is more flexibility. I think if I were to describe what

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1 that flexibility was, that is where we would be on
 2 sensitive grounds, but it has changed.
 3 SIR JOHN SAUNDERS: Do they mean the same things now or not?
 4 CHRISTIAN COOPER: They mean exactly the same things. There
 5 is an option to deploy more assets under certain
 6 descriptors of it, but in general the same principles
 7 apply.
 8 MR GREANEY: The question is: has the confusion which did
 9 exist been cured now or is there a risk that --
 10 CHRISTIAN COOPER: I think there is still a risk. I think
 11 it is clearer now and I think, by virtue of some of the
 12 learning that's already taken place from the events of
 13 2017, I think commanders across the services are more
 14 clear, at least of the need to make sure you're clear
 15 whether you're operating under Operation Plato or not.
 16 But whenever you've got two designations exactly the
 17 same, hot, cold, warm, but depending on the nature of
 18 what you have declared the incident, there will always
 19 be a risk that somebody is confused by that.
 20 Q. That's perhaps an issue that needs --
 21 CHRISTIAN COOPER: Yes.
 22 MR GREANEY: Sir, would that be a convenient --
 23 SIR JOHN SAUNDERS: No, I just want to finish this off.
 24 Dan Smith, by the time he sent HART people in, only
 25 believed it was a warm zone, I think we're all agreed

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1 there. So he could send HART people into a warm zone
 2 under either, whichever category we're talking about.
 3 In relation to non-specialists, in a warm zone in Plato
 4 he had no discretion. If he was operating in a warm
 5 zone under a major incident, did he have a discretion to
 6 send in unprotected --
 7 CHRISTIAN COOPER: Yes, sir.
 8 SIR JOHN SAUNDERS: He did? Okay.
 9 CHRISTIAN COOPER: One that would be required for him to
 10 have assessed the risk, but yes, he had that discretion.
 11 SIR JOHN SAUNDERS: He could send in paramedics?
 12 CHRISTIAN COOPER: Yes.
 13 SIR JOHN SAUNDERS: I'm afraid I cannot remember, but did
 14 Mr Smith ever express a view as to whether -- he never
 15 was told it was Plato, not in the early stages.
 16 MR GREANEY: I do have a recollection, but can I check that
 17 over lunch to make sure?
 18 SIR JOHN SAUNDERS: Yes, an hour. Thank you very much.
 19 (12.52 pm)
 20 (The lunch adjournment)
 21 (1.52 pm)
 22 MR GREANEY: Let's move on in time. At 11.13 pm, the first
 23 part of HART team 1 arrived at the scene. Can we have
 24 the image on screen, please? {INQ035612/252}.
 25 NWS HART paramedics Chris Hargreaves and

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1 Lea Vaughan enter the station.
 2 What we understand from the evidence, Mr Cooper,
 3 is that within moments of that, within a minute, they
 4 have volunteered to enter the City Room. So first
 5 question: was it appropriate that the question of
 6 whether HART did or did not enter the City Room should
 7 have been a matter of volunteering?
 8 CHRISTIAN COOPER: No, that is not appropriate.
 9 Q. How should that situation have been resolved?
 10 CHRISTIAN COOPER: It should be part of a formally agreed
 11 deployment process, normally through the commander or
 12 through their team leader.
 13 Q. Image {INQ035612/258} next, please, Mr Lopez.
 14 SIR JOHN SAUNDERS: In any event, it's greatly to their
 15 credit they did.
 16 CHRISTIAN COOPER: Yes.
 17 MR GREANEY: Quite, sir.
 18 At 23.15, just gone, Christopher Hargreaves and
 19 Lea Vaughan are in the City Room. So by that stage,
 20 nearly 45 minutes after the explosion, there are three
 21 paramedics in that room.
 22 Was three paramedics a sufficient number to deal
 23 with the situation in the City Room?
 24 CHRISTIAN COOPER: No, it wasn't.
 25 Q. As for other members of that first HART team, Mr Priest

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1 arrived at 23.18 and paramedics Devine and English
 2 arrived at 23.21. To where should they have been
 3 deployed?
 4 CHRISTIAN COOPER: You would normally expect a HART team to
 5 deploy as a team together. They're very limited in
 6 number, so the expectation would have been if two of
 7 their colleagues were operating in the City Room at that
 8 point, that the expectation would have been that any
 9 subsequent HART personnel arriving should have gone to
 10 that location as well.
 11 Q. You are dropping your voice slightly. Is that what in
 12 your view should have happened?
 13 CHRISTIAN COOPER: Yes, it is.
 14 Q. Whose responsibility was it for the fact that, as we
 15 know, those three did not deploy in the City Room?
 16 CHRISTIAN COOPER: In the first instance, it's the HART team
 17 leader that's responsible for leading the team and who
 18 deploys where, but that is under the command of the
 19 operational commander, so it is ultimately the
 20 operational commander's responsibility.
 21 Q. Of course we have Mr Ennis, the advanced paramedic,
 22 who's in the City Room at that stage once the other
 23 three members have arrived, as indeed are two other
 24 members of the HART team. Do they have in your
 25 judgement at that stage any responsibility for

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1 communicating back down to the concourse that more
 2 assistance is needed?
 3 CHRISTIAN COOPER: It may or may not have been an assumption
 4 on the part of the HART paramedics that they would be
 5 joined by their colleagues as would be normal practice.
 6 It would be true to say that if any operational
 7 paramedic is struggling to do what they need to do, they
 8 should ask for assistance and help. That's fair .
 9 Q. But the impression that you're giving is that in terms
 10 of responsibility , the responsibility for achieving the
 11 state of affairs that should have been in place
 12 principally rests with Dan Smith, but Mr Beswick also
 13 has some responsibility?
 14 CHRISTIAN COOPER: Yes, I'd agree.
 15 SIR JOHN SAUNDERS: If you're going to ring downstairs you
 16 actually need to stop doing what you're doing to ring
 17 through, explain the situation , and they're doing
 18 invaluable treating and triaging at the time.
 19 CHRISTIAN COOPER: That's right and once you're engaged in
 20 that kind of triage activity , that is your focus.
 21 SIR JOHN SAUNDERS: I'm sure, yes.
 22 MR GREANEY: That HART team as a whole should have been in
 23 the City Room as soon as they were available to be
 24 deployed there. Mr Beswick was the team leader. If
 25 things had been done appropriately, what role would

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1 you have expected him to have been performing and where?
 2 CHRISTIAN COOPER: As a HART team leader, in the agreed
 3 major incident structure --- and this is replicated in
 4 both NWS's major incident plan and the national generic
 5 version of the major incident plan --- the HART team
 6 leader would be expected to be given one of those
 7 functional roles. In this case, as is usually the case,
 8 you would assign a sector commander role to a HART team
 9 leader and allow them to manage the warm zone/inner
 10 cordon response. So I would have expected the HART team
 11 leader to have been assigned a sector commander role and
 12 to be made responsible for the area of the City Room.
 13 SIR JOHN SAUNDERS: And be there?
 14 CHRISTIAN COOPER: Indeed. Perhaps not inside the
 15 City Room, although that may well have been appropriate
 16 in this case, but certainly right on the edge of the
 17 City Room. So where the mezzanine is, the doors that
 18 enter the City Room, that is the location I would expect
 19 that individual to be so they can effectively and
 20 practically control what NWS assets are going into that
 21 City Room and have a really good oversight and idea of
 22 what's going on there on behalf of the operational
 23 commander.
 24 MR GREANEY: That probably leads to the issue of the CCP and
 25 CCS to which I'll turn in a moment, but just a couple of

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1 things first .
 2 If that first HART team had all deployed into the
 3 City Room, what different would it have made?
 4 CHRISTIAN COOPER: We know that a HART team, they train as
 5 a team, they operate as a team --- that's unusual, if not
 6 unique, within the Ambulance Service --- and as a result,
 7 they're very effective as a team. So there is
 8 a significant difference between two individuals from
 9 that team fulfilling a function and five fulfilling
 10 a function. And if five had been in that City Room
 11 performing triage, very, very basic clinical
 12 interventions and stabilisation and also managing the
 13 effective extrication of those casualties , I think that
 14 would have been more effective.
 15 Q. By more effective, what result would have been achieved
 16 or achieved earlier in your view?
 17 CHRISTIAN COOPER: I think you would have had --- the triage
 18 process would have been faster and I think the
 19 identification and management of the extrication of
 20 casualties , even if that was involving support from
 21 other agencies, members of the public and others that
 22 were clearly offering support in that area, that would
 23 have been more decisive, more rapid and more effective.
 24 Q. Just before we turn on to the CCP/CCS issue ---
 25 SIR JOHN SAUNDERS: I have another question about this, if

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1 that's all right .
 2 In the lead-up to the first question, were three
 3 paramedics a sufficient number to deal with the
 4 situation in the City Room --- let's leave aside for
 5 a moment which sort of paramedic could actually go into
 6 the City Room. What would be, if you can say, you may
 7 not be able to say, an ideal number of paramedics to
 8 have been in there? One's tempted to say as many as
 9 possible , but actually that may not be the correct
 10 answer because it may be you can have too many.
 11 CHRISTIAN COOPER: I think --- so you've got a limited number
 12 of resources at the scene. The more you put into that
 13 one location, the less you have to do other functions
 14 behind. Perhaps this was slightly unusual in that it
 15 was very rapid and people were moving away from the
 16 scene and there were seriously injured casualties not
 17 only in the City Room but elsewhere as well, so that
 18 will have been playing on the operational commander's
 19 mind.
 20 I'm not sure you can have too many paramedics in
 21 there. You would need to have proper command and
 22 control of them, but more is certainly preferable to
 23 less .
 24 SIR JOHN SAUNDERS: Right. Could more have been taken away
 25 from what was going on downstairs without damaging the

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1 effectiveness of the casualty centre?
 2 CHRISTIAN COOPER: I think the HART staff could have been
 3 allowing other paramedics to do those other functions.
 4 I think that would have been a more efficient use of
 5 resources and perhaps I should say it's not just about
 6 the number, there is a -- I've seen paramedics
 7 performing triage effectively and I have seen HART staff
 8 performing triage. There's a marked difference in the
 9 speed and the efficiency and the effectiveness of that.
 10 That's not to detract from the -- and I should say, all
 11 of the paramedics, Patrick Ennis as well and the job he
 12 did in the City Room and all of the paramedics as
 13 individuals do an absolutely sterling job in very, very
 14 difficult circumstances. I don't want to detract from
 15 that. It's just the way those resources have been
 16 deployed and managed could have been more effective in
 17 terms of the outcome.
 18 SIR JOHN SAUNDERS: Thank you.
 19 MR GREANEY: So if it were to be suggested that the three,
 20 Priest, Devine and English, turn up a little later, that
 21 they were better deployed, not into a hazardous area
 22 in the City Room but in fact were better deployed to set
 23 up a CCP or CCS, or deliver oxygen via the mass oxygen
 24 delivery system, what would your response be?
 25 CHRISTIAN COOPER: It is certainly the case that HART staff

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1 spend more time training to deal with major incidents
 2 and incidents of that nature, so they tend to be good at
 3 doing quite a wide range of functions. The difficulty
 4 is you've only got six of them initially, and an
 5 ambulance trust -- some ambulance trusts only have six
 6 on duty at any one time, some benefit from having two
 7 units and therefore have 12 on duty at all times. There
 8 were six in Manchester, six in Liverpool in the case of
 9 NWAS. It's still a very, very small number of
 10 responders, so you need to be very careful what you do
 11 with them.
 12 They are trained and equipped to fulfil a very
 13 specific purpose, which is to operate in areas that
 14 other paramedics cannot, so it is unusual to see a HART
 15 team split, first of all. And then if you've got those
 16 other HART people doing other functions, it's quite
 17 appropriate to challenge why other paramedics that can
 18 operate in that area are not fulfilling those functions.
 19 Q. So a way of looking at it is to ask: was there any
 20 better or more important task for those members of the
 21 HART team to be deployed to that night once they arrived
 22 than going into the City Room?
 23 CHRISTIAN COOPER: I don't think so, no.
 24 SIR JOHN SAUNDERS: And you have considered the matter of
 25 setting up the oxygen cylinders, which was what was

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1 suggested?
 2 CHRISTIAN COOPER: I have looked at that. I saw the
 3 evidence of Mr Blezard on Monday. Now, when HART was
 4 originally set up many years ago they had those mass
 5 oxygen delivery systems as part of their equipment and
 6 they at that time were the only ones that could have
 7 deployed and used that equipment.
 8 Then the national mass casualty vehicles came along
 9 and they too had mass oxygen delivery systems on the
 10 back and there were a number of national conversations
 11 had at that time, and NWAS were represented in those
 12 conversations, that said: now we've got that, it is
 13 probably not appropriate for HART to be detracted (sic)
 14 to do that function.
 15 The other thing is that mass oxygen delivery system,
 16 when it was given to HART initially, was given for the
 17 purpose of running oxygen into a CBRN environment, a
 18 hazardous environment with toxic chemicals. It was for
 19 that particular purpose.
 20 But it is quite right that if you haven't got a CBRN
 21 situation and you've got other patients that might
 22 benefit from oxygen, people were using the HART team to
 23 do that. But there was a conscious decision taken prior
 24 to 2017 that the national mass oxygen delivery system
 25 should be part of a mass casualty response using that

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1 vehicle, that's not a HART-specific response. So there
 2 should have been other people within NWAS at that time
 3 capable of deploying and using that mass oxygen delivery
 4 system.
 5 If there were not, for whatever reason, if that was
 6 an omission, and the only people within NWAS that were
 7 capable of using mass oxygen delivery systems were HART,
 8 and the operational commander knew that and knew that
 9 they had people at a CCS that would have benefited from
 10 that, then there is some justification there for making
 11 that decision to potentially split the HART team.
 12 MR GREANEY: Although, sir, it would be fair to observe that
 13 that was not the evidence that the operational commander
 14 gave --
 15 SIR JOHN SAUNDERS: No.
 16 MR GREANEY: -- as for his rationale.
 17 MS ROBERTS: (Inaudible: no microphone).
 18 MR GREANEY: That was not the reason that was given by the
 19 operational commander, Mr Smith, for splitting the team.
 20 MICHAEL HERRIOT: Once the system is established, of course,
 21 any paramedic could use it.
 22 SIR JOHN SAUNDERS: It's the setting-up that's the problem?
 23 MICHAEL HERRIOT: Yes.
 24 SIR JOHN SAUNDERS: And we know from what Mr Blezard said
 25 that people who were AIT trained could use it. I think

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1 there were two people there who were AIT trained.
 2 Anyway it's a matter of choosing who does what.
 3 MICHAEL HERRIOT: Yes.
 4 MR GREANEY: I haven't quite finished with the issue of
 5 deployment of the HART team. You mentioned a moment ago
 6 that NWAS benefited from the fact that it had two HARTs
 7 available.
 8 CHRISTIAN COOPER: Yes.
 9 Q. The other being the Liverpool team, as you describe
 10 them.
 11 CHRISTIAN COOPER: Yes.
 12 Q. And according to the documentation that emanates from
 13 NWAS, and for which we're grateful, they were allocated
 14 at 23.14 and mobile the same minute, arrived at the
 15 Thompson Street RVP at 23.43, and arrived at the scene,
 16 so at the arena, at 00.19, so at a time when it might be
 17 suggested they were unable to provide meaningful
 18 assistance to casualties, at least in the City Room.
 19 Do you have any view to express about that state of
 20 affairs?
 21 CHRISTIAN COOPER: I think the Liverpool HART team should
 22 have been mobilised earlier. HART teams nationally are
 23 on a 30-minute notice to move anywhere in the
 24 United Kingdom because they are both a national asset
 25 and a locally held asset. But they are finite in

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1 number, and as a result, they are well rehearsed and
 2 well practised to mobilise quickly.
 3 At the local level, with what was going on at
 4 Manchester Arena, and certainly on the declaration of
 5 a major incident of that type, you would want to get the
 6 small number of resources you've got that are capable of
 7 operating, in an area where potentially the paramedics
 8 are not, to the scene as quickly as possible.
 9 There was the other complexity that the Manchester
 10 HART team were already deployed on another incident
 11 requiring their skills at the time, and all the more
 12 reason therefore for the control room to have picked up
 13 on that and have mobilised the Liverpool team earlier.
 14 Q. That's a reference to the fact that the Manchester-based
 15 HART team were deployed at the time the call came in to
 16 the Stockport factory fire?
 17 CHRISTIAN COOPER: Yes.
 18 Q. Thank you, I have understood what you would have
 19 expected to happen in relation to the Liverpool team.
 20 Who would you expect to have been making the
 21 decision that they needed to be mobilised earlier than
 22 in fact was the case?
 23 CHRISTIAN COOPER: The control room initially, because
 24 they're best placed to understand where people are and
 25 what they're doing, and part of the major incident

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1 arrangement should be for the control room to check what
 2 resources are required to deploy. So initially the
 3 control room and then, very shortly thereafter, the
 4 HART team leader deployed or the operational commander
 5 should have recognised the need potentially, if not
 6 actually, for additional support from specialist
 7 resources and to have cross-checked with control that
 8 additional resources had been mobilised.
 9 Q. Would that have been just their responsibility or would
 10 responsibility for identifying that situation and the
 11 need for specialist resources also have fallen on the
 12 command structure at a higher level?
 13 CHRISTIAN COOPER: Yes, it would indeed and certainly the
 14 ambulance incident commander or tactical commander,
 15 they're in a position where they are removed from the
 16 scene, where they can take a broader view of what
 17 resources are required specifically for that incident.
 18 So we talked in the morning session about a role for the
 19 strategic commander taking a complete step back and
 20 looking at business as usual for the whole
 21 Ambulance Service and the pressure and effect there.
 22 It's absolutely the job of the tactical commander to be
 23 focused on the incident and what resources are necessary
 24 for that incident.
 25 Q. Is it your view that the NWAS strategic commander made

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1 any material contribution to the emergency response?
 2 CHRISTIAN COOPER: I don't believe they did, no.
 3 Q. What about the NWAS tactical commander, did that person
 4 make any material contribution to the emergency
 5 response?
 6 CHRISTIAN COOPER: Yes, I believe they did. There are
 7 a number of examples within their oral evidence and
 8 within their statements of things we would have expected
 9 to happen that did. There were some omissions.
 10 Q. We're talking about Annemarie Rooney. Can you identify
 11 what you would have expected her to have done that she
 12 did do first of all?
 13 CHRISTIAN COOPER: She went to where she was supposed to go,
 14 which was the police force HQ, to be part of the TCG.
 15 She made attempts to ensure a JESIP process was put in
 16 place and made attempts to have a joint meeting.
 17 Q. Yes.
 18 CHRISTIAN COOPER: She was in close communication with the
 19 operational commander, as is right and proper, and
 20 certainly as the incident developed, Annemarie Rooney
 21 played an important role in supporting the onward
 22 distribution of casualties to appropriate facilities,
 23 the casualty distribution model.
 24 So those are some examples, there are others, of
 25 a meaningful contribution made by Annemarie Rooney.

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1 Q. And you have identified others in your reports and I am
 2 going to make a statement about your reports in due
 3 course.
 4 You said that there were omissions. Could you tell
 5 us what those were, please?
 6 CHRISTIAN COOPER: I think one of the omissions, as we have
 7 just alluded to, was an early — early efforts to ensure
 8 that all of the specialist resources that could have
 9 been of benefit were mobilised. The Liverpool HART team
 10 being one specific example, but also identifying and
 11 potentially mobilising the AIT team.
 12 The AIT team presents much greater complexity to the
 13 Ambulance Service because these AIT-trained staff are
 14 otherwise deployed on normal front line ambulances. So
 15 you firstly have to identify which ambulances have got
 16 an AIT person on board and then take steps to try and
 17 get not only those ambulances but the ambulances with
 18 the AIT members on them to the scene. So that is quite
 19 complex.
 20 There's systems within the control room that allow
 21 them to quickly identify where those people are and what
 22 vehicles they're on. The important thing is that if it
 23 isn't done early, you have missed the window to do it
 24 really quite early on in the incident. So if there were
 25 considerations some way into the incident that AIT may

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1 have been beneficial but perhaps the time's passed to
 2 mobilise them, I do understand that, I can recognise
 3 that as being a justifiable approach to decision-making.
 4 If you know it's not a Plato, you know that's been
 5 resolved, I think AIT members of staff have had
 6 a contribution to make at this incident, certainly in
 7 the very early phases. But if you miss the window to
 8 mobilise them, not mobilising them once you're
 9 30 minutes into this incident is probably understandable
 10 given the complexities and the time it would take to
 11 bring them into play.
 12 Q. Thank you, Mr Cooper. I'm going to just pause the
 13 chronological analysis and look at some particular
 14 topics, but before I do so, Mr Herriot, do you have
 15 anything that you wish to disagree with in what's been
 16 said by Mr Cooper about the deployment of HART?
 17 MICHAEL HERRIOT: No, I completely concur, thank you.
 18 MR GREANEY: The first topic, the casualty collection point
 19 and the casualty clearing station, so the CCP and CCS.
 20 In a few sentences could you describe each of those
 21 to us, please?
 22 CHRISTIAN COOPER: A casualty clearing station is somewhere
 23 located in the cold zone of the incident, at an area of
 24 the incident known to be relatively safe. And it is the
 25 main area where you will move casualties to in order to

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1 further triage them, stabilise them, in some cases
 2 conduct fairly advanced medical interventions, and
 3 organise them to work out which is the most appropriate
 4 receiving medical facility for them to be transported
 5 to.
 6 It's a crucial part of the major incident process,
 7 which allows you to link closely with the ambulance
 8 loading officer to work out how you're going to move
 9 those casualties and, crucially, in what order from
 10 a casualty clearing station to onward definitive care.
 11 By contrast, then, a CCP — and this came about
 12 mainly when we were developing the MTFA doctrine, as was
 13 then, MTA now, but it's used in other circumstances
 14 other than MTA now, a casualty collection point is
 15 a point that is closer to the inner cordon or warm zone
 16 of the incident than a CCS is, so you would often locate
 17 a CCP within a warm zone. And it is an area,
 18 a temporary, very temporary area, where you might group
 19 some casualties together prior to their extrication to
 20 a CCS.
 21 And the scenario — in the first instance it was
 22 envisaged that you would use — CCPs would be for an
 23 incident spread over a fairly large geographical area,
 24 we might say a shopping centre or outside, an open
 25 space, where you might have pockets of casualties in

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1 various different locations. It allows the forward
 2 responders to formally nominate a CCP in a particular
 3 spot to say: I'm going to initially move my casualties
 4 to that location. At this point, it still may be the
 5 case that they have only had an initial triage sieve and
 6 very, very basic life saving interventions applied, but
 7 you're moving them to that point so that a coordinated
 8 effort can be put in place behind you to extricate the
 9 patients from that casualty collection point to the CCS.
 10 Q. So there are two points of triage, primary triage or
 11 triage sieve, and secondary triage?
 12 CHRISTIAN COOPER: Yes.
 13 Q. First occurring at the CCP, the second occurring at the
 14 CCS?
 15 CHRISTIAN COOPER: Well, the initial triage sieve may occur
 16 over a fairly broad — it doesn't have to occur at
 17 a CCP, you could have sieved them already and then moved
 18 them. And another use of a CCP may be to say: I'm going
 19 to have a CCP for my P1 patients at this location, they
 20 are the priority and you need to move them from there
 21 first; there may be others located elsewhere.
 22 Q. So is the point or a point that at the stage of primary
 23 triage, one is making assessment but would not generally
 24 treat unless there is a need for an urgent life-saving
 25 intervention —

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1 CHRISTIAN COOPER: That's correct.
 2 Q. -- such as the application of a tourniquet or to
 3 maintain an airway?
 4 CHRISTIAN COOPER: Indeed.
 5 Q. But that at the stage of the secondary triage, more
 6 advanced or complex treatment would be expected?
 7 CHRISTIAN COOPER: Yes, that is the principle. I have seen
 8 occasions where CCPs have been in operation and for
 9 whatever reason there has been a delay in extricating
 10 a patient from a CCP to a CCS. There's been a paramedic
 11 at that CCP, the paramedic has completed their primary
 12 triage, and the paramedic has then moved on to more
 13 advanced treatments of the patient at the CCP.
 14 Now, that's not to say that that is wrong.
 15 I wouldn't expect a paramedic to slavishly stick to
 16 those triage principles -- the triage principles are
 17 there because if the paramedic is overwhelmed and there
 18 are more patients than they can treat it is quite right
 19 and proper that you restrict what treatments are applied
 20 so that the triage process can be completed first. But
 21 if a paramedic were to find themselves in a situation
 22 where that process has already been concluded, they're
 23 stuck at a CCP waiting for their patients to be
 24 extricated, then there's nothing to stop that paramedic
 25 using their skills further.

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1 Q. I understand. I want you to deal with two issues, and
 2 I'll identify what each is and then leave it to you to
 3 answer.
 4 First of all, I'm going to ask you to help us with
 5 what ought to have been done in your judgement in this
 6 regard, so CCP and CCS, on the occasion of the
 7 Manchester Arena attack. Secondly, I would like you to
 8 compare and contrast that with what in fact happened, if
 9 something different to what you would have expected
 10 occurred.
 11 CHRISTIAN COOPER: I would have expected at Manchester there
 12 would definitely be a requirement for a CCS, a casualty
 13 clearing station. That is best located in an area
 14 deemed to be safe, ideally an area protected from the
 15 elements, an area -- it's not going to be sterile but an
 16 area that is as appropriate as it possibly can be for
 17 anticipated and fairly advanced treatments of
 18 casualties.
 19 There are a number of other things that a commander
 20 may consider as being appropriate location for a CCS.
 21 In this case, locating a CCS on the station concourse,
 22 just within the doors of the station, would seem
 23 entirely appropriate to me.
 24 Whether or not a CCP was required here, I think is
 25 debatable. Because the City Room -- given its size but

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1 given the fact that it is one location, and not huge in
 2 its dimensions, as in it is not spread over a wide
 3 geographical area, it is one location, you could almost
 4 treat that effectively as a CCP in its own right because
 5 everybody knows if you were to say, "The casualties are
 6 located in the City Room", they know where that is.
 7 Q. Yes.
 8 CHRISTIAN COOPER: CCPs are often also used where there's
 9 some confusion over geography, "I don't know where the
 10 casualties are", so somebody can locate a CCP to say,
 11 "We'll move them to there", so it's a commonly
 12 understood place. From that perspective it may not have
 13 been appropriate to set a CCP up.
 14 However, you've got the matters of the stairs, which
 15 present a difficulty for rapid extraction of seriously
 16 injured patients to a location where they can receive
 17 more definitive care or more advanced care in the CCS,
 18 so it may have been appropriate, and something that
 19 I would certainly have considered, to have located a CCP
 20 potentially somewhere at the top of those stairs outside
 21 of the City Room, so in effect the mezzanine itself,
 22 because that would have removed people from the
 23 City Room but then allowed a certain amount of
 24 organisation and prioritisation to take place before
 25 they then come down the stairs.

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1 However, for what you are materially gaining there,
 2 what you would not want to do is build in unnecessary
 3 delay. So it's a consideration, I am sure some
 4 commanders would consider doing that, other commanders
 5 may not, and I don't think it's clear enough for me to
 6 be able to say whether or not that's right or wrong.
 7 In other words, I suppose it would be entirely
 8 appropriate for a commander to say, "Given the geography
 9 of this location, I don't need a CCP, I just need proper
 10 management of the City Room and an effective route for
 11 those patients to make it to the CCS".
 12 Q. What is your view of what actually happened on the
 13 ground that night?
 14 CHRISTIAN COOPER: I think there was some confusion around
 15 the location of the CCS because there was some things
 16 that we would normally associate to be within a CCS set
 17 up outside the stairs on the pavement on the run-up.
 18 Q. We have heard suggestions that there was an intention to
 19 set up a CCP outside of the station.
 20 CHRISTIAN COOPER: Yes. That is somewhat at odds with the
 21 methodology of a CCP, because as I've described, the CCP
 22 is normally forward of a CCS. Once somebody has been
 23 through a CCS, it would be unusual -- I have never heard
 24 of an occasion where they would then retreat beyond
 25 a CCS to a CCP. Normally, the loading officer's

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1 responsibility is to liaise with the CCS officer and
2 between them they have a conversation about who's coming
3 out of that CCS next and where they're going and then
4 they facilitate the loading of them.

5 If there is some sort of temporary location that is
6 not the CCS, that is to enable the loading of casualties
7 appropriately on to vehicles — that would be entirely
8 appropriate, but I wouldn't call that a casualty
9 collection point, not least because it's going to
10 confuse people if that's what you call it in the whole
11 set-up of a major incident.

12 Q. Ultimately, the issue is whether you criticise the
13 arrangements that were made that night for the CCS
14 and/or CCP.

15 CHRISTIAN COOPER: I don't take odds with the lack of a CCP
16 between the City Room and the casualty clearing station.
17 I think it's very important that the operational
18 commander is really clear about where the CCS is and
19 what it's doing. Having looked at the statements and
20 the oral evidence of several NWS staff, I think there
21 was some confusion in the early phases of the incident
22 particularly about a CCP, a CCS and the location of
23 those.

24 SIR JOHN SAUNDERS: There certainly was in the evidence.
25 Some people talked about a CCP and others didn't at all,

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1 and if there were two, it appears they merged together
2 pretty quickly.

3 CHRISTIAN COOPER: I agree, sir.

4 MR GREANEY: Mr Herriot, do you have anything you wish to
5 add on this issue of the CCP/CCS?

6 MICHAEL HERRIOT: No, I think the norm would be to assume
7 that if you need a CCP, you certainly should consider
8 it. Then it should be a staging point that exists
9 between the scene and the CCS.

10 I have certainly never seen any other configuration
11 other than that and I can't envisage any reason why
12 anybody would actually adopt that sort of configuration,
13 and again, as was said by Mr Cooper, we have heard
14 evidence about there being confusion about what's the
15 CCS, what's the CCP, and the introduction of the term
16 CCA, which isn't something that's used within the
17 Ambulance Service terminology.

18 SIR JOHN SAUNDERS: In relation to consideration of a CCP
19 actually on the landing, I suppose one consideration
20 is that, if you're taking people off on some precarious
21 makeshift stretcher, that in a way once you get them
22 moving you keep going as far as you need to go?

23 CHRISTIAN COOPER: I'd agree with that. And there is
24 another risk that if you set a CCP up there, I think
25 there's a real risk that that would end up actually

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1 becoming a CCS.

2 SIR JOHN SAUNDERS: People said it was too narrow.

3 CHRISTIAN COOPER: There was a risk that it affects access
4 and egress too, certainly.

5 SIR JOHN SAUNDERS: Yes, thank you.

6 MR GREANEY: That's all I propose to ask about the CCP/CCS.

7 I'm moving to a separate topic, which is equipment.

8 I want to consider with you, please, Mr Cooper,
9 first of all, whether in your view equipment that should
10 have been at the scene was not at the scene and, if not,
11 why not.

12 So can we first of all deal with stretchers. What
13 view do you hold about stretchers and their relevance in
14 this context?

15 CHRISTIAN COOPER: I think the availability of stretchers
16 was clearly an issue when it comes to evacuating
17 casualties from the City Room to the CCS. In terms of
18 availability of stretchers, every front line ambulance
19 doesn't only carry the large wheeled stretcher that the
20 patient is transported on. There are other forms of
21 stretcher in the rear of an ambulance, for example
22 a scoop or a spinal board.

23 I don't think it would have been appropriate to use
24 spinal boards in this case. For the reasons that have
25 been stated by NWS in their evidence, I do agree with

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1 that, that it's not just — it's not a question of
2 training somebody how to use it, because I'm quite sure
3 most people have never been trained to use advertising
4 hoardings or barriers to transport people, but with
5 spinal boards, there is a real risk if you put somebody
6 on there and you do not strap them to it properly, and
7 strapping them to it takes time, particularly when you
8 descend the stairs and the angle of that spinal board
9 changes, you risk serious consequences to that casualty.
10 So I think it's quite right and proper that that was
11 ruled out as an option.

12 There are other options, particularly canvas
13 stretchers and orthopaedic or scoop stretchers, which
14 are — yes, they have a clasp, yes, you require training
15 to use them properly, but if used as an alternative by
16 fire, police and — fire weren't there, but police or
17 others that were on the scene, they could have been
18 a much more effective way of moving casualties.

19 Q. You have just mentioned that fire weren't there, as
20 indeed is right, during the period of extrications from
21 the City Room. Is it your view that had Fire and Rescue
22 Service firefighters been within the City Room at that
23 relevant time, they would have been capable of making
24 a difference?

25 CHRISTIAN COOPER: Absolutely. The Fire and Rescue Service

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1 and Ambulance Service work very closely together on
 2 a daily basis and that often involves the extrication of
 3 casualties from all sorts of different places. So both
 4 the Fire and Rescue Service and the Ambulance Service
 5 are highly experienced at undertaking that task and,
 6 given that there was a difficulty here moving
 7 casualties, that to me, probably more than anything
 8 else, is the real benefit that the Fire and Rescue
 9 Service could have brought to that situation, because
 10 the Fire and Rescue personnel could easily have moved
 11 some of those casualties without the use of anything if
 12 that was absolutely necessary, but certainly organising
 13 themselves with the task of extricating as many people
 14 from the City Room down to the CCS location is something
 15 the Fire and Rescue Service would have been arguably
 16 better placed than any to facilitate.

17 SIR JOHN SAUNDERS: So not using spinal boards, justified;
 18 not using scoops, not justified (overspeaking)?

19 CHRISTIAN COOPER: I think scoops could and should have been
 20 used.

21 SIR JOHN SAUNDERS: Is there evidence, and forgive me for
 22 not appreciating this, that deliberate decisions were
 23 made, ie somebody said to themselves, "Shall we go and
 24 get the spinal boards from the ambulances", "No, they
 25 wouldn't be suitable", "Shall we get the scoops?", "I

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1 don't think they'd be suitable either"? Were there
 2 deliberate decisions made?

3 CHRISTIAN COOPER: I don't know about deliberate — I know
 4 there is evidence from NWS that the operational
 5 commander particularly was of the view that the movement
 6 of casualties was happening in front of them, they were
 7 satisfied with the movement that was occurring, and
 8 therefore they let that process continue. I think there
 9 was an opportunity to intervene earlier and do it more
 10 appropriately.

11 MR GREANEY: That's an entirely accurate summary according
 12 to my recollection of Dan Smith's evidence.

13 SIR JOHN SAUNDERS: Thank you very much.

14 MICHAEL HERRIOT: And we know that NWS did have other types
 15 of stretcher available at the scene because of the
 16 vehicles that were brought by the HART team carried
 17 other types of stretcher, not in vast numbers, but there
 18 were alternatives that they could have used that would
 19 have prevented some of those agonising journeys for
 20 people on the makeshift stretchers.

21 MR GREANEY: When you say there was an opportunity earlier
 22 to identify the need for more formal stretchers to be
 23 brought in, whose opportunity was that to take and not
 24 taken?

25 CHRISTIAN COOPER: I think it was the operational

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1 commander's.

2 Q. The next issue on equipment, you have mentioned already
 3 the mass casualty vehicle. First of all, what is that,
 4 please?

5 CHRISTIAN COOPER: These are first and foremost a set of
 6 national assets that ambulance trusts host locally, so
 7 specified nationally, they are all the same, they all
 8 carry the same kit and equipment. Depending on — the
 9 size, geography and population of an ambulance trust
 10 dictated how many of these assets they got. The idea
 11 being that if there was a mass casualty event of any
 12 kind, it doesn't matter what the cause was, if you have
 13 a situation where you have a large number of casualties,
 14 these vehicles were envisaged to support the response to
 15 that by bringing additional equipment that was deemed
 16 necessary to deal with large numbers of patients.

17 Q. We know that no mass casualty vehicle actually did reach
 18 the scene. Is it your view that one should have?

19 CHRISTIAN COOPER: Yes.

20 Q. If it had, what difference would it have made or been
 21 capable of making?

22 CHRISTIAN COOPER: I think there needs to be recognition
 23 here that NWS did have other major incident vehicles
 24 that carried equipment. Those particular vehicles that
 25 they had are not part of a national specification. That

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1 was something that NWS undertook of its own volition as
 2 part of its right and proper major incident planning
 3 process. So it did have these alternative vehicles, if
 4 you like. They don't carry the same things as the
 5 national assets do, but they do have this alternative
 6 vehicle. Nevertheless —

7 Q. Were they called equipment vehicles?

8 CHRISTIAN COOPER: They're the major incident equipment
 9 vehicles, yes. If a trust did not have those and did
 10 not mobilise the national mass casualty vehicles, the
 11 consequences would have been far greater. So we need to
 12 recognise the consequence in this case was perhaps
 13 mitigated to some degree by the fact that NWS had its
 14 own equipment vehicles as well that were mobilised to
 15 the scene.

16 But the national expectation was that for any
 17 incident, and certainly a major incident with multiple
 18 casualties, it is NWS's responsibility to mobilise that
 19 national asset to that location.

20 Q. Before I turn to Mr Herriot, finally on this topic of
 21 equipment, is there anything else that you wish to draw
 22 to the chairman's attention in relation to equipment
 23 that was not at the scene that you would have expected
 24 to have been there?

25 CHRISTIAN COOPER: I don't think so, no.

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1 SIR JOHN SAUNDERS: I understand the argument which says
2 this national asset is there for precisely this occasion
3 and therefore you should use it. But if the reality
4 is that because of their own particular assets they have
5 their own major incident vehicles, because they have
6 them there, it actually made no difference.

7 CHRISTIAN COOPER: I think the difference it could have made
8 is — if I give you three specific examples. The
9 national mass casualty vehicle contains the national
10 mass oxygen delivery system. Okay, in this case that
11 was deployed by HART, but that created its own problems
12 at the scene because you then need to split your HART
13 team to do it. If NWAS not only mobilised that vehicle
14 but had the people there to offload it and use the kit
15 that would have made a real difference.

16 There's talk about the HART cubes being used. These
17 are the large cubes that contain lots of clinical
18 consumable items that are very useful at a major
19 incident, except the national mass casualty vehicle
20 carries not those cubes but similar stocks of consumable
21 equipment that could have negated the need for HART to
22 be using the cubes at the CCS.

23 If HART were going to use their cubes anywhere,
24 I would argue they should have been taken into the
25 City Room for people to help themselves to the contents.

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1 The third thing on the national mass casualty
2 vehicles is it carries large quantities of the drugs
3 that both doctors and paramedics may need extra supplies
4 of and I believe indeed in NWAS's — one of NWAS's
5 evidence submissions, I'm afraid I don't know the INQ
6 number, but it's the lessons learned from the debriefing
7 events, there is a table in there and one of the things
8 identified in there is there was a shortage of things
9 like tranexamic acid, TXA, and metoclopramide and some
10 other drugs and ketamine, and the mass casualties
11 vehicles certainly carry much larger quantities of those
12 pharmaceuticals that were needed at the scene.

13 SIR JOHN SAUNDERS: My recollection is because they're
14 carried on individual ambulances in much smaller
15 numbers, you have to get there, each time you have to
16 get — go to a vehicle it's another trip rather than
17 having a mass casualty vehicle and there's a much bigger
18 bulk of them which you can take, presumably, in one
19 trip.

20 CHRISTIAN COOPER: That's quite right, sir, and of course at
21 a major incident there is something else that needs to
22 be in the contemplation of the commander and that is the
23 more equipment you can use from specialist vehicle means
24 you're using less equipment from an ambulance that may
25 subsequently need to transport somebody.

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1 SIR JOHN SAUNDERS: Okay.

2 MR GREANEY: That's an important topic that I want to turn
3 to very soon indeed. But first of all, Mr Herriot, is
4 there anything you wish to add on the issue of
5 equipment?

6 MICHAEL HERRIOT: I think NWAS were very well equipped
7 regarding additional incident support vehicles, public
8 support vehicles, all over the various locations in the
9 north—east (sic)

10 Q. Do you mean in general terms?

11 MICHAEL HERRIOT: In general terms, all of which carried
12 stretchers, for example. I just don't think that there
13 was probably the consideration given to whether or not
14 those assets could have been brought to the scene at an
15 early stage.

16 CHRISTIAN COOPER: If I may just add, because I don't know
17 if it's in your contemplation for recommendations, sir,
18 but the one thing the national mass casualty vehicle did
19 not carry at this time was stretchers. It didn't have
20 any of any type. There are plans to change those
21 vehicles, they're at the end of their life now, and the
22 replacement vehicles and the contents that are coming
23 into place in the new financial year, based on what we
24 already understand from Manchester and other learning as
25 well, means that those new assets will carry a large

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1 quantity of portable stretchers.

2 SIR JOHN SAUNDERS: Thank you.

3 MR GREANEY: Next topic, command structure and action cards.
4 Did the NWAS command structure involve command roles
5 beyond Gold, Silver and Bronze?

6 CHRISTIAN COOPER: It included the functional roles within
7 the major incident plan, but those were the three key
8 levels of command, yes.

9 Q. That's what I had in mind. The key levels of command,
10 Gold, Silver and Bronze. But within the structure there
11 are functional roles also?

12 CHRISTIAN COOPER: Yes.

13 Q. That's the right way of putting it, thank you.

14 Were there important roles in that structure, the
15 functional role structure, that were not appointed on
16 the night of the arena attack?

17 CHRISTIAN COOPER: Yes, of particular note are the lack of
18 a safety officer and the lack of an equipment officer.

19 Q. First of all, the safety officer. What role does that
20 person have?

21 CHRISTIAN COOPER: First and foremost, to consider the risks
22 at the scene and the safety of the responding ambulance
23 crews. The role can then go broader and consider
24 broader safety risks at the scene, the safety of
25 casualties and the like.

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1 Q. We know that a safety officer, as Mr Smith candidly
 2 accepted, was not appointed that night through
 3 oversight. In your judgement, what difference would the
 4 appointment of a safety officer have made?
 5 CHRISTIAN COOPER: I think, firstly, it eases the pressure
 6 and burden on the operational commander because you've
 7 got one person whose focus is to look at what the true
 8 risks are and to help with that risk assessment process
 9 and, in this case, that would have been particularly
 10 relevant to understanding what risks were present in the
 11 City Room and what, if anything, was holding the
 12 operational commander back from deploying assets into
 13 that area.
 14 Q. As you explained, no equipment officer was appointed, as
 15 again was accepted. What would have been the role of an
 16 equipment officer had one been appointed?
 17 CHRISTIAN COOPER: Again — and this is the purpose of all
 18 the functional roles, really — the operational
 19 commander is there to oversee and make sure that the
 20 operational response is going effectively. To give them
 21 the capacity to do that, a number of key roles and
 22 functions are delegated to these functional roles, and
 23 if you had an equipment officer, that is somebody who
 24 can step back without worrying about all the other
 25 things the operational commander has to worry about and

1 focus solely on, "Have we got the right equipment to do
 2 the job here? If we haven't I can make early requests
 3 for it". And you would also expect the equipment
 4 officer to pick up on gaps or issues that it is perhaps
 5 understandable that an operational commander might miss
 6 given their capacity for what's going on.
 7 Q. So is it your view that the appointment of an equipment
 8 officer would have been of assistance that night?
 9 CHRISTIAN COOPER: It is my view, yes.
 10 Q. So do you regard the failure to appoint to those
 11 functional roles as being a significant one?
 12 CHRISTIAN COOPER: Yes.
 13 Q. As we know, NWS had action cards for the various
 14 positions in the command structure and roles, and I'm
 15 not going to look at any of them with you at all, save
 16 just to look at the page that lists them.
 17 So this is {INQ013422/1}, please, Mr Lopez.
 18 We can see a list of 29 of them. Have you had
 19 an opportunity to consider these action cards?
 20 CHRISTIAN COOPER: I have.
 21 Q. And do you consider them as being fit or unfit for
 22 purpose?
 23 CHRISTIAN COOPER: They are fit for purpose. These are
 24 action cards that are NWS's own action cards, they're
 25 not the national action cards issued by the National

1 Ambulance Resilience Unit, but that's entirely
 2 appropriate. Some trusts use the NARU action cards
 3 directly and don't modify them, some trusts choose to
 4 modify them to put some of their own local provisions in
 5 there and that too is entirely appropriate. But in
 6 terms of the list and scope covered in terms of what
 7 functional roles have what action cards I think that's
 8 entirely appropriate.
 9 Q. Do action cards such as this have value in your view?
 10 CHRISTIAN COOPER: I believe they do, yes.
 11 Q. What is their value?
 12 CHRISTIAN COOPER: No one would expect commanders or those
 13 in functional roles to break out a copy of the major
 14 incident plan or site-specific plans even, necessarily,
 15 once they are in the middle of trying to manage an
 16 incident. That isn't practical. The idea of an action
 17 card is a checklist, it's a reminder, it's a cross-check
 18 for a commander or somebody in a functional role so that
 19 they can just reacquaint themselves with that role if
 20 that's necessary, but more importantly to check that
 21 everything that is deemed necessary to do that role
 22 effectively has been done.
 23 So it's a checklist, and the purpose of it is to
 24 make sure that you've discharged that function
 25 effectively and appropriately.

1 Q. In your view, was sufficient regard had that night by
 2 the operational commander to action card 4?
 3 CHRISTIAN COOPER: No.
 4 Q. If proper regard had been had to that action card, what
 5 difference do you consider it may have made?
 6 CHRISTIAN COOPER: Well, we looked at the action card. Some
 7 of the things, some of the omissions that were made by
 8 the ambulance operational commander were things that
 9 were on that checklist. So we don't expect an
 10 operational commander to pick up a checklist and
 11 carefully read it off. It's more that at some point
 12 in that incident, and very early on, I would suggest,
 13 certainly within the first 15 minutes, there will be an
 14 opportunity to very quickly pull it out of your pocket
 15 and just have a quick look at it and say: I've done
 16 that, I've done that, yes, hang on, safety officer,
 17 I forgot that, safety officer, yes, that might be
 18 useful, I'm going to do that.
 19 So it's an aide-memoire, it's a ready reckoner, and
 20 I think the analogy that we use with action cards a lot,
 21 and indeed one of the reasons why we've developed the
 22 national cards in the way that we have, is based on what
 23 a pilot might use if an aircraft is in distress. The
 24 pilot will break out an emergency checklist, often
 25 a physical thing, and go down to make sure they don't

1 miss any of the points. That is in no way reflective of
2 the pilot's competence, it is merely a device to ensure
3 that key things are not missed and that is the purpose
4 of these action cards: to make sure that key things are
5 not missed.

6 Q. Mr Herriot, can I ask you, do you have anything that you
7 wish to add or disagree with in relation to the command
8 structure and action cards?

9 MICHAEL HERRIOT: I think, particularly with the action
10 cards, they're an extremely valuable asset, and they've
11 been within the Ambulance Service for many years.
12 Generally, they're used to very good effect.

13 As Mr Cooper describes, it's not to look at them in
14 absolute detail, it is just a quick reference to make
15 sure nothing's been omitted. They're fit for purpose,
16 yes.

17 SIR JOHN SAUNDERS: And perhaps particularly in a case where
18 a person hasn't necessarily been doing that particular
19 function.

20 CHRISTIAN COOPER: That's certainly the case for a number of
21 those roles. It is highly likely, certainly in the
22 early phases of a major incident, that when you get down
23 to some of these functional roles they're being assigned
24 to an operational paramedic who may never, ever have
25 done that or even trained in it.

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1 SIR JOHN SAUNDERS: Absolutely, thank you.

2 MR GREANEY: Let's return to the chronology. Did there come
3 a time, plainly there did, when there were casualties
4 who needed to go to hospital and were ready to go to
5 hospital?

6 CHRISTIAN COOPER: Yes.

7 Q. At that stage, were there ambulances available to take
8 them at the arena?

9 CHRISTIAN COOPER: Yes.

10 Q. But is it the position that, certainly for a period of
11 time, the paramedic staff who had arrived in those
12 ambulances were inside treating casualties?

13 CHRISTIAN COOPER: Yes.

14 Q. So that they were not available to drive the ambulances
15 to hospital?

16 CHRISTIAN COOPER: Indeed, yes.

17 Q. In your view, was that a problem on the night?

18 CHRISTIAN COOPER: Well, I think it would — if patients
19 could have been moved quicker, if patients were ready to
20 go to hospital and the means is there to transport them,
21 that is preferable. But likewise it's entirely
22 foreseeable and understandable that you will have
23 a period within a major incident where the ambulance
24 response arrives largely by ambulances, but you need
25 a certain critical mass of people to do the functional

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1 roles and put the major incident roles and processes
2 into place for the benefit of all to make sure that if
3 you're dealing with a large number of casualties, you're
4 prioritising them appropriately, moving them to where
5 they need to be, stabilising them, and then making
6 a proactive decision not just to put them into a vehicle
7 and take them to the nearest accident and emergency
8 department because that will lead to serious problems.

9 There have been major incidents in the
10 United Kingdom before where all patients went to the
11 nearest hospital and quickly overloaded that emergency
12 department and then you are having to facilitate onward
13 transfers to other facilities.

14 The other thing is, I think as we heard from the
15 evidence of Mr Blezard on Monday and others, which
16 I agree with, the nearest hospital may often not be the
17 most appropriate place.

18 SIR JOHN SAUNDERS: I think we absolutely accept that. It
19 seems to be clear on the evidence. And also the — so
20 the hospital allocation plan and sorting that out, who
21 went where, when, no one is saying did anything but work
22 extremely well. My concern, as I have expressed — and
23 I understand what you're saying about people need to be
24 stabilised. What you're aiming to do is have the best
25 outcome for the patients?

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1 CHRISTIAN COOPER: Yes.

2 SIR JOHN SAUNDERS: Now, it seems, we've got empty
3 ambulances outside and they can't be moved because you
4 cannot get the staff to put people in. That will have
5 meant that some people got to hospital later than they
6 otherwise might have done for that reason. It might be
7 actually that no one was going to be ready before they
8 had the paramedics to do it, so the balance was
9 definitely that.

10 But you can have people — clearly we're not just
11 talking about people who die, we are talking in this
12 case about a large number of injured people who — I'm
13 just concerned to know whether their injuries could have
14 been less or the treatment less protracted if they had
15 been got to hospital quicker and if utilising those
16 ambulances was possible and could have resulted in that.
17 So that's the issue.

18 CHRISTIAN COOPER: And I think it's very important that we
19 look again at that issue. I understand how it happens,
20 it is common for it to happen, it happens at most major
21 incidents. You have a period of time that varies where
22 you have a large number of ambulances sitting there in
23 full public view and a need to move people quickly and
24 nothing seems to happen in regard to those ambulances.

25 I think we need to look harder at whether or not

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1 there is something because there may be and I know
2 myself and Mike have started to look at that and I think
3 we'd like the opportunity to take a bit more time, but
4 I hope there is.

5 I mean, we've got a number of functional roles
6 there. Not every functional role is needed at a major
7 incident. If you get an early decision from an
8 operational commander as to which of those functional
9 roles might be needed and what number of paramedics is
10 the minimum you need to have the stabilisation at the
11 CCS, given that 20 have arrived and you only need 10,
12 maybe there is some scope there, and I think that at
13 least is worthy of further exploration certainly.

14 SIR JOHN SAUNDERS: We did hear that on some occasions
15 police officers have driven ambulances. Mr Blezard will
16 say, they're not easy things to drive, you need training
17 and all the rest of it. But the reality is, you have
18 got a lot of policemen, I'm not saying doing nothing,
19 but who could have been spared to help with ambulances
20 and taking people to hospital if necessary. You have a
21 large number of people there who could help and still
22 the ambulances are sitting there. Is there not some way
23 of saying, we'll have a policeman for the driver and
24 a paramedic in the back helping, which you may need, and
25 that way we only need half of them? It doesn't seem to

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1 be beyond the wit of man.
2 CHRISTIAN COOPER: I agree. Ambulances are very complex
3 vehicles. They're not vans. I think that is important
4 to note. The driving bit is probably the easy bit.

5 SIR JOHN SAUNDERS: Right. Okay.

6 MR GREANEY: So the point is, as of May 2017, it was
7 foreseeable that this kind of issue would arise?

8 CHRISTIAN COOPER: Yes.

9 Q. I think you're acknowledging it's an issue that does
10 need to be thought about seriously to identify
11 a solution?

12 CHRISTIAN COOPER: Yes.

13 Q. And you and Mr Herriot have already begun to think of
14 what the solution might be and you will set out your
15 views in writing?

16 CHRISTIAN COOPER: Yes.

17 SIR JOHN SAUNDERS: Thank you very much, I'd be really
18 grateful. It may be impossible, there may be nothing
19 we can do, but anything that actually looks odd to the
20 general public, there's normally a reason why it looks
21 odd, and we might be able to get over it.

22 CHRISTIAN COOPER: It is an area of -- and I apologise for
23 digressing but it is an area -- and something else we
24 identified is that bit is often not exercised because of
25 the difficulties logistically in doing so. So a lot of

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1 these major incident exercises focus on the other part
2 and not that part. So it has probably not benefited
3 from years of learning through exercise either. So the
4 time is right, I feel, to have another good look at
5 that.

6 SIR JOHN SAUNDERS: Thank you.

7 MR GREANEY: So the final stage of events that I want to
8 look at with you, and we'll be finished by 3 or very
9 shortly afterwards.

10 As we all know, at 11.50 pm, Mr Hynes arrived at
11 scene.

12 CHRISTIAN COOPER: Yes.

13 Q. And he was a very senior officer with NWSA, was he not?

14 CHRISTIAN COOPER: He was.

15 Q. And he took over the role of operational commander from
16 Dan Smith?

17 CHRISTIAN COOPER: Yes.

18 Q. A consequence of that was that it was to mean that in
19 terms of rank, the Bronze commander was senior to the
20 Silver commander.

21 CHRISTIAN COOPER: Yes.

22 Q. In your analysis of the case, did you identify any
23 problems with that?

24 CHRISTIAN COOPER: Yes. It's highly unusual and it creates
25 the obvious problem that you have a very high-ranking

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1 individual now operating in a lower command capacity,
2 the person above them that is supposed to be in charge
3 of the overall incident response at the tactical level
4 is subordinate to them, so it naturally subverts the
5 command structure that you've got in place and I think
6 there was -- there are a number of issues with it, but
7 I think to draw out one particular example where
8 Mr Hynes was requesting resources and, given his
9 seniority, that would be enacted very quickly by
10 a control room or somebody else without the tactical
11 commander being aware or having a say in whether or not
12 that was done, which affects their view of the overall
13 picture.

14 Q. The different but connected issue relating to the
15 Silver commander, the tactical commander, is one I know
16 that you have a view about, which I invite you to
17 express, and it relates to this: you told us earlier
18 that Annemarie Rooney did what she was expected to do
19 and went to the GMP force headquarters.

20 CHRISTIAN COOPER: Yes.

21 Q. So it seems from what you're saying that the expectation
22 was that tactical would be embedded at force
23 headquarters?

24 CHRISTIAN COOPER: Yes.

25 Q. In your view is that the right place or always the right

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1 place for Silver to be and was it the right place for
 2 Silver to be that night?
 3 CHRISTIAN COOPER: In my view, I don't think that is always
 4 the right place for an ambulance tactical commander to
 5 be. It has become common practice that that is where
 6 they go. That has emerged over relatively recent times.
 7 In some occasions, for something like a protest that
 8 might be spread over a large city centre or where
 9 intelligence feeds to the police are particularly
 10 important, I can absolutely see the virtue of
 11 co-locating your tactical commanders at a police force
 12 HQ. So it has its benefits, it's entirely right and
 13 proper for certain incidents. I don't believe that is
 14 the right place in all major incidents and possibly not
 15 for this incident on the night.
 16 The operational commander had an awful lot to do and
 17 you've got the strategic commander and the tactical
 18 commander both effectively in the same place, arguably
 19 discharging broadly similar functions, albeit we can
 20 delineate them in terms — but they're together and
 21 they're doing a similar thing. For many incidents,
 22 I think the Ambulance Service would benefit from
 23 a greater command presence at the scene.
 24 Q. So an issue which is not dissimilar has arisen
 25 in relation to the police deployment, namely the

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1 question of whether Silver should deploy to the scene or
 2 deploy to headquarters and it sounds as if what you're
 3 saying is that this is an issue that needs to be
 4 considered also by the Ambulance Service?
 5 CHRISTIAN COOPER: I agree. I totally see that a presence
 6 is needed at both. Where the command function is
 7 discharged is something that we need to look at.
 8 Q. Mr Herriot, do you have anything to add on that issue?
 9 MICHAEL HERRIOT: I certainly agree. I think the span of
 10 control is such for the operational commander that their
 11 job is extremely difficult and they would benefit from
 12 a tactical commander there standing back a level from it
 13 and taking a broader overview.
 14 MR GREANEY: Sir, subject to any questions that you have,
 15 it's just about 3 o'clock. So we are entirely on time,
 16 but we would, I think, benefit from a short break at
 17 this stage.
 18 SIR JOHN SAUNDERS: Do you have further things to come to?
 19 MR GREANEY: No, I have finished.
 20 SIR JOHN SAUNDERS: Walking wounded? There have been some
 21 criticisms of the fact that it appeared that Nwas didn't
 22 pay sufficient attention to the walking wounded.
 23 Would you agree with that just in general terms?
 24 CHRISTIAN COOPER: In general terms I would agree,
 25 I recognise the challenge.

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1 SIR JOHN SAUNDERS: They seemed to be abandoned across the
 2 road somewhat and left to their own devices.
 3 CHRISTIAN COOPER: Yes, and it perhaps would have been
 4 preferable for the operational commander to assign that
 5 as a sector commander role, somebody that is purely
 6 responsible for that.
 7 SIR JOHN SAUNDERS: I think I am right in saying that it was
 8 Mr Dexter who in the end arranged for transportation to
 9 take them to hospital, which didn't seem entirely the
 10 right thing.
 11 CHRISTIAN COOPER: No.
 12 SIR JOHN SAUNDERS: Okay.
 13 MR GREANEY: I entirely understand why you have raised that,
 14 sir, you were right to do so. Can I indicate that the
 15 ambulance experts have provided their answers to
 16 a series of questions that were posed by your legal
 17 team, it's a document dated 30 July 2021, {INQ041856/1}.
 18 It runs to 32 pages.
 19 SIR JOHN SAUNDERS: I have seen it.
 20 MR GREANEY: That will be uploaded to the inquiry website.
 21 It deals with many issues that I have not addressed
 22 today because I have sought to focus on those that
 23 seemed to me to be most important.
 24 SIR JOHN SAUNDERS: Is 10 minutes long enough for a break?
 25 MR GREANEY: I believe so.

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1 SIR JOHN SAUNDERS: Ms Roberts, I will be finishing at or
 2 before 4.30, so if you could gear your questions to
 3 that, I'd be very grateful.
 4 (3.01 pm)
 5 (A short break)
 6 (3.14 pm)
 7 MR GREANEY: Sir, thank you. First, Ms Roberts on behalf of
 8 the North West Ambulance Service.
 9 Questions from MR ROBERTS
 10 MS ROBERTS: Just so far as timetable is concerned, you know
 11 how long I have been afforded on behalf of the
 12 organisation to ask my questions. I have about an hour
 13 and 17 minutes left this afternoon. I'll do my best to
 14 conclude as best as I can, but I can't promise I'll be
 15 finished this afternoon for the reasons that —
 16 SIR JOHN SAUNDERS: You've been allowed more time than this
 17 afternoon. Have you been given — I can't remember
 18 (overspeaking) so we never expected you to finish this
 19 afternoon.
 20 MS ROBERTS: Thank you.
 21 SIR JOHN SAUNDERS: Don't let that discourage you from going
 22 quickly, Ms Roberts!
 23 MS ROBERTS: Noted.
 24 Gentlemen, so far as timetable for this afternoon is
 25 concerned, then, a few general comments at the outset to

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1 you both. It's important that I make clear at the
2 outset that NWAS welcomes the reports that you have
3 provided and is very grateful for the assistance and the
4 clarification that you have given to us all,
5 self—evidently.

6 It's important that I make that clear at the outset
7 so that the organisation can learn from this, if
8 learning is needed, as self—evidently I think from
9 a number of people it is, so that improvements can be
10 made where they are needed and so that the organisation
11 can strive, as always, to do better.

12 The reason I say that now is in order for that to
13 happen, I think you'll both agree that the organisation
14 needs to understand why you have, if I may say so, in
15 this most recent report of yours, reached views that
16 you have that at first blush you may not have reached in
17 the reports that you have submitted previously.

18 I'll explain what I mean by that in due course.

19 SIR JOHN SAUNDERS: Ms Roberts, can I raise a gloss on that?

20 I think it's important for NWAS to understand this, not
21 you. I think it has become apparent that there are
22 difficult issues which arise in making things better.

23 MS ROBERTS: Yes.

24 SIR JOHN SAUNDERS: And I don't think it's a matter
25 necessarily for you to be learning or NWAS from the

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1 experts; I think it's a matter of NWAS and the experts
2 and all of us working together to try and find solutions
3 which will actually work in the future, so I'm grateful
4 for any help I can get.

5 MS ROBERTS: Yes.

6 Following on from that, you will note there have
7 been a number of practical issues. For example, when
8 Mr Blezard gave his evidence on Monday, the chairman
9 quite properly asked if you need somebody to drive the
10 ambulance why can't you just have a police officer drive
11 the ambulance, that type of practical solution which
12 I know you gentlemen on behalf of the organisation that
13 you represent are looking at actively. It's those kind
14 of practical solutions that we are all looking for.

15 But with regard to the views that you have
16 expressed, in my respectful submission, most recently in
17 this fourth report in the summer, that's the one of
18 July 2021, would you agree that the views expressed,
19 specifically with regard to the deployment of
20 non—specialist responders into the City Room, may have
21 changed or there may be a different gloss that you have
22 put on that in this most recent report than that which
23 you have set out in earlier reports? Do you agree or
24 disagree with that? Perhaps you, first, Mr Herriot.

25 MICHAEL HERRIOT: I think that's quite possible. But

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1 of course, evidence has been appearing at pace
2 throughout this process. So of course we've all learned
3 and adapted from that evidence.

4 Q. And would you agree that in order for NWAS and everyone
5 to understand why you may have reached that view, and as
6 I understand from your evidence today, that may in
7 itself still be a fluid issue? We'll see if we can
8 resolve that either this afternoon or on Monday. It's
9 important to know what aspect of this inquiry process
10 has perhaps influenced or caused you to change that
11 view, if in fact change your view you have. You say,
12 and Mr Herriot, you have picked up on this already, you
13 repeatedly cite within the most recent report the series
14 of issues that have been set out that you rely upon the
15 evidence of, for example, Dan Smith or Paddy Ennis in
16 support of the conclusions that you have reached. And
17 is it that kind of evidence, the evidence of the
18 paramedics themselves, upon which you have placed most
19 reliance in forming the views that you have in this
20 fourth report?

21 MICHAEL HERRIOT: It's the evidence in the round, I would
22 say, but certainly influenced heavily by the evidence of
23 the paramedics and others from NWAS, yes.

24 Q. Does that accord with your —

25 CHRISTIAN COOPER: I think the reason for that is because

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1 the key difference between the writing of the initial
2 reports and dealing with the central issues that are put
3 to us has been the oral evidence that has happened in
4 between. So naturally, our view has kept pace and
5 developed with that. But I'm not aware of any conflicts
6 between views expressed in the original reports and
7 views expressed here. I think it's more of
8 a development, but it would be interesting to see what
9 specific areas you have concerns about.

10 Q. I'll be blunt, if I may. The conflicts, which may on
11 paper have seemed more stark, I think actually there's
12 been a narrowing of those issues today, for which
13 I think we may all be grateful because that will by
14 necessity narrow or shorten the number of references
15 that I will have to put to you or would otherwise have
16 had to put to you with regard to that.

17 So it's primarily the witness testimony that you
18 have heard over the last few months or so, but was there
19 anything within the testimony, just picking out those
20 individuals if we may, Dan Smith in particular,
21 if we focus on him, was there anything in his evidence
22 that surprised you or differed dramatically from that
23 which he had set out in his statements to which you did
24 have access when you wrote your earlier reports?

25 CHRISTIAN COOPER: Not for me.

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1 MICHAEL HERRIOT: I think there's greater clarity in his
 2 more recent evidence than there was at the outset and
 3 that has certainly assisted us.
 4 MS ROBERTS: That is very helpful because we can look at his
 5 evidence and you're aware that there are parts of his
 6 evidence that I want to draw your attention to.
 7 MICHAEL HERRIOT: I'm sure he's had the opportunity to
 8 reflect further and develop his thoughts on those.
 9 MS ROBERTS: As he would hope and he and others have done.
 10 Again, so that it's clear for everybody, we have
 11 talked about the narrowing of issues and I think you
 12 were provided a little while ago with what has become
 13 known as the paragraph 20 or the para 20 document, which
 14 was an attempt by NNAS to focus on the criticisms within
 15 your reports because each of the organisational core
 16 participants was asked to reflect upon your expert
 17 reports and really to set out or to narrow those down
 18 and set out those criticisms that you set out within
 19 your reports as to which they accepted, which they
 20 accepted in full, and which they wanted to push back on
 21 or deny. I think you saw that document in the summer of
 22 last year.
 23 Within that document, we identified 16 key issues,
 24 our summary, and as I say there may be more and
 25 Mr Greaney has touched upon a number this morning. But

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1 again, it might help you and others to know that of the
 2 16 key issues, the key criticisms that you brought and
 3 articulated within those reports, of those 16 key
 4 issues, 11 were accepted by NNAS without qualification
 5 and the remaining five were accepted in part. So of the
 6 16, none were disputed, all were accepted in whole or in
 7 part.
 8 Again, I think it's helpful to you and to others --
 9 I think you already knew that in any event -- to set
 10 that out.
 11 I think you would agree, would you, gentlemen, that
 12 no matter how much one plans or prepares or trains for
 13 events and incidents, such as that which occurred in May
 14 of 2017, that nothing can fully prepare any of the
 15 responders for that which unfolds before them and to
 16 which they must react?
 17 MICHAEL HERRIOT: Every event is unique by its nature, so no
 18 event that they have trained for or planned for will
 19 roll out exactly as it might have been envisaged.
 20 Q. That's presumably why within your second report, and I'm
 21 going to give the reference but what I don't want to do
 22 is slow proceedings by asking Mr Lopez to turn up
 23 documents. So I will just give the reference. The INQ
 24 for the second report is {INQ032665/18}.
 25 That's presumably why you both reached the

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1 conclusion that, your words:
 2 " ... adaptive, creative and original thinking is
 3 sometimes necessary to achieve the desired outcomes."
 4 SIR JOHN SAUNDERS: I'm just going to interrupt you, if you
 5 don't mind, Ms Roberts. I can well understand somebody
 6 saying, as indeed they have through the evidence, such
 7 is the horrifying nature of a real incident like this
 8 that you can never be prepared for the sort of shock and
 9 the conditions in which you're working. But as for the
 10 event, and what happened, and the bomb going off and the
 11 casualties, where is it that you couldn't be -- what
 12 part of that could training not prepare you for? Shock,
 13 I understand, but actually training you for dealing with
 14 the situation? What part of training couldn't cope with
 15 that?
 16 CHRISTIAN COOPER: Sir, those events are foreseeable and
 17 they are foreseen within the training programmes, the
 18 planning processes and so on and so forth. So nothing
 19 about the event should have been a surprise. But
 20 I think I would absolutely agree that it's extremely
 21 difficult to prepare individual responders to deal with
 22 that.
 23 SIR JOHN SAUNDERS: For the horror?
 24 CHRISTIAN COOPER: Yes.
 25 SIR JOHN SAUNDERS: I am just trying to put that in context

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1 about the preparation.
 2 Mr Herriot, we may hit a problem: it's not too bad
 3 at the moment, but you perfectly reasonably, and I'm not
 4 asking you to do it differently, are looking at
 5 Ms Roberts when you talk, but that's away from the mic.
 6 We'll sort it for next time if we can in some way, but
 7 I think it is very unreasonable to expect you not to
 8 look at each other, but just bear that in mind, will
 9 you?
 10 MICHAEL HERRIOT: I apologise.
 11 SIR JOHN SAUNDERS: No, you don't need to apologise.
 12 MS ROBERTS: I'm more concerned with him twisting his back.
 13 SIR JOHN SAUNDERS: Actually, your microphone is on the
 14 other side from where you are. I'm sure no one's ever
 15 accused of talking too quietly before, Ms Roberts.
 16 MS ROBERTS: Only you, sir.
 17 SIR JOHN SAUNDERS: But that's of course because I am deaf
 18 but it's also because of the plastic.
 19 Okay, thank you.
 20 MS ROBERTS: Thank you, sir.
 21 You would agree, and I think you've agreed this
 22 afternoon, that it is imperative for the operational
 23 commander to establish a series of functional roles
 24 before he or she, my phrase, leaps in to a situation,
 25 gets hands-on -- in fact, that is specifically not what

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1 he or she should do — and they should appoint those key
2 functional roles for all the good reasons that we now
3 understand.

4 Can I thank you on behalf of the organisation for
5 clarifying that particular point so far as
6 Mr Patrick Ennis, Paddy Ennis, is concerned as well.
7 And although Consultant Paramedic Dan Smith, as he
8 readily acknowledged in his evidence — and you've
9 listened carefully, as I know you have, to his
10 evidence — he did not appoint certain roles, so you've
11 been asked about the safety officer and the equipment
12 officer, that he did appoint a number of key functional
13 roles, did he not?

14 CHRISTIAN COOPER: He did.

15 Q. In fact, a significant number of key functional roles
16 were given by Dan Smith in the very early stages to
17 people who I think you have told us performed those
18 roles, your word, I think, in an exemplary fashion.

19 CHRISTIAN COOPER: Yes.

20 Q. Thank you. Would you agree therefore that the key
21 functional roles which, by and large, were given out by
22 Mr Dan Smith, that they enhanced the response and that
23 the response would have been the poorer for it had they
24 not been given?

25 CHRISTIAN COOPER: Yes.

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1 MICHAEL HERRIOT: Yes.

2 Q. And had the actions of those individuals, your word in
3 your reports, not been as exemplary as it so plainly
4 was?

5 MICHAEL HERRIOT: It was essential that he established those
6 functional roles. Clearly he couldn't have undertaken
7 all of those particular roles as an individual, so those
8 roles are there to facilitate what the Ambulance Service
9 needs to do in terms of triage, treatment, transport,
10 et cetera. So it's necessary to establish that command
11 and control and those functional roles for that purpose.

12 Q. Gentlemen, you will have seen, either by following the
13 inquiry or perhaps that which has been said within the
14 press, that there has been a repeated criticism that
15 although Advanced Paramedic Paddy Ennis was in the
16 City Room from about 11 pm onwards, that other
17 paramedics as they arrived at the scene — and I'm not
18 talking about HART, but I'm talking about those other
19 paramedics prior to about quarter past 11 — that they
20 too didn't go up the stairs and didn't go and join their
21 colleague Mr Ennis. You have no criticism of that,
22 do you?

23 MICHAEL HERRIOT: No, because they were confronted with
24 a number of patients when they arrived and we've spoken
25 about critical mass and how it's essential that the

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1 Ambulance Service develops a cadre of people that can
2 treat those that are seriously injured and have been
3 evacuated to the CCS.

4 Q. Yes.

5 MICHAEL HERRIOT: So I have got no criticism of not sending
6 regular paramedics to the City Room at that stage.

7 Q. Thank you. When you say "at that stage", what time are
8 we talking about?

9 MICHAEL HERRIOT: The first ambulance arrived at 23.00, so
10 it took probably 30 minutes to build up what we would
11 say was a critical mass —

12 Q. Yes.

13 MICHAEL HERRIOT: — so sufficient paramedics to treat those
14 that were arriving at the CCS.

15 Q. It has been suggested, not by me, but suggested and
16 I think is now embedded within the inquiry evidence that
17 it is realistic to think that between the point of
18 explosion and those first paramedics being able to get
19 to the scene, whether they are specialist responders or
20 otherwise, that a period of about half an hour or so is
21 not an unreasonable period of time; would you agree?

22 CHRISTIAN COOPER: I would agree.

23 MICHAEL HERRIOT: Yes.

24 Q. For the reasons you have told us about, because of the
25 pressures that any ambulance organisation is under and

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1 because they don't sit around in the ambulances waiting
2 for events to happen, the events wait for the ambulances
3 to arrive.

4 MICHAEL HERRIOT: Yes, I think that was well demonstrated in
5 some of the evidence about how many vehicles were
6 actually available. I think out of 319, I think, across
7 the region it was only, I think, six or so immediately
8 available to respond and that is pretty typical in my
9 experience.

10 Q. So it's typical in your experience. I think in addition
11 to the witness statements, in addition to the evidence
12 that you have listened to, you've also been asked to
13 look at a number of analyses, in other words a normal
14 number of documents that have drawn that information
15 together and you have seen those and they accord, do
16 they, with the evidence as you understand it to be?

17 MICHAEL HERRIOT: Yes.

18 Q. Thank you. That being so, the fact that Mr Paddy Ennis
19 got to the scene as swiftly as he did is — what view
20 do you have about that?

21 MICHAEL HERRIOT: It was commendable, I think. We've heard
22 a lot about self-mobilisation, but of course he was
23 monitoring the system, he identified an issue, and he
24 did communicate with the control room, so...

25 Q. He made it plain at the outset what he was doing and

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1 where he was going and within a very short space of time
 2 was at the arena?
 3 MICHAEL HERRIOT: And of course the incident was quite
 4 unusual in that aspect because it's unusual to get
 5 commanders to a scene prior to crews, so there was
 6 a slightly different set-up than might have been
 7 expected otherwise --
 8 Q. All right.
 9 MICHAEL HERRIOT: -- and that was probably to the advantage
 10 of the incident.
 11 Q. Right. So that's Mr Paddy Ennis' deployment at the
 12 scene. We're now talking from the period about
 13 11 o'clock onwards and I think you said, Mr Herriot,
 14 that so far as deployment into the City Room is
 15 concerned, that would be -- did you say limited to
 16 specialist responders?
 17 MICHAEL HERRIOT: Yes. That would depend on the assessment
 18 of risk, but yes.
 19 CHRISTIAN COOPER: I think we would make a concession for
 20 Mr Ennis here because as the first responding ambulance
 21 person, he is under a duty to gain situational awareness
 22 and pass that back and I think it is commendable that he
 23 did that in the way he did and that was entirely
 24 appropriate.
 25 From the point at which the situation is then better

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1 understood, and you then have potentially a hazardous
 2 area, a warm zone or whatever, then that needs more
 3 careful consideration about who should be deployed, but
 4 I don't think we make any criticism of Mr Ennis' initial
 5 deployment into the room in order to gain situational
 6 awareness. Quite the contrary, I think that was very
 7 helpful.
 8 Q. Indeed. And we're certainly not going to disagree with
 9 you in relation to that. So from the point -- let's
 10 take that first quarter of an hour from 11 o'clock, when
 11 he's already gone in, he's made his assessment, he's
 12 come out, he's given that report back, major incident
 13 already declared, he goes back into the room, and you're
 14 saying at that stage -- are you saying that at that
 15 stage, 11 o'clock onwards, that that was a room into
 16 which, other than Mr Ennis, that just specialist
 17 responders should have deployed?
 18 CHRISTIAN COOPER: I think the details in our report,
 19 I think that really is down to what was considered by
 20 Mr Ennis, NWSA and the operational commander at the time
 21 as to what that zone was. And their actions seem to
 22 show that --
 23 SIR JOHN SAUNDERS: Not just the zone, sorry, but whether
 24 they were operating under Plato or under the major
 25 incident plan.

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1 CHRISTIAN COOPER: Quite so, sir, yes. So I think if we go
 2 purely on their actions, that deployment with Consultant
 3 Paramedic Smith's agreement for Mr Ennis to go back into
 4 the room and operate would be indicative of it being
 5 a non-MTFA warm zone, where their situational awareness
 6 had informed their understanding of risk and they were
 7 content for a non-specialist person in the form of
 8 Mr Ennis to operate in there.
 9 Now, providing it is not being treated as an MTFA
 10 warm zone, it is being treated as a major incident warm
 11 zone, whilst unusual to deploy a non-specialist
 12 paramedic into that area, as long as a proper risk
 13 assessment has been done on it and they are content to
 14 do that, that's not in itself unreasonable.
 15 SIR JOHN SAUNDERS: I am sorry to interrupt, but you have to
 16 bear in mind the context: you have a large number of
 17 unarmed police and members of the public who all
 18 operated there and apparently safely. If anyone is
 19 suggesting I should criticise Mr Ennis for going back in
 20 at that stage, it'll require quite a lot of persuasion,
 21 but of course I'm always open to persuasion about
 22 anything.
 23 MS ROBERTS: No criticism from me, sir.
 24 It depends really, doesn't it, on the view that is
 25 taken by the operational commander at the time? You

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1 heard and you listened to what Mr Smith said about that,
 2 that's Dan Smith. There was a brief discussion, wasn't
 3 there, with Derek Poland about whether Derek Poland, not
 4 a member of HART, but whether he was going to go into
 5 the City Room? My recollection, if I'm wrong I'll be
 6 corrected and it's important that I'm corrected if I am
 7 wrong, but my recollection is that that was -- it was
 8 decided by Mr Smith that Mr Poland was not going to go
 9 into the City Room and that the deployment of
 10 a non-specialist responder into the City Room was going
 11 to be limited to Mr Ennis because of the situational
 12 awareness of which you spoke.
 13 MICHAEL HERRIOT: I think he offered to go in, but it was
 14 decided that he wouldn't but I think he also asked for
 15 an ETA for HART at that time.
 16 MS ROBERTS: Yes.
 17 SIR JOHN SAUNDERS: I think we need to check that. Part of
 18 my recollection, which again can be entirely faulty,
 19 is that it was thought Mr Poland had rather better
 20 things to do than going into the City Room, which may
 21 well have been the right assessment if there were other
 22 jobs to do.
 23 MS ROBERTS: He was one of the first people there, he
 24 arrived seconds after Dan Smith and he was appointed as
 25 parking officer. Just pausing there, on the face of it,

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1 it doesn't sound a terrifically important role, but
 2 it is, isn't it?
 3 MICHAEL HERRIOT: It is. It's not a parking attendant role.
 4 Q. No. The appointment of and the fulfilling of the role
 5 of parking officer again greatly enhanced the response,
 6 did it not?
 7 MICHAEL HERRIOT: Yes, because, you'll correct me if I'm
 8 wrong, but 17 ambulances, I think, arrived over the next
 9 20 or so minutes. So clearly they had to be managed as
 10 they were arriving. So that parking officer briefing
 11 role is clearly important.
 12 Q. Thank you. Just another few more general points if
 13 we can, please, and then I think it might help
 14 if we look at and just try and narrow down and clarify
 15 the zones or how that City Room was being treated.
 16 I think you told us that so far as the reaction, as
 17 I say, to the incoming information that an attack had
 18 taken place, reading from your reports, that it is your
 19 view that a sufficient number of resources were deployed
 20 to that incident. I'm reading from your second report
 21 at page 102 and 103.
 22 MICHAEL HERRIOT: Yes, overall a very impressive number of
 23 resources were deployed to the incident.
 24 Q. I think you also said, didn't you:
 25 "They provided a large number of ambulance personnel

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1 and experienced medical staff to provide care to many
 2 with life-threatening injuries?"
 3 And that remains, does it, your view?
 4 MICHAEL HERRIOT: That's correct.
 5 Q. So far I'm quoting from the earlier reports, you see,
 6 before the evidence was heard and I'm keen that we
 7 establish that those are still your views; they are.
 8 I think you have dealt with it because in the second
 9 report you talked about the perceived delay, in other
 10 words when the patient is in the CCS why that patient
 11 isn't immediately transferred to hospital. I think you
 12 clarified that towards the end of your evidence. As
 13 I understand it, it's this: the number of patients being
 14 dealt with by the paramedics within that CCS meant that
 15 there was a number of ambulances outside effectively
 16 with nobody to drive them and nobody to accompany the
 17 patient in the back of the vehicle; correct?
 18 MICHAEL HERRIOT: Yes.
 19 CHRISTIAN COOPER: Yes.
 20 Q. Am I to understand from the evidence you gave towards
 21 the end of your evidence this afternoon that that is
 22 something that both of you are looking at, so at
 23 a national level? And it appears from that answer that
 24 so far as you are concerned, nationally that issue has
 25 still not been resolved?

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1 CHRISTIAN COOPER: Yes.
 2 SIR JOHN SAUNDERS: So everyone does the same at the moment,
 3 do they?
 4 CHRISTIAN COOPER: Yes.
 5 SIR JOHN SAUNDERS: So no one uses other people to help with
 6 the driving?
 7 CHRISTIAN COOPER: I will check whether or not there is
 8 a specific solution that may have been found at a local
 9 level within an ambulance trust, but I'm not aware of it
 10 if there is.
 11 MICHAEL HERRIOT: There certainly have been cases, sir,
 12 where that has been done, but not entirely successfully.
 13 SIR JOHN SAUNDERS: Yes, we heard that. Right, okay.
 14 MS ROBERTS: Does it follow that because here we are some 4
 15 or more years on and the issue is still being looked at
 16 at a national level and NARU, for example, hasn't quite
 17 found the solution to it yet -- that's not
 18 a criticism -- that that period of time in the CCS
 19 before those patients were able to be transferred to
 20 hospital, that you don't necessarily have any criticism
 21 of that period of time?
 22 MICHAEL HERRIOT: No, I think we --
 23 SIR JOHN SAUNDERS: Sorry, I've lost track of the question.
 24 The period of time from then until now trying to resolve
 25 it or the period of time outside?

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1 MS ROBERTS: The period of time in the CCS. What I am
 2 trying to understand is: if the issue has still not been
 3 resolved at a national level, then does it follow from
 4 that that you do or don't have criticism of the period
 5 of time that the patients waited in the CCS?
 6 MICHAEL HERRIOT: I think we felt that the patients could
 7 have been -- some of the patients could have been moved
 8 earlier, but we felt that that was probably marginal
 9 because again it was more about the critical mass to
 10 treat and then identify a resource that could drive
 11 those vehicles.
 12 But again, as the chair has quite rightly picked up,
 13 one of the issues is of course as those crews arrive,
 14 they strip the vehicles of equipment and then you can't
 15 carry out adequate patient care if you don't have that
 16 equipment. We've been talking about different solutions
 17 to that particular issue.
 18 Q. Right.
 19 SIR JOHN SAUNDERS: I am sorry, at the risk of interrupting
 20 all the time and irritating any cross-examiner
 21 enormously, it actually raises another concern for me
 22 which I have raised with the fire people. The fact that
 23 it hasn't been -- that no solution has been found yet is
 24 not necessarily indicative to me that it can't be found
 25 because one of the problems I want to talk about at some

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1 time and get help from the experts about is: was the
 2 debrief process actually effective and has this issue
 3 only been thrown up by the inquiry? That may be because
 4 people have looked at this in the past and thought,
 5 "Actually, there is absolutely nothing you can do about
 6 it", but we haven't yet heard that. So the
 7 effectiveness of a debrief and actually getting the
 8 issues early on I think is something that we may need to
 9 look at.
 10 MS ROBERTS: I agree.
 11 SIR JOHN SAUNDERS: Thank you.
 12 MICHAEL HERRIOT: We certainly recognise the issue and will
 13 endeavour to assist you wherever we can.
 14 SIR JOHN SAUNDERS: Thank you.
 15 MS ROBERTS: I think as you said this afternoon -- I mean,
 16 the casualty plan, the mass casualty distribution plan,
 17 worked extremely well, didn't it?
 18 MICHAEL HERRIOT: I agree.
 19 Q. That had been trained or exercised, I should say,
 20 fairly --
 21 MICHAEL HERRIOT: Socrates.
 22 Q. -- only a month or so beforehand, hadn't it, and that
 23 had gone extremely well itself, that particular training
 24 exercise, yes? So the distribution plan worked
 25 exceptionally well.

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1 And you've also seen, I think, the statement of
 2 Martin Smith, haven't you, the ambulance consultant,
 3 with regard to the mass casualty distribution plan?
 4 MICHAEL HERRIOT: Yes.
 5 Q. Thank you. As I understand it from your evidence this
 6 morning, I think it was, in the session, under JOPs 3,
 7 which governed the blue light response on 22 May, there
 8 was no flexibility to commanders; is that your evidence?
 9 CHRISTIAN COOPER: Yes.
 10 MICHAEL HERRIOT: Yes.
 11 Q. Are you sure? There was a hesitation. That's the only
 12 reason I'm asking.
 13 MICHAEL HERRIOT: It's purely that NHS England say in their
 14 guidance that plans should be flexible. That's the only
 15 caveat. So it rather implies that there is within plans
 16 an ability to be flexible. Certainly, as it was trained
 17 in this circumstance, that flexibility wasn't ever
 18 applied.
 19 Q. Right. So with a general caveat from the NHS that there
 20 should be flexibility to plans, there was no flexibility
 21 to JOPs 3? Is that the view of both of you or do you
 22 differ in relation to that?
 23 CHRISTIAN COOPER: We do not differ on JOPs 3. I think in
 24 general, plans are expected to be flexible, that's quite
 25 correct.

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1 Q. Yes.
 2 CHRISTIAN COOPER: On the matter of who can operate in
 3 certain zones under JOPs 3 in place at the time of this
 4 incident, there was no flexibility for the ambulance
 5 commander to determine who could operate in those zones.
 6 The JOPs are very clearly on that.
 7 SIR JOHN SAUNDERS: I want to look at that a bit more. The
 8 whole aim of the Ambulance Service is to protect life.
 9 Of course, you have to protect the life of the
 10 paramedics as well as the members of the public. But
 11 within that, does that general overriding duty provide
 12 a discretion, however strict the plan may be, that if
 13 you can be satisfied that you're doing the best thing
 14 for the patients and on what you can see from your own
 15 eyes you are actually -- you're not causing unnecessary
 16 risk to paramedics (inaudible) go in there so that
 17 overriding discretion which comes with doctors, the
 18 Hippocratic Oath, and things like that, that is what
 19 they are doing?
 20 CHRISTIAN COOPER: And the duty of care for -- I absolutely
 21 agree, sir. I think --
 22 SIR JOHN SAUNDERS: So if that is right, there is a
 23 discretion somewhere?
 24 CHRISTIAN COOPER: I think there is discretion somewhere and
 25 I think it's best placed, as you have said, in that

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1 understanding of risk. In JOPs 3 the hot zone is
 2 describing a location where there is an active exchange
 3 of gunfire, where you would not place a paramedic.
 4 MS ROBERTS: Any paramedic?
 5 CHRISTIAN COOPER: Any paramedic.
 6 Q. Thank you.
 7 CHRISTIAN COOPER: If the paramedics, given that there has
 8 been a breakdown in JESIP here, and a paramedic very
 9 early on, the actions of Mr Ennis, has given you a good
 10 situational awareness of what is going on in that
 11 location and you are satisfied that it is not a hot
 12 zone, regardless of what you're being told it is,
 13 I think that's where the flexibility exists.
 14 Q. Right. At which point it becomes a JOPs warm zone?
 15 CHRISTIAN COOPER: In the view of the Ambulance Service,
 16 quite so.
 17 Q. Do you agree that having formed that view, and you'll
 18 recall Dan Smith's evidence on this, that that was the
 19 view he had formed, he talks about it in terms of JESIP
 20 and in terms of JOPs -- having formed the view that it
 21 was warm in terms of JOPs --
 22 CHRISTIAN COOPER: Yes.
 23 Q. -- that having formed that view -- and he didn't, didn't
 24 he?
 25 CHRISTIAN COOPER: He did.

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1 Q. He did, thank you.
 2 That so far as --
 3 MR GREANEY: There is a risk we are again confusing the
 4 zoning under the major incident plan and the zoning
 5 under JOPs. It certainly isn't my recollection that
 6 Mr Smith said he was seeking to apply JOPs 3, because
 7 of course he wasn't aware that Plato had been declared.
 8 SIR JOHN SAUNDERS: What we will do is -- ask your question
 9 on the premise that you asked it and then we'll look at
 10 it on the other premise and then we'll check the
 11 evidence.
 12 MS ROBERTS: I can give you the evidence reference now and
 13 that can be checked now. It's Day 110, Mr Dan Smith's
 14 evidence, page 151, line 15 {Day110/151:15}, and it is
 15 at page 141 where he said that he was treating it as if
 16 JOPs, in other words applying the JOPs terminology, to
 17 which there was no discretion. It is accepted that he
 18 didn't know about Plato along with a number of other
 19 people.
 20 He was specifically asked, I think by you, sir, as
 21 to what -- if he could ascribe terminology to it, that
 22 that is what he was applying. The reason I say that is
 23 within the major incident plan, they're not described as
 24 cold, warm and hot zones, it's described as an inner and
 25 outer cordon.

1 SIR JOHN SAUNDERS: I'm aware of that, but I think
 2 conventionally some of the people actually used hot,
 3 warm and cold as well even in a major incident plan.
 4 MS ROBERTS: They have, you're absolutely right, but within
 5 the major incident plan, those words don't exist. It's
 6 described as inner and outer cordon.
 7 MICHAEL HERRIOT: Within a major incident the terminology
 8 always was inner and outer cordon. Since the
 9 introduction of the MTFA arrangements that has sort of
 10 crept across into other --
 11 SIR JOHN SAUNDERS: Right. We'll analyse the evidence in
 12 due course.
 13 Let's deal with this on the basis that what
 14 Dan Smith was regarding a warm zone would be a warm zone
 15 in JOPs terms, ie no one without protective equipment
 16 could go in there. So let's assume that to be the
 17 position because I want to ask a question when we follow
 18 up on that.
 19 MS ROBERTS: I think that was the question I asked of both
 20 of you, that having reviewed his evidence, he had
 21 plainly formed that view, hadn't he?
 22 MICHAEL HERRIOT: Yes.
 23 Q. And formed that view at the time?
 24 CHRISTIAN COOPER: Yes. I think the difficulty we tried to
 25 articulate in the reports and where I think some of the

1 confusion is creeping in is there's the actions of
 2 committing a non-protected, non-specialist responder
 3 into that area and then his perception of what he
 4 thought the area was and the two don't necessarily
 5 tally. I think at the very least it's somewhat
 6 confused.
 7 SIR JOHN SAUNDERS: Let's assume, and we'll just come back
 8 to my question, if I may -- I quite understand you say
 9 in a hot zone in an MTFA, that means there's an armed
 10 shooter around, it's not very hard to work out whether
 11 you can actually put anyone in there when there's
 12 someone with a gun in there and you're sending in
 13 someone who is not armed.
 14 In an MTFA warm zone, that is not the position, it's
 15 not immediately apparent that you are sending someone in
 16 to inevitably get injured unless they have protective
 17 equipment on. Do you agree, is it right, that that
 18 overwhelming discretion, ie your duty to do the best to
 19 save life, does provide some discretion not to adopt the
 20 exact words of JOPs in a warm zone, not a hot zone,
 21 because it seems to me it's obvious, but in a warm zone?
 22 CHRISTIAN COOPER: I believe it does. It certainly does
 23 now.
 24 SIR JOHN SAUNDERS: Okay.
 25 MICHAEL HERRIOT: Yes.

1 MS ROBERTS: You'll understand why we're asking about
 2 what was the situation then so far as JOPs was
 3 concerned.
 4 Right at the beginning of JOPs, it might just be
 5 worth us looking at this document, sir. The INQ,
 6 Mr Lopez, is {INQ008372/1}. We will look at the first
 7 page and then we can all familiarise ourselves with the
 8 document --
 9 SIR JOHN SAUNDERS: Now it's not just me who is having
 10 difficulty hearing you.
 11 (Pause).
 12 Ms Roberts, can I say right from the outset that the
 13 fact that there has been changes to JOPs may indicate
 14 and may well indicate that actually putting them into
 15 practice, there have been shown to be problems with
 16 them, which have led to changes.
 17 MS ROBERTS: Yes.
 18 SIR JOHN SAUNDERS: So absolutely right, some of the
 19 problems may arise with how JOPs was constructed in the
 20 first place --
 21 MS ROBERTS: I agree.
 22 SIR JOHN SAUNDERS: -- and I'm certainly not trying to
 23 challenge any of that.
 24 MS ROBERTS: No. All right, so we've got the -- we all know
 25 the document that we're looking at. If we look, please,

1 at {INQ008372/2}. I just want you to look at the second
 2 paragraph of page 2:
 3 "The JOPs set out in this document have been
 4 developed by the MTFA Joint Operational Working Group
 5 and will act as a significant enabler in the delivery of
 6 a consistent and integrated national emergency service
 7 response to an MTFA. This guidance should be used to
 8 inform existing major incident procedures."
 9 Pausing there, that presumably would be captured in
 10 the major incident plan, the MIRP?
 11 CHRISTIAN COOPER: Yes.
 12 Q. Just pausing there tangentially, if I may, the NWAS
 13 major incident plan at the time was -- I think you
 14 described it as fit for purpose and compliant. I think
 15 you'd seen that and you're content with that document?
 16 CHRISTIAN COOPER: Yes.
 17 Q. Thank you. It says:
 18 "The guidance should be used to inform existing
 19 major incident procedures [the like of which I have
 20 referred to] and must be used in conjunction with local
 21 and national standard operating procedures."
 22 It's this really:
 23 "In non-terrorist attacks of a similar nature these
 24 principles may still deliver an effective response and
 25 consideration should be given to their use."

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1 Just looking at that final sentence, would that then
 2 capture this incident that did in fact unfold on 22 May?
 3 And you're both nodding.
 4 CHRISTIAN COOPER: Yes.
 5 MICHAEL HERRIOT: Yes.
 6 SIR JOHN SAUNDERS: Sorry to put the other point of view as
 7 well: what significance do you attach to the word
 8 "guidance", as it were, to these directions or these
 9 instructions must be used?
 10 CHRISTIAN COOPER: I have some knowledge of the context of
 11 this document and the purpose of this, and indeed other
 12 paragraphs within it, are to carefully insert this
 13 within what is already a body of operational procedures
 14 and practice across the emergency services, which is
 15 quite a tricky thing to do.
 16 So what it's trying to do is say: we recognise that
 17 these specialist teams, firearms teams, Hazardous Area
 18 Response Teams, are very strictly governed by their own
 19 standard operating procedures on a day-to-day basis
 20 covering a wide range of events. So what it's trying to
 21 do is say: this does not replace those, though this is
 22 catering for a very specific set of circumstances where
 23 we expect you to follow this, but expect it to the
 24 best -- expect you to follow it to the best of your
 25 ability in a compliant manner with your existing

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1 standard operating procedures, if that helps.
 2 SIR JOHN SAUNDERS: Okay, thank you.
 3 MS ROBERTS: Would you agree that the risk in an explosion
 4 site, such as that on 22 May, by which I mean the
 5 City Room, that the risk was significant? Post
 6 explosion the risk was still significant? Do you agree
 7 or disagree?
 8 MICHAEL HERRIOT: There was residual risk without a doubt,
 9 yes.
 10 CHRISTIAN COOPER: Yes. There were certainly risks present
 11 in that area, yes.
 12 Q. I suppose that might be one of the explanations as to
 13 why the firearms officers remained within that area.
 14 CHRISTIAN COOPER: Yes, but I think it's all relative.
 15 There were risks present, significant risks compared to
 16 an armed terrorist, perhaps much, much less so, but no
 17 doubt risks were still present, certainly.
 18 Q. The chairman thought the other day -- I think it was
 19 2 days ago -- about the risk of ambush, for example.
 20 Do you agree or disagree with that?
 21 SIR JOHN SAUNDERS: That's not the context in which I was
 22 saying that.
 23 MS ROBERTS: Forgive me, then I'll move on.
 24 SIR JOHN SAUNDERS: No, no, that's fine. I'm not suggesting
 25 the point is not a good one. What we have to

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1 contemplate, don't we, is once the armed officers have
 2 gone, they've cleared the area, there's no gunman there,
 3 and what's more, they are guarding the area and can
 4 ensure that no gunman returns and gets through into the
 5 area. So that's why -- but that doesn't appear, from
 6 what the police are doing, to take into account the
 7 unexploded bomb. This is where, for me, the difficulty
 8 of two different interpretations, what people are
 9 looking at, becomes a difficulty.
 10 MS ROBERTS: Yes. All right.
 11 We know from what you've told us, and within your
 12 reports, that there were reports, I think from at
 13 least -- well, from two hospitals, Oldham Hospital and
 14 North Manchester General Hospital, of suspect behaviour
 15 there. I think one of the hospitals in fact went into
 16 lockdown, albeit that was after this particular period
 17 that we're looking at.
 18 This was and remained -- despite the fact that the
 19 armed police officers had gone in there, would you agree
 20 that there remained a good deal of uncertainty about the
 21 City Room, about the risks posed in the City Room?
 22 CHRISTIAN COOPER: Yes, I think that's fair.
 23 Q. Thank you. And do you see now why Mr Smith, Dan Smith,
 24 made the assessment that he did when he gave his
 25 evidence that he was treating the City Room as a warm

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1 zone as if it were a Plato, in other words JOPs warm
 2 zone? You understand that?
 3 CHRISTIAN COOPER: Yes. I don't think we're critical of his
 4 thinking there. I think what we then go on to analyse
 5 is — because the difficulty we have then is translating
 6 the risk he perceived with the decision to redeploy
 7 a non-specialist paramedic into that area versus
 8 deploying the specialists that he did have elsewhere
 9 at the scene.
 10 Q. Right. So is one conclusion to draw from what you're
 11 saying in your reports that, if anything, Mr Ennis
 12 should have been removed and HART should have gone in?
 13 CHRISTIAN COOPER: That would have been closer to the
 14 expectation of what we would have expected to happen,
 15 yes.
 16 SIR JOHN SAUNDERS: They would be two consistent decisions?
 17 CHRISTIAN COOPER: Yes.
 18 MS ROBERTS: But would be consistent with the zoning that
 19 he'd formed in his own head, Mr Smith, yes?
 20 CHRISTIAN COOPER: Yes.
 21 Q. To remove Paddy Ennis, to replace him with HART, who
 22 were the specialist responders who could go into that
 23 zone, into the City Room, yes?
 24 CHRISTIAN COOPER: Yes. And conversely, if he was content
 25 for a non-specialist, non-protected responder to operate

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1 in that area, then by definition more could have, unless
 2 he's content to place one at risk and not more than one,
 3 in which case if that is the scenario, then absolutely
 4 he needs to come out and HART need to go in.
 5 Q. I'm going to suggest the two aren't necessarily mutually
 6 exclusive, by which I mean that surely in an area where,
 7 as you have acknowledged, there remains a risk, a
 8 continuing risk, despite the presence of the armed
 9 officers, that one would surely want to limit the number
 10 of personnel within that room?
 11 CHRISTIAN COOPER: That does — but this — the Hazardous
 12 Area Response Teams, the clue is in the title, are there
 13 to go into areas of risk. You would be more comfortable
 14 with them being in an area of those risks than other
 15 non-protected, non-specialist staff. They are trained
 16 and equipped and protected against a wider range of
 17 risks than non-specialist responders are.
 18 Q. And I'm not going to disagree with you about that.
 19 I think perhaps you misunderstood my point and it's
 20 doubtless my fault. What I mean by that is that simply
 21 because you have one unprotected, non-specialist
 22 responder in that room and that Mr Smith had assessed
 23 that at the time, in those rapidly made moments,
 24 decision-making moments, that that was acceptable. What
 25 I'm suggesting to you is it doesn't necessarily follow,

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1 does it, that that then opens the doors metaphorically
 2 to several other non-specialist responders
 3 wearing non-protective equipment —
 4 SIR JOHN SAUNDERS: I have the point if no one else does.
 5 Just because you are exposing one person to what may be
 6 too much of a risk, it doesn't mean you expose lots more
 7 people to too much of a risk.
 8 CHRISTIAN COOPER: I understand that, but there are three
 9 people on scene better equipped to deal with those risks
 10 than Mr Ennis was.
 11 SIR JOHN SAUNDERS: I think we understand that too.
 12 MS ROBERTS: I think we all understand that and, again, I'm
 13 not going to disagree with you in relation to that.
 14 You have made your points very clearly so far as the
 15 deployment of the second part of that first HART team
 16 are concerned.
 17 CHRISTIAN COOPER: I think limiting the number of people in
 18 an area because you're concerned about risk in itself is
 19 a principle that we would recognise and —
 20 Q. Yes.
 21 CHRISTIAN COOPER: — agree with. But there were people in
 22 there that needed help and assistance and it is our view
 23 that the risks that were present were not risks that
 24 needed to concern a HART deployment or prevent a full
 25 HART deployment. That, I think, is our issue in terms

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1 of the numbers. So we're not saying open the doors and
 2 flood it with ambulance resources, but we are saying
 3 more ambulance resources should have gone in and those
 4 resources were available at the scene.
 5 Q. And are you saying that those resources should have been
 6 HART?
 7 CHRISTIAN COOPER: Yes.
 8 MICHAEL HERRIOT: Yes.
 9 SIR JOHN SAUNDERS: Can I just take that up? We're on the
 10 basis that armed police have gone through, there is no
 11 live risk from a gunman. The remaining risk which is
 12 there is from an IED, which the police — are you saying
 13 you support NWAS's view that you should take the fact
 14 there may be IEDs into context when you're deciding
 15 whether or not to put in unprotected paramedics?
 16 CHRISTIAN COOPER: I think an IED is difficult because an
 17 IED is going to cause damage to HART staff as much as
 18 it's going to cause damage to non-protected staff.
 19 Arguably, if they're in ballistic protection perhaps
 20 less, but still. If there is an IED present and you're
 21 confident there's an IED present, the Ambulance Service
 22 would not deploy its resources.
 23 SIR JOHN SAUNDERS: But you can't be confident, you just
 24 don't know.
 25 CHRISTIAN COOPER: Quite, and I think — and there's been

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1 guidance issued on this. I'd have to check, I think,
 2 since 2017, to be a bit more specific about: are you
 3 just thinking there may be an IED or is there something
 4 that's leading you to give you more concrete -- you
 5 know, is there something that's --
 6 SIR JOHN SAUNDERS: Well, here we have: someone's exploded
 7 a bomb. So therefore you're thinking: is there a risk
 8 he's left another bomb in there? There are a number of
 9 bags there in which you could hide a bomb. That's the
 10 information. That there may be a bomb. As a result of
 11 that, do you say, "We're not going to send paramedics in
 12 who are not protected"? And, as you've pointed out, if
 13 you send the HART team in, they're not going to be
 14 protected from a bomb going off. So do you send no one
 15 in or can you send them all in?
 16 CHRISTIAN COOPER: It's a matter for the operational
 17 commander on the night.
 18 SIR JOHN SAUNDERS: Okay. You're the operational commander
 19 on the night, those are the facts.
 20 CHRISTIAN COOPER: If it were me and the police were in
 21 there and had cleared that area and I had two HART
 22 paramedics operating in that area already, I would
 23 absolutely commit a full HART team and further HART
 24 resources.
 25 SIR JOHN SAUNDERS: Paramedics? Ordinary paramedics?

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1 CHRISTIAN COOPER: If they were required and extra resource
 2 was needed and we've got a situation where we've got
 3 unprotected police officers in there treating
 4 casualties, members of the public treating casualties,
 5 and all I've got is the fact that one bomb's gone off,
 6 there could be possibly be another device or any -- but
 7 I don't have any -- you know, the police are not
 8 concerned about a particular rucksack that they're
 9 dealing with and haven't ordered an evacuation, then I,
 10 as an operational commander, would be content to commit
 11 resource, yes.
 12 MICHAEL HERRIOT: I think it has to be viewed in the context
 13 that the police are not ordering other people to leave
 14 that area. There are a lot of people doing their best
 15 to treat those that are present. So it would seem
 16 rather anomalous to --
 17 SIR JOHN SAUNDERS: Ms Roberts, these are sort of very
 18 difficult issues that we have to contend with as to what
 19 the right thing to do is. That does not necessarily
 20 mean that Dan Smith didn't send them in, that he was
 21 wrong, but we do need, I think, to try and get some sort
 22 of, at least, guidance and formula as to how anyone
 23 should face these sorts of situations in the future.
 24 MS ROBERTS: I agree. I would imagine not just locally, but
 25 nationally, I would think, yes.

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1 MICHAEL HERRIOT: There seems to be a difference between
 2 what was happening in reality and the assumptions about
 3 the zoning of that particular --
 4 Q. Yes.
 5 MICHAEL HERRIOT: -- location, excuse me.
 6 Q. You talked -- you were asked about if you were the
 7 commander and if you were there. Might I ask
 8 individually, Mr Cooper, first of all, if I may. I know
 9 that you've been a HART and special operations manager.
 10 Have you been a HART operative?
 11 CHRISTIAN COOPER: Not an operative.
 12 Q. Have you been a commander at a major incident?
 13 CHRISTIAN COOPER: Yes.
 14 Q. You have, thank you.
 15 CHRISTIAN COOPER: At all three levels.
 16 Q. All three levels, thank you very much.
 17 Same question of you, please.
 18 MICHAEL HERRIOT: Yes, at all three levels.
 19 Q. And have you been a HART operative as well?
 20 MICHAEL HERRIOT: No, (inaudible) equivalent of HART from
 21 scratch in 2002.
 22 Q. All right, thank you very much.
 23 Well, having the benefit, as we now know that
 24 you have, of operational command at a major incident,
 25 you would presumably agree with the evidence -- you saw

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1 the evidence of Mr Thomas, Richard Thomas, earlier this
 2 week, did you? You've had the opportunity to look at
 3 that?
 4 UNKNOWN SPEAKER: Yes.
 5 Q. Good. You would presumably agree with his assessment,
 6 so far as the command is concerned, that there is -- the
 7 burden of command rests on the shoulders of the
 8 commanders, self-evidently?
 9 CHRISTIAN COOPER: Yes.
 10 Q. And although you might have made that decision at the
 11 time, had you been the operational commander, Mr Cooper,
 12 you're not saying, are you, that the decision made by
 13 Mr Smith at the time, this is Dan Smith, was an
 14 unreasonable one?
 15 CHRISTIAN COOPER: I'm not saying that his -- no. Had he
 16 made the determination that he felt the risk in that
 17 room was too great for non--specialist responders to
 18 operate in, I agree. Where I have an issue with the
 19 decision--making is that he is willing to commit
 20 a non--specialist, non--protected responder into there
 21 along with some HART staff whilst there are other HART
 22 staff elsewhere. That is the difficulty. That doesn't
 23 seem to stack up with an understanding of risk unless
 24 the only reason is simply to limit the number.
 25 Q. Yes.

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1 CHRISTIAN COOPER: In which case, again, then I would
 2 replace the non-specialist -- because you're clearly so
 3 concerned about risk in there that you want to limit the
 4 number to 3. Then that is fairly significant risk.
 5 SIR JOHN SAUNDERS: The unreasonable decision in your mind,
 6 both of your minds, as I understand it, is not to commit
 7 the whole of the HART team?
 8 CHRISTIAN COOPER: Yes.
 9 MICHAEL HERRIOT: Yes.
 10 SIR JOHN SAUNDERS: The other one is much more arguable.
 11 MS ROBERTS: Thank you.
 12 SIR JOHN SAUNDERS: The way I'm looking at it.
 13 MS ROBERTS: It might be then the right time at which we
 14 look at the deployment and the, in your view, failure to
 15 deploy the second part of that first HART team. I think
 16 you've seen the HART timeline that sets out -- it's
 17 a document that we have prepared on behalf of NWS --
 18 sets out the timings of the deployment of HART. Can we
 19 just -- we don't need to turn it up now, but can we just
 20 agree with this, that so far as the arrival of the first
 21 HART team, the Greater Manchester HART team, so far as
 22 their arrival on scene is concerned, given where they
 23 were, the other side of Stockport, and doing what they
 24 were doing at the time, you have no criticism of the
 25 time that it took them to get to scene, do you?

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1 CHRISTIAN COOPER: No.
 2 MICHAEL HERRIOT: No, that was reasonable.
 3 Q. Thank you. And it follows from what you said earlier
 4 that you have no criticism of either Lea Vaughan or
 5 Chris Hargreaves in terms of the time it took them, once
 6 arrived at scene, to get into the City Room?
 7 MICHAEL HERRIOT: No.
 8 Q. My understanding is quite the contrary in fact.
 9 CHRISTIAN COOPER: It was very rapid --
 10 Q. Very rapid.
 11 CHRISTIAN COOPER: -- and commendable.
 12 Q. Thank you. Have you now had the opportunity to look at
 13 a document which compares the number of priority 1 and
 14 priority 2 patients that were in the CCS at the point at
 15 which the other three, that's Mr Devine, Mr Priest and
 16 Mr English, are seen within the war memorial entrance or
 17 just on the street outside?
 18 MICHAEL HERRIOT: Yes.
 19 Q. And you've had the opportunity to compare and contrast
 20 the number of P1s and P2s in the CCS and the number of
 21 P1s and P2s in the City Room?
 22 MICHAEL HERRIOT: Yes.
 23 Q. You've had the opportunity to do that?
 24 MICHAEL HERRIOT: Yes.
 25 Q. Mr Devine, I think it was, is shown as arriving on scene

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1 at about 23.14 and shown outside on the street at about
 2 23.21. We know that he put on ballistic gear. That in
 3 itself, reasonable or unreasonable?
 4 CHRISTIAN COOPER: Given the confusion there was about the
 5 zonings, I think if he was of the view that there was
 6 a chance he was going into a potential Plato event, or a
 7 Plato event that may have concluded or whatever, then
 8 it would be reasonable for him to select that form of
 9 PPE, yes.
 10 MICHAEL HERRIOT: His expectation seems to be that he will
 11 be deployed to a warm zone.
 12 Q. Yes. How long does it take to put that kit on, do you
 13 know?
 14 CHRISTIAN COOPER: Minutes. No more than a couple of
 15 minutes.
 16 Q. A couple of minutes, all right. A couple of minutes --
 17 he walks about 300 yards up Hunts Bank, convenes with
 18 his colleagues, and they are captured on the CCTV at
 19 about 23.22. So it is for that reason that the time of
 20 that table was compiled at 23.22. In a sense, in order
 21 for that second part of HART 2 to go into the City Room,
 22 they would have had to walk past a number of P1 and P2
 23 casualties in front of them, wouldn't they?
 24 MICHAEL HERRIOT: Yes, but I think that's the case for most
 25 of the ambulance personnel that arrived at the scene.

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1 Q. Yes.
 2 MICHAEL HERRIOT: I mean, certainly we're clearly alive to
 3 the fact that the number of patients in the CCS was
 4 increasing, the number in the City Room was decreasing,
 5 but we still think that the deployment should have been
 6 made to put HART into the City Room.
 7 SIR JOHN SAUNDERS: The purpose of this document, is it to
 8 say, "Well, Dan Smith made a positive decision: well,
 9 there really aren't enough P1s up there to make it
 10 worthwhile for you to go, so we've done what we can up
 11 there, so you have no need to go in", or is the purpose
 12 of it to say, "Okay, maybe they should have gone in, but
 13 actually they wouldn't have made any difference"?
 14 MS ROBERTS: I think the purpose is to say that -- or to
 15 dispel the suggestion that there was not pressing upon
 16 them, and pressing upon the others who arrived at the
 17 scene, a need to treat and to care for a number of very
 18 seriously ill people right in front of them as they
 19 arrived at scene, lest it be thought that all of those
 20 people were still within the City Room. It's to show
 21 a balance between the numbers who were coming down and
 22 the numbers who remained up there --
 23 SIR JOHN SAUNDERS: Okay.
 24 MS ROBERTS: -- to try and give some context as to what was
 25 happening downstairs.

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1 SIR JOHN SAUNDERS: I understand the context, but actually I
 2 think the point's been made that actually they are
 3 designed to work in that area like the City Room.
 4 MS ROBERTS: Yes.
 5 SIR JOHN SAUNDERS: That's what they're there for. So you
 6 leave the ones that are downstairs to be dealt with by
 7 the other paramedics who were not being sent into it, so
 8 it's horses for courses in a way.
 9 MS ROBERTS: Yes.
 10 SIR JOHN SAUNDERS: I'm not meaning to be rude about anyone.
 11 MS ROBERTS: No.
 12 MICHAEL HERRIOT: And all that time, of course, the number
 13 of regular paramedics had increased to a point that they
 14 were able to treat the patients that were arriving
 15 in the CCS.
 16 Q. Yes. We can look at the numbers. It's my
 17 understanding, though, at that particular time, so at
 18 about 23.22 — and we can look at the numbers of
 19 non-specialist responding paramedics who were there at
 20 that time in addition to HART — but there were still
 21 more casualties in the CCS than paramedics at that
 22 stage, were there not?
 23 SIR JOHN SAUNDERS: I thought they were needed to get the
 24 oxygen out.
 25 MS ROBERTS: They did get the oxygen out.

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1 SIR JOHN SAUNDERS: I know, but I didn't think the need was
 2 for them to be treating P1 patients downstairs is why
 3 they stayed. They stayed because they needed to get the
 4 oxygen out, as I understand it, because they could put
 5 it together.
 6 MS ROBERTS: They did treat P1 patients downstairs.
 7 SIR JOHN SAUNDERS: Before they did the oxygen or after?
 8 MS ROBERTS: I'm not entirely clearly on the sequence of
 9 events, we can get that for you, but, having viewed the
 10 CCTV, that is what was taking place.
 11 SIR JOHN SAUNDERS: Okay, thank you.
 12 MS ROBERTS: Again, I'm not here to disagree with your view,
 13 as you plainly and clearly hold it to be, that your view
 14 is, and you've maintained this view throughout, that the
 15 second part of that first Greater Manchester HART team
 16 should have been sent into the City Room.
 17 CHRISTIAN COOPER: Yes. That's not to say that those
 18 individuals did not make a meaningful contribution doing
 19 what they did at the CCS. I think quite the contrary,
 20 I think they did a very, very good job. It is just to
 21 say that that job in the CCS could and should have been
 22 done by the other paramedics available rather than the
 23 finite HART resources who — while the number in the
 24 City Room was still coming down, there were still people
 25 in the City Room in need of assistance. And it's not

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1 just a case of triage, of course, it's a case of
 2 robustly managing their extrication.
 3 Q. All right. We'll leave that particular point then.
 4 I'm moving through because many of the points I was
 5 going to deal with, have already been dealt with by my
 6 learned friend Mr Greaney and I'm very grateful to him.
 7 I think it might be helpful if we look, please — in
 8 terms of — because you have mentioned it a number of
 9 times, and this is the decision by Advanced Paramedic
 10 Paddy Ennis, the decision to re-enter the City Room at
 11 23.05. As we try to square that deployment of one
 12 non-specialist responder with, as you see it, the
 13 failure to deploy the second part of HART.
 14 So we're going to look, please, if we may, at the
 15 transcript of evidence of Dan Smith, Day 110, beginning
 16 at page 136 {Day110/136:12}, please. About two-thirds
 17 of the way down, following an answer from Mr Dan Smith,
 18 which concludes:
 19 "Answer: Obviously I then have to turn to our
 20 process for managing that type of incident, so I was
 21 aware obviously that there was an explosion, that this
 22 was —
 23 "Question: Did your processes prevent you from
 24 sending further paramedics into that room?
 25 "Answer: In my view, yes.

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1 "Question: How can that be so when at 23.15, two
 2 HART operatives did go in?
 3 "Answer: Sorry, actually my process really say that
 4 I, at the time, should not have allowed Paddy to go back
 5 into that room. By 23.15, as HART operatives arrive,
 6 they are a different resource available to me, so they
 7 do then provide — there was a potential for extra —
 8 "Question: We know about what they provide —
 9 sorry, I didn't mean to cut you off and I have jumped
 10 ahead to 23.15."
 11 And there were then questions about that. Then
 12 Mr Greaney said:
 13 "Question: By that stage, the information to you
 14 has increased, your thoughts have had an opportunity to
 15 process, and by that stage you know that the issue or at
 16 least the main issue for you to confront is that
 17 City Room, do you not?
 18 "Answer: Yes.
 19 "Question: You know that you have multiple
 20 casualties in that room including P1s?
 21 "Answer: Yes.
 22 "Question: And you know or you believe that there
 23 is just a single paramedic in there with them?
 24 "Answer: Yes.
 25 "Question: Obviously there are others in there, but

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1 in terms of NWS resources, there is one paramedic. By
 2 that stage, was it not crying out for you to send
 3 further paramedics into that room, and if not, why not?
 4 "Answer: In my view, the policies and procedures,
 5 or the procedures that I am permitted to follow at the
 6 time, did not allow for the deployment of any of the
 7 resources that I had at scene into the City Room. I
 8 qualify that by saying that HART operatives are able to
 9 work in -- and I know there's been a lot of discussion
 10 around whether it was a warm zone, an inner cordon --
 11 "Question: We'll get to that. Just make the point
 12 you wanted to make.
 13 "Answer: The options available to me are dependent
 14 on that, whether it's zoning or whether you want to call
 15 it an inner cordon, in terms of a major incident
 16 response, the options available to me -- and I do
 17 understand completely the thought process of wanting or
 18 needing lots of paramedics in that room, but the
 19 processes available to me to do that -- or my view is
 20 that the processes restricted me from doing that."
 21 Again, please, if we can just move on so far as
 22 Mr Dan Smith is concerned to page 140 {Day110/140:10},
 23 please, Mr Lopez.
 24 Answer about a third of the way down:
 25 "Answer: I think the expectations will always be

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1 that we will send multiple resources in to an incident
 2 scene like that. The reality, unfortunately, since I
 3 started training as a paramedic, has been that we would
 4 not, and that was the reason from my understanding of
 5 the 7/7 inquests, that that was the reason for the HART
 6 team deployment -- not deployment, sorry, the reason
 7 that the HART team were brought about was for that area
 8 working, because you know, as I say, since I started
 9 training as a paramedic, the thoughts have always been
 10 that paramedics don't work in that inner cordon area.
 11 Of course, I understand the reason for the questions
 12 you're asking, but that has unfortunately been always
 13 our treatment pathway."
 14 And so far as Mr Ennis is concerned, and his --
 15 before we turn to them, could we have page 146
 16 {Day11/146:6}, please, of Mr Dan Smith's evidence?
 17 A third of the way down question from Mr Greaney:
 18 "Question: Bearing in mind that a very important
 19 part of your thought process was the risk that anyone
 20 going into this room would be at, was it important that
 21 you should have a clear understanding of what that risk
 22 was? A rather clumsy question but I hope you understand
 23 what I'm driving at.
 24 "Answer: I do, yes.
 25 "Question: Because that was the thing or an

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1 important thing that was inhibiting more paramedics
 2 going in?
 3 "Answer: It was. But actually, I think as much as
 4 I've criticised perhaps the JOPs that were in existence
 5 at the time, the reality is a previous presence of a
 6 terrorist and obviously the consequence of the bomb that
 7 we saw defined it as a warm zone. It was almost a
 8 given, to be honest, because it's not anything that --
 9 it's not even something that would be ambiguous in my
 10 view, and this is obviously my view of the policies.
 11 "Question: We understand that.
 12 "Answer: It's not ambiguous, you know: a terrorist
 13 has been active in that area."
 14 Page 151, please, Mr Lopez. He talks there about it
 15 being an inner cordon.
 16 Line 15 {Day110/151:15}:
 17 "SIR JOHN SAUNDERS: Yes, but I thought you were
 18 actually using the major incident plan rather than the
 19 Plato JOPs.
 20 "Answer: The zoning would be from the JOPs, really,
 21 but I think our major incident plan refers to the JOPs.
 22 "SIR JOHN SAUNDERS: When you've been talking about
 23 inner cordon which is your major incident plan?
 24 "Answer: That was the plan, yes."
 25 Mr Greaney then referred to the major incident plan.

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1 If we turn now please to Mr Ennis' evidence,
 2 Day 110, pages 43 {Day110/43:6} onwards of Mr Ennis'
 3 evidence.
 4 Just so that we understand what Mr Ennis and his
 5 level of understanding at the time -- we've got an
 6 answer about third of the way down:
 7 "Answer: No. I knew what a marauding terrorist
 8 firearms incident was and I knew what the difference in
 9 terms of zoning and management at a major incident -- if
 10 it was a firearms incident. But the term Operation
 11 Plato is one that wasn't familiar to me. The
 12 implications were, but not that term.
 13 "Question: So far as your consideration was on the
 14 night, this was a major incident, the City Room was
 15 a hot zone.
 16 "Answer: Yes.
 17 "Question: So far as the paramedic response, the
 18 NWS response is concerned what was your understanding
 19 about which paramedics if any could enter a hot zone in
 20 a major incident?
 21 "Answer: My understanding is that the HART team
 22 were the operatives who would be trained and able to be
 23 deployed into that area.
 24 "Question: Anybody else within the NWS response?
 25 "Answer: No, only those with a HART level of PPE

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1 would be usually, as per the plan, deployed into that
2 area."
3 Sir John:
4 "I'm interested in this, as you asked you whether
5 there was any discretion in relation to that, you said
6 there was some discretion.
7 "Answer: So the plan suggests that the correct
8 people to be deployed into that area are the HART team.
9 The plan is — it is a plan, it's a guide, it isn't
10 decided — sorry, it isn't a definitive thing. But I
11 think it's fair to say that an operational commander
12 would need to perform quite a robust risk assessment and
13 would be deviating from the plan if they decided to
14 deploy paramedics without that level of PPE and without
15 the HART level of PPE into that area.
16 "SIR JOHN SAUNDERS: As you explained, you can get
17 situations where HART may just not be there for quite a
18 long time, in which case you have to make that sort of
19 decision presumably?
20 "Answer: Yes, and it'd one that would need to be
21 justified, particularly if anything were to go wrong and
22 any harm were to come to those people, then the
23 operational commander would then be held to account
24 because they would have deviated from the suggested
25 plan.

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1 "SIR JOHN SAUNDERS: Thank you."
2 And I was asking questions at this stage:
3 "Question: And deviate from the plan is precisely
4 what you did, in fact, because you are neither HART nor
5 were you wearing the kind of protective equipment, the
6 ballistic equipment for example, that they would have
7 been or might have been wearing?
8 "Answer: Yes.
9 "Question: So you self-deployed into the hot zone,
10 flexing the plan that you've told us about, and thus
11 operating outside what ordinarily takes place or ought
12 to take place within a major incident hot zone?
13 "Answer: I think the... Until obviously seeing the
14 City Room, it wasn't apparent that that was a... that
15 indeed it was definitively a major incident or that it
16 was potentially a dangerous area.
17 "Question: But at 11.05, when you went back in
18 there, that was patently obvious to you?
19 "Answer: Yes.
20 "Question: Yes. When you went back into the City
21 Room at 11.05, that was after your discussion with
22 Dan Smith, who was by then the operational commander;
23 correct?
24 "Answer: Yes.
25 "Question: Right. Can you help us, and forgive me

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1 if you've already told us about this, but the discussion
2 that you had with Dan Smith when you and he congregated
3 on or around the station concourse in what was to become
4 the CCS, what discussion was there about whether you
5 were content to go back into the City Room, first
6 question, and second question, whether anybody was going
7 to be going with you?
8 "Answer: I don't recall... Sorry, I... I believe
9 that I suggested that I was going to be going back into
10 the City Room and didn't wait for instructions from
11 Dan Smith to tell me whether he agreed with this or
12 otherwise. I think I explained to him that was what I
13 intended to do. At the time, I don't think there was
14 any discussion about anybody else joining me in there
15 based on the fact that the other NWS personnel who were
16 there were required in other capacities."
17 Would you agree that so far as risks, so far as who
18 could deploy into there, who shouldn't deploy into
19 there, that whole process would have been enhanced
20 considerably had there been a better discussion or any
21 discussion between the operational commander within —
22 from the police within the City Room and the operational
23 commander from NWS in the CCS or thereabouts?
24 CHRISTIAN COOPER: Yes.
25 Q. And you have told us about, and again we're not going to

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1 disagree with — I'm not going to disagree with you, far
2 from it, in relation to this, but in deciding on zones,
3 whether we call them inner or outer, hot, warm or
4 otherwise, in other words deciding whether and who
5 should be deployed into a particular area, that is best
6 informed, is it not, with a discussion between all three
7 of the responders?
8 CHRISTIAN COOPER: Yes.
9 Q. Would you also acknowledge that there doesn't appear to
10 have been any communication to Dan Smith by the police
11 that they had classified the area in the City Room as
12 either hot, warm or cold?
13 CHRISTIAN COOPER: That's my understanding, yes.
14 Q. Right. So nobody directly said from the police, or any
15 other organisation, "It's now what we call a cold zone
16 up there"? In fact I think the phrase cold zone has
17 come from the police experts, hasn't it?
18 CHRISTIAN COOPER: Yes.
19 MICHAEL HERRIOT: Yes.
20 Q. And nobody said that to Dan Smith at the time, did they?
21 CHRISTIAN COOPER: Not on my understanding of the evidence,
22 no.
23 Q. Right. Did anybody say — obviously Paddy Ennis, let's
24 focus on him for a moment, he was within the City Room
25 and could see what was unfolding, the catastrophe that

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1 there was within, the devastation that there was within
 2 that room, and no doubt heard, as we have heard, the
 3 pleas of those in the room and the pleas of the police
 4 as well. Was there any communication by Inspector Smith
 5 to Paddy Ennis about the nature of the zone or who could
 6 or couldn't respond to that particular zone?
 7 CHRISTIAN COOPER: Not that I'm aware of.
 8 MICHAEL HERRIOT: Not that I'm aware of.
 9 Q. It's my recollection in fact that so far as
 10 Inspector Smith is concerned, his knowledge of Plato and
 11 MTFAs was, if not limited -- I was going to say
 12 non-existent but I don't want to do him a disservice at
 13 all and I don't mean a disservice to him. But is there
 14 not the situation therefore that of the three responding
 15 organisations, one is downstairs and has formed his own
 16 clear view about who should and shouldn't be in there,
 17 so there's a slight disconnect with the fact that
 18 Paddy Ennis was in there, but he wasn't sending anybody
 19 else up there, was he?
 20 CHRISTIAN COOPER: No.
 21 Q. There was a view that had been taken by Inspector Smith
 22 and those within the City Room that more paramedics were
 23 in there, no clear understanding as to whether they
 24 could or couldn't deploy into there, and if they could
 25 who could deploy into there, and a third responder who

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1 wasn't there, by which I mean, of course, the fire. So
 2 in those circumstances, and operating in real time as we
 3 know that Dan Smith was, and without that benefit of the
 4 huddle at the early stage or an agreement as to who
 5 could or couldn't go into the City Room, the decision
 6 that he took as to how he classified that particular
 7 area was a reasonable one, wasn't it?
 8 MICHAEL HERRIOT: He certainly needed to make a pragmatic
 9 decision under those circumstances, yes.
 10 SIR JOHN SAUNDERS: I don't think we've gone any further,
 11 have we, than -- they still say HART should have gone in
 12 and they are not criticising him in particular for not
 13 sending other paramedics in; is that right?
 14 CHRISTIAN COOPER: Quite so, yes.
 15 MS ROBERTS: May we conclude there for the evening?
 16 SIR JOHN SAUNDERS: Okay. Thank you.
 17 MS ROBERTS: I can refine my thoughts over the weekend.
 18 SIR JOHN SAUNDERS: All right, thank you.
 19 Monday morning, 9.30.
 20 (4.31 pm)
 21 (The inquiry adjourned until 9.30 am
 22 on Monday, 13 September 2021)
 23
 24
 25

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