Manchester Arena Inquiry

Day 144

September 10, 2021

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Friday, 10 September 2021
(9.30 am)
(Delay in proceedings)
(9.47 am)
MR GREANEY: Sir, good morning. As Mr de la Poer ——
SIR JOHN SAUNDERS: Can I say, I'm really sorry to be sitting late. As people knew from yesterday, I have been having some back pain. That is much better today, but there is another symptom which requires some investigation. As we're dealing with NWAS matters today, we couldn't be in better hands if I need any help. I will try to make sure that anything I need to have done does not interfere with the progress of the inquiry.
MR GREANEY: Thank you very much for saying that. We know if at any stage if you need to take a break, you'll just walk out.
As Mr de la Poer explained yesterday, we are going to turn now, as you just indicated, to the evidence of the Ambulance Service experts. They are, as everyone knows, Christian Cooper and Michael Herriot. Mr Cooper is in the witness box and Mr Herriot is in the position commonly occupied by Mr Atkinson and I'm going to asked if they could both be sworn at this stage, please.

MR CHRISTIAN COOPER (affirmed)
MR MICHAEL HERRIOT (affirmed)
Questions from MR GREANEY
MR GREANEY: I will begin by inviting each of you to identify yourself. Mr Cooper, first of all, tell us your full name, please.
CHRISTIAN COOPER: Christian Paul Cooper.
MICHAEL HERRIOT: Michael Francis Herriot.
MR GREANEY: So that you and everyone else know, generally speaking, unless I indicate to the contrary, I will be directing my questions in the first instance to Mr Cooper and then seeking any contribution that Mr Herriot has to make. But if at any stage either of you wish to indicate that one or the other is better off dealing with a topic, please let me know.
First of all, the scope of your instructions. This is a topic that is well—known, but in summary, Mr Cooper, have you been asked to assist the inquiry in relation to three connected issues? First of all, whether NWAS was adequately prepared for an event such as the attack at the Manchester Arena?
CHRISTIAN COOPER: Yes.
Q. Secondly, whether the response of NWAS to the attack was adequate?
CHRISTIAN COOPER: Yes, that's correct.

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

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

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

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

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

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

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

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

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

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

Q. And moreover, I don't know whether you can help with this, one of the things it might be thought didn't go at all well on the night —— I don't just mean for NWAS, I mean more generally —— was the identification of a single or at least a consistent rendezvous point. Would you expect a site—specific plan to have anything to say about an RVP?
CHRISTIAN COOPER: That would be good practice and indeed such plans for airports, key transport hubs usually do include that. That will normally be protectively marked and sensitive because obviously we do not want that disclosed in advance, but it would be good practice to include all of the factors that you have just listed.
Q. Obviously, anything can change in the event of an incident which might make the identified RVP not appropriate, but having an RVP identified that would generally be the correct place to meet would seem sensible, would it not?
CHRISTIAN COOPER: Yes.
Q. We're also very familiar with the concept of a forward command point or post. Would you expect anything to be said about such a location in a site—specific plan?
CHRISTIAN COOPER: If we're talking about the FCP that is defined within the JESIP doctrine ——
Q. I am.

CHRISTIAN COOPER: —— that tends to be more dynamic. That tends to be —— there's an expectation that the three commanders will form up and create one of those. It would not, I would suggest, be normal to pre—identify a JESIP FCP.
Q. That's helpful. But an RVP, yes, an FCP ——
CHRISTIAN COOPER: If you had a site—specific plan that contained established RVPs, places that are already known to be a suitable location for that, then of course that would be a preferential point to locate an FCP.
Q. Next issue. The difference that having a site—specific plan, if any, might have made on the night. It's probably the case that you have identified one already. Things didn't go well in relation to the identification of an RVP; do you agree with that?
CHRISTIAN COOPER: I do agree.
Q. If there had been a pre—identified RVP, do you think that that would have been a more straightforward issue on the night?
CHRISTIAN COOPER: Yes, it's always an option available to the commanders to say, "We don't think this is suitable for our purposes given what's going on, we would need to relocate", and then they can relocate together.
SIR JOHN SAUNDERS: Can we deal with the mechanics of that for a moment? There are two things. First of all,

obviously new issues will arise as we go through it. Did we ask questions relating to this with those witnesses who gave evidence about the activities of the LRF?
MR GREANEY: Mr Argyle was the principal witness who gave evidence about the LRF. Do you mean did we ask him questions about site—specific plans?
SIR JOHN SAUNDERS: Yes.
MR GREANEY: I'm not sure we did, sir, no.
SIR JOHN SAUNDERS: It would be helpful, if we're going to make recommendations, if we could ask them —— I'm just saying this now because I'll forget otherwise —— to make any comments they have in relation to it.
MR GREANEY: I entirely agree, sir, and you're quite right that obviously if issues arise or a stronger focus rests on issues as we go along, and I'm sure Mr Argyle will understand why he wasn't asked about that, if he wasn't, and that he will assist or one of his colleagues will.
SIR JOHN SAUNDERS: Thank you.
The nomination of the RVP, as we've heard, came from Inspector Smith, who was the first police officer and most senior police officer on the site to start with and he did that really from his own local knowledge of where may have been a suitable place to do that. Would you expect a local inspector in that situation to know what

would be the nominated RVP on the site plan or is that something which would have to go through the force duty officer?
CHRISTIAN COOPER: I think with site—specific plans, it's probably unrealistic to expect every front line member of staff within the emergency services to be fully familiar with everything in that plan. The plan needs to be available to commanders who might be expected to adopt those roles, to tactical advisers, but of crucial importance, it needs to be available to the control room so that when a call comes in at that location, the control room very quickly can make reference to that plan. And usually, certainly all the site—specific plans I've seen, they're very easy to navigate to the key information you need early on, like where the key RVPs are.
SIR JOHN SAUNDERS: Thank you.
MICHAEL HERRIOT: Sir, if I may, it's also fairly common for there to be a summary of that plan, which may include an action card or a summary of the type of response that would be expected to be mounted.
SIR JOHN SAUNDERS: Thank you. And of course we do know as well that BTP were actually on the site, so they no doubt would have known that in any event.
MR GREANEY: Yes.

So what we are having in mind, just looking to the future, is a site-specific plan into which all three emergency services have made a contribution, which is available to each of them, is within the control room for each of them and readily accessible, and which has a pre-identified rendezvous point, which at the very least provides a starting point?
CHRISTIAN COOPER: Yes.
Q. So on the night of the arena attack, when discussion started about rendezvous points, that would have been a difference if such a document had existed?
CHRISTIAN COOPER: It would have been enormously helpful to have had at least a starting point for where those RVPs should be. And in terms of the mechanism, I think it's fair to say there is a national expectation at the moment that the mechanism for this should be that the Local Resilience Forum is best placed to understand the risks across a particular geography. They are under a statutory obligation to risk assess that geography and, one would hope, that as part of that risk assessment process, a site such as Manchester Arena would be identified and then the LRF is best placed to undertake the relevant planning activity and that would include details such as the pre-identification of RVPs.
Q. So Manchester Arena, a location that can accommodate

14,000 people, more than 14,000 people --
SIR JOHN SAUNDERS: 20,000, isn't it?
MR GREANEY: It's approaching 20,000 maximum, sir, you're quite right, but about 14,500 on the night. In the city centre, above a major transport hub. That is the kind of location that you'd expect to be the subject of a site-specific plan?
CHRISTIAN COOPER: Yes.
Q. You are anticipating something, the chairman's suggestion, across the three emergency services, prepared by the Local Resilience Forum?
CHRISTIAN COOPER: Yes.
Q. A number of the issues that we've identified have been related to the resourcing of the Local Resilience Forum and I have no doubt therefore that it will be your view that the Local Resilience Forum would need to be properly resourced for this purpose?
CHRISTIAN COOPER: Yes, and that is a particular challenge for the Ambulance Service because ambulance services are regional rather than local. Their geography is considerably larger than police and Fire and Rescue Services. So as a result, a single ambulance trust needs to service multiple LRFs, which makes it a greater resource challenge for an ambulance trust than a police or Fire Service that is only usually resourcing one LRF.

Q. So there are two sides to this. One, each of the organisations needs to ensure that it has a proper level of representation on each Local Resilience Forum?
CHRISTIAN COOPER: Yes.
Q. Secondly, the Local Resilience Forum itself needs to be properly resourced so that it can produce what is needed in the form of these site-specific plans?
CHRISTIAN COOPER: Yes, and as a category 1 responder under the Civil Contingencies Act the Ambulance Service has an obligation to do that.
Q. So difference 1, RVPs. Are there any other differences that you consider a proper site-specific plan would have made to the response of NWAS on the night if it had existed?
CHRISTIAN COOPER: For Manchester Arena?
Q. Yes.
CHRISTIAN COOPER: I think for an event of this nature -- and we may be straying into evidence around the Purple Guide and event planning here, but it is synonymous with the site-specific plan because the site-specific plan should also contain details of what that site intends to do in the event of emergency in the very early phases which assists the emergency services to dovetail their response against that. That, I think, is probably one of the most important elements for the

emergency services of a site-specific plan.
The situation is very likely to develop to a point where that site-specific plan then gets superseded by the emergency response arrangements of the responding agencies, but certainly in the early phases, in addition to the RVP, the access and egress routes to that location, what steps that location may take in the early phases -- and of course it may be different for Manchester Arena to COMAH sites or other sites where there might be very different arrangements that need to take place early on. So I guess it's hard for me to say because the very nature of a site-specific plan is that it has to be very specific to that site.
Q. Yes.
CHRISTIAN COOPER: But what you're effectively doing with a site-specific plan is taking what would otherwise be a very generic set of major incident arrangements and augmenting that with the extra detail that you would need to make an effective response. The best major incident plans I have seen within ambulance trusts have a generic section and then they effectively have appendices of all these additional site-specific arrangements for the local airport, local hazardous sites, local stadia, and so on and so forth.
SIR JOHN SAUNDERS: Whatever we are going to later say about

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

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

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

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

emergency calls within its control room. Those are emergency calls that have been graded and are waiting for an ambulance to be sent.
SIR JOHN SAUNDERS: So it's playing catch-up?
CHRISTIAN COOPER: Yes. The Ambulance Service has very established procedures and very experienced people in its control rooms on a daily basis that prioritise those calls to ensure that the emergencies of the highest priority receive an ambulance as quickly as possible. But it's inescapable that there are so many calls within that system that the Ambulance Service is, as you say, sir, always playing catch-up in terms of the amount of vehicles it's got versus demand.
In the context of a PDA then, if you were to have a predetermined attendance for various different types of emergency that take 20 ambulances immediately out of that system, that is going to have a significant impact. It's not necessarily the wrong thing to do, but it needs to be recognised the impact that that will have.
But what is very commonplace in ambulance trusts is for jobs that are graded as requiring a hazardous area response or a potential terrorism or a potential bomb that may have gone off or anything of that nature, it is very common for the Ambulance Service to have arrangements to send its specialist assets without

delay, so mobilise its HART teams, if it's potentially terrorism with firearms, start to prepare its AIT responders, and prepare to deploy them, prepare to deploy certain key commanders in key roles. That is commonplace. That's certainly good practice and I would go further to suggest it's a national expectation that they have that.
The predetermined attendance of and how many ambulances you are going to send with it I think is perhaps less clear. There is no specification for that nationally, so we would deem it good practice to have that in place. And I think if we take the context of Manchester Arena, it would perhaps have been more helpful for a set number of ambulances to be sent and then stood down if not required, so at least you reach a critical mass of resources quickly rather than expecting commanders at various different points in those very early and quite chaotic stages to be trying to make decisions about what number of ambulances they think they need.
And when indeed you reach a point of realisation that you need a large number, it would have been more fortuitous if those had been mobilised automatically earlier. So it is perhaps an area that would benefit from a review.

SIR JOHN SAUNDERS: So predetermined attendance, we became very familiar with, with GMFRS and NWFC yesterday. And I don't know whether you did hear any of that evidence, but clearly there can be problems relating to that as well.
CHRISTIAN COOPER: Indeed.
SIR JOHN SAUNDERS: If you get action cards, that sort of thing, identifying which are the right ones, so I'm not saying it's a bad idea, but at least no doubt those sort of problems or potential problems need to be taken into account as well?
CHRISTIAN COOPER: Indeed, sir, and PDAs are very well-established in the Fire and Rescue Service, less so in the Ambulance Service, but the Ambulance Service is a little more flexible now with its arrangements. It tends to have them for its specialist assets rather than its day-to-day assets.
MICHAEL HERRIOT: I would suggest at the very least there should be a PDA for a generic major incident, so when a major incident is declared, a fixed number and type of asset would be sent. And the order of those assets would be specified also in that procedure.
SIR JOHN SAUNDERS: Thank you.
MR GREANEY: I just want to understand in a moment what difference this might have made on the night. But if in

your view there should be a review of the use by ambulance services of PDAs, whose responsibility should it be to carry out that review?
CHRISTIAN COOPER: There are a number of national groups established, national directors of operations group, there's an Emergency Response and Resilience Group. NARU itself is probably very well placed to do that. But it would need to be a collaboration of all ambulance trusts because what we would hopefully want to achieve is some standardisation.
Q. In terms of a difference on the night, and let's just envisage that there is a PDA for a terrorist attack, would you expect that a PDA relating to a terrorist attack would make provision for the attendance of specialist assets?
CHRISTIAN COOPER: Yes.
Q. And on the night, we know, we are not identifying where they were based, but we know on the night that one HART was at a factory fire in Stockport where in fact, not their fault, they were not able to provide any value. The other was based in Merseyside and they weren't mobilised for a period of, I think, about 40 minutes.
Are you envisaging a situation in which the PDA says: we need one team or two teams, specialist teams, at location of the terrorist attack as soon as possible?

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

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

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

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

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

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

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

CHRISTIAN COOPER: Yes.

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

CHRISTIAN COOPER: Yes.

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

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

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

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

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

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

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

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

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

MICHAEL HERRIOT: No, sir.

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

CHRISTIAN COOPER: They did.

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

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

CHRISTIAN COOPER: I do.

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

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

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

CHRISTIAN COOPER: Indeed.

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

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

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

identify a whole series of features. I'm just going to pick out the ones that seem to me to be the most relevant in light of the issues that now exist.

First of all, did Exercise Dawn Vigil take place in July 2015?

CHRISTIAN COOPER: Yes.

Q. Was that a multi-agency exercise in which NWAS played a part, including its commanders and specialist teams?

CHRISTIAN COOPER: Yes.

Q. Was the scenario a terrorist attack?

CHRISTIAN COOPER: Yes.

Q. Among other learning points, of which I recognise there were many, were there the following? First of all, during the course of that exercise, was there a delay in appointing a safety officer?

CHRISTIAN COOPER: Yes.

Q. We're going to get on to what a safety officer is in due course, although we probably know about it already.

Would it be fair to say that that problem occurred, but even more acutely, in May of 2017?

CHRISTIAN COOPER: Yes.

Q. In fact, it wasn't a case of a delay in appointing a safety officer, no safety officer was appointed?

CHRISTIAN COOPER: That's correct.

Q. That was one learning point.

Secondly, was there a delay on the occasion of that exercise in committing HART staff to triage and treat patients because they were used to, as it was put, construct other structures?

CHRISTIAN COOPER: Yes.

Q. So in 2015, in the exercise, they weren't being used for what they are designed to be used for, getting into a hazardous location, triaging and treating, they were given some other task to do?

CHRISTIAN COOPER: Yes.

Q. Did that repeat itself in May 2017?

CHRISTIAN COOPER: It did.

Q. So lessons that have been identified but change, at least no sufficient change, being implemented on the face of it?

CHRISTIAN COOPER: I agree.

Q. Now turning over the page {INQ032665/59}. I'm not going to deal with every exercise you've identified, although I will deal with them in general terms at the end.

Did Exercise Lawman 2 take place in March 2016?

CHRISTIAN COOPER: Yes.

Q. Again, was that a multi-agency exercise in which NWAS played an active part?

CHRISTIAN COOPER: Yes.

Q. And the Fire and Rescue Service also played a part,

although GMFRS would want us to note that it was not GMFRS that took part but instead Merseyside Fire and Rescue Service?

CHRISTIAN COOPER: Yes, that's my understanding.

Q. Again, was the scenario for that exercise a terrorist attack?

CHRISTIAN COOPER: It was, yes, a terrorist and mass casualty attack, yes.

Q. Indeed. In fact, it was an MTFA mass casualty exercise?

CHRISTIAN COOPER: Yes.

Q. Among other learning points, were, on the occasion of that exercise, Airwave operational groups not used at the operational level?

CHRISTIAN COOPER: Yes, that's correct.

Q. Again, does that resonate with what occurred in May of 2017?

CHRISTIAN COOPER: It does.

Q. And was the Fire and Rescue Service -- bearing in mind it was not GMFRS of course, were the specialist responders of that Fire and Rescue Service held back from the warm zone whilst permissions were sought?

CHRISTIAN COOPER: Yes.

Q. Leaving the specialist resources of the Ambulance Service to go in effectively alone?

CHRISTIAN COOPER: Yes.

Q. And again, as everyone knows, that was something which also occurred on 22 May 2017.

CHRISTIAN COOPER: Apologies, I think the Ambulance Service who were in that exercise went in with the police, but without fire.

Q. You're quite right to make that qualification.

As we know very well indeed, Exercise Winchester Accord took place in May 2016. Learning points for lots of organisations, but was a learning point for NWAS that joint situational awareness was not achieved across the three emergency services?

CHRISTIAN COOPER: Yes.

Q. To say the least, that repeated itself on 22 May 2017?

CHRISTIAN COOPER: It did.

Q. We also know within the inquiry that Exercise Hawk River took place in March 2017 and again was that a multi-agency exercise in which NWAS played an active part?

CHRISTIAN COOPER: Yes.

Q. The scenario was an MTFA mass casualty incident again?

CHRISTIAN COOPER: Yes.

Q. On the occasion of that exercise, were there conflicting views about the boundaries concerning warm zones?

CHRISTIAN COOPER: Yes.

Q. Which the exercise revealed in a real time situation

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

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

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

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

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

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

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

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

CHRISTIAN COOPER: There certainly are. There are complexities to using a tourniquet that are known and that have come out in the evidence. It's those complexities that raise concerns about them being applied incorrectly and the consequences of doing so. That always has to be balanced against the consequences of not, which may, to be stark, be the loss of life versus the loss of a limb.
SIR JOHN SAUNDERS: So we will try and look at and get some agreed medical —— at least accept what the position is. Can I say I'm not for a moment suggesting Brigadier Hodgetts was wrong. He has been generally accepted as being extremely impressive and helpful and the app is also accepted that way. Please don't think I'm criticising him.
MR GREANEY: You certainly did make plain at the end of the evidence to the brigadier that you wanted absolute clarity in relation to that particular issue and I know that people are dealing with that.
MICHAEL HERRIOT: In fairness, there is far greater consensus now than there has been previously, and the use of tourniquets is being taught on some first aid courses, which is I'm sure commendable. Some of the concerns have been rather than —— not about the damage done by applying the tourniquet but of course it

actually not being applied effectively.
SIR JOHN SAUNDERS: I may be getting myself into an extremely complex topic.
MR GREANEY: I hope this is capable of a yes—or—no answer. When you say there is greater consensus now, do you mean there is greater consensus that the view expressed by Brigadier Hodgetts is correct?
MICHAEL HERRIOT: About the value and efficacy of the use of a tourniquet, yes.
MR GREANEY: So the public need to be educated and the issue, I don't know if this is a matter for you, but you may have a view, is how that is to be achieved. Obviously there's the extraordinary work of Brigadier Hodgetts and citizenAID. Do you have any further ideas either to express now or in writing in due course about how we educate the public about what difference they can make?
CHRISTIAN COOPER: I think it's something I would like to give some thought to.
SIR JOHN SAUNDERS: On the face of it, doing it in schools sounds like a very good idea to me.
CHRISTIAN COOPER: Indeed, and there are a number of very well—established charities in this country who do similar work that could potentially be expanded, so yes.
MICHAEL HERRIOT: It's fair to say that there have been

a great number of initiatives over the years. I was reflecting that there was an initiative called Save a Life back about 30 years ago with the aim of educating members of the public to ensure that if someone collapsed, they would be within view of someone who could do something effective. That thinking has continued to the current day, particularly through the voluntary societies, but they haven't been terribly effective getting that embedded. Perhaps that's the issue.
SIR JOHN SAUNDERS: It may be that we'll ask for comments from the Department of Education.
MR GREANEY: Indeed, sir, thank you.
We were discussing bridging this care gap and educating the public. Secondly, as the events of the arena attack reveal, those likely to be on the scene very quickly will include police officers and an issue that has arisen is whether police officers should also be trained in the basic skills of life support, including the use of a tourniquet and maintaining an airway. Do you have a view about whether that is something which seems sensible?
CHRISTIAN COOPER: I think in general, yes. I think the key is basic skills because it is basic skills in the very early phases that will assist in saving life. I think

there is a risk in potentially overtraining police officers in advanced trauma and the danger that creates in conflicting their role, and of course there are certain police officers in the early phases of incidents like this where there may still be a terrorist threat present where —— it sounds callous but the best thing for all is they concentrate on neutralising that threat first to stop further injury and others being affected and we wouldn't want that process to be delayed by those particular officers feeling obligated to slow that response in relation to patient care. So there are some complexities to this, but in general, where there are a number of police officers that find themselves with casualties that have suffered potentially life—threatening injuries, equipping those police officers to be able to do something to buy some time I think has great value.
Q. In fact, the first police officers into the City Room were not the armed officers, they were officers of British Transport Police, so those are the kind of officers that I have in mind. And I believe you're saying that it's very sensible that those be equipped with those kind of techniques?
CHRISTIAN COOPER: Yes.
Q. So public, police. Thirdly, of course we're dealing

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

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

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

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

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

MR GREANEY: I'm all ears.

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

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

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

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

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

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

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

very reluctant to take on responsibility for them.

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

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

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

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

SIR JOHN SAUNDERS: Thank you, Mr Herriot.

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

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

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

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

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

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

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

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

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

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

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

of course, is that it originated in the early 1990s, first edition. There were issues with the first edition because when it looked at risk ——

SIR JOHN SAUNDERS: I'm really sorry, do you mind if I cut across you? What I'm going to ask you is if in due course you would specify for me in a written document where you see the Purple Guide could benefit from updating and improvement.

MICHAEL HERRIOT: Yes, sir. It assessed risk at one level, which was numbers, and clearly we would wish to influence it. It included a wider number of factors and while that is in the text, it doesn't necessarily get applied as we would anticipate.

SIR JOHN SAUNDERS: Thank you very much.

MR GREANEY: That is your view, not adequate numbers, not adequately skilled. And there is a question at least as important as those first two questions: were those ETUK first aiders adequately managed in your view?

MICHAEL HERRIOT: No. I think there was a deficit of leadership. There was certainly a number of plans, but they weren't followed on the night by the contractor.

SIR JOHN SAUNDERS: Okay. Sorry to cut across you again. We have, as people will know, received a statement from a gentleman from the ——

MR GREANEY: Jeremy Cowen.

SIR JOHN SAUNDERS: —— thank you very much —— who sets out the problems about management.

MR GREANEY: It's a really important statement and in fact I was going to read it out at this stage and then ask the experts if they have a view about it. It's going to take a bit of time, but it's sufficiently important to warrant that in my opinion.

I'm going to read the statement of Jeremy Cowen dated 19 August 2021. The INQ reference is {INQ041868/1}. Can I, before I read it, express the gratitude of the inquiry legal team to Mr Cowen for the work that he has done.

SIR JOHN SAUNDERS: I would join with that. Thank you.

MR GREANEY: I am going to start at paragraph 3. He states:

"I am currently employed by the Northern Ireland Ambulance Service as an emergency planning officer, a role that I have held for 14 years. However, I make this statement in a personal capacity and not as a representative of NIAS. I am not providing expert evidence, rather to provide an informed perspective, but it is relevant for me to outline my history and experience with NIAS so that the inquiry can decide what weight to attach to my evidence.

"I have worked for the Northern Ireland Ambulance Service for 24 years, following on from a previous

career in broadcasting, originally starting in the Ambulance Service as a non—emergency ambulance person, through ambulance technician, station supervisor, paramedic supervisor, project officer, station officer and finally to the post that I hold now.

"My current role is of the same rank as a station officer, although I report directly to an assistant director, whereas a station officer reports to an area manager, who in turn reports to an assistant director.

"My duties involve all aspects of emergency preparedness and resilience and include working with all partner agencies, both public sector and private sector. I have a special interest in event and venue safety with the aim of ensuring safe delivery of events and minimising impact on the wider health and social care system, as well as the local communities.

"I have been involved in a wide range of events and venue planning, ranging from small local events up to major international events such as the Tall Ships Festival of 2015, which had an overall attendance of about 500,000 over a four—day period. I sit on a number of safety advisory and other planning and preparedness groups locally, and was a member for the Department of Communities (NI) Safety Technical Group, which was a multi—agency team tasked with offering guidance and

advice vis—a—vis venue and spectator safety to the department's regional stadia development project.

"In addition, I have contributed locally on a number of guidance documents regarding venue and event safety, this included reviewing the section on medical provision in the Northern Ireland Red Guide. The Red Guide was originally Northern Ireland's guide to safety at sports grounds but this has now been replaced with the Green Guide which originated from England and Wales.

"I have witnessed at first—hand the damage to individuals, to families and to entire communities, the aftermath of such incidents, and I want at the outset to offer my very deepest and dearest condolences to all that have been affected by this particular atrocity, and also to formally record my admiration to all those who responded to it, the statutory, the voluntary and the ad hoc for the amazing work they did during and in the aftermath of the bombing.

"I am passionate about lessons learned and outcomes and have been taking a keen professional interest in the inquiry and I wish to assist it in offering this statement to the inquiry. I do not know the event, the venue or the medical or other providers at the venue, so this statement is based solely upon my own personal observations and experiences at events. It is not

written to assess or comment upon the issues being investigated by this inquiry, nor the actions of any individual or organisation in any way. However, I do believe that there is a risk for a potential gap in the quality and assurance of medical management at venues, which this inquiry has a unique opportunity to consider.

"Whilst there are a number of excellent pieces of guidance and some specific legislation, such as those for health, safety and welfare, there is no set national standard relating to qualifications or competencies in terms of those managing medical systems at venues.

"I am sure, by reason of my experience and observations, that the vast number of providers do an excellent job and have competent persons fulfilling each role. However, there is no yardstick to measure or give assurance of their competency, and with changing threats and times, and how they keep up to speed with latest developments. In other words, there is no recognised standard against which those providing first aid cover at events and those managing them can be assessed. My view is that without any standard, there can be no assurance.

"Such a standard exists for stewarding operations, the national occupational standard SKASS series of performance criteria, and these were recently reviewed

and updated to include, for example, some basic life-saving interventions for stewards to take should an incident occur.

"In terms of sports stadia, the Sports Ground Safety Authority have defined three layers of spectator safety qualification, levels 2, 3 and 4. Their corporate website contains the following quote:

"'At the heart of a successful event is the safety and security of the spectators. At sports grounds this is achieved through a safety management team. A fundamental part of this is the education and training of everyone involved.'.

"It is my firm belief that this ethos carries over to each and every event for each and every role, including that of medical manager.

"I regard the position of medical manager as being of critical importance. By that I mean that they will have a critical role to play if an incident occurs, particularly so if the incident is a major incident.

"There is no issue in terms of the medical qualifications or competencies of the individual medical professionals. These are adequately covered by the various qualification frameworks that exist for the role, eg paramedic, technician, doctor, nurse, first aider, et cetera, but there is no set standard or

training for those who have to direct, plan and operate a medical system, and these folk are the key decision-makers.

"The phrase 'medical management' can also be read as treatment of injury or condition, so for clarity when I refer here to medical management I am specifically discussing the operational management, not the clinical management.

"The role of medical manager is a key one. It is not the same skill set as being a medic, nor is it simply a command role. Neither is it simply a slips/trips/falls type risk skill set. It is about being able to fundamentally understand medical and delivery/operational risks throughout the life cycle of an event and to pre-empt them to mitigate impacts on the patient, the event and the wider community accordingly. It is also, I believe, a bit of a hybrid operational/tactical role and thus requires perhaps a more bespoke approach.

"The statutory ambulance services of the NHS do have a national occupational standard for the various incident command roles: operational, tactical and strategic.

"The importance of a medical manager becomes obvious if, for example, a terrorist bombing occurs at an event.

There may be, for good reason, a delay before the paramedics and specialist responders of the Ambulance Service physically arrive at the scene. Once they have arrived, treatment may not start immediately due to the need for triage to be initiated and established. This may well leave the event first aid provider as the first available source of emergency medical treatment as they may well be there immediately.

"A medical manager should be expected to understand what a METHANE message is, and to pass it on to the emergency services at the earliest possible opportunity. The METHANE message and situational awareness of the medical manager will be invaluable to the emergency services.

"A medical manager should also be expected to begin the process of triage. In the first instance, this may be as simple as instructing those patients who can walk to remove themselves from the immediate scene so that a focus could be put upon those unable to walk for whatever reason. This could happen quite quickly after an incident, so that by the time the Ambulance Service and partner agencies arrive at the scene, things are already moving forward.

"However, in order for this to be achieved, a number of things will need to occur:

"(a) There needs to be a standard to which medical managers can be judged. The inquiry offers a unique opportunity to explore this at a national level and I would suggest that consideration be given to looking at creating a formal national occupational standard or similar framework for those who are required to operate as a medical manager at an event. This will ensure that they are able to perform this important role adequately. I set out what that framework may look like in the next paragraph of this statement;

"(b) Those who provide first aid capacity at an event beneath the medical manager need to be properly trained;

"(c) The organisations, medical managers and first aid providers who represent first aid provision at an event need to be regulated so that there can be public assurance that a proper standard is being met. It is not for me, of course, to say by whom that regulation should be done.

"The proposed framework may include for example:

"Relevant legislation and guidance;

"Medical risk assessment, factoring in specifics such as the venue, event and audience, and surrounding supporting infrastructure;

"Linking to other medical strategies such as the

resuscitation strategy, alternative care pathways;

"Resourcing options to reflect risk assessment, understanding tool sets available in terms of skill sets;

"Major incident procedures and handover to statutory services;

"Working with statutory and non-statutory partners (including JESIP awareness);

"Decision-making and rationale for those decisions;

"Resilience and business continuity arrangements to support delivery;

"Governance, including management of medicines, infection prevention and control, indemnities required;

"Managing complaints;

"Counter-terrorism awareness and the part medical services play in this;

"Health, safety and welfare;

"Roles of other partners in a venue (what they can do and cannot do for you);

"Testing and exercising of plans;

"Briefing, debriefing and lessons learned from debriefs;

"Equality, disability, dignity and safeguarding;

"Record keeping, including Caldecott, data protection, and patient confidentiality;

"Role of media and communications;

"Working with statutory ambulance liaison officers;

"Understanding event phases and how medical systems need to reflect the phases;

"Environmental and waste management.

"This is not to suggest that there are no courses or training on offer, but against what standard are they being delivered? For an event steward, the public know exactly what it says on the tin. Same for a medic. But for those charged with the running of the medical system, there is no tin at all -- before we can even imagine what the contents of the tin might be. The list above does not contain anything new, rather it is a composite of relevant areas from the Civil Contingencies Act 2004, the National Ambulance Resilience Unit command and control guidelines, the Purple, Green and Pink Guides, as well as the basic standards that apply in terms of assurance within the Ambulance Service."

He is now moving on to deal with a separate albeit connected issue:

"The presence of an ambulance liaison officer at events where there has been an agreed risk threshold reached is good practice. The liaison officer can then facilitate the venue in terms of access to real time

informatics, such as delays or pressures on receiving emergency departments, any diverts or alternative pathways available for the care of patients.

"An ambulance liaison officer may also be able to quickly initiate the trust major incident plan and could be in a position to give a METHANE report and other situational awareness directly to the ambulance control room for dissemination to partner agencies relatively quickly.

"The construction of an occupational standard should give venues comfort and confidence that their provider has all of the necessary skills and attributes to competently manage and interface with all partners involved in an event. For medical providers, they should be able to draw similar confidence that they have all of their key bases covered, and for the public they too can be reassured that their individual unique medical needs can be met. I do not see this as a win/win, rather than a win/win/win scenario.

"As I have emphasised already, in the event of a mass casualty event, there may well be a delay before specifically the Ambulance Service arrives at the scene. This creates a care gap that needs to be bridged. I have commented on how, for example, early initiation of triage would help, but the immediate needs of those

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

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

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

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

statement, this is a personal view.

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

I appreciate that's taken a little time, but it's going ——

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

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

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

CHRISTIAN COOPER: No.

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

CHRISTIAN COOPER: I do.

Q. Mr Herriot, anything you disagree with?

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

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

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

CHRISTIAN COOPER: Yes, I do.

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

CHRISTIAN COOPER: Yes.

Q. And for staff also?

CHRISTIAN COOPER: Yes.

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

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

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

CHRISTIAN COOPER: Yes.

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

the wayside.

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

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

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

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

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

MICHAEL HERRIOT: Mm—hm.

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

CHRISTIAN COOPER: Yes.

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

CHRISTIAN COOPER: Yes.

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

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

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

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

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

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

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

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

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

commanders in the three respective emergency services to stand back and manage an incident, we train our responders to follow command instructions and deploy according to set principles. All JESIP is seeking to do is co-locate those commanders and rather than the three of them doing an individual assessment of risk or an individual approach to decision-making, do it together.

SIR JOHN SAUNDERS: Okay. You may not know the answer to this, but do you happen to know whether for Westminster and London Bridge JESIP was deemed to have worked satisfactorily?

CHRISTIAN COOPER: I would prefer to review that in a bit more detail before I comment.

SIR JOHN SAUNDERS: Thank you.

MICHAEL HERRIOT: I think as a personal observation, sir, at incidents where there's a requirement for JESIP, I think it's not that frequently used at a higher level, it's used every day at operational level. But one observes people retreating into their silos because they're under pressure and they have their own imperatives and I think the more pressure they're under, the more they retreat into their silos. That's a personal observation.

SIR JOHN SAUNDERS: Thank you.

MR GREANEY: You began to deal with a situation which in fact existed in the circumstances of Manchester where

there is a disagreement between the emergency services about how to deal with a particular situation. One can postulate quite extreme examples. Let's imagine that there is an FCP identified, not that that happened here, the commanders to get together, so they've co-located. They are communicating, they are coordinating, but there is a fundamental disagreement in the context of a Plato incident about whether a particular location is hot, warm or cold. And what we've been exploring is whether one of the emergency services in that situation should have what I described as a trump card and be able to say, "All right, I've listened to what you have to say, I disagree, this is what we're all going to do".

That was a rather long lead-in to a question. Is that a good idea and if it isn't, how are we to deal with the situation in which there is disagreement?

CHRISTIAN COOPER: Before I assess whether it's a good idea I think there are certain things, like the allocation of an RVP, for example, where it is certainly accepted by the ambulance services -- I am not just talking about NWAS, I'm talking about all of them -- that the police are probably best placed to make that determination based on the access to intelligence that they've got, their ability to secure that area if necessary, their understanding of local geography in relation to sites

that are appropriate.

It is very rare when there is a proper JESIP discussion and the police articulate a preference for an RVP for that to be disputed. It's far more likely to cause an issue when the conversation hasn't taken place properly and people are making judgements for themselves. So I think there are certain elements where primacy or making decisions in the event of there being a disagreement could work potentially. It creates difficulties when you place a responsibility and authority on one organisation to direct the actions of another. I think that's a complex area that needs some careful thought. But in terms of these disagreements that occur, JESIP may not be explicit about what to do if there is a disagreement, but it has in effect created the circumstance to resolve it. And if you can't resolve it, at the very least you have three commanders --

Q. What do you mean, created the circumstance to resolve it? Do you mean because they're together?

CHRISTIAN COOPER: Yes, they are co-located, they have a common understanding of risk, even if they disagree about that risk and what to do about it, they've shared what they each know and, in simple terms, if the outcome is, "We think an RVP should be there", "We disagree, we

thin an RVP should be there", at least if they're working together within the JESIP model that disagreement is well-known and understood. That doesn't mean that they are then fundamentally inhibited from continuing a joint emergency response, it simply means one agency will be using that RVP, another will be using that one, as long as everybody knows that, any difficulties arising from that can be overcome in that joint decision.

I guess what I'm suggesting is that the model still works even if there is a disagreement among commanders and if there is going to be a disagreement between the agencies, better it's done within that JESIP framework than outside of it.

SIR JOHN SAUNDERS: It's rather an awful idea that we're having a long discussion, or it could be a long discussion because we are disagreeing about the RVP, and eventually we have to work out, "Well, we are not going to agree it, we are all going to different ones", and now it is, "How are we going to manage to communicate?" By this time the emergency will be over, won't it?

CHRISTIAN COOPER: I don't disagree, which is why I say in relation to the RVP I think it may be sensible for the police to have a trump card that says: okay, we've had a conversation about this, but in order to effect

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

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

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

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

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

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

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

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

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

manage that risk. This isn't going to be risk-free.

SIR JOHN SAUNDERS: So do we have —— sorry to cut across this. You have a police view which is actually, when you're dealing with secondary unexploded devices, you still go in and you have an Ambulance Service view, if there are unexploded devices in there, you don't go in. So it's all very well having a huddle, but before you started you actually have different views of what you're going to do.

CHRISTIAN COOPER: That can happen.

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

CHRISTIAN COOPER: It certainly did happen there.

SIR JOHN SAUNDERS: And it could happen again tomorrow?

CHRISTIAN COOPER: I think it could, almost certainly will. I think the issue is: but is it better dealt with under the JESIP model or without a JESIP model?

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

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

SIR JOHN SAUNDERS: Okay. Thank you.

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

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

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

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

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

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

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

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

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

been talking about nationally and I have no doubt that Mr Greaney will, if he is going to seek questions as to whether this affected what happened on the night, which would of course relate to NWAS, I'm sure he'll make that clear. But I am clear that at the moment we are talking about a national picture and the extreme example is clearly nothing to do with NWAS at all.

MS ROBERTS: It would be helpful for our benefit if that were flagged beforehand that it's not NWAS and a hypothetical example or something that relates to somebody else or relates to another organisation rather than this, because it's very easy to conflate the two. Thank you very much.

MR GREANEY: It was made plain before the example was given and it wasn't hypothetical, it was real.

At all events, let's move into the events of the night.

SIR JOHN SAUNDERS: I think it's Friday, that could be the problem, if we're all going to fall out now.

MR GREANEY: I'm not sure that was a falling—out, sir.

MS ROBERTS: We never fall out; we just disagree.

SIR JOHN SAUNDERS: Just a minor tiff, we will call it that.

MR GREANEY: In all events I am going to move into the events of night and what I'm going to do is to seek to deal with things principally in themes but I'm going to

deal with them chronologically to the extent that's possible.

Sir, we can either take an early lunch or I can go on for another 15 minutes.

SIR JOHN SAUNDERS: I don't mind. When is it easier to get lunch? I think we have actually got a time for lunch of 1245.

MR GREANEY: I will go on.

What I'm going to do is start with Advanced Paramedic Patrick Ennis. Just to remind ourselves of some of the critical times, by 22.46, he was at the scene and, whilst outside, he declared a major incident standby. First of all, what is a major incident standby?

CHRISTIAN COOPER: When it comes to a major incident declaration there are two options for any ambulance member of staff to make: a major incident standby, which is a warning in effect that a major incident may be about to be declared. It allows, effectively, a run—up or a warm—up period, it allows people to start to be moved into post or assets to be examined. It prepares people for what might be a major incident coming. That would be as opposed to a formal declaration of a major incident.

Q. And bearing in mind what he knew at that stage, having

not by that time gone into the City Room, was a declaration of major incident standby appropriate or inappropriate?

CHRISTIAN COOPER: I think it was appropriate at that time.

SIR JOHN SAUNDERS: We do actually know it was treated as being the actual event anyway.

MR GREANEY: It was, absolutely, although as we know Mr Ennis did go on to formally declare a major incident ——

SIR JOHN SAUNDERS: It was being treated that way —— (overspeaking).

MR GREANEY: (Overspeaking) you're quite right, sir.

I'm going to show on the screen some images now from the sequence of events, so I just give a warning that we are going to be looking at some images of the City Room. They have been redacted in the way that we are all now familiar with but I just pause for a moment to give anyone an opportunity to switch off the screen or who wants to leave this room to do so.

(Pause)

{INQ035612/142}, please. This is 22.52.48. Advanced paramedic Patrick Ennis is on the overbridge walking towards the City Room. If we go over the page to {INQ035612/143}, please. At 22.53.01, by now Mr Ennis is in the City Room and in company with

Inspector Michael Smith. So as 22.52 ticks over to 22.53, he enters the City Room.

Then we know at 22.54, Mr Ennis made a call to the EOC whilst he was still in the City Room and he passed a message containing information about, for example, the number of casualties that he was aware of at that stage.

Was that in your judgement a METHANE message?

CHRISTIAN COOPER: Yes.

Q. Was it an adequate METHANE message?

CHRISTIAN COOPER: Yes.

Q. {INQ035612/170}, please, at 23.00, or just shortly before, Mr Ennis has left the City Room. So he was within there for a period of round about 7 minutes.

During that seven—minute period of time ——

SIR JOHN SAUNDERS: Sorry, do the DPAs there relate to the names of people? I think the indication is it does. Thank you.

MR GREANEY: So we have Mr Ennis in the City Room for a period of round about 7 minutes. As the footage reveals, and indeed as Mr Ennis was to explain to us, he did not during that period treat any of the casualties who were within that room.

At the time that Mr Ennis gave evidence, that resulted in a headline along the lines of:

"First paramedic on scene does not treat

casualties."

And in turn that generated a social media reaction. So out of fairness to Mr Ennis, let me ask you a direct question: are you in any way critical of the fact that Mr Ennis did not during that period treat any casualty or instead is that what you would have expected of him?

CHRISTIAN COOPER: It's what I would have expected and I am in no way critical of him. I appreciate the sensitivity of it and I should also express, having been a paramedic myself, it's an extremely difficult thing to do when you are highly trained to be able to help people, not to go to that first patient and render care. But it is absolutely necessary that the first ambulance person on scene gains the relevant situational awareness and passes the information necessary back to the control room to enable the Ambulance Service to provide its full and effective response.

What he did was difficult and entirely appropriate and in line with major incident planning and doctrine.

Q. Mr Herriot, do you agree or disagree?

MICHAEL HERRIOT: I do. I think any criticism of him is unfair and he was required to gain that situational awareness. Had he not done so, it was more likely to compromise what came after.

MR GREANEY: Dan Smith arrived at the scene at almost

exactly 11 pm. By way of training, he was a tactical commander, but as I recall it at any rate, not an operational commander. Was it in those circumstances appropriate for him to take up the role as operational commander?

CHRISTIAN COOPER: I think it's right for that to be examined. It's not uncommon for a person that is a qualified tactical commander and an experienced tactical commander to possess the necessary skills and ability to function as an operational commander. But if there is an on-call assigned operational commander already on scene, then we would normally expect some sort of reason or justification for that assigned operational commander not to be the very person that takes operational command.

It may be that Dan Smith felt that his level of seniority, his experience, rendered him a more appropriate person to take operational command, and as a commander that is his prerogative.

SIR JOHN SAUNDERS: I'm afraid I can't remember the evidence, whether he had gone through the necessary training for an operational commander in the past and had acted as that in the past. Ms Roberts is indicating that that was the evidence.

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

pre-NARU.

CHRISTIAN COOPER: I think that's correct. At some point in his career he had been trained as an operational commander, he wasn't current or what we would class as current --

SIR JOHN SAUNDERS: You would still expect -- a current operational commander, if they're on duty, your view is that would be the appropriate person to do it, but I'm just putting it within the further context that Mr Smith had done it in the past.

MR GREANEY: Quite right, sir, thank you very much indeed for that context.

In terms of Mr Smith, obviously we could go into a huge amount of detail but it's probably more helpful to deal with things in headline, I'm going to pose three questions. You've answered the first.

First, did Mr Smith do sufficient in your judgement to ensure JESIP worked?

CHRISTIAN COOPER: No.

Q. Second, in your judgement did he do sufficient to ensure that there was adequate paramedic presence in the City Room?

CHRISTIAN COOPER: No.

Q. Thirdly, did he do, in your view, sufficient to ensure that adequate equipment and other physical resources

were present at the scene?

CHRISTIAN COOPER: No.

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

MICHAEL HERRIOT: I agree.

Q. The police are the ones, and the only ones, who are able to declare Operation Plato.

CHRISTIAN COOPER: That's correct.

Q. Then they must communicate that declaration?

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

Q. And they need to do so as a matter of urgency, as we know. Do you agree that a critical part of Operation Plato is the designation of zones?

CHRISTIAN COOPER: I agree.

Q. Should the way in which particular zones or areas have been designated be communicated to other emergency services?

CHRISTIAN COOPER: Yes.

Q. Why is that important?

CHRISTIAN COOPER: It has direct implications to their response. If it is a Plato hot zone, as has been adduced in evidence, that then means it is not possible for any ambulance responders to operate in that area. If it's a Plato warm zone, or if it's indeed not being treated as Plato, then certain ambulance resources can deploy. So purely from a deployment perspective, if

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

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

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

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

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

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

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

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

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

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

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

CHRISTIAN COOPER: Yes.

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

CHRISTIAN COOPER: Yes.

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

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

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

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

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

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

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

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

CHRISTIAN COOPER: Yes.

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

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

SIR JOHN SAUNDERS: In major incidents?

CHRISTIAN COOPER: In major incidents, absolutely, sir. More often than not a major incident will still be zoned in that regard, hot, warm and cold.

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

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

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

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

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

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

CHRISTIAN COOPER: Yes.

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

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

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

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

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

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

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

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

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

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

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

spend more time training to deal with major incidents and incidents of that nature, so they tend to be good at doing quite a wide range of functions. The difficulty is you've only got six of them initially, and an ambulance trust —— some ambulance trusts only have six on duty at any one time, some benefit from having two units and therefore have 12 on duty at all times. There were six in Manchester, six in Liverpool in the case of NWAS. It's still a very, very small number of responders, so you need to be very careful what you do with them.

They are trained and equipped to fulfil a very specific purpose, which is to operate in areas that other paramedics cannot, so it is unusual to see a HART team split, first of all. And then if you've got those other HART people doing other functions, it's quite appropriate to challenge why other paramedics that can operate in that area are not fulfilling those functions.

Q. So a way of looking at it is to ask: was there any better or more important task for those members of the HART team to be deployed to that night once they arrived than going into the City Room?
CHRISTIAN COOPER: I don't think so, no.
SIR JOHN SAUNDERS: And you have considered the matter of setting up the oxygen cylinders, which was what was

suggested?
CHRISTIAN COOPER: I have looked at that. I saw the evidence of Mr Blezard on Monday. Now, when HART was originally set up many years ago they had those mass oxygen delivery systems as part of their equipment and they at that time were the only ones that could have deployed and used that equipment.

Then the national mass casualty vehicles came along and they too had mass oxygen delivery systems on the back and there were a number of national conversations had at that time, and NWAS were represented in those conversations, that said: now we've got that, it is probably not appropriate for HART to be detracted (sic) to do that function.

The other thing is that mass oxygen delivery system, when it was given to HART initially, was given for the purpose of running oxygen into a CBRN environment, a hazardous environment with toxic chemicals. It was for that particular purpose.

But it is quite right that if you haven't got a CBRN situation and you've got other patients that might benefit from oxygen, people were using the HART team to do that. But there was a conscious decision taken prior to 2017 that the national mass oxygen delivery system should be part of a mass casualty response using that

vehicle, that's not a HART—specific response. So there should have been other people within NWAS at that time capable of deploying and using that mass oxygen delivery system.

If there were not, for whatever reason, if that was an omission, and the only people within NWAS that were capable of using mass oxygen delivery systems were HART, and the operational commander knew that and knew that they had people at a CCS that would have benefited from that, then there is some justification there for making that decision to potentially split the HART team.

MR GREANEY: Although, sir, it would be fair to observe that that was not the evidence that the operational commander gave ——
SIR JOHN SAUNDERS: No.
MR GREANEY: —— as for his rationale.
MS ROBERTS: (Inaudible: no microphone).
MR GREANEY: That was not the reason that was given by the operational commander, Mr Smith, for splitting the team.
MICHAEL HERRIOT: Once the system is established, of course, any paramedic could use it.
SIR JOHN SAUNDERS: It's the setting—up that's the problem?
MICHAEL HERRIOT: Yes.
SIR JOHN SAUNDERS: And we know from what Mr Blezard said that people who were AIT trained could use it. I think

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

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

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

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

Q. And you have identified others in your reports and I am going to make a statement about your reports in due course.

You said that there were omissions. Could you tell us what those were, please?

CHRISTIAN COOPER: I think one of the omissions, as we have just alluded to, was an early —— early efforts to ensure that all of the specialist resources that could have been of benefit were mobilised. The Liverpool HART team being one specific example, but also identifying and potentially mobilising the AIT team.

The AIT team presents much greater complexity to the Ambulance Service because these AIT—trained staff are otherwise deployed on normal front line ambulances. So you firstly have to identify which ambulances have got an AIT person on board and then take steps to try and get not only those ambulances but the ambulances with the AIT members on them to the scene. So that is quite complex.

There's systems within the control room that allow them to quickly identify where those people are and what vehicles they're on. The important thing is that if it isn't done early, you have missed the window to do it really quite early on in the incident. So if there were considerations some way into the incident that AIT may

have been beneficial but perhaps the time's passed to mobilise them, I do understand that, I can recognise that as being a justifiable approach to decision—making.

If you know it's not a Plato, you know that's been resolved, I think AIT members of staff have had a contribution to make at this incident, certainly in the very early phases. But if you miss the window to mobilise them, not mobilising them once you're 30 minutes into this incident is probably understandable given the complexities and the time it would take to bring them into play.

Q. Thank you, Mr Cooper. I'm going to just pause the chronological analysis and look at some particular topics, but before I do so, Mr Herriot, do you have anything that you wish to disagree with in what's been said by Mr Cooper about the deployment of HART?

MICHAEL HERRIOT: No, I completely concur, thank you.

MR GREANEY: The first topic, the casualty collection point and the casualty clearing station, so the CCP and CCS.

In a few sentences could you describe each of those to us, please?

CHRISTIAN COOPER: A casualty clearing station is somewhere located in the cold zone of the incident, at an area of the incident known to be relatively safe. And it is the main area where you will move casualties to in order to

further triage them, stabilise them, in some cases conduct fairly advanced medical interventions, and organise them to work out which is the most appropriate receiving medical facility for them to be transported to.

It's a crucial part of the major incident process, which allows you to link closely with the ambulance loading officer to work out how you're going to move those casualties and, crucially, in what order from a casualty clearing station to onward definitive care.

By contrast, then, a CCP —— and this came about mainly when we were developing the MTFA doctrine, as was then, MTA now, but it's used in other circumstances other than MTA now, a casualty collection point is a point that is closer to the inner cordon or warm zone of the incident than a CCS is, so you would often locate a CCP within a warm zone. And it is an area, a temporary, very temporary area, where you might group some casualties together prior to their extrication to a CCS.

And the scenario —— in the first instance it was envisaged that you would use —— CCPs would be for an incident spread over a fairly large geographical area, we might say a shopping centre or outside, an open space, where you might have pockets of casualties in

various different locations. It allows the forward responders to formally nominate a CCP in a particular spot to say: I'm going to initially move my casualties to that location. At this point, it still may be the case that they have only had an initial triage sieve and very, very basic life saving interventions applied, but you're moving them to that point so that a coordinated effort can be put in place behind you to extricate the patients from that casualty collection point to the CCS.

Q. So there are two points of triage, primary triage or triage sieve, and secondary triage?

CHRISTIAN COOPER: Yes.

Q. First occurring at the CCP, the second occurring at the CCS?

CHRISTIAN COOPER: Well, the initial triage sieve may occur over a fairly broad —— it doesn't have to occur at a CCP, you could have sieved them already and then moved them. And another use of a CCP may be to say: I'm going to have a CCP for my P1 patients at this location, they are the priority and you need to move them from there first; there may be others located elsewhere.

Q. So is the point or a point that at the stage of primary triage, one is making assessment but would not generally treat unless there is a need for an urgent life—saving intervention ——

CHRISTIAN COOPER: That's correct.
Q. -- such as the application of a tourniquet or to maintain an airway?
CHRISTIAN COOPER: Indeed.
Q. But that at the stage of the secondary triage, more advanced or complex treatment would be expected?
CHRISTIAN COOPER: Yes, that is the principle. I have seen occasions where CCPs have been in operation and for whatever reason there has been a delay in extricating a patient from a CCP to a CCS. There's been a paramedic at that CCP, the paramedic has completed their primary triage, and the paramedic has then moved on to more advanced treatments of the patient at the CCP.

Now, that's not to say that that is wrong. I wouldn't expect a paramedic to slavishly stick to those triage principles -- the triage principles are there because if the paramedic is overwhelmed and there are more patients than they can treat it is quite right and proper that you restrict what treatments are applied so that the triage process can be completed first. But if a paramedic were to find themselves in a situation where that process has already been concluded, they're stuck at a CCP waiting for their patients to be extricated, then there's nothing to stop that paramedic using their skills further.

Q. I understand. I want you to deal with two issues, and I'll identify what each is and then leave it to you to answer.

First of all, I'm going to ask you to help us with what ought to have been done in your judgement in this regard, so CCP and CCS, on the occasion of the Manchester Arena attack. Secondly, I would like you to compare and contrast that with what in fact happened, if something different to what you would have expected occurred.
CHRISTIAN COOPER: I would have expected at Manchester there would definitely be a requirement for a CCS, a casualty clearing station. That is best located in an area deemed to be safe, ideally an area protected from the elements, an area -- it's not going to be sterile but an area that is as appropriate as it possibly can be for anticipated and fairly advanced treatments of casualties.

There are a number of other things that a commander may consider as being appropriate location for a CCS. In this case, locating a CCS on the station concourse, just within the doors of the station, would seem entirely appropriate to me.

Whether or not a CCP was required here, I think is debatable. Because the City Room -- given its size but given the fact that it is one location, and not huge in its dimensions, as in it is not spread over a wide geographical area, it is one location, you could almost treat that effectively as a CCP in its own right because everybody knows if you were to say, "The casualties are located in the City Room", they know where that is.
Q. Yes.
CHRISTIAN COOPER: CCPs are often also used where there's some confusion over geography, "I don't know where the casualties are", so somebody can locate a CCP to say, "We'll move them to there", so it's a commonly understood place. From that perspective it may not have been appropriate to set a CCP up.

However, you've got the matters of the stairs, which present a difficulty for rapid extraction of seriously injured patients to a location where they can receive more definitive care or more advanced care in the CCS, so it may have been appropriate, and something that I would certainly have considered, to have located a CCP potentially somewhere at the top of those stairs outside of the City Room, so in effect the mezzanine itself, because that would have removed people from the City Room but then allowed a certain amount of organisation and prioritisation to take place before they then come down the stairs.

However, for what you are materially gaining there, what you would not want to do is build in unnecessary delay. So it's a consideration, I am sure some commanders would consider doing that, other commanders may not, and I don't think it's clear enough for me to be able to say whether or not that's right or wrong.

In other words, I suppose it would be entirely appropriate for a commander to say, "Given the geography of this location, I don't need a CCP, I just need proper management of the City Room and an effective route for those patients to make it to the CCS".
Q. What is your view of what actually happened on the ground that night?
CHRISTIAN COOPER: I think there was some confusion around the location of the CCS because there was some things that we would normally associate to be within a CCS set up outside the stairs on the pavement on the run-up.
Q. We have heard suggestions that there was an intention to set up a CCP outside of the station.
CHRISTIAN COOPER: Yes. That is somewhat at odds with the methodology of a CCP, because as I've described, the CCP is normally forward of a CCS. Once somebody has been through a CCS, it would be unusual -- I have never heard of an occasion where they would then retreat beyond a CCS to a CCP. Normally, the loading officer's

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

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

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

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

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

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

CHRISTIAN COOPER: I agree, sir.

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

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

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

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

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

becoming a CCS.

SIR JOHN SAUNDERS: People said it was too narrow.

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

SIR JOHN SAUNDERS: Yes, thank you.

MR GREANEY: That's all I propose to ask about the CCP/CCS. I'm moving to a separate topic, which is equipment.

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

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

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

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

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

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

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

CHRISTIAN COOPER: Absolutely. The Fire and Rescue Service

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

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

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

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

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

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

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

SIR JOHN SAUNDERS: Thank you very much.

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

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

CHRISTIAN COOPER: I think it was the operational

commander's.

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

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

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

CHRISTIAN COOPER: Yes.

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

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

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

Q. Were they called equipment vehicles?

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

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

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

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

SIR JOHN SAUNDERS: I understand the argument which says this national asset is there for precisely this occasion and therefore you should use it. But if the reality is that because of their own particular assets they have their own major incident vehicles, because they have them there, it actually made no difference.
CHRISTIAN COOPER: I think the difference it could have made is -- if I give you three specific examples. The national mass casualty vehicle contains the national mass oxygen delivery system. Okay, in this case that was deployed by HART, but that created its own problems at the scene because you then need to split your HART team to do it. If NWAS not only mobilised that vehicle but had the people there to offload it and use the kit that would have made a real difference.
There's talk about the HART cubes being used. These are the large cubes that contain lots of clinical consumable items that are very useful at a major incident, except the national mass casualty vehicle carries not those cubes but similar stocks of consumable equipment that could have negated the need for HART to be using the cubes at the CCS.
If HART were going to use their cubes anywhere, I would argue they should have been taken into the City Room for people to help themselves to the contents.

The third thing on the national mass casualty vehicles is it carries large quantities of the drugs that both doctors and paramedics may need extra supplies of and I believe indeed in NWAS's -- one of NWAS's evidence submissions, I'm afraid I don't know the INQ number, but it's the lessons learned from the debriefing events, there is a table in there and one of the things identified in there is there was a shortage of things like tranexamic acid, TXA, and metoclopramide and some other drugs and ketamine, and the mass casualties vehicles certainly carry much larger quantities of those pharmaceuticals that were needed at the scene.
SIR JOHN SAUNDERS: My recollection is because they're carried on individual ambulances in much smaller numbers, you have to get there, each time you have to get -- go to a vehicle it's another trip rather than having a mass casualty vehicle and there's a much bigger bulk of them which you can take, presumably, in one trip.
CHRISTIAN COOPER: That's quite right, sir, and of course at a major incident there is something else that needs to be in the contemplation of the commander and that is the more equipment you can use from specialist vehicle means you're using less equipment from an ambulance that may subsequently need to transport somebody.

SIR JOHN SAUNDERS: Okay.
MR GREANEY: That's an important topic that I want to turn to very soon indeed. But first of all, Mr Herriot, is there anything you wish to add on the issue of equipment?
MICHAEL HERRIOT: I think NWAS were very well equipped regarding additional incident support vehicles, public support vehicles, all over the various locations in the north-east (sic)
Q. Do you mean in general terms?
MICHAEL HERRIOT: In general terms, all of which carried stretchers, for example. I just don't think that there was probably the consideration given to whether or not those assets could have been brought to the scene at an early stage.
CHRISTIAN COOPER: If I may just add, because I don't know if it's in your contemplation for recommendations, sir, but the one thing the national mass casualty vehicle did not carry at this time was stretchers. It didn't have any of any type. There are plans to change those vehicles, they're at the end of their life now, and the replacement vehicles and the contents that are coming into place in the new financial year, based on what we already understand from Manchester and other learning as well, means that those new assets will carry a large

quantity of portable stretchers.
SIR JOHN SAUNDERS: Thank you.
MR GREANEY: Next topic, command structure and action cards.
Did the NWAS command structure involve command roles beyond Gold, Silver and Bronze?
CHRISTIAN COOPER: It included the functional roles within the major incident plan, but those were the three key levels of command, yes.
Q. That's what I had in mind. The key levels of command, Gold, Silver and Bronze. But within the structure there are functional roles also?
CHRISTIAN COOPER: Yes.
Q. That's the right way of putting it, thank you.
Were there important roles in that structure, the functional role structure, that were not appointed on the night of the arena attack?
CHRISTIAN COOPER: Yes, of particular note are the lack of a safety officer and the lack of an equipment officer.
Q. First of all, the safety officer. What role does that person have?
CHRISTIAN COOPER: First and foremost, to consider the risks at the scene and the safety of the responding ambulance crews. The role can then go broader and consider broader safety risks at the scene, the safety of casualties and the like.

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

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

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

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

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

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

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

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

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

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

SIR JOHN SAUNDERS: Absolutely, thank you.

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

CHRISTIAN COOPER: Yes.

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

CHRISTIAN COOPER: Yes.

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

CHRISTIAN COOPER: Yes.

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

CHRISTIAN COOPER: Indeed, yes.

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

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

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

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

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

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

CHRISTIAN COOPER: Yes.

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

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

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

I think we need to look harder at whether or not

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

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

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

be beyond the wit of man.

CHRISTIAN COOPER: I agree. Ambulances are very complex vehicles. They're not vans. I think that is important to note. The driving bit is probably the easy bit.

SIR JOHN SAUNDERS: Right. Okay.

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

CHRISTIAN COOPER: Yes.

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

CHRISTIAN COOPER: Yes.

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

CHRISTIAN COOPER: Yes.

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

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

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

SIR JOHN SAUNDERS: Thank you.

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

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

CHRISTIAN COOPER: Yes.

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

CHRISTIAN COOPER: He was.

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

CHRISTIAN COOPER: Yes.

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

CHRISTIAN COOPER: Yes.

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

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

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

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

CHRISTIAN COOPER: Yes.

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

CHRISTIAN COOPER: Yes.

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

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

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

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

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

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

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

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

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

SIR JOHN SAUNDERS: Ms Roberts, can I raise a gloss on that? I think it's important for NWAS to understand this, not you. I think it has become apparent that there are difficult issues which arise in making things better.

MS ROBERTS: Yes.

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

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

MS ROBERTS: Yes.

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

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

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

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

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

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

Q. Does that accord with your --

CHRISTIAN COOPER: I think the reason for that is because

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

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

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

CHRISTIAN COOPER: Not for me.

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

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

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

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

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

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

CHRISTIAN COOPER: He did.

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

CHRISTIAN COOPER: Yes.

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

CHRISTIAN COOPER: Yes.

MICHAEL HERRIOT: Yes.

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

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

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

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

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

Q. Yes.

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

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

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

Q. Yes.

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

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

CHRISTIAN COOPER: I would agree.

MICHAEL HERRIOT: Yes.

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

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

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

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

MICHAEL HERRIOT: Yes.

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

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

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

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

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

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

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

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

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

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

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

time and get help from the experts about is: was the debrief process actually effective and has this issue only been thrown up by the inquiry? That may be because people have looked at this in the past and thought, "Actually, there is absolutely nothing you can do about it", but we haven't yet heard that. So the effectiveness of a debrief and actually getting the issues early on I think is something that we may need to look at.

MS ROBERTS: I agree.

SIR JOHN SAUNDERS: Thank you.

MICHAEL HERRIOT: We certainly recognise the issue and will endeavour to assist you wherever we can.

SIR JOHN SAUNDERS: Thank you.

MS ROBERTS: I think as you said this afternoon —— I mean, the casualty plan, the mass casualty distribution plan, worked extremely well, didn't it?

MICHAEL HERRIOT: I agree.

Q. That had been trained or exercised, I should say, fairly ——

MICHAEL HERRIOT: Socrates.

Q. —— only a month or so beforehand, hadn't it, and that had gone extremely well itself, that particular training exercise, yes? So the distribution plan worked exceptionally well.

And you've also seen, I think, the statement of Martin Smith, haven't you, the ambulance consultant, with regard to the mass casualty distribution plan?

MICHAEL HERRIOT: Yes.

Q. Thank you. As I understand it from your evidence this morning, I think it was, in the session, under JOPs 3, which governed the blue light response on 22 May, there was no flexibility to commanders; is that your evidence?

CHRISTIAN COOPER: Yes.

MICHAEL HERRIOT: Yes.

Q. Are you sure? There was a hesitation. That's the only reason I'm asking.

MICHAEL HERRIOT: It's purely that NHS England say in their guidance that plans should be flexible. That's the only caveat. So it rather implies that there is within plans an ability to be flexible. Certainly, as it was trained in this circumstance, that flexibility wasn't ever applied.

Q. Right. So with a general caveat from the NHS that there should be flexibility to plans, there was no flexibility to JOPs 3? Is that the view of both of you or do you differ in relation to that?

CHRISTIAN COOPER: We do not differ on JOPs 3. I think in general, plans are expected to be flexible, that's quite correct.

Q. Yes.

CHRISTIAN COOPER: On the matter of who can operate in certain zones under JOPs 3 in place at the time of this incident, there was no flexibility for the ambulance commander to determine who could operate in those zones. The JOPs are very clearly on that.

SIR JOHN SAUNDERS: I want to look at that a bit more. The whole aim of the Ambulance Service is to protect life. Of course, you have to protect the life of the paramedics as well as the members of the public. But within that, does that general overriding duty provide a discretion, however strict the plan may be, that if you can be satisfied that you're doing the best thing for the patients and on what you can see from your own eyes you are actually —— you're not causing unnecessary risk to paramedics (inaudible) go in there so that overriding discretion which comes with doctors, the Hippocratic Oath, and things like that, that is what they are doing?

CHRISTIAN COOPER: And the duty of care for —— I absolutely agree, sir. I think ——

SIR JOHN SAUNDERS: So if that is right, there is a discretion somewhere?

CHRISTIAN COOPER: I think there is discretion somewhere and I think it's best placed, as you have said, in that

understanding of risk. In JOPs 3 the hot zone is describing a location where there is an active exchange of gunfire, where you would not place a paramedic.

MS ROBERTS: Any paramedic?

CHRISTIAN COOPER: Any paramedic.

Q. Thank you.

CHRISTIAN COOPER: If the paramedics, given that there has been a breakdown in JESIP here, and a paramedic very early on, the actions of Mr Ennis, has given you a good situational awareness of what is going on in that location and you are satisfied that it is not a hot zone, regardless of what you're being told it is, I think that's where the flexibility exists.

Q. Right. At which point it becomes a JOPs warm zone?

CHRISTIAN COOPER: In the view of the Ambulance Service, quite so.

Q. Do you agree that having formed that view, and you'll recall Dan Smith's evidence on this, that that was the view he had formed, he talks about it in terms of JESIP and in terms of JOPs —— having formed the view that it was warm in terms of JOPs ——

CHRISTIAN COOPER: Yes.

Q. —— that having formed that view —— and he didn't, didn't he?

CHRISTIAN COOPER: He did.

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

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

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

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

at {INQ008372/2}. I just want you to look at the second paragraph of page 2:

"The JOPs set out in this document have been developed by the MTFA Joint Operational Working Group and will act as a significant enabler in the delivery of a consistent and integrated national emergency service response to an MTFA. This guidance should be used to inform exists major incident procedures."

Pausing there, that presumably would be captured in the major incident plan, the MIRP?

CHRISTIAN COOPER: Yes.

Q. Just pausing there tangentially, if I may, the NWAS major incident plan at the time was -- I think you described it as fit for purpose and compliant. I think you'd seen that and you're content with that document?

CHRISTIAN COOPER: Yes.

Q. Thank you. It says:

"The guidance should be used to inform existing major incident procedures [the like of which I have referred to] and must be used in conjunction with local and national standard operating procedures."

It's this really:

"In non-terrorist attacks of a similar nature these principles may still deliver an effective response and consideration should be given to their use."

Just looking at that final sentence, would that then capture this incident that did in fact unfold on 22 May? And you're both nodding.

CHRISTIAN COOPER: Yes.

MICHAEL HERRIOT: Yes.

SIR JOHN SAUNDERS: Sorry to put the other point of view as well: what significance do you attach to the word "guidance", as it were, to these directions or these instructions must be used?

CHRISTIAN COOPER: I have some knowledge of the context of this document and the purpose of this, and indeed other paragraphs within it, are to carefully insert this within what is already a body of operational procedures and practice across the emergency services, which is quite a tricky thing to do.

So what it's trying to do is say: we recognise that these specialist teams, firearms teams, Hazardous Area Response Teams, are very strictly governed by their own standard operating procedures on a day-to-day basis covering a wide range of events. So what it's trying to do is say: this does not replace those, though this is catering for a very specific set of circumstances where we expect you to follow this, but expect it to the best -- expect you to follow it to the best of your ability in a compliant manner with your existing

standard operating procedures, if that helps.

SIR JOHN SAUNDERS: Okay, thank you.

MS ROBERTS: Would you agree that the risk in an explosion site, such as that on 22 May, by which I mean the City Room, that the risk was significant? Post explosion the risk was still significant? Do you agree or disagree?

MICHAEL HERRIOT: There was residual risk without a doubt, yes.

CHRISTIAN COOPER: Yes. There were certainly risks present in that area, yes.

Q. I suppose that might be one of the explanations as to why the firearms officers remained within that area.

CHRISTIAN COOPER: Yes, but I think it's all relative. There were risks present, significant risks compared to an armed terrorist, perhaps much, much less so, but no doubt risks were still present, certainly.

Q. The chairman thought the other day -- I think it was 2 days ago -- about the risk of ambush, for example. Do you agree or disagree with that?

SIR JOHN SAUNDERS: That's not the context in which I was saying that.

MS ROBERTS: Forgive me, then I'll move on.

SIR JOHN SAUNDERS: No, no, that's fine. I'm not suggesting the point is not a good one. What we have to

contemplate, don't we, is once the armed officers have gone, they've cleared the area, there's no gunman there, and what's more, they are guarding the area and can ensure that no gunman returns and gets through into the area. So that's why -- but that doesn't appear, from what the police are doing, to take into account the unexploded bomb. This is where, for me, the difficulty of two different interpretations, what people are looking at, becomes a difficulty.

MS ROBERTS: Yes. All right.

We know from what you've told us, and within your reports, that there were reports, I think from at least -- well, from two hospitals, Oldham Hospital and North Manchester General Hospital, of suspect behaviour there. I think one of the hospitals in fact went into lockdown, albeit that was after this particular period that we're looking at.

This was and remained -- despite the fact that the armed police officers had gone in there, would you agree that there remained a good deal of uncertainty about the City Room, about the risks posed in the City Room?

CHRISTIAN COOPER: Yes, I think that's fair.

Q. Thank you. And do you see now why Mr Smith, Dan Smith, made the assessment that he did when he gave his evidence that he was treating the City Room as a warm

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

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

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

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

guidance issued on this. I'd have to check, I think, since 2017, to be a bit more specific about: are you just thinking there may be an IED or is there something that's leading you to give you more concrete -- you know, is there something that's --

SIR JOHN SAUNDERS: Well, here we have: someone's exploded a bomb. So therefore you're thinking: is there a risk he's left another bomb in there? There are a number of bags there in which you could hide a bomb. That's the information. That there may be a bomb. As a result of that, do you say, "We're not going to send paramedics in who are not protected"? And, as you've pointed out, if you send the HART team in, they're not going to be protected from a bomb going off. So do you send no one in or can you send them all in?

CHRISTIAN COOPER: It's a matter for the operational commander on the night.

SIR JOHN SAUNDERS: Okay. You're the operational commander on the night, those are the facts.

CHRISTIAN COOPER: If it were me and the police were in there and had cleared that area and I had two HART paramedics operating in that area already, I would absolutely commit a full HART team and further HART resources.

SIR JOHN SAUNDERS: Paramedics? Ordinary paramedics?

CHRISTIAN COOPER: If they were required and extra resource was needed and we've got a situation where we've got unprotected police officers in there treating casualties, members of the public treating casualties, and all I've got is the fact that one bomb's gone off, there could be possibly be another device or any -- but I don't have any -- you know, the police are not concerned about a particular rucksack that they're dealing with and haven't ordered an evacuation, then I, as an operational commander, would be content to commit resource, yes.

MICHAEL HERRIOT: I think it has to be viewed in the context that the police are not ordering other people to leave that area. There are a lot of people doing their best to treat those that are present. So it would seem rather anomalous to --

SIR JOHN SAUNDERS: Ms Roberts, these are sort of very difficult issues that we have to contend with as to what the right thing to do is. That does not necessarily mean that Dan Smith didn't send them in, that he was wrong, but we do need, I think, to try and get some sort of, at least, guidance and formula as to how anyone should face these sorts of situations in the future.

MS ROBERTS: I agree. I would imagine not just locally, but nationally, I would think, yes.

MICHAEL HERRIOT: There seems to be a difference between what was happening in reality and the assumptions about the zoning of that particular --

Q. Yes.

MICHAEL HERRIOT: -- location, excuse me.

Q. You talked -- you were asked about if you were the commander and if you were there. Might I ask individually, Mr Cooper, first of all, if I may. I know that you've been a HART and special operations manager. Have you been a HART operative?

CHRISTIAN COOPER: Not an operative.

Q. Have you been a commander at a major incident?

CHRISTIAN COOPER: Yes.

Q. You have, thank you.

CHRISTIAN COOPER: At all three levels.

Q. All three levels, thank you very much.

Same question of you, please.

MICHAEL HERRIOT: Yes, at all three levels.

Q. And have you been a HART operative as well?

MICHAEL HERRIOT: No, (inaudible) equivalent of HART from scratch in 2002.

Q. All right, thank you very much.

Well, having the benefit, as we now know that you have, of operational command at a major incident, you would presumably agree with the evidence -- you saw

the evidence of Mr Thomas, Richard Thomas, earlier this week, did you? You've had the opportunity to look at that?

UNKNOWN SPEAKER: Yes.

Q. Good. You would presumably agree with his assessment, so far as the command is concerned, that there is -- the burden of command rests on the shoulders of the commanders, self-evidently?

CHRISTIAN COOPER: Yes.

Q. And although you might have made that decision at the time, had you been the operational commander, Mr Cooper, you're not saying, are you, that the decision made by Mr Smith at the time, this is Dan Smith, was an unreasonable one?

CHRISTIAN COOPER: I'm not saying that his -- no. Had he made the determination that he felt the risk in that room was too great for non-specialist responders to operate in, I agree. Where I have an issue with the decision-making is that he is willing to commit a non-specialist, non-protected responder into there along with some HART staff whilst there are other HART staff elsewhere. That is the difficulty. That doesn't seem to stack up with an understanding of risk unless the only reason is simply to limit the number.

Q. Yes.

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

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

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

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

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

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

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

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

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

"Answer: In my view, the policies and procedures, or the procedures that I am permitted to follow at the time, did not allow for the deployment of any of the resources that I had at scene into the City Room. I qualify that by saying that HART operatives are able to work in -- and I know there's been a lot of discussion around whether it was a warm zone, an inner cordon --

"Question: We'll get to that. Just make the point you wanted to make.

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

Again, please, if we can just move on so far as Mr Dan Smith is concerned to page 140 {Day110/140:10}, please, Mr Lopez.

Answer about a third of the way down:

"Answer: I think the expectations will always be

that we will send multiple resources in to an incident scene like that. The reality, unfortunately, since I started training as a paramedic, has been that we would not, and that was the reason from my understanding of the 7/7 inquests, that that was the reason for the HART team deployment -- not deployment, sorry, the reason that the HART team were brought about was for that area working, because you know, as I say, since I started training as a paramedic, the thoughts have always been that paramedics don't work in that inner cordon area. Of course, I understand the reason for the questions you're asking, but that has unfortunately been always our treatment pathway."

And so far as Mr Ennis is concerned, and his -- before we turn to them, could we have page 146 {Day11/146:6}, please, of Mr Dan Smith's evidence?

A third of the way down question from Mr Greaney:

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

"Answer: I do, yes.

"Question: Because that was the thing or an

important thing that was inhibiting more paramedics going in?

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

"Question: We understand that.

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

Page 151, please, Mr Lopez. He talks there about it being an inner cordon.

Line 15 {Day110/151:15}:

"SIR JOHN SAUNDERS: Yes, but I thought you were actually using the major incident plan rather than the Plato JOPs.

"Answer: The zoning would be from the JOPs, really, but I think our major incident plan refers to the JOPs.

"SIR JOHN SAUNDERS: When you've been talking about inner cordon which is your major incident plan?

"Answer: That was the plan, yes."

Mr Greaney then referred to the major incident plan.

If we turn now please to Mr Ennis' evidence, Day 110, pages 43 {Day110/43:6} onwards of Mr Ennis' evidence.

Just so that we understand what Mr Ennis and his level of understanding at the time -- we've got an answer about third of the way down:

"Answer: No. I knew what a marauding terrorist firearms incident was and I knew what the difference in terms of zoning and management at a major incident -- if it was a firearms incident. But the term Operation Plato is one that wasn't familiar to me. The implications were, but not that term.

"Question: So far as your consideration was on the night, this was a major incident, the City Room was a hot zone.

"Answer: Yes.

"Question: So far as the paramedic response, the NWAS response is concerned what was your understanding about which paramedics if any could enter a hot zone in a major incident?

"Answer: My understanding is that the HART team were the operatives who would be trained and able to be deployed into that area.

"Question: Anybody else within the NWAS response?

"Answer: No, only those with a HART level of PPE

would be usually, as per the plan, deployed into that area."

Sir John:

"I'm interested in this, as you asked you whether there was any discretion in relation to that, you said there was some discretion.

"Answer: So the plan suggests that the correct people to be deployed into that area are the HART team. The plan is -- it is a plan, it's a guide, it isn't decided -- sorry, it isn't a definitive thing. But I think it's fair to say that an operational commander would need to perform quite a robust risk assessment and would be deviating from the plan if they decided to deploy paramedics without that level of PPE and without the HART level of PPE into that area.

"SIR JOHN SAUNDERS: As you explained, you can get situations where HART may just not be there for quite a long time, in which case you have to make that sort of decision presumably?

"Answer: Yes, and it'd one that would need to be justified, particularly if anything were to go wrong and any harm were to come to those people, then the operational commander would then be held to account because they would have deviated from the suggested plan.

"SIR JOHN SAUNDERS: Thank you."

And I was asking questions at this stage:

"Question: And deviate from the plan is precisely what you did, in fact, because you are neither HART nor were you wearing the kind of protective equipment, the ballistic equipment for example, that they would have been or might have been wearing?

"Answer: Yes.

"Question: So you self-deployed into the hot zone, flexing the plan that you've told us about, and thus operating outside what ordinarily takes place or ought to take place within a major incident hot zone?

"Answer: I think the... Until obviously seeing the City Room, it wasn't apparent that that was a... that indeed it was definitively a major incident or that it was potentially a dangerous area.

"Question: But at 11.05, when you went back in there, that was patently obvious to you?

"Answer: Yes.

"Question: Yes. When you went back into the City Room at 11.05, that was after your discussion with Dan Smith, who was by then the operational commander; correct?

"Answer: Yes.

"Question: Right. Can you help us, and forgive me

if you've already told us about this, but the discussion that you had with Dan Smith when you and he congregated on or around the station concourse in what was to become the CCS, what discussion was there about whether you were content to go back into the City Room, first question, and second question, whether anybody was going to be going with you?

"Answer: I don't recall... Sorry, I... I believe that I suggested that I was going to be going back into the City Room and didn't wait for instructions from Dan Smith to tell me whether he agreed with this or otherwise. I think I explained to him that was what I intended to do. At the time, I don't think there was any discussion about anybody else joining me in there based on the fact that the other NWAS personnel who were there were required in other capacities."

Would you agree that so far as risks, so far as who could deploy into there, who shouldn't deploy into there, that whole process would have been enhanced considerably had there been a better discussion or any discussion between the operational commander within -- from the police within the City Room and the operational commander from NWAS in the CCS or thereabouts?

CHRISTIAN COOPER: Yes.

Q. And you have told us about, and again we're not going to

disagree with -- I'm not going to disagree with you, far from it, in relation to this, but in deciding on zones, whether we call them inner or outer, hot, warm or otherwise, in other words deciding whether and who should be deployed into a particular area, that is best informed, is it not, with a discussion between all three of the responders?

CHRISTIAN COOPER: Yes.

Q. Would you also acknowledge that there doesn't appear to have been any communication to Dan Smith by the police that they had classified the area in the City Room as either hot, warm or cold?

CHRISTIAN COOPER: That's my understanding, yes.

Q. Right. So nobody directly said from the police, or any other organisation, "It's now what we call a cold zone up there"? In fact I think the phrase cold zone has come from the police experts, hasn't it?

CHRISTIAN COOPER: Yes.

MICHAEL HERRIOT: Yes.

Q. And nobody said that to Dan Smith at the time, did they?

CHRISTIAN COOPER: Not on my understanding of the evidence, no.

Q. Right. Did anybody say -- obviously Paddy Ennis, let's focus on him for a moment, he was within the City Room and could see what was unfolding, the catastrophe that

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

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

I N D E X

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