Manchester Arena Inquiry

Day 145

September 13, 2021

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Phone: +44 (0)20 3008 5900

Email: transcripts@opus2.com

Website: https://www.opus2.com

Monday, 13 September 2021
(9.30 am)
MR CHRISTIAN COOPER (continued)
MR MICHAEL HERRIOT (continued)
Questions from MS ROBERTS (continued)
SIR JOHN SAUNDERS: Good morning.
MR GREANEY: Good morning, sir, we can see and hear you fine.
SIR JOHN SAUNDERS: I can simply see the Manchester Arena Inquiry screen: I can't actually see anybody else, which is slightly disconcerting.
MR GREANEY: Mr Suter is going to leave the room to sort that out.
SIR JOHN SAUNDERS: That's been sorted out. I'm sorry not to be with you today. If I appear not to be here, it's because I am walking around, but I am listening to everybody and I will tell everybody if I'm going to leave the room.
Mr Greaney, if you will please keep a check on the fact that we're keeping to the timetable as far as week.
MR GREANEY: I'll do that, sir, thank you very much. I will now turn to Ms Roberts and ask her to resume her questioning.
MS ROBERTS: Good morning, gentlemen.
Could we have on look, please, at the role of

Dan Smith, operational commander. I would like in particular your views as to his ability to take the role of operational commander. Knowing what you do now from the statements that you have read, the exhibits that you have seen and particularly the evidence that you heard Mr Smith give during this inquiry process, could you tell us, please, either individually or one of you speak on behalf of both of you, as to your overall view of his ability to take the role of operational commander, please?
CHRISTIAN COOPER: I think we have outlined in our reports, and particularly the responses to the list of central issues, that we deemed Mr Smith overall to have been competent. He was a qualified and experienced tactical commander, but it's our experience that in practice, a tactical commander often retains sufficient knowledge and experience to also function at the operational command level. So overall, I think we deemed him to be competent.
Q. Thank you. Agreed?
MICHAEL HERRIOT: Yes.
Q. Was there anything within the evidence, his evidence, but particularly the evidence of others from the organisation who have been heard by this inquiry, that caused you to think anything other than he inspired in

those a level of authority and command at scene, so command with a little c as opposed to a big C?
CHRISTIAN COOPER: I think there is evidence of that, yes. We were particularly struck by the evidence of the debrief and what was fed back at that debrief by other NWAS staff that they felt some degree of confidence in Mr Smith's ability. So we think he did bring confidence as well as competence to his role.
Q. I suppose both are important in a fast-moving situation as that which unfolded on 22 May?
CHRISTIAN COOPER: Indeed, yes.
Q. So although he had operational command for about an hour or so between 11 pm and midnight when had Mr Steve Hynes took over, is it your evidence that there is nothing within that hour to cause you to doubt his competence or his confidence to be the operational commander?
CHRISTIAN COOPER: We have set out in our report some omissions and some things that we felt could have been done better. With those matters aside, in general we think he was both competent and confident.
Q. Thank you. I'm going to ask us just to look at the third report of yours.
Mr Lopez, it's {INQ035306/28}, please.
We start at the top of the page and this is dealing with Mr Smith, Dan Smith:

"He states he had experience of operating at the tactical command level, however, he also states that he had not been trained as an operational commander, nor has he ever been on the operational commander rota."
That's paragraph 20 of your earlier document. Pausing there, he hadn't had the operational commander training under NARU, as I understand it, but he had had training and had experience as an operational commander hitherto?
CHRISTIAN COOPER: Yes. We've seen that and we do accept that. I think the concern is always with roles such as these and other roles within the profession that those skills and abilities need to be maintained --
Q. Yes.
CHRISTIAN COOPER: -- and the tactical commander role and the operational commander role are different. So the concern we tried to articulate in the report was that Mr Smith may not have maintained sufficient skill and competence to operate at the operational commander that could be demonstrated through things like refresher training, continued professional development, because he will have done that at the tactical rather than the operational command level.
Whether or not that played into some of the omissions that we saw or not, I don't think is quite so

clear−cut, because they may have been the result of the incident itself and some of the other multi−agency failings at the incident.

So the point we make is he was not a designated operational commander at the time, he doesn't appear to have maintained specific CPD at the operational commander level, but we were comfortable that he was both qualified and competent to operate at the tactical level. And the fact he'd been an operational commander in the past with that experience, it's often our finding that tactical commanders and operational commanders can dual function.

Q. Yes. Would you agree that that's in fact what he appeared to be doing on the evening in question?

CHRISTIAN COOPER: Yes, in general, yes.

Q. Thank you. Save for the omissions that you have told us about and which I think we agreed on Friday he had readily accepted both in his evidence and in his written statements?

CHRISTIAN COOPER: Yes.

Q. Thank you.

I would like now to focus on the decision by Dan Smith to be the operational commander as opposed to Derek Poland, who arrived just seconds afterwards and who, we remind ourselves, was the on−call operational

commander for that evening.

I think you said that in general, it was, I think this is something you said on Friday, his prerogative, in other words it was Dan Smith's prerogative at the time if he felt he were better able, able to inspire that level of confidence that I think you agree he obviously did inspire in others, to take the lead and to take operational command on the evening.

Is my understanding correct that you are not overly critical of the fact that he, as opposed to Derek Poland, took that role?

CHRISTIAN COOPER: We've expressed a concern for the reasons I think I've previously articulated about Dan Smith's detailed level of operational practice at that stage. But yes, we agree, it would have been his prerogative as an experienced commander to have a conversation with Mr Poland at the scene and for them to determine who the most appropriate person was to take operational command.

Q. Thank you. If we could just go back to your third report, {INQ035306/28}, please, Mr Lopez.

You deal with this at paragraphs 142 and in summary at 143, you say this:

"In his statement, Dan Smith indicates that the other potential operational commander was Derek Poland and he showed a reluctance to take on the role.

Derek Poland was an experienced and qualified operational commander. Derek Poland's statement suggests that Dan Smith assumed the role of operational commander."

As we reminded ourselves on Friday, Derek Poland then immediately began to undertake the important role of parking officer, which you told us on Friday benefited the response to the incident greatly. I think that was your evidence on Friday; is that right?

CHRISTIAN COOPER: Yes.

Q. Thank you. If we look at what Dan Smith himself said about this when he gave evidence. Transcript, Day 110, please, Mr Lopez, at page 103 {Day110/103:3}.

Mr Smith was asked a question by Mr Greaney at the top of the page:

"Question: Was there any discussion between the two of you about who was best suited to that role or did you just decide it should be you?

"Answer: I'm not convinced I would describe it perhaps as a discussion, but we certainly −− my recollection −− I'm aware it's not Mr Poland's because we've spoken about it since the incident −− my recollection is that I did say to him, 'Do you want to take this', and I sort of pointed at the tabard."

Pausing there, there's a specific tabard, isn't

there, that operational commanders wear at scene so as to identify them to others within their own organisation and others from other organisations that they are the operational commander; correct?

CHRISTIAN COOPER: Yes.

Q. And he wore that tabard, didn't he, Mr Smith?

CHRISTIAN COOPER: He did.

Q. And again would you agree that the wearing of a tabard in itself, however minor a point it seems, did again enhance the response because everybody knew immediately who the operational commander was?

CHRISTIAN COOPER: I think that's a very important point and the use of the tabard is important to communicate not only to other ambulance staff but to other agencies who that commander is. It is very important.

Q. I suppose to members of the public as well, should they need to speak to him, he's easily identifiable: it's the man −− it's black and white cross−checked, is it not, the operational commander tabard?

CHRISTIAN COOPER: The operational commander is yellow above, but yes.

Q. Thank you. So that deals with that point:

"Answer: ... I sort of pointed at the tabard invariably meaning: do you want to take operational command? And from that moment on he said, no, so I was

operational commander. That wasn't an attempt to offload operational command. I think we were both competent and trained to take that role. We had a choice and I took it."

Then Sir John asked towards the bottom of the page:

"SIR JOHN SAUNDERS: You're the lead paramedic in Manchester; is that right?

"Answer: Yes."

So far as his clinical abilities and his competence is concerned there can have been little doubt on the night that he was one of the best people within the organisation?

CHRISTIAN COOPER: I think clinical seniority is not necessarily something that would dictate whether or not the person was appropriate for a command role. We would ideally expect to see a more decisive and robust handover or confirmation of command, but I think the fact that a discussion of whatever magnitude did -- but the discussion that is articulated there took place meant it was properly considered.

The fact that both of them deemed themselves both competent to do the role is the key bit and then they've made a decision as to who is going to undertake that role so I don't think we take issue with that.

Q. Over the page, please, to 104 {Day110/104:1}, Mr Lopez.

He says:

"Answer: In rank it does, but we're not an organisation that really focuses much on rank but officially yes --

"SIR JOHN SAUNDERS: No, maybe not, but if it was going to be the senior person who took the operational commander job, that would have been you?

"Answer: It would be me, yes."

To page 191, please, Mr Lopez {Day110/191:11}.

Mr Gozem Queen's Counsel was asking questions on behalf of the families. He began by saying:

"Question: Can I begin by saying to you that I have no doubt, and I'm sure nobody has any doubt, that absolutely you wanted to do the very best you could on that night, not just for yourself but for all of the people who were there and your efforts are much appreciated. But as you know, I think as you foresaw in some of the interviews that you underwent, this process is one that is necessary for learning.

"Answer: Absolutely.

"Question: Can I begin by asking you this: had you acted as an operational commander before?

"Answer: Had I performed the role before?

"SIR JOHN SAUNDERS: Yes.

"Answer: Yes, I had, yes."

So he confirmed it at that stage. Over the page, please, Mr Lopez. He talks at the top of the page, and I think we've looked at this before, about his operational command pre-NARU around 2004 through to 2009 and then towards the bottom much the page a question from Mr Gozem {Day110/192:21}:

"You're quite right, your statement does say that you had never undertaken any and that is why I wanted to ask you about it."

He clarified the statement was in fact incorrect and he had undertaken some in the past:

"Question: Derek Poland was perhaps a more recently trained operational commander than you, wasn't he?

"Answer: Yes. In fact, actually, we started on operational command at the same time, so had been doing it the same length of time as me. I moved on to tactical commander or had training to enable me to do tactical command. Derek had remained at operational commander level, yes."

Just finally in relation to this point, if we could look at a different document, please. It's the NARU National Ambulance Service command and Control guidance in force in October 2015 and therefore in force at the time of the incident. {INQ013227/40}, first of all, please.

It sets out what is expected of a tactical commander. There are eight bubbles surrounding the centre. If we go, please, to the next page, {INQ013227/41}, "Operational", with seven bubbles around the centre circle. As I look at those two diagrams, the only difference seems to be, if we go back to tactical on the page before {INQ013227/40}, please, Mr Lopez, tactical -- the qualities and the abilities of the tactical commander demanded an ability at D11 to lead meetings which, if we go back to operational command on {INQ013227/41}, is something that the operational commander it seems wasn't required to do. So there's that extra step up to tactical command level of the ability to lead meetings. I'll be corrected if I'm wrong. Other than that, the other seven bubbles appear to be identical skills, do they not?

CHRISTIAN COOPER: Yes, and they are very similar. There's certainly a lot the overlap between the operational commander's competence and the tactical commander's competence. It is just worth keeping in mind that whilst those are generic competency provisions, they apply differently at the two levels and we would expect an operational commander to be practising and applying those competencies within the operational arena and a tactical commander in the tactical arena.

So how they apply is different, but I absolutely agree, they are very similar.
Q. Thank you. Next topic, please, RVP. I think you said within your reports that the establishment, the early establishment of an RVP is key. I think you also said that it may be one of the deficiencies of not having a PDA, that clear understanding as to where an RVP should be.
Can I just understand this? Was your evidence on Friday, I think in answer to questions from my learned friend Mr Greaney, that the RVP, were a PDA to be in existence, might be a fixed point, but an FCP should be fluid because it rather depends, particularly in a site as enormous as the arena, attached to the station, where the incident occurs as to where the FCP is set up.
Mr Herriot, is that right as a general rule?
MICHAEL HERRIOT: I think there's a difference here, which is between the RVP and the FCP. And there's also a difference between a PDA and a site-specific plan. So it would be the site-specific plan that detailed options for an RVP in advance of an incident. The PDA wouldn't be that specific. It would say: mobilise X resources to an RVP. So it wouldn't detail where that RVP would be in the PDA unless the PDA was site specific.
Q. That's my fault because I've conflated two issues and

you're right to correct me. So the site-specific plan might deal with RVPs because those are specific to the site, but the PDA, does that focus more on the number and the type of resources to be deployed in a particular incident?
MICHAEL HERRIOT: There's different types of PDA, which we started to explore on Friday. So there may be a PDA that's specific to a site, in which case it may have that level of detail or there may be a PDA that's generic to, for instance, a major incident, which would detail the type of resource that would be sent, the number and the order in which those resources would be dispatched.
Q. It seems to me there will be -- no matter how many PDAs one has, whether they are specific or generic, ditto perhaps to a lesser extent a site-specific plan, but there's almost an infinite number of possibilities, even with all the plans that one might have, which requires the need to flex that particular plan. Otherwise you might have a PDA for an IED, but the IED isn't quite as one might have expected to be and therefore there has to be some sort of flexibility built into that, doesn't there?
MICHAEL HERRIOT: There would be usually a number of options, and typically you'd find this say at an

airport, where there may be a number of options for RVPs and which one is selected will depend on the circumstances of that particular incident.
Q. Within your most recent report, I think when you are quite right to highlight the difficulties in those early stages in terms of determining where the RVP should be, can I just be clear, those are not criticisms that are levelled solely at NWAS, are they, those are multi-agency criticisms?
CHRISTIAN COOPER: That's correct, yes.
MICHAEL HERRIOT: Yes.
Q. I think it might help if we reminded ourselves about the calls that were made between the organisations in an attempt to establish, critical as it was, an RVP. I'm going to -- we don't need to put the references on the screen, but I'm going to give them in any event so that those who wish to check them may do so.
At 22.36, there's a call between NWAS and GMP. {INQ015140T/1}. No RVP is mentioned. The summary of the call being in effect NWAS asking for assistance, GMP knew about the explosion, GMP thought they had officers at the scene, and NWAS had five vehicles en route and were already shouting for vehicles to clear.
Next reference, {INQ015150T/1}. A call between NWAS and NWFC, 22.37, RVP. NWFC stating that the police have

confirmed that the RVP is the car park area outside the cathedral. This is the call, of course, during which NWAS request the assistance of the Fire Service at the arena. I think you'll recall that. That was an early request for assistance from the Fire Service saying that a bomb had gone off.
There are a number of other calls that take place in which, of course, Thompson Street is mentioned or no RVP is mentioned. These are calls between NWAS and the other emergency organisations.
At 22.51, {INQ015139T/1}, a call between NWAS and GMP, with GMP saying their inspector is asking for all available ambulances to Hunts Bank. This is 22.51. Not specifically described as an RVP by Greater Manchester Police, but would you agree that it is clear during that call or appears to be clear that during that call, NWAS have interpreted that call as GMP requesting that Hunts Bank be an RVP? I'll explain why it may be that that had been an assumption, because at 22.53, {INQ015142T/1}, there's a call between NWAS and BTP. So about a minute or so after the call between NWAS and GMP had taken place, during which there was a request for all available ambulances to Hunts Bank, and during that call BTP asked for all ambulances to the arena and NWAS confirmed during that call to BTP that GMP have just

provided an RVP and confirmed that the GMP RVP is Hunts Bank.

So would you agree that there's no -- there isn't that definitive clarity that you and no doubt others seek at a very early stage for an RVP?

CHRISTIAN COOPER: Yes, I agree.

Q. Ideally who should call it? Who should say where the RVP is going to be?

CHRISTIAN COOPER: The preference for the ambulance would always be the police.

Q. So the preference is that the police call it and say, "This is where the RVP is going to be", but would you agree from those calls to which I have drawn your attention that by 22.51, and certainly by 22.53 or thereabouts, there was an understanding by NWAS that GMP had said, or they'd understood them to say, that it was going to be Hunts Bank?

CHRISTIAN COOPER: Yes.

Q. Thank you.

SIR JOHN SAUNDERS: Ms Roberts, my recollection of the evidence is that Inspector Smith, having initially declared the cathedral car park, was the person who changed the RVP to Hunts Bank. So the police (inaudible: distorted) from then on and no doubt we have the timing of it.

MS ROBERTS: Yes. Thank you.

MICHAEL HERRIOT: I think the Ambulance Service declared Thompson Street as the RVP very early on in the proceedings.

Q. Yes.

MICHAEL HERRIOT: And whilst Cathedral Gardens was corrected, that wasn't actioned because the Ambulance Service was sending its resources initially to Thompson Street and then on the request from the police to go to Hunts Bank, clearly Hunts Bank was adopted for a period of time.

Q. Right. So they reacted to that which they were told by the police?

MICHAEL HERRIOT: Yes.

Q. From whom they would expect the lead to be taken so far as an RVP is concerned?

MICHAEL HERRIOT: Yes.

Q. Thank you.

FCP, next topic, please, and I start by prefacing my questions to you with this: the failure to have an FCP or the failure by Dan Smith to specifically announce where the FCP was going to be in his view has long been accepted by him, has it not?

CHRISTIAN COOPER: It has.

Q. Both within his written statements and the evidence he

gave to the inquiry?

CHRISTIAN COOPER: Yes.

Q. Thank you.

Where in your view was the ideal place for an FCP?

CHRISTIAN COOPER: We would normally expect an FCP to be located as close as possible to a warm or hot zone, depending on the type of the incident, but not within it. So it's very much a forward point where the three operational commanders from the three respective services are gaining enough situational awareness to be able to command the response forward of that point. In the case of Manchester Arena, the concourse at the bottom of the stairs would have been an appropriate point.

Q. So before the CCS?

CHRISTIAN COOPER: Ahead of the CCS. The forward control point we would normally expect to be forward of the CCS, but not in the City Room.

Q. Okay. We know now, and I suppose once the decision had been made to get those seriously injured people out of that bomb zone as quickly and as effectively as happened, that they were being brought down the stairs. You're not suggesting right at the bottom of the stairs, are you, for the FCP?

CHRISTIAN COOPER: No.

Q. Whereabouts then?

CHRISTIAN COOPER: It needs to be a decision by the commanders that are there as to where they feel it's the most appropriate place for them to co-locate. But you've got a large station concourse area, you've got the stairs, you've got the mezzanine area at the top of the stairs that leads to the City Room, which is wide in itself.

So somewhere within those confines where they're not obstructing the flow of patients but where they feel it's a suitable location for them to co-locate and command the incident would have been appropriate.

Q. Right. So what is your view then of the area outside the war memorial entrance, so just outside the station where there appears to have been discussions between, for example, Chief Inspector Dexter and Dan Smith? What's your view about the suitability of that particular area as an FCP?

CHRISTIAN COOPER: Well, that's not an ideal location for an FCP given the amount of activity that's happening ahead of it. But if three commanders from three agencies have co-located somewhere, that's better than nothing, so we wouldn't quibble over the precise location of where they're standing. I go back to -- that really is a judgement call for those commanders

based on their understanding of risk and where the most effective place is for them to co−locate to achieve their role.

Q. All right. My recollection of the evidence is that the discussion between Chief Inspector Dexter −− when he saw Dan Smith, there was an assumption on his part that that was the FCP, I think, where that discussion took place. You seem to be suggesting that that wasn't the ideal place for one?

CHRISTIAN COOPER: It's not an ideal place for one, but it's better than −−

Q. Better nothing?

CHRISTIAN COOPER: Better than nothing, quite.

Q. I want to go back now to the PDA, which we've touched on earlier, and again quite right, as you know, NWAS have always accepted there wasn't a PDA at the time for the arena.

Is it your evidence that a PDA kicks in once a major incident has been declared?

CHRISTIAN COOPER: Yes, that would be ideal. So I think with a PDA, the PDA −− I think the point we were trying to explore on Friday with the benefits of a PDA is not so much that you would have a specific PDA for a whole host of different specific incidents, it's more something that gets a predetermined set of assets

rolling towards that incident on the declaration of a major incident because it takes some of the pressure off the operational and tactical commanders of requesting specific assets that are needed before they've got a full understanding of the situational awareness because in effect those assets are already coming and it places the operational and tactical commanders in the easier position of standing them down if they're not required. I think that's the main benefit we were seeking to describe on Friday.

Now, as Mike alluded to earlier, you will have certain sites that, based on the risk assessment and the unique features of that site, the PDA will be more specific. An airport is a good example because you know in advance if an aircraft is coming in in distress, there are particular assets that you will always want to have available to you at that scene, so that would be included within the predetermined attendance.

For more general major incidents, the suggestion from us is that best practice would be to have a general predetermined attendance for a major incident of multiple casualties and then the commanders can adapt that predetermined attendance as needed once they gain more situational awareness. But the lack of a PDA in this case and the lack of a predetermined critical mass

of assets being deployed by the control room in the very early stages of the major incident declaration, we think that's just something that could have been improved.

Q. All right. I think one of the things you said on Friday was because it might have meant that the ambulances got there rather sooner than they did?

CHRISTIAN COOPER: Yes, we think that ambulances probably would have, yes.

Q. We'll look at that in a moment or so, but just so I'm absolutely clear, does the PDA only come into effect once the major incident is declared?

CHRISTIAN COOPER: That would be the usual trigger for activating one, yes.

Q. All right. I think picking up on the evidence that you gave on Friday that the absence of a PDA may −− and to be fair to you gentlemen, you put it no higher than that at the time −− it may have slowed the deployment of the ambulances and HART. So I just want to explore the timings that unfolded on the evening in question to see whether in fact it did slow the ambulances and the arrival of HART in the way that it might otherwise have.

We are going to look at some calls, please, Mr Lopez, the first of which is {INQ023884T/1}.

It's at 22.39, and this is NWAS −− NWAS Control to all crews:

"Golf Mike to all crews. Golf Mike to all crews. Any crews can clear for a priority incident. That's any crews can clear for a priority incident."

So no specific numbers given, but a clear direction or so it seems at that stage at 22.39.16.

Next one, please, Mr Lopez, {INQ015025T/1}. I preface this with saying it appears to be in identical terms to the previous one, but it has a different INQ and the call is of a different length in duration the first one was 10 seconds and this is 17 seconds. I'll read it:

"Golf Mike to all crews. Golf Mike to all crews. Any crews can clear for a priority incident. That's any crews can clear for a priority incident."

Next one, please, Mr Lopez, {INQ015353/1}. This is control and Annemarie Rooney. This is a call which begins at 22.38:

"Operator: What information have we got? Can anybody update me? Shot in the leg?

"AR: Hello?

"Operator: Annemarie, hi it's Nicola, erm, we are getting reports of a bomb gone off at the Manchester Arena.

"AR: Right.

"Operator: We are getting quite multiple calls, erm,

saying there may be somebody shooting as well."
"AR: When did this come in?
"Operator: It's just come in now, about 5 minutes ago."
Just pausing there, that would take it back 22.33, so within a minute or so of the bomb going off:
"AR: OK, who have you got on? What time is it now?
"Operator: Nobody, we are going to get, erm, Derek. Shall we tell both of them, Derek and Matt..."
Derek Poland and Matt Calderbank who were the on-call operational commanders that evening:
"... I've just done Silver, do you want me -- are you going to escalate to Gold?
"AR: Err, yeah. Who is it, Neil?
"Operator: It is, yeah. It looks like it's a marauding terrorist incident.
"Both: Right.
"Operator: [Speaking to someone else] All right, please, Derek and Matt please."
So apparently Derek and Matt being mobilised at that stage:
"AR: Right. We need to get HART. We need to find out who's the AITC."
That's the AIT commander presumably:
"Operator: Yeah.

"AR: Identify your AIT on duty, if you've got that.
"Operator: Right, sorry, Annemarie, yeah.
"AR: You've got your Plato cards out?
"Operator: Yeah, I'm just updating them now. Obviously I didn't know it was --
"AR: Go through your Plato card.
"Operator: Yeah, yeah.
"AR: I'll grab mine and see where they are up to. Do we know who is on at the arena?
"Operator: [Speak to someone else] Is it Take That today? Does anybody know? [To AR] Ariana Grande.
"AR: Ariana Grande, okay. Right, I'll notify Gold now.
"Operator: Right.
"AR: You start making...
"Operator: Yeah, I'll go through the Plato cards.
"AR: Yeah, all right.
"Operator: All right then, thank you.
"AR: I'll speak to you shortly."
It's a call that begins at 22.38, during which Annemarie Rooney is apparently already asking for HART and the services of the AIT commander; do you agree?
CHRISTIAN COOPER: Yes.
Q. Next one, please, {INQ015082/1}, NWAS Control and 304. 304 is the call sign for Chris Hargreaves who was one of

the HART operatives who did go into the City Room as we know. A call at 22.40 lasting just 43 seconds:
"304: 304.
"NWAS Control: Apologies, we're going reports of a large-scale incident in the city centre. We're asking if we can redirect you to that, over."
Pausing there, HART, as we know -- Chris Hargreaves with the HART team are on the other side of the Stockport receiving this call:
"304: Yeah, have you spoken to the team leader... currently I'm just liaising with the fire on this job."
Because the fire were at, obviously, the fire incident on the other side of Stockport as well.
"NWAS Control: Roger, no problems, I'll try and get hold of him, I couldn't a second go.
"304: Yeah, no problem what's the incident?
"NWAS Control: We're getting reports of an ongoing either shooting or bombing at the arena with 30 patients reported up to now, over.
"304: Yeah, all received. I'll try and get hold of him.
"NWAS Control: Thank you."
Finally, please, Mr Lopez, if we could look, please -- and just before we do, HART in fact cleared and left or asked to leave the incident at 22.46 and we

know that from the HART timeline, which you have looked at, gentlemen, as I understand. Thank you. Finally, please, {INQ015335T/1}.
Declaration of major incident at 22.45, the call starts.
"NWAS Control: Hello, Julie speaking.
"HC: Hi Julie, it's Chloe on Health Control. Just a quick one: is this a major incident standby or is it declared?
"NWAS Control: It's not yet been declared yet, love, I don't know, just bear with me a second.
"HC: All right.
"NWAS Control: [Speaking to colleague] Nicola, have we declared this or is it still standby? Reply [inaudible] - speaking to colleague - if we haven't declared this then it's still stand by until we get things on scene is it? Reply: Yeah, might just declare it]. Yeah, right, we will call it declared as from now 22.46.
"HC: 22 -- you're declaring it at 22.46?
"NWAS Control: Yeah.
"HC: Yeah, okay.
"NWAS Control: thanks.
"HC: Bye, thanks."
So we've got the major incident declared there at

22.46. So just pausing there, and accepting as we do the deficiencies in not having a PDA, it seems, does it not, from the transcripts that we've looked at, all of which are timed before the declaration of the major incident at 22.46, that not only had all ambulances crews been told to clear for the priority incident but also HART had been contacted, told to clear from the incident they were at, and were making their way to the arena, and all that is before the major incident was declared? Would you agree with that?
CHRISTIAN COOPER: Yes.
Q. Next topic, please, equipment. On Friday, you talked about the potential —— and I think within your reports as well —— the deficiencies, or so it was perceived, as to potentially a lack of equipment at the scene. I just want to understand what your evidence is about that. Are you saying that there was insufficient equipment generally or are you pointing to specific items of equipment that were lacking, leaving aside the vehicles at the moment or perhaps incorporating those if they contained the equipment? Perhaps Mr Herriot, if you'd like to tell us or Mr Cooper.
CHRISTIAN COOPER: I think it's specific items that we would have expected to be at an incident of that type that weren't that were our concern rather than a general

observation that there was generally a lack of equipment.
Q. I see. Are you able to help us in understanding what the specific items were that were lacking?
CHRISTIAN COOPER: I think there was some indication in the debrief reports that paramedics felt they could have benefited from more mass casualty—related pharmaceutical drugs, those are carried on the national mass casualty vehicle, so that would have been of benefit.
Q. Yes.
CHRISTIAN COOPER: We've done analysis, to the best of our ability, on stretchers because we know that's a key issue and we feel there were more stretchers wither available there and not used or that could have been mobilised to scene.
Those were the two main ones we had. I'm looking at you, Mike, if there are others.
MICHAEL HERRIOT: Certainly there was a great deal of equipment available at the scene because the HART team brought a number of vehicles that contained a lot of different items of equipment that would have been of value, not only to the paramedics but also to members of the public. It was really a matter of: they were there but the equipment could have been distributed better at least.

Q. Right, let's just break that down. So the equipment was there on the HART vehicles. You've identified, Mr Cooper, the deficiencies and I'm not going to challenge you in relation to that.
But as a general concept, there was a large amount of equipment present, wasn't there?
MICHAEL HERRIOT: There was.
Q. I think you say, Mr Herriot, a lot of which was carried on the HART vehicles and there were a number of them in attendance. Is it right that that equipment was removed from the HART vehicles or a lot of it was removed from the HART vehicles —— I think it's called a kit dump, where they effectively plonk the equipment on the floor for anyone to use. Is that right in your understanding?
MICHAEL HERRIOT: Certainly some of it was but in the absence of an equipment officer that probably wasn't done in a systematic way.
Q. Yes, and you have made your observations about that and, again, I am not going to challenge you in relation to that. That is accepted by Mr Smith as one of then deficiencies.
So I think you said it could have been distributed or deployed better? What do you mean by that?
MICHAEL HERRIOT: Well, equipment could have been deployed, for instance to the City Room, including triage packs,

perhaps a little earlier. Similarly, equipment could have been deployed for use by the public —— in fact there was a vehicle there that was designed for that specific purpose.
Q. Right. Which was?
MICHAEL HERRIOT: The public support unit.
Q. Yes. There's a little confusion, isn't there, in terms of whether that was a PSU, as one understands it to be, or whether it was a vehicle that had been swapped with other one because of there being —— as you heard, I think the other day, from Mr Blezard one of the vehicles was out of action at the time?
CHRISTIAN COOPER: Yes and I think it's good that the equipment was put to good use. I think we recognise that. I think in terms of our expectations, the HART equipment, the cubes that they carry that contain quite a lot of consumable items, some of their special drag stretchers and various other items of HART equipment, including in fact the mass oxygen delivery system, have all been given to HART for the purpose of using it within a hazardous area, a warm zone.
So our starting point, not the mass oxygen, that would have been appropriate necessarily, but certainly the cubes and some of those stretchers carried by HART which ended up in the equipment dump outside of

Victoria Station, our expectation would have been the starting point for that equipment would have been —— that should have been up in the City Room.

For the wider walking wounded, the people that found themselves on the concourse but not receiving medical treatment, for all of those people, and indeed to provide equipment to the CCS itself, we would expect that to all come from these major incident support vehicles.

In the event, it looks like most of the additional equipment that didn't come from a front line ambulance has been provided from this vehicle that HART brought. And as I say, better that that's got out and used regardless of where than not at all.

So I don't think we're overly critical in that regard, but the deployment of the equipment didn't quite meet our expectations.

Q. Right. Just a brief touch, if we may, in relation to operational plan. There was plainly an operational plan to extricate those seriously injured from the City Room as rapidly and as effectively as could be achieved in the circumstances, accepting, as we do, that the manner in which they were extricated was not ideal, and I make that plain.

Do you agree as a general principle that that

priority, that operational plan, the priority to move, was the right operational plan?

CHRISTIAN COOPER: Yes.

Q. Thank you. Next topic, please, in relation to TAC advisers. Within your most recent report you talk about the roles and Steve Taylor and Jon Butler took on the evening.

Within your final report, we don't need to turn it up, but I'll give the reference to those who want to know where I am within the document. I'm at page 21 of your document, and it's {INQ041856/21}. It doesn't need to go on the screen, Mr Lopez, thank you.

Within that document, at page 21, you say this —— in relation to the direct question you were asked:

"Did Jon Butler discharge his duties as TAC AD/NILO adequately?"

You say this:

"As there was a failure of JESIP..."

We can't lay that at the feet of Mr Jon Butler, I think, can we?

MICHAEL HERRIOT: No, only inasmuch as their role is to contribute to that multi-agency response.

Q. All right. So:

"As there was a failure of JESIP, we must conclude that the NILO/TAC adviser role was not discharged

adequately. Although not a role stipulated expressly in action cards we suggest that Mr Butler's expertise may have been of greater value at the scene or as an Airwave tactical adviser at the EOC."

You caveat that criticism, however gentle it is, with:

"Although not a role stipulated expressly in the action cards."

We take it from that that what he did and the actions he took that night were stipulated in the action cards and he complied with what he was meant to do.

MICHAEL HERRIOT: Yes, he was asked initially to respond to the scene and he was diverted to police headquarters, which was a role that would be expected, yes, of a tactical adviser.

Q. Yes. You say here that his expertise may have been of greater value at the scene and those of us who heard his detailed evidence, he appeared to have a good knowledge of both the plans and the procedures and what was required of him, he appeared to be a very competent individual, would you agree?

MICHAEL HERRIOT: Yes.

CHRISTIAN COOPER: Yes.

Q. Thank you. Is that one of the reasons that you say his expertise may have been of greater value at the scene?

CHRISTIAN COOPER: I think we would absolutely expect that a tactical adviser makes their way to support the tactical commander ——

Q. And she was at GMP?

CHRISTIAN COOPER: She was at GMP, yes. I think what we're saying is the operational commander would have benefited from tactical advice as well, not necessarily from this individual, but from a TAC adviser role. So if this individual made their way to the scene to support the operational commander, the other tactical adviser could potentially have supported Annemarie Rooney in police force HQ. But either way we think it would have been of benefit for both the operational and the tactical commanders to have had a tactical adviser. That's the point we make.

Q. Thank you. That's helpful. So in terms of —— I'll just ask directly: what did he do wrong, what did Jon Butler do wrong, anything or nothing?

CHRISTIAN COOPER: I think a key concern is that of all the people, the person that is perhaps the most familiar with JESIP and how it should work and the person best placed to recognise when it's not is the NILO and tactical adviser. So I think we would have expected —— that's another cross-check that was perhaps missed where that tactical adviser could have said, "Things don't

appear right here from the way that's happening".

So I think when we say:

"As there was a failure of JESIP we must conclude that the NILO and tactical adviser role was not discharged adequately."

It's because we would have expected that role particularly to have supported JESIP and to have insisted on some sort of corrective action to get JESIP up and running more effectively and sooner.

Q. And just dealing with Steve Taylor, we know he remained at home. I don't think you're critical of that in itself. In fact, is that where he should have been?

CHRISTIAN COOPER: It's not inappropriate for him to remain at home. I think for this particular incident, and this is I would say with the benefit of hindsight, it would have been better for a NILO or tactical adviser to be supporting the operational commander as well as the tactical commander. But if you've got two and an incident is unfolding, it's my experience that it's not uncommon for one of them to remain at home with access to materials, to be looking things up immediately, to be maybe making some communications whilst another mobilises to a location, wherever that may be. That is fairly common practice.

Q. Triage, next topic. Would you agree that the better the

primary triage, in fact the better the triage process as a whole at scene, the better the chances of the mass casualty distribution plan working and the better the chances of the outcome for the patient?

CHRISTIAN COOPER: I'd agree, yes.

Q. Thank you. I would like us, please, with that in mind, to look at the statement, and it's a statement that's been recently served, I referred to it on Friday, and I think I described Mr Smith as an ambulance consultant. He's not, he's a hospital consultant, so we're going to look at his statement now, please.

It is {INQ041974/1}, please. Mr Smith tells us he's employed at the Salford Royal Hospital as a consultant in emergency medicine and he has held the position for about 18 years. He tells us a little of his qualifications, tells us also that he's the clinical director of the Greater Manchester Major Trauma Network, appointed to that post in 2015. In that role, as the clinical director of the trauma network, he has been involved in a number of projects linking EPRR, emergency planning resilience and response, and the major trauma network in the years running up to the Manchester Arena attack. He has provided this statement to assist the chair in relation to the development of the Greater Manchester mass casualty dispersion plan.

{INQ041974/4}, please, Mr Lopez. It's paragraph 20 dealing with the specifics of the incident on 22 May:

"Although the plan had been agreed, tested and received broad approval, final sign-off had not occurred by the night of the arena bombing. However, crucial personnel present at scene and within the incident command had knowledge of and had been involved in its development. They were also aware of the Socrates Report."

Pausing there, that's the training exercise that happened a month or so before which you told us on Friday had gone well:

"... aware of the Socrates Report and its recommendations. The decision which those individuals made to enact the casualty distribution plan was crucial and positively contributed to the care of victims that night."

Page 5, please, Mr Lopez {INQ041974/5}. Paragraph 23:

"I wish to highlight the summary provided by Professor Moran in consideration of the pre-planning and prior exercising of the dispersal plan. When he reflected on the whole system response, he felt that the planning, desktop exercises and rehearsal were enormously beneficial and made a great difference to the

response on the day. He thought the rehearsal meant that many staff were familiar with the major incident plan. The presence of a regional mass casualty plan identifying receiving units, their capability and their capacity in advance was invaluable for casualty distribution. Accurate triage and casualty distribution directly to the appropriate hospitals greatly facilitated patient care and minimised secondary transfer. Indeed [he concluded], each region must have a patient dispersal framework and a casualty capability chart."

Just picking up on that last sentence, are we to understand therefore, and I think Mr Smith talks about this earlier in his statement, that this particular plan and the way it worked on the night was seen thereafter as somewhat of a beacon to others?

CHRISTIAN COOPER: Yes.

Q. Others who hadn't got this type of plan in place at the time?

CHRISTIAN COOPER: No, at this point in time there was quite a lot of work being done by NHS England at the national level, led by Professor Moran, looking at the management of mass casualties in general and more specifically how the overall NHS system would cope and the dispersal plans from scene were part of that work. But the

exercise that's mentioned there was the first real comprehensive test of those arrangements and they had not been put into operational practice at a live incident until they were used at the Manchester Arena incident. We've been equally positive in our report that I think it took some courage from the commanders in NWAS on the night to invoke a plan that was still -- a set of arrangements that were still technically in draft. But they were familiar with it from that exercise, they put it into place and we are of the view that, generally speaking, that was a very positive thing to do. And certainly after that I think it is fair to describe the events of Manchester as a catalyst to certainly rolling that out much quicker than it otherwise would have been because, as well as the exercise, they now had confirmation that this works in operational practice.

Q. Thank you. Page 8, please, Mr Lopez, at paragraph 40 {INQ041974/8}. Further discussion here:

"The EMJ paper..."

That being a paper within a medical journal, wasn't it?

MICHAEL HERRIOT: The Emergency Medical Journal, yes.

Q. "Patients were evacuated, based on clinical priority, to a variety of hospitals with agreed predefined care

capacity and clinical expertise best suited to a patient's needs. We believe that the data presented here are consistent with successful implementation of this plan to enable an already under pressure regional hospital healthcare system to maintain resilience at a time of increased demand and provide the best available care to the patients it serves. For example, more severely injured adults and children were likely to be conveyed to hospital emergency departments by ambulance and these receiving hospitals were likely to be [major trauma centres], suggesting that incident scene triage was performed effectively. For this incident, effective implementation of the patient dispersal framework at incident scene appeared particularly important to assure timely access to very specialised services, such as paediatric trauma care.

"Without the considerable work to develop, modify exercise and agree such a plan, the dispersal of patients may not have been as smooth. In the case of the arena, the use of the plan linked to opportunities taken to perform accurate primary triage resulted in minimal secondary transfers within the first 24 hours and a scene clearance time of just over 4 hours."

{INQ041974/9}, please. Paragraph 44:

"Note was made of the care given by bystanders and

first -aiders. With appropriate training and education, bringing military learning to the civilian arena (citizenAID and the like) further improvements could be made. These actions would bridge the inevitable gap that occurs in any major incident before emergency services can attend. This must have felt an extremely long time for the victims and we must recognise the opportunity to do more in this period of time."

Gentlemen, just finally, if I may, please. Inevitably this process looks at, and quite correctly this process looks at, the inadequacies of a response. You say in your third report that you could not state that the overall response by NWAS was adequate in all the circumstances because some aspects were less than adequate. Your evidence over the last day and a half or so has gone some way to show us and the organisation what those inadequacies were.

But you conclude within that report, and I want to know whether your conclusions remain the same today, having heard the evidence and having had the benefit of the evidence over the last year or so, in that report you conclude that there were some failings and some missed opportunities. Is that still a conclusion that you hold?

CHRISTIAN COOPER: Yes.

Q. You agreed on Friday that you had seen the documents submitted by NWAS over a year ago which set out a number of key issues that you had drawn to the organisation's attendance (sic) in the three reports that you had submitted at that stage. You have seen that document and you noted and agreed with me on Friday that of the 16 key areas, all were either accepted in whole or in part.

Is it still your conclusion, as you set out in your earlier reports, that the overall response by NWAS was mostly good and mostly compliant?

CHRISTIAN COOPER: Yes.

MICHAEL HERRIOT: Yes.

MS ROBERTS: Thank you. Sir, I have no more questions. Thank you.

SIR JOHN SAUNDERS: Thank you very much, Ms Roberts.

MR GREANEY: Thank you, Ms Roberts. Sir, I'm going to invite Mr Taylor to ask his questions now on behalf of SMG.

Questions from MR TAYLOR

MR TAYLOR: Good morning, sir. Good morning, gentlemen.

Many of my questions will relate to the Purple Guide. Mr Herriot, maybe more of these are for you as I understand that you had some part to play in the writing of the guide in part of its history; is that

right?
MICHAEL HERRIOT: Yes, I was the lead author for the medical chapter of the 1999 version and contributed to the following version up until the stage that it became an industry code of practice rather than an HSE document.
Q. So to be clear on the history, there was a first edition by the Health and Safety Executive in 1993?
MICHAEL HERRIOT: That's correct.
Q. The second edition in 1999?
MICHAEL HERRIOT: That's correct.
Q. And you state in the note, your response to the list of central issues, that there was work on a third edition by the Health and Safety Executive ——
MICHAEL HERRIOT: That's correct.
Q. —— which was never published; is that right?
MICHAEL HERRIOT: That's correct.
Q. And then is it around 2014 or 2015 that the document is handed over to the Events Industry Forum?
MICHAEL HERRIOT: Yes, maybe slightly earlier. I can't remember the exact date.
Q. Did you have any involvement with the document after that stage?
MICHAEL HERRIOT: No, I didn't.
Q. Okay. First topic, first aid training and qualifications. At your response to the list of issues,

ETUK3 you write:
"ETUK medics were trained to a standard below that recommended in the Purple Guide (currently FREC3)."
FREC3 means First Response Emergency Care level 3; yes?
MICHAEL HERRIOT: That's correct, yes.
Q. On Friday you said that:
"[The first aiders at ETUK] certainly did not meet the standards recommended in their industry code of practice, the Purple Guide."
At that was Day 144, page 60 {Day144/60:1}. Do you remember that?
MICHAEL HERRIOT: And I think it's fair to say that from its inception, the Purple Guide has suggested that a First Aid at Work qualification on its own is probably insufficient to provide first aid at a public event such as we saw at the arena.
Q. It's right, isn't it, that FREC3 was not recommended at the time of the attack in 2017 by the Purple Guide?
MICHAEL HERRIOT: That's correct. Although it was supplied to us in evidence, it was later shown that that was a 2018 edition.
Q. So to be clear, because your reports may appear elsewhere and may be read by some who aren't in this room, when you wrote your report you were working from

the 2018 document, although it was labelled the 2017 edition?
MICHAEL HERRIOT: Yes.
Q. That for the note is the document that appears at {INQ020216/1}. So anyone reading your reports and seeing reference to that number should bear in mind that in fact it is the 2018 edition that's being referred to?
MICHAEL HERRIOT: That's correct, notwithstanding the previous comment about the First Aid at Work qualification.
Q. Perhaps we can look at that now then in the November 2015 version as we now believe it to be. Mr Lopez, please, {INQ041126/10}.
Paragraph 5.47:
"A first aider is a person who holds a current certificate in first aid competency issued by an organisation that meets the HSE guidelines on first aid training."
Over the page, please, at the top {INQ041126/11}:
"The holding of a Health and Safety at Work or three-day First Aid at Work certificate does not in itself qualify a person as competent to administer first aid to the public at events".
That's the part you were referring to, was it, Mr Herriot?

MICHAEL HERRIOT: That's correct the First Aid at Work qualification was intended for employees at a particular site. It hadn't been designed for first aid given to others, for instance at public events.
Q. The guidance then does not, as it does now, suggest an alternative nationally recognised qualification?
MICHAEL HERRIOT: Not specifically, no.
Q. Is that because there was nothing like FREC3 in the history of the Purple Guides?
MICHAEL HERRIOT: The position has changed substantially over the years. Certainly in earlier editions of the guide, first aid was described as something that was taught to a standard issued by the voluntary aid societies and in keeping with the HSE guidance. The HSE guidance ceased in 2013 when HSE stopped regulating first aid, although they do still own the syllabus, Emergency First Aid at Work and First Aid at Work.
Q. The way that that passage was referring to First Aid at Work was not, as it does now, saying, "Do not use this for events, medical staffing", only that that particular qualification wasn't enough on its own?
MICHAEL HERRIOT: That's correct.
Q. And it didn't go as far as to identify how one would fill the gap, would you agree? So could it have been the case that some medical providers, before 2018, would

reasonably read the guidance and take the view: we can start off with this qualification but if it's supplemented by other training, competencies, experience, that might fill the gap?
MICHAEL HERRIOT: Yes. I think the issue here is that we're looking at first aid in isolation, whereas in fact, the guidance talks about a comprehensive risk assessment leading to the provision of the right skills that would be required in anticipation of the type of medical conditions that one may encounter. So it implies that there should be skills other than first aid, that there should be a skills mix in fact, which may include registered healthcare professionals in addition to first aiders.
Q. Without meaning to detract from that point, the conversation that you were having when you said the first aiders certainly didn't meet the requirements of the Purple Guide was about the competencies of first aiders as it appears in the guide?
MICHAEL HERRIOT: Indeed, yes.
Q. So do you agree then with the proposition I made that some event medical providers may have read the guidance and thought for their first aiders, not paramedics or others, that having a certificate plus some other training or competency might meet what the Purple Guide

suggested they required?
MICHAEL HERRIOT: It might do, yes.
Q. Can we agree that at least now the standard is FREC3?
MICHAEL HERRIOT: Yes.
Q. It's a lot clearer?
MICHAEL HERRIOT: Much clearer, yes.
Q. And very little room for interpretation around that, is there?
MICHAEL HERRIOT: Correct.
Q. Mr Cooper, I give you an opportunity before I move on.
CHRISTIAN COOPER: Nothing to add, thank you.
Q. Do you, Mr Herriot or Mr Cooper, have any experience of the content of the first aid training, that owned by the Health and Safety Executive or FREC3?
CHRISTIAN COOPER: No.
MICHAEL HERRIOT: Yes, not in great detail but as an overview, yes.
Q. Are you aware of the changes of the Health and Safety Executive in 2013 that you referenced?
MICHAEL HERRIOT: Yes.
Q. Are you aware of regulatory or industry regulatory bodies that may have come about since then?
MICHAEL HERRIOT: Yes. I'm aware of the first aid forums, et cetera.
Q. Have you heard of an organisation called the First Aid

Industry Body?
MICHAEL HERRIOT: Yes, I have read of that.
Q. Do you know anything about this organisation?
MICHAEL HERRIOT: I'm not familiar with its work.
Q. Then I'll leave that there. Thank you.
You'll know of Brigadier Hodgetts' evidence on Day 68 of the oral evidence hearings. He said at page 22, line 21 {Day68/22:21}:
"Within the civilian community, the prevailing narrative at the time of the arena attack would have been: don't use tourniquets and first aid because they may cause harm."
Do you agree with that comment as it relates to the content of first aid training at the time?
MICHAEL HERRIOT: I'm aware that at that time some first aiders were being taught the use of tourniquets. It wasn't universal by any means.
Q. Thank you. I'll move on. Mr Cooper, you're nodding, thank you.
On Friday, Mr Herriot, you were asked a discrete question about numbers of first aiders at the arena on 22 May 2017. You were asked in your view whether there was an adequate number of ETUK first aiders. Your answer:
"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."
MICHAEL HERRIOT: That's correct.
Q. A comment you have recently made?
MICHAEL HERRIOT: Yes.
Q. Is it right to say that your focus throughout this process has actually been on the skills mix rather than the numbers as a discrete issue?
MICHAEL HERRIOT: I think that the provider is required to carry out a risk assessment, which should lead them to the type of cover, the type of skills mix, and number of providers that are present. So provided that risk assessment has been carried out competently, then that would give them an idea about the number of first aiders and other staff that would be required to cover that particular event.
Q. The reason I ask the question, maybe I'm wrong about this, but is it right that you have not in any of your written documents specifically said the numbers were insufficient, the focus has always been on the competencies?
MICHAEL HERRIOT: It does and of course different versions

of the guidance give a slightly different interpretation of the numbers that would be required, and that's the reason why, in the 1999 guidance, the expert group specifically tried to move away from the formula of so many first aiders per so many audience and that was because we believed that organisers were focusing primarily at looking at the numbers they had and saying, "Well, X number needs X number of first aiders", when clearly that wasn't the case because evidence was showing that there are a lot of other factors that should influence that cover rather than purely numbers.

Q. The 1999 guide did still have that approach to numbers.

MICHAEL HERRIOT: The 1999 guide was the first guidance anywhere that looked at a thorough risk assessment, including the different relevant factors, to arrive at the number and the skill mix of first aiders, ambulance personnel, et cetera whereas, as the guidance has become an industry code of practice, a table has been reintroduced which, on the face of it, looked a little more simplistic. So the proposal in the 1999 guidance around moving to a risk assessment-based approach probably hasn't been carried through to the same degree.

Q. Thank you. That's where I was going. You have referred to what we believe to be the 2015 table, and that is defined between small, medium and large events.

MICHAEL HERRIOT: That's correct.

Q. And the medium event is 10,000 to 50,000 attending and a large event is over 50,000 attending?

MICHAEL HERRIOT: That's right, yes.

Q. I read out to you what you said on Friday about the numbers and you in summary fairly said it could be argued that the provision met the guidance. Can I just try to understand that for a moment? Are you saying that there is a reasonable range of responses to the guidance and that what there was fell within it?

MICHAEL HERRIOT: There is, yes.

Q. Thank you.

SIR JOHN SAUNDERS: I am sorry, I don't understand what that answer means. There were two questions there. Can we separate them off and I will find out whether the answers were yes to both?

MR TAYLOR: Thank you, sir. I'll try that.

There was the guidance and are you saying that the guidance can be interpreted in different ways as it was in 2015?

MICHAEL HERRIOT: I think, as you have postulated, the table in the recent guidance covers a wide variation, events from 20,000 to 50,000. Now, clearly, there will be a wide range of different hazards and risks within a population covering that magnitude of difference. So

clearly, a competent risk assessment is required to enable the provider to ascertain the correct number and skill mix of staff, so in that respect there is a variation, and it is open to some interpretation.

Q. Is that why you said on Friday, arguably it met that guidance?

MICHAEL HERRIOT: Exactly.

MR TAYLOR: Sir, does that clear up the question?

SIR JOHN SAUNDERS: Yes, thank you.

MR TAYLOR: A slightly related topic is historical data. In your note at ETUK5, which is on page 30 if anyone is following it, you say that:

"Providers/medical providers should keep records of patients seen."

MICHAEL HERRIOT: Yes.

Q. It seems like a rather obvious comment to make, but perhaps it needs stating. Do you agree the evidence has shown there was a log being kept at the arena?

MICHAEL HERRIOT: Certainly that has been published. The ratio of patients seen at events seems to have been recorded, yes.

Q. That's been calculated and it comes from a log. Perhaps to be clear, I won't put it up but I'll read a very short part of Mr Allen's eighth witness statement. For those who would like a reference it is {INQ040488/2}:

"This log sets out data per show including the number of people in the audience, the number of EMTs and first aiders on duty, the number of individuals seen by the medics at the event, whether an ambulance was called, the types of medical incident reported."

And as you've observed, Mr Herriot, there has been statistics which have been quoted so far that come from that data. Do you agree that the guidance in part referred to the importance of looking at your own data from previous events?

MICHAEL HERRIOT: That's correct. As a means of learning from previous events, that would include not just looking at the numbers, looking at the cause of the incident, if there was an incident, or the types of conditions seen that could be then contrasted against the activity at the time. Again it's well-known that different types of act, different types of audience, the different make-up of audience makes a big difference in the number of people that seek medical assistance.

Q. The Purple Guide aims to educate those putting on a wide range of events and maybe, for the first time, some may be only periodic events?

MICHAEL HERRIOT: That's correct.

Q. Not everyone who reads the guide will be putting on several events a week, hundreds of events a year?

MICHAEL HERRIOT: That's right.
Q. So in the case of the arena, with data from every show going back over a decade, would you agree in that context they had very good data about past medical incidents?
MICHAEL HERRIOT: They should have, yes.
Q. No comments on that topic, Mr Cooper?
CHRISTIAN COOPER: I have nothing further to add, thank you.
SIR JOHN SAUNDERS: Sorry, can we stop for a moment? I am not quite sure of the significance or what is going to be said to be the significance of the last series of questions. So is that to say: well, we look at the past data of what's been required, and from that we get some sort of indication of the sort of medical service provision we need to supply? If that were the case then we would simply ignore anything such as happened on 22 May. Is that the argument?
MR TAYLOR: Not so much an argument, sir, but it's right to say that the table in the 1999 Purple Guide —— one of the scores depends on how good the past data is. Is that right, Mr Herriot?
MICHAEL HERRIOT: Yes. The past data is one element to be considered. Not the most important element, I would say, but one in a wide range of factors that need to be taken into consideration.

Q. Perhaps since, sir, you have raised it and Mr Herriot's given that answer, I might ask you about the 2018 version. Mr Lopez, please can you place on screen {INQ020216/2}. It might be {INQ020216/1}, apologies. It's paragraph 5.4.1:
"The best way to medically identify the needs of an established event is it look at the quantity and type of incidents that have happened previously."
That's what the 2018 guidance was saying. But I think based on your last answer you would disagree with that, it's not the best way?
MICHAEL HERRIOT: I think it's a factor.
MR TAYLOR: Sir, I propose to move to the next topic ——
SIR JOHN SAUNDERS: That's fine, I just needed to know where we were going. Clearly, it is an argument to say you judge what medical provision you need to provide on the basis of what's happened before. But actually, that then would exclude this sort of incident as being a consideration for medical provision. If that is what the trade is actually saying and suggesting in its guidance, then it's something I need to be aware of.
MR TAYLOR: Yes, sir, hence the questions.
MICHAEL HERRIOT: Yes. And the guidance says and has always said that each event requires its own risk assessment.
SIR JOHN SAUNDERS: Okay, thank you very much.

MR TAYLOR: Handover of responsibility document. Mr Cooper, you dealt with this mainly, I think, on Friday. There is reference to a handover of responsibility document in the Purple Guide. Is this where you take the requirement from?
CHRISTIAN COOPER: Yes.
Q. Mr Lopez, please, {INQ041126/23}. Paragraph 5.95:
"At large events, it is best practice that a handover of responsibility document is drawn up between the statutory Ambulance Service and the event medical provider, ready for use should a major incident occur. This will detail when the assets of the medical provider were handed over to the statutory Ambulance Service for the duration of the incident. Part of the document will also outline the handback procedure when the recovery from the major incident commences."
Was your evidence on Friday, Mr Cooper, that you would expect a handover of responsibility document in every event where there is a contracted medical provider?
CHRISTIAN COOPER: Well, I think that's good practice as part of the planning. The Purple Guide requirement there is clearly requiring it in response to a major incident. I'm also acutely aware of the practicalities

of actually achieving that at that phase. So it's absolutely right and proper that one is drawn up in advance. That will help inform planning. It'll help both parties to understand that when you've got an incumbent medical provider at an event, if there were a large-scale major incident, at that event at some stage the statutory Ambulance Service is going to need to take control of that. And that needs to be anticipated, it needs to be planned, and there's an attempt here to put that into a formal document.
I think the point I was trying to articulate on Friday is the actual physical handover and perhaps a countersigning of a document at that stage in a major incident is probably unrealistic.
Q. Yes, and some might read the second sentence:
"This will detail when the assets were handed over."
As indicating that this is a template or form that has to be completed at the time?
CHRISTIAN COOPER: Indeed.
Q. And that's the practical difficulty that you're discussing, is it?
CHRISTIAN COOPER: Yes.
Q. When you said on Friday that perhaps it's advisable for every event, is that an aspirational recommendation rather than a statement of the guidance at the time?

CHRISTIAN COOPER: That is not a requirement by the Purple Guide.
Q. And one may read the Purple Guide and the table at the back I was discussing with Mr Herriot that calls a large event of over 50,000 as possibly excluding -- containing the requirement for a handover of responsibility document to those events of over 50,000?
CHRISTIAN COOPER: Yes, but of course a handover of responsibility document isn't going to be required at the vast majority of events where there isn't a major incident. So I think my point is: you don't know when a major incident is going to occur, so better have one in place then.
Q. So perhaps the guidance should say every event?
CHRISTIAN COOPER: Quite.
Q. The nature of the document -- I, think Mr Herriot, you mentioned this on Friday and it appears in your reports, both of you -- is not just about explaining what has happened to the Ambulance Service once they arrive and leaving them to it, there's a suggestion of, or at least an indication of, the Ambulance Service taking control of the personnel of the private medical provider. That might be a complication for some ambulance services, a national issue, not specific to this case necessarily. So the ability to even have a handover of responsibility

as envisaged here may be affected by in fact the attitude or beliefs of the relevant local Ambulance Service?
MICHAEL HERRIOT: I think based on the fact that healthcare is generally highly regulated, but provision of healthcare within an arena, an environment such as the arena, is completely unregulated. It's one of the very few areas that's unregulated. That's one of the reasons why some NHS ambulance services would be nervous about entering into such an agreement.
Q. The final point on this topic is the initiative. For one-off events or less frequent events, there may be a Safety Advisory Group meeting. That will bring together the multi-agency parties to help organise the event and provide a forum for communication between them; yes?
MICHAEL HERRIOT: Yes.
Q. The arena had its multi-agency planning meetings which fulfilled this function; correct?
MICHAEL HERRIOT: It did, yes.
Q. And are you aware that the arena also communicated with the relevant agencies schedules of events with details of --
MICHAEL HERRIOT: I've read that evidence, yes.
Q. So Mr Cooper, when you were asked on Friday by the

chairman who should take the initiative in preparing a handover of responsibility document, I think your answer was the medical provider because the Ambulance Service might not know there is an event.
CHRISTIAN COOPER: Quite.
Q. But one would hope, if the guidance about Safety Advisory Groups or multi-agency meetings is followed, that they were well aware there was an event?
CHRISTIAN COOPER: Yes.
Q. So if one of these documents is required in every case or in most cases, as you recommend, is it not going to be a shared initiative or is there any reason why it shouldn't be a shared initiative?
CHRISTIAN COOPER: I think the aspiration is that it is shared, absolutely. There's a sharing of responsibility, so one would hope a sharing in the production of the document, yes.
Q. And the final topic from me is the question of METHANE message. Mr Greaney read out the statement of Mr Cowen on Friday with which you both agreed about the regulation of the medical management role at an event. Mr Cowen in his statement states that a medical manager should be able to understand and give a METHANE message.
MICHAEL HERRIOT: Yes.
Q. And then to be expected to begin the process of triage.

Do you agree with that?
MICHAEL HERRIOT: Yes.
Q. It's the expectation, is it, that the METHANE message should come from the medical provider, not the event organiser?
MICHAEL HERRIOT: That's correct.
Q. You have seen the ETUK emergency plan?
MICHAEL HERRIOT: I have, yes.
Q. Without going into how that plan was or was not put into operation, can we agree that the plan did require the communication of a METHANE message by the medical manager?
MICHAEL HERRIOT: The plan made provision for that, yes.
Q. And it made provision for the commencement of triage?
MICHAEL HERRIOT: It did.
Q. In your response to list of central issues on page 18, labelled NWAS29, you state:
"No sitrep/ETHANE/CHALET message was passed to NWAS by ETUK (or SMG)."
Is the "or SMG" meant to be read as a criticism of SMG?
MICHAEL HERRIOT: It's pointing out that within the plan the METHANE message, or any similar message, should have been passed to the Ambulance Service to enhance their situational awareness and inform their response. And

that hadn't been achieved, as suggested in the plan.
Furthermore, the Ambulance Service hadn't been contacted by SMG, although the police had. So it was purely an observation that that was the case.
Q. But you are aware of the 999 call from the arena control room, are you?
MICHAEL HERRIOT: Yes.
Q. It's detailed in a master transcript of relevant 999 calls, I won't ask for it to go up, but I will, if I may, read it out. The reference is {INQ023493T/4}. Entry number 16. Timed at 22.34.12. Caller, Paul Johnson, fire safety officer at the arena. And this is the summary:
"Control at Manchester Arena reporting bomb gone off in City Rooms. States there are a lot of children hurt. End of summary."
So there's no spelling out of METHANE, obviously.
MICHAEL HERRIOT: No.
Q. But there's information given as to the type of incident; yes?
MICHAEL HERRIOT: Given to the police?
Q. The 999 operator.
MICHAEL HERRIOT: So it wasn't given to the Ambulance Service, it was given to the police.
Q. How does it get from the 999 operator to the

Ambulance Service?
MICHAEL HERRIOT: It would require the police to pass that message. But it didn't contain the sort of information that the Ambulance Service would require to inform their response earlier. The Ambulance Service was purely relying on, at that stage, the information from the general public: 30 calls, I think, in the first 10 minutes.
Q. I don't mean to say that Mr Johnson's call is alone amongst all the calls that were being received and providing information about what was happening, but for Mr Johnson's call there is information as to there having been an explosion, the type of incident; yes?
MICHAEL HERRIOT: But not to the Ambulance Service, that's the point.
Q. So you would make a criticism that the Ambulance Service weren't requested to the 999 operator or that it wasn't passed on to the Ambulance Service from the 999 operator?
MICHAEL HERRIOT: No, my criticism is there is a plan that details the fact that that call will be made to the Ambulance Service and that call was not made.
Q. So no criticism of the efforts that were made to contact 999 by the control room?
MICHAEL HERRIOT: No, but it didn't meet the requirement.

Q. Because they didn't reach NWAS or because ——
MICHAEL HERRIOT: Yes, because they didn't contact NWAS, as had been stipulated in their plan.
Q. The way to contact NWAS would be to dial 999?
MICHAEL HERRIOT: Yes.
Q. I'm going to finish that topic. Mr Cooper, I give you the opportunity if you have anything to add.
CHRISTIAN COOPER: I don't think so. The key thing we have to look at is what the plan says that they should do. The plan says that that METHANE message needs to be passed to NWAS. Yes, of course, you do that via the 999 system and then you ask for the Ambulance Service and you pass the METHANE message. That is our expectation and that didn't happen, absolutely agreeing that the main responsibility for that in the plan and our expectation would be that that would be done by ETUK. I think the other thing we were considering here with the "or SMG" bit in brackets was if there's a control room operating or something of that nature that SMG have control over, perhaps there's an opportunity there to make sure that that message has gone in. I think that was why we were saying ETUK, or more broadly SMG, but we do recognise that the —— that METHANE message particularly should have been passed by ETUK to NWAS.

MR TAYLOR: Thank you, gentlemen, thank you, sir, those are my questions.
SIR JOHN SAUNDERS: Thank you very much, Mr Taylor.
MR GREANEY: Sir, that would be a convenient moment for our 15—minute morning break.
SIR JOHN SAUNDERS: Okay. Thank you very much. Quarter of an hour.
(11.05 am)
(A short break)
(11.20 am)
MR GREANEY: Sir, we have heard from Mr Wood, on behalf of Sexton and Dexter, and from Mr Horwell on behalf of GMP, and Mr Warnock and on behalf of GMCA, that they no longer have any questions and so I am going to turn straight to Mr Atkinson to ask his questions on behalf of the families.
SIR JOHN SAUNDERS: Mr Greaney, I understand we're well up to time?
MR GREANEY: We are ahead of time, sir, yes. We will certainly finish the evidence of these witnesses today.
SIR JOHN SAUNDERS: Thank you. Don't take that as an invitation to be longer!
Questions from MR ATKINSON
MR ATKINSON: Perish the thought, sir, good morning.
Gentlemen, as you understand, I ask questions on

behalf of the bereaved families and if I initially direct my questions towards you, Mr Cooper, it's so I don't look less like a nodding dog going backwards and forwards between you, but please, Mr Herriot, join in at any point you find helpful.

In very broad overview, does it come to this: that to respond to a major incident such as this, there needed to be planning by any organisation that was likely to be involved in that response in advance?

CHRISTIAN COOPER: Yes.

Q. And for that planning to work, and more particularly for that response to work, that planning could not be done in isolation by individual organisations, it needed to be done collectively?

CHRISTIAN COOPER: That's correct, yes.

Q. And that involved or should have involved a collective assessment of the risks in relation to a terrorist attack and how those risks would be dealt with?

CHRISTIAN COOPER: Yes.

Q. And that involves the venue, the arena, and its medical provider, but also the emergency responders who would attend such an incident?

CHRISTIAN COOPER: Yes.

Q. And they all needed to plan for it?

CHRISTIAN COOPER: Yes.

Q. They all needed to assess the risks relating to it?

CHRISTIAN COOPER: Yes.

Q. And they had to do that together in order for that to work properly?

CHRISTIAN COOPER: Yes.

Q. And that did not happen?

CHRISTIAN COOPER: There were -- no, not in entirety, no.

Q. In various respects you've identified things that the Ambulance Service could have done better. In part, would you agree, those were things that had they done better, they would have addressed the deficiencies in other people's planning and/or other people's response?

CHRISTIAN COOPER: In part, yes.

Q. So for example, in terms of the risk assessment and the identification of medical needs for the arena, clearly that was something for the arena and its medical provider to do but the Ambulance Service could, and I suggest should, have had a role in that?

CHRISTIAN COOPER: Yes, either directly or via the LRF mechanism or the Safety Advisory Group mechanism, but by some mechanism, yes.

Q. In relation to the application of JESIP to the response, standing back, we can together see a range of ways in which JESIP was not properly applied by the response.

CHRISTIAN COOPER: Yes.

Q. In some cases, not the particular fault of a particular emergency service, but each had a responsibility to correct the areas of the others?

CHRISTIAN COOPER: That's correct, yes.

Q. And so far as operational command is concerned, the operational commanders in particular had a role to question their counterparts to make sure between them they had covered it?

CHRISTIAN COOPER: Yes.

Q. And that didn't happen?

CHRISTIAN COOPER: It did not.

Q. In terms of planning, you identified on Friday that NWAS had the necessary major incident plans in place for its own purposes?

CHRISTIAN COOPER: Yes.

Q. Would it be fair to say that there was less evidence that those plans had been shared with others?

CHRISTIAN COOPER: I think we were content that efforts had been made within NWAS's planning to incorporate more of a multi-agency response than there was prior to the JESIP doctrine and we could see evidence of attempts to include that prior to the attack within their planning.

Q. But it was still within their plan which they saw --

CHRISTIAN COOPER: Yes.

Q. -- rather than within their plan that they shared with

everybody else who was going to have to be a part of that response to make sure they'd seen it too?

CHRISTIAN COOPER: I'm not sure NWAS shared their response plan with other agencies.

Q. And equally in fairness, those other agencies had shared their plans with NWAS?

CHRISTIAN COOPER: Correct.

Q. For example, GMP had a plan relating to the arena but you could see no evidence that NWAS, for example, had seen that?

CHRISTIAN COOPER: No.

Q. SMG had a plan for the arena but no evidence that that had been shared and worked through with the emergency services?

CHRISTIAN COOPER: We couldn't see evidence that it had been worked through, no.

Q. Or trained together with?

CHRISTIAN COOPER: Indeed not.

Q. So far as a major incident plan for the arena is concerned, and focusing for a moment on NWAS in that respect, does it come to this, that there was no mandated requirement at the time of the bombing for them to have produced a site-specific plan for the arena?

CHRISTIAN COOPER: Not for NWAS, no. There was a requirement to work through high-risk locations as

part of Community Risk Register activity through the LRF, which we would have expected NWAS to be a key part of, but there was no specific requirement on NWAS to have a site-specific plan for a specific site.
Q. Although do we also understand from your evidence on Friday that it would have been good practice for them to have done so?
CHRISTIAN COOPER: Yes.
Q. Just to understand how such a site-specific plan would have helped them, and this, gentlemen, you deal with in your second report, I don't ask for it to come up on screen, but {INQ032665/27} of that, paragraph 3.34 if it helps you, that:
"A site-specific plan will provide, as it says on the tin, site-specific information that a generic major incident plan will not contain. But it will include maps and plans, lists of particular risks of a location, specific procedures relating to a particular location, and action that can be taken by personnel there."
So in terms of -- let's take some practical examples. In terms of the operation control room understanding the geography of the location, if there was a site-specific plan that would have helped them, would it not?
CHRISTIAN COOPER: Yes, and for context in relation to this

paragraph, a plan either produced by NWAS and the site or a plan produced jointly through the LRF mechanism, either way. But yes, something that yields that specific data set for NWAS and the NWAS control room, yes.
Q. The qualification you have just made is entirely valid, Mr Cooper, and we'll look at the LRF role in just a moment, but just looking at how a site-specific NWAS plan would have helped NWAS on 22 May, it would have helped their control room understand the geography of the location?
CHRISTIAN COOPER: Yes.
Q. Because clearly, NWAS, as you commented on a number of times on Friday, dealt with a much wider area than Manchester. And so to expect a particular person in the control room to have that detailed knowledge of the layouts of the streets around a particular venue is unrealistic?
CHRISTIAN COOPER: Yes.
Q. It would therefore identify potential locations to which resources could be sent --
CHRISTIAN COOPER: Yes.
Q. -- as potential RVPs?
CHRISTIAN COOPER: Yes.
Q. Clearly, whether they actually worked as RVPs would be

something even at a first stage you'd need to liaise with the police about?
CHRISTIAN COOPER: Yes.
Q. But it would give some locations?
CHRISTIAN COOPER: Yes.
Q. It would potentially identify the type of locations that an FCP could be, again that would depend on where the actual incident was happening?
CHRISTIAN COOPER: I wouldn't expect a site-specific plan to necessarily contain specific references to where there would be an FCP, but I think, as I mentioned on Friday, the RVP is a natural starting point for that. It gives you a natural point to form up an FCP unless you have a more suitable location in mind at the time.
Q. And if it reminds people of the need to establish an FCP, that can't hurt?
CHRISTIAN COOPER: No.
Q. It would put in black and white who at the arena was responsible for its medical response so that from the outset, the two, NWAS and ETUK, would have that contact set out?
CHRISTIAN COOPER: Yes.
Q. Ideally, a site-specific NWAS plan would want to feed off and indeed feed into the ETUK site-specific plan for a major response, so the two worked together?

CHRISTIAN COOPER: Yes, and it's an opportunity to make sure that NWAS' generic major incident plan, which they had, which we found was good, could slot into the specific requirements of a response at a unique location.
Q. In terms of major risks, if an assessment of a venue like this had identified the risk, which given the national terrorism level, was one that needed to be addressed, the risk of a bomb, the type of resources that NWAS would be expected to provide in response to that?
CHRISTIAN COOPER: Yes.
Q. Would that almost inevitably involve the deployment of HART?
CHRISTIAN COOPER: Yes.
Q. Potentially also AIT and SORT?
CHRISTIAN COOPER: Yes.
Q. And at the very least, would you agree that such a plan ought to identify those as things that needed to be considered as soon as you knew something had happened?
CHRISTIAN COOPER: Yes.
Q. Which would aid them being deployed the quicker?
CHRISTIAN COOPER: Yes.
Q. The arena was a venue that, from a policing point of view, was somewhat unusual because of its location above a railway station and therefore there was the issue of

primacy between the BTP and the GMP. In fact, and as was likely to be the case, BTP officers were on the ground the quickest of emergency responders. Again, a major incident plan that identified that the BTP were actually the force you needed to speak to first, but certainly early, would help, would it not?
CHRISTIAN COOPER: Yes.
Q. Because you wouldn't necessarily think of that in the heat of the moment, "I remember where it is, therefore we need to involve the BTP"?
CHRISTIAN COOPER: Yes.
Q. A clear route to ensuring that there was such a plan was the LRF?
CHRISTIAN COOPER: Yes.
Q. Because actually, although you needed a plan that would deal with NWAS resources and NWAS deployment, it had to involve the other emergency services from the outset?
CHRISTIAN COOPER: Yes.
Q. Because, for example, you would need police involvement in identifying where the RVP actually was going to be rather than potentially going to be?
CHRISTIAN COOPER: Yes.
Q. This was an issue, sir, that came up on Friday as to whether Mr Argyle had been asked about the LRF's role in relation to this. In fact, he was. Day 58, page 155

{Day58/155:1} when, as it happens, I asked him about the LRF's role in ensuring that there were site-specific plans for major incidents. His answer was that the GMRF did not try to develop site-specific plans.
Would you, Mr Cooper, consider that was a matter of regret?
CHRISTIAN COOPER: Well, I recognise the challenge given the geography of an area covered by the LRF. But the LRF is required to risk assess that geography and whether we're talking about regret through hindsight or at the time, I'm not sure, but I think I articulated on Friday that a location such as that, coterminous with a transport hub, the kinds of numbers of people and the threat level that we were at and what we knew about terrorism at the time, you would have expected there to be arrangements, ideally multi-agency arrangements, agreed through the LRF mechanism to deal with that location and certainly I think given the events that have transcribed (sic) that is now obvious, I would suggest.
Q. It is clear there needed to be a mechanism by which the emergency services could get together and plan their response to a potential major incident at key locations within their remit?
CHRISTIAN COOPER: Yes.
Q. And large entertainment venues would almost certainly

feature on that list?
CHRISTIAN COOPER: Yes.
Q. And a venue in which they were getting together and in part getting together to consider risks and their joint response to them was the LRF, and so had the LRF been proactive in encouraging joint planning in relation to key venues, that would clearly have helped?
CHRISTIAN COOPER: Yes.
Q. And the fact that it wasn't meant that in that important respect, it was not helping?
CHRISTIAN COOPER: Yes.
Q. A step down from that, but equally important, was for the arena itself to plan its medical response to a major incident and it did produce a major incident plan. And ETUK produced a plan.
Looking at it on paper, was that plan satisfactory?
CHRISTIAN COOPER: Can I let Mike lead on that answer, if that's okay?
MICHAEL HERRIOT: It was fairly rudimentary, but it did set out the initial actions they should carry out.
Q. Would you agree that any such plan is only as good as the organisation's ability to actually put it into practice?
MICHAEL HERRIOT: That's correct.
Q. And here, there is no evidence that they put it into

practice really at all?
MICHAEL HERRIOT: No, I think Mr Parry said -- it went out of the window, I think was his expression.
Q. Yes. That's the absolute opposite of what should have been the case, surely?
MICHAEL HERRIOT: Well, yes, the whole idea of developing the plan is that, in extremis, you turn to the plan and follow the concepts in the plan.
Q. So what you need is for that plan to be absolutely understood by anyone who's going to have a role in deploying it?
MICHAEL HERRIOT: Anybody that would be involved in it should understand it and preferably be trained in it.
Q. You say preferably. Are there really any circumstances in which people who are going to be working at a venue where they may have to respond to a major incident would not be trained in how to respond to a major incident?
MICHAEL HERRIOT: They should be trained.
Q. And given that this was a response that would need to involve ETUK, not just until the Ambulance Service arrived but then once the Ambulance Service had arrived, working with the Ambulance Service before there's to be consultation between the two as to how the plan between them would work?
MICHAEL HERRIOT: Yes, unfortunately there didn't seem to be

a productive relationship between the two.
Q. I think you observe in your most recent report there doesn't appear to have been a relationship at all between ETUK and NWAS.
MICHAEL HERRIOT: That's correct.
Q. Clearly, if one were to use the word fault, there would be fault on both sides in that, would you agree?
MICHAEL HERRIOT: Yes. In so much as NWAS would be expected to have assessed the risks within their operational area, the logical progression of that would have been for there to be dialogue with ETUK.
Q. In that context, beyond having a major incident plan that you actually trained to and understood and liaised with your local Ambulance Service about, also the need for a risk assessment for each event as to what the risks were and how you would deal with them?
MICHAEL HERRIOT: Yes.
Q. We'll come back in due course to the care gap and how long such a gap should be, but unless there are ambulances on scene already, there will be a gap before they arrive?
MICHAEL HERRIOT: Yes, that's right.
Q. And at a major venue, that gap really can only be filled, in terms of any kind of professional, by the medical team on site?

MICHAEL HERRIOT: Yes, some venues used to have NHS ambulances or an NHS ambulance officer on site for that very purpose, that they can initiate the response to a major incident and call upon the resources of the Ambulance Service, being extensive.
Q. We're going to look in just a moment as to whether there should have been ambulances on site here.
But just dealing with it in the abstract first, in terms of ambulance liaison officers, do we understand from your evidence on Friday that there had been a much more common presence of ambulance personnel at major venues, and still is in relation to football grounds, for example, but less so in relation to other types of venues?
MICHAEL HERRIOT: Football grounds are, of course, are regulated by the Football Ground Safety Association, so the context is rather different. But certainly, quite a number of particularly larger events would have an NHS ambulance officer present. Even if the Ambulance Service wasn't providing the service they would have an ambulance officer there for liaison purposes and to initiate a wider response if required.
Q. In terms of how that person would work, clearly they would be a person who could, on scene, gain immediate situational awareness, and send a METHANE message to the

Ambulance Service?
MICHAEL HERRIOT: Yes.
Q. And indeed to know what control rooms beyond the Ambulance Service they might need to speak to?
MICHAEL HERRIOT: Yes.
Q. They would also presumably be able to give direction to the on-site team as to the things they needed to be doing?
MICHAEL HERRIOT: That would be a feature, yes.
Q. So both an overview of the people who are there but also importantly getting the message out, the right message out, to people who aren't?
MICHAEL HERRIOT: Indeed.
Q. Would they in effect be in that situation acting as the first ambulance on scene in the sense of that action card?
MICHAEL HERRIOT: Yes, they would carry out that role.
Q. So just considering that -- Mr Lopez, it's {INQ013422/3}.
We may need to go back a page, sorry {INQ013422/2}.
If we could enlarge the lower half of the page, please.
This is the action card that did apply to Mr Ennis, isn't it?
MICHAEL HERRIOT: Mm-hm.

Q. But it's the type of things that you would expect an ambulance liaison officer to do in the immediate response because they're already there?
MICHAEL HERRIOT: Yes.
Q. So looking at number 4, "Sending a METHANE message"?
MICHAEL HERRIOT: That's right, yes.
Q. And, "Liaising with police and fire"?
MICHAEL HERRIOT: Yes.
Q. {INQ013422/3}:
"Identifying what specialist teams might be required."
In terms of how that would work, if we imagine there has been an ambulance liaison officer there at 22.31, within minutes they could have gained the first situational awareness as to what had just happened. They could have sent a METHANE message to communicate that to others.
MICHAEL HERRIOT: Yes.
Q. They could have seen where this bomb had gone off and therefore what kind of specialists were going to be needed?
MICHAEL HERRIOT: Yes, and declared a major incident, of course.
Q. And declared a major incident. So the identification, for example, of the need for HART and SORT and AIT, all

of whom, I think it's your collective view, should have been there early doors ——
MICHAEL HERRIOT: Yes.
Q. —— could have been reached very early doors?
MICHAEL HERRIOT: Yes.
Q. And then:
"Identifying in liaison with the others ... "
And of course the first BTP officers would be coming in, for example:
"... identifying an RVP within minutes"?
MICHAEL HERRIOT: Mm—hm.
Q. And egress routes and so on?
MICHAEL HERRIOT: Yes. And again with the benefit of a site—specific plan and a predetermined attendance plan, that would enhance the response greatly.
Q. In terms of why venues don't take advantage of that, is it a matter of the cost?
MICHAEL HERRIOT: That would certainly be something to do with it, yes. I think because ambulance services have come under increasing pressure, I think as we said on Friday, over a 10—year period the number of emergency calls to ambulance services more than doubled, because of that clearly the ambulance structures, the particular management structures, which are very lean in any gap, being under additional pressure, that became quite

difficult, I think, for ambulance services to provide that resource. But as you correctly say, the cost would be a factor because that cost would have to be passed on to the venue or the promoter.
Q. In terms of a venue assessing what it needed, the Purple Guide, in its various iterations, has sought to provide a structured approach to that assessment, has it not?
MICHAEL HERRIOT: Yes, it certainly aimed to allow venues and operators to provide a safe event. That was the aim of it.
Q. Would you agree that a venue ought to have regard to the current iteration of the Purple Guide at any point in time?
MICHAEL HERRIOT: Yes, certainly.
Q. One of the matters you comment on in relation to ETUK was that Mr Parry appeared to have no familiarity with the current version, and we may have seen that from his evidence.
MICHAEL HERRIOT: Yes.
Q. Perhaps as a tribute to you, Mr Herriot, he was using your edition, the 1999 edition, rather than the 2015. But just so we can understand what you and your version of the guide were seeking to do, {INQ001452/129}, please.

This is something you were referring to earlier today, I think, Mr Herriot, the recommended minimum number of first aiders at small events where no special risks are considered likely is 2:1,000 for the first 3,000 attending.
MICHAEL HERRIOT: Yes.
Q. Do we understand that the point you were making is that that is only the first step in identifying who you actually need as your medical cover for an event, it is not the answer?
MICHAEL HERRIOT: Yes, and this is really referring to the smallest, simplest events.
Q. Because if we go on, please, to {INQ001452/134}, and again it's the bottom of the page, there are then set out in the 1999 version a series of tables that identify what the resources actually you're going to need for your event are by reference to the nature of the event, using table 1; available history and pre—event intelligence, table 2; various additional elements that are set out in table 3; and resource requirements set out in table 4.
I took Mr Parry through, using this version, because that was the version he was familiar with, and he and I didn't reach entire agreement as to the score, but we were on a score over 30.

If we go on, please, to {INQ001452/138}, the bottom half of the page —— I think I reached a score of 35, he was nearer 31, but it did therefore reach a score that required, just looking at the —— following that process through, two ambulances.
A number of first aiders but also ambulance personnel and a doctor.
MICHAEL HERRIOT: Yes.
Q. So even on the 1999 version, your version of the Purple Guide, applying that properly, it is never just a question of: how many people have we got coming, therefore we need this number of first aiders?
MICHAEL HERRIOT: That's correct.
Q. It's first aiders plus ——
MICHAEL HERRIOT: Yes.
Q. —— on this assessment, at least two ambulances with presumably the two paramedics that would be in them and all the kit that would be in them?
MICHAEL HERRIOT: That's correct.
Q. Plus a doctor, plus first aiders, and that collective package is what will give you the skill set that you need and presumably also again ensure that you have ambulance personnel on scene at the moment something happens, who can then swing into action using that action card for first ambulance on scene and all the

steps we looked at?
MICHAEL HERRIOT: That's correct, yes.
Q. Thank you, Mr Lopez.
I think you'd agree, Mr Herriot, that the 2015 version would not have come to a different conclusion as to the need for ambulances... I'm so sorry, sir.
SIR JOHN SAUNDERS: Not your problem, but it's just the difficulty of intervening remotely. I want to be assured that when we're talking about ambulances being required they are in this case NWAS ambulances or are we talking about private ambulances?
MICHAEL HERRIOT: At the time this was written, they would have been NHS ambulances because it was only via the NHS that you could secure qualified paramedics. So that's not of course now the case, so a private ambulance company could provide those resources.
SIR JOHN SAUNDERS: Thank you.
Thank you, Mr Atkinson.
MR ATKINSON: And so would you agree, Mr Herriot, that another way of addressing the care gap, applying the Purple Guide, even the wrong version of the Purple Guide, would be to assess the need to have ambulances on site and so there wouldn't be a care gap because they'd be there already?
MICHAEL HERRIOT: That's correct, yes.

Q. Moving on to training, I don't need to detain you long in relation to the training of the NWAS staff because you are both very clear that the methods of training for NWAS were appropriate and the competency of their staff, by reference to that training and the national standards, was more than adequate.
CHRISTIAN COOPER: Yes. And those standards have changed since and are now more onerous, but at the time NWAS certainly met the standard for their commanders and their staff.
Q. The area that you were able to comment on, on Friday -- Mr Greaney took you through this, I don't need to detain you on it -- was that whilst there was proper training and indeed proper training excised for NWAS, there was perhaps less learning of lessons from training exercises than there should have been.
CHRISTIAN COOPER: That's correct.
Q. Mr Greaney took you through what those lessons were in relation to various exercises; I don't seek to take you through that again, you'll be relieved to hear.
Moving on to the other organisation whose training you can speak to, which is ETUK in this regard, the Purple Guide, your version, the 1999 version and since, has always made clear that First Aid at Work is not enough?

MICHAEL HERRIOT: That's correct, yes.
Q. Because it is what it says on the tin, again, it is the first aid skills that someone working in an office or another workplace can have to help a colleague who slips on a wet surface or cuts themselves or the kind of first aid incidents that one might expect to have in an office?
MICHAEL HERRIOT: Yes, you're very likely to encounter a different set of conditions at an event, clearly.
Q. Not only different circumstances at an event in terms of where you are but also who you are dealing with. You're not dealing with your colleague, you are dealing with members of the public and, depending on what your office is, the risk assessment is less likely perhaps to identify a major incident where you could have significant numbers of casualties for whom you are going to be the first responder?
MICHAEL HERRIOT: That's right, yes.
Q. The reality is that the vast majority of ETUK's team on that night only had First Aid at Work training?
MICHAEL HERRIOT: Yes. Some had additional skills, some were in training to be medical professionals, but of course they're casual staff, so it was pretty much luck of the draw as far as you who you encountered there and what skills they had.

Q. Let's just consider that for a moment. This is in your third report, which is {INQ035306/41}. Again, I don't ask it to come up, but this is to help you in particular, Mr Herriot. From paragraph 206 of that you identify each of the ETUK people who was working that night and what skills they had.
MICHAEL HERRIOT: Yes.
Q. So we have Mr Parry, who was Medic 1.
MICHAEL HERRIOT: Yes.
Q. There was an expectation for that role that he would be MIMMS qualified. You'll recall his evidence that he had had MIMMS training back in the day but it wasn't up to date.
MICHAEL HERRIOT: That's right. Certainly the tender for cover at the arena set out a range of skills that are required for the EMT A, EMT B, and the first aiders. I think that that table probably originated from Mr Parry's company and it set out a range of skills that were required by particularly EMT A, some of which we would dispute were actually available to a person that wasn't a registered healthcare professional.
Q. Just following that through, does it follow from that that, on the one hand, the tender was setting out unreal expectations of the kind that -- whether they would ever get staff of the kind that they were asking for that

actually had the skills that they were asking for?
MICHAEL HERRIOT: Yes, the tender set out skills such as ECG interpretation and advanced life support. That would be unusual, to say the least, in someone that wasn't a registered healthcare professional.
Q. Just to help you, rather than you doing it from memory, Mr Herriot, {INQ001405/5}, please, Mr Lopez.
The bottom half of the page. This is EMT A. We can see a list of skills that they were required to have:
"Advanced life support. Advanced airway management."
A range of diagnostic skills, including, as you say, ECG analysis:
"The administration of prescription-only medications. Advanced triage skills."
As we can see near the bottom of this.
Taking a step back, Mr Herriot, what kind of person would actually have all those skills? Are we talking a paramedic, a doctor?
MICHAEL HERRIOT: You'd need to be a registered healthcare professional, so usually a paramedic would be experienced in providing that sort of range of skills. Equally a registered nurse with a range of skills or, of course, a doctor.
Q. So those who, at least nominally, were carrying out the

EMT roles at the arena, on the material you have seen, did not have those skills, did they?
MICHAEL HERRIOT: It was very unlikely. Some of the aspects, for instance of advanced life support, it is possible to carry out the training but then not have authority to practice.
Q. Mr Parry's number 2 on the night, Liz Woodcock, who was Medic 2, had 4 years of First Aid at Work experience, didn't she --
MICHAEL HERRIOT: Yes.
Q. -- rather than anything like the list we've just looked at?
There were some, I think you give the examples of Marianne Gibson and Ryan Billington, who had acquired skills through what they were doing when they weren't working for ETUK: she is a nurse, he is a trainee paramedic. But those were skills that they had the good fortune to have because of that rather than anything that ETUK had given them?
MICHAEL HERRIOT: Yes, that's correct. And of course, whether or not they'd be able to offer additional practical assistance would rather depend on what stage of their training they were at and what they were authorised to actually do.
Q. Would you agree also that in terms of them working as

a team, they would need to know what the others knew as well? They would need to know who amongst them had triage experience for example or who had life support training in advance so they could make sure the right people were doing the right things?
MICHAEL HERRIOT: Yes.
Q. If all you have is a list of names of who's turning up today, that's not going to prepare the team to respond to a major incident, is it?
MICHAEL HERRIOT: No, no. Presumably, they knew each other and had worked together, but that wouldn't necessarily be the case, of course.
Q. Moving on to a different topic, but still in relation to training, and that's going back to NWAS and action cards. I'm not sure if this is back to you, Mr Cooper.
Is the basic idea of action cards that they set out in a remarkably small amount of paper, if they are on paper, the things that someone doing a particular job needs to know that it is their job to do?
CHRISTIAN COOPER: Yes.
Q. Would this be right? It's not a substitute for being trained in a particular role, but it is a way of the right bits of your training coming immediately to mind when that role is thrust upon you?
CHRISTIAN COOPER: That's true of the commanders, so for an

operational, tactical or strategic commander we would expect them to be using the action cards effectively as a very quick cross-check that they'd done the key things that their competence and training requires them to do. It's the very basics of what must happen or must be considered.
They serve a slightly different purpose for the functional roles because functional roles, given the number of them and given how quickly they need to be appointed, would normally be assigned to the initial responding paramedics. It just isn't feasible or practical to train every front line paramedic in every functional role in any kind of detail. Nevertheless, there is an expectation that they have an awareness of those functional roles and that is normally delivered through mandatory training programmes, annual training programmes, where there are directed to the major incident plan, directed to read action cards including the functional roles, so if suddenly they arrive at an incident and are given a functional role to play, they've got some familiarity with what that functional role is intended to achieve. This arguably is where the action cards are even more important because when you're new to that role, you haven't done any perhaps practical application for real or in training of that particular

functional role, then it is all the more important that you follow that action card so the key things that are envisaged that that role should complete are done.

Q. You make the point in each of your reports, but perhaps most clearly in your most recent response to the series of questions -- this is {INQ041856/16}, topic NWAS25, the top of that page of that document, gentlemen, if you have it -- where you say:

"Major incident action cards have been designed so they can be quickly and easily utilised during the most complex and stressful phases of an incident. They are simple checklists that are easy to read in seconds and convey the key actions that need to be taken to ensure an effective response."

And then you give the analogy, as you did on Friday, of the emergency checklist for a pilot.

CHRISTIAN COOPER: Yes.

Q. The reality, would you agree, is, looking at what various of those who had roles on behalf of NWAS at the arena are concerned, what they had to say about it and what you could say that they did, there was not effective use of action cards by a number of those with roles?

CHRISTIAN COOPER: Yes.

Q. The operational commander, Mr Smith, we'll come back to

in a moment, he was a key example of that, would you agree?

CHRISTIAN COOPER: Yes.

Q. But also those who were given particular jobs, like Mr Poland and the parking officer, the loading officer, the CCS medical lead, did not happen to be using their cards?

CHRISTIAN COOPER: Yes.

Q. And nor did it appear Mr Ennis, as the first ambulance on scene, used his?

CHRISTIAN COOPER: Yes.

Q. With each of those people, clearly Mr Ennis, you are understandably at pains to stress the considerable things that he did do given what he was confronted with, but critical things that he could have and should have done as first ambulance on scene were spelt out for him on the action card?

CHRISTIAN COOPER: They were.

Q. Such as an RVP?

CHRISTIAN COOPER: Yes.

Q. In relation to the operational commander, in particular in that respect -- and Mr Lopez, it's {INQ013422/6}, please.

This is the operational commander action card, so the one that was available to Mr Smith. Just as

a preliminary question in relation to this: clearly, the first ambulance on scene, and that action card, gives that person the effective role of operational commander until an actual operational commander turns up.

CHRISTIAN COOPER: Yes.

Q. That card lists things such as RVPs as things to be considered?

CHRISTIAN COOPER: Yes.

Q. Less so on this card. Is that because this card is predicated on those things already having been done by the first ambulance on scene?

CHRISTIAN COOPER: Yes.

Q. But without a reminder on this card: check that they've been done?

CHRISTIAN COOPER: Yes, that's fair.

Q. Would that be an improvement, if the things that anyone adopting the operational commander role should do ought to be set out on this card, it would make it a little bit longer but not a lot?

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

Q. But in terms of assessing what needs to be done, we can see number 12 on this list, the need to consider other specialist assets that need to attend. That should already have been addressed by the first ambulance on scene, but something spelt out that the operational

commander needs to that address again when they're on scene?

CHRISTIAN COOPER: Yes.

Q. Which in the case of Mr Smith would have meant considering SORT and AIT as well as HART, and Liverpool as well as Manchester when it comes to HART?

CHRISTIAN COOPER: Yes.

Q. Over the page, please {INQ013422/7}:

"Consideration of [number 2 on the list] forward control point (FCP)."

And then a series of locations and roles, including safety officer and equipment officer and HART team leader.

So if Mr Smith had gone through this and checked it off, he would have realised that he didn't yet have a safety officer?

CHRISTIAN COOPER: No. You don't have to appoint every functional role for every incident. But the purpose of this is to give a very quick reference to an operational commander to -- rather than having them in a position where they've got to think about what they might need, to speed things up and in the interests of efficiency, it gives them a list of what they need to consider and then effectively proactively reject what is not required from that list.

Q. So for example, looking at this list, he could have gone down the list and in terms of the requirement of a decontamination officer, he would realise he didn't need to worry about that?
CHRISTIAN COOPER: Correct.
Q. But he did need to worry about safety, did he not?
CHRISTIAN COOPER: Yes.
Q. And more particularly, given all that someone in his role was having to deal with, someone alongside him helping assess the risks at the scene and who could go where would have been helpful?
CHRISTIAN COOPER: Yes.
Q. It certainly wouldn't have hurt?
CHRISTIAN COOPER: No.
Q. And it meant that that kind of assessment was entirely down to him so far as NWAS was concerned on the scene rather than being shared with someone whose focus that would be?
CHRISTIAN COOPER: Yes, and the operational commander has got an awful lot to do in a very short period of time, and information is usually conflicting, difficult to decipher, so they have to gain situational awareness quickly and they have to determine a key set of priorities very quickly.
Having a safety officer alongside them where there's

some confusion about zoning or who can operate where is an extra person that can then, if they don't have a clear understanding of that, go away and find out or contact relevant people on behalf of the operational commander to try and ascertain it.
Of course, that problem was particularly exacerbated here due to the lack of an FCP and a joint understanding of risk being performed by the operational commanders together under JESIP.
SIR JOHN SAUNDERS: I just want to understand, please: on that action card that we have been looking at, these are things that the operational commander needs to do in conjunction with the incident commander. Can I understand how that is meant to work in practice?
CHRISTIAN COOPER: There is quite a bit of overlap between the operational commander card and the ambulance incident commander or the tactical commander's incident card, but that is deliberate because it's built in as a cross-check, in effect. So the person who has overall responsibility for ensuring the right resources are sent to that incident is the tactical commander, the ambulance incident commander. However, they will be reliant on the operational commander to be determining what they think they need to get the job done. So you see a reference there to bullet points, the key

functional roles that the operational commander needs to carefully consider whether or not they need, and you see some repetition around resources and the requirement to make sure the incident is well resourced in the tactical commander action card, so that it prompts that tactical commander to speak to the operational commander and, in simple terms, say: have you got what you need?
SIR JOHN SAUNDERS: So we would expect not only the operational commander to look at that card and ask for what he needs, maybe ask the tactical commander, but you'd also expect the tactical commander to be prompting the operational commander to say: have you got a safety officer, have you thought about this, have you thought about that?
CHRISTIAN COOPER: Yes, sir, yes.
SIR JOHN SAUNDERS: Okay. Thank you very much. Thank you, Mr Atkinson.
MR ATKINSON: Thank you, sir.
Is that a reason why having the tactical commander on scene rather than in a police control room might have been useful?
CHRISTIAN COOPER: Yes, for this type of incident, yes. I think we explored it on Friday. It is accepted practice now that the ambulance incident commander, the tactical commander, is normally located in a police

force headquarters somewhere because that is an attempt to co-locate them with their equivalent officer from the police. That's built into standard doctrine now, but I think it was Mike that mentioned on Friday that the Ambulance Service has had to adapt to effectively that police-led model.
It does still -- there are incidents that occur where it would be of benefit to the Ambulance Service, we would suggest, to have a greater command presence at the scene, recognising all of the different roles and functions that an operational commander is expected to be in charge of, particularly for a large major incident that is in one location.
Now, there is a counter to that argument, which is why perhaps it hasn't changed to date and that is because there are multi-sited attacks or other types of incident where it's undeniably more beneficial for the Ambulance Service to locate their tactical commander at police force HQ with a police commander, which is why I think we've been hesitant to make firm recommendations in that regard.
But in this incident, given what was going on and actually given some of the positive command contributions made by Annemarie Rooney, we think in this particular set of circumstances the response would have

been enhanced had she perhaps been there rather than at police force HQ. But as I say, there are arguments either side so it's difficult for us to give a very clear recommendation about what should have happened.
Q. You may be aware, from evidence that's not NWAS-related that the inquiry has heard, there are different schools of thought more generally as to where tactical commanders are best put and the observation and number of people in that role is made that when it's a pre-planned incident, having the Silver commanders all in a control room makes a lot of sense.
CHRISTIAN COOPER: Yes.
Q. Where you are having to react to something that's not been expected, having that level of command nearer the scene or at the scene helps?
CHRISTIAN COOPER: Yes.
Q. Particularly where it's focused on one scene rather than, as you say, something that may have repercussions elsewhere?
CHRISTIAN COOPER: Yes, and something that was in our mind, we weren't seeking to be overcritical of NWAS in relation to the actual physical deployment of their commanders, recognising that they followed a perfectly reasonable model. But when you don't have a tactical commander at the scene, you only have an operational

commander in charge of that whole scene, it is all the more important then to make sure you've got all of the functional roles you need to give that operational commander the span of control they need to be able to step back and manage that incident effectively. When you don't have certain roles appointed and things start to not go particularly well, it is even more challenging for that operational commander to deal with it and manage it effectively.

So the fact that the tactical commander went to consider it is no surprise and where it is expected they should have gone, it does mean that we are in a position where we recognise in our analysis that it was more important then for as many functional roles as possible to have been appointed in this case to make sure that that operational commander -- because the functional roles are not only about going away, following the action cards, and discharging those duties; it means you've got somebody who is focusing on that particular issue, that particular problem -- an equipment officer, for example, can devote all of their effort and energy to working out when there might be an equipment shortfall, what might be needed, what else is not here that perhaps should be here, which takes that responsibility away from the operational commander.

The operational commander still has overall responsibility for making sure those things are there but it's an extra person that can then say quickly to the operational commander, "I think we've got a gap and that gap needs to be addressed", and in the absence of those functional roles being appointed, it is more likely that the gap would go unnoticed.
Q. So, just to give a couple of examples in relation to the equipment officer and what they could have brought to this, Mr Smith will have seen people being brought down from the City Room on makeshift stretchers but he would be dealing with what was going to happen to those people, where they were going to go, where the ambulances were going to be to pick them up, and all the rest of it, an equipment officer could be thinking, "They need some stretchers"?
CHRISTIAN COOPER: Yes, exactly, yes.
Q. When it was obvious that there were people who needed painkilling medication, that may not have been something that someone in Mr Smith's position would have had the moment to think about, the equipment officer would have done?
CHRISTIAN COOPER: Yes.
Q. So in terms of the command above an operational commander, wherever they were, them checking that the

operational commander was filling in all the roles that needed filling and was getting the resources that were needed to the scene, is essential, isn't it?
CHRISTIAN COOPER: Yes.
Q. Because you can't expect the operational commander to do it all on their own?
CHRISTIAN COOPER: No, and when you are a tactical commander remote from that scene, and I've been in that position myself, you don't have the same situational awareness of what's going on. I use situational awareness in a slightly different context here. That's not just situational awareness about what's going on in the City Room, what's needed for members of the public and casualties, it's the situational awareness that the tactical commander needs to have on how effectively is this incident being managed by the Ambulance Service.

So if you have a remote tactical commander, you would expect far more questions from that commander of the operational commander to cross-check that there was the relevant grip and focus of incident at the scene.
Q. The other thing that those higher up the command chain and/or remote from the scene can do perhaps more than someone who is in the heat of it is identify whether JESIP is working or not?
CHRISTIAN COOPER: Yes.

Q. Because if you're in a police control room, you are actually in a position where you can make joint decisions that can then be sent to those who are the scene?
CHRISTIAN COOPER: Yes.
Q. And you can ask the questions, for example asking someone on the scene, "What are the Fire Brigade doing?" and if the answer back is, "I haven't seen them", then that's something that, up the chain, can be taken forward to work out where they are?
CHRISTIAN COOPER: Yes. I think the more obvious cues to the tactical commander would have been around risk and the confusion around zoning and not quite understanding about what status the City Room was as well as the flow of casualties and other factors, but yes certainly in the early stages it's about understanding risk jointly. And it should have been apparent to the tactical commander fairly early on that there was at the very least confusion around how that area was being treated and what the implications were for ambulance resources, so that would have been a point to check with the operational commander, "You are co-located, aren't you? You are discussing the status of that room with fire and police colleagues?" If that question had been asked very early on, it might have at the very least

prompted the operational commander to make perhaps more decisive action on scene to try and encourage that to happen.
Now, we are careful in our analysis to suggest it's not NWAS -- it's not entirely NWAS's responsibility to make that happen, but perhaps more pressure could have been brought to bear at the operational level when it was obvious that it wasn't happening and, failing that, the tactical level is then in a position to try and resolve it at their level, and ultimately if it's still not getting resolved, that's where the strategic commander is expected to intervene.
Q. Going back to where I started in relation to whether this was a JOPs incident or a major incident without that nuance, training via JESIP would have told an operational commander and a tactical commander and a strategic commander, but told an operational commander that the things you'd be expecting to happen are that you'd be speaking to your opposite numbers, you'd be in radio contact with your opposite numbers very quickly and speaking to them very soon thereafter?
CHRISTIAN COOPER: Yes.
Q. So if you weren't, if you were on your own, then you would know that something was not going according to plan?

CHRISTIAN COOPER: Yes, and particularly in these circumstances. Of course, there are incidents every day where JESIP is applied and applied very successfully, but likewise there are incidents that the Ambulance Service will deal with where there may or may not be some police officers on scene, but they are not material to the Ambulance Service effecting response. At this particular incident it was of course and self-evidently obvious that it had to be a joint response. So yes, it should have been very clear to the operational commander very early on that something was amiss because that wasn't happening.
Q. And if the operational commander was so focused on any other number of bits of their ambulance-related job, it was the role of those above them in the chain to find out from them whether that was happening and, if not, do something about it?
CHRISTIAN COOPER: Yes, recognising that is of course harder when they're remote, but yes, the check should still be made, yes.
Q. And that, you'd agree, is where a tactical adviser or NILO has a particular role?
CHRISTIAN COOPER: Yes.
Q. You were taken by Ms Roberts this morning to a paragraph of page 21 of your most recent report. It's the

paragraph that begins:
"As there was a failure of JESIP we must conclude that the NILO tactical adviser role was not discharged adequately."
CHRISTIAN COOPER: Yes.
Q. Is it appropriate perhaps to read that in the context of the paragraph before it, which reads:
"The fundamental role of the NWAS NILO tactical adviser is to bring together the commanders of the responding emergency services to ensure that liaison is taking place, confirm that the appropriate plans have been initiated and are working effectively, provide specialist emergency procedural advice, and to ensure effective inter-agency working as required by JESIP"?
If that is the job of a tactical adviser, and that was not happening, then there has then -- does it not inevitably follow that the tactical adviser was not discharging their role adequately?
CHRISTIAN COOPER: That was our finding, yes.
Q. Because making JESIP happen was what they were there for?
CHRISTIAN COOPER: Yes.
Q. And it didn't happen?
CHRISTIAN COOPER: No.
Q. In terms of particular aspects of JESIP, clearly the

chairman has heard a good deal of evidence about what JESIP says on paper, but does it really come down to a lot to common sense, that if you are responding to an incident together, then you need to work together?
CHRISTIAN COOPER: Yes, that's a fair assessment.
Q. And to work together, you need to be with each other and speaking with each other?
CHRISTIAN COOPER: Yes.
Q. To understand what the other services are doing, why they are doing it, and what your role is?
CHRISTIAN COOPER: Yes.
Q. And it is absolutely vital, would you agree, to the assessment together of risk?
CHRISTIAN COOPER: Yes.
Q. Because to take this as an example, NWAS were not on the scene when the bomb went off, BTP were. GMP were very soon thereafter. When the first 999 calls started coming through to NWAS, BTP and GMP had already seen the City Room and what was going on there. So from the outset, those police forces had information about what had happened and the risks that NWAS couldn't have ——
CHRISTIAN COOPER: Yes.
Q. —— but needed?
CHRISTIAN COOPER: Yes.
Q. And so just applying common sense, as soon as you're

told that something like this has happened, if you're NWAS, you would need to know what the police had found and what they were doing about it and what the risks were?
CHRISTIAN COOPER: Yes, and it's not just the situational awareness that the police gain from their presence at the location, the police have access to various intelligence feeds and an understanding of existing risk, which means when it comes to assessing whether or not that's likely to be a lone person or a multi—person attack, whether just afterwards additional IEDs being present and things —— the police don't just make decisions on that risk based on what they see, they make them in the wider context of what they know from an intelligence picture and the Ambulance Service is reliant on that information as well as part of that joint understanding of risk to make sure that the response is an effective one.
Q. So if in an NWAS control room you are not hearing from the police but you know this has happened, then that is enough in common sense to tell you you need to get in touch with the police to find out what they can tell you about it?
CHRISTIAN COOPER: Yes.
Q. Which is why failures on both sides in terms of

communication —— but it is on both sides, it's not for one service to say, "They didn't call us"?
CHRISTIAN COOPER: I'd agree, yes.
Q. You know that you need to have a rendezvous point because any number of action cards tell you, common sense tells you, you need to go to a stopping—off point to go to a scene. And ideally, that ought to be one that you know is safe?
CHRISTIAN COOPER: Yes.
Q. And the police are the most likely organisation to be able to help you with whether it's safe or not?
CHRISTIAN COOPER: Yes.
Q. And so you need to speak to them about what the RVP should be?
CHRISTIAN COOPER: Yes. I hope we haven't created the impression on Friday —— for an RVP, they are often the single RVP where all three emergency services operate from, but it doesn't have to be. You can have different RVPs for different functions. The Ambulance Service's core aim of having an RVP as well as making sure its staff are safe is to start that staging process of a place where you locate your ambulance vehicles ready to call them forward.
So I suppose what I'm saying is in the absence of the police defining a multi—agency RVP, it's not

necessarily going to stop the Ambulance Service from defining its own, but the whole point of JESIP is that even where that happens and even if it's not going to be a multi—agency RVP, it's going to be an RVP for the purposes of what the Ambulance Service need it for, all three agencies are aware of that, they know that's happening, they know where the Ambulance Service are and what they are doing, so Fire and Rescue Service know that for example, that's what the Ambulance Service are doing. And I think —— so I don't want to create the impression that everybody is waiting on everybody else to decide what the location of an RVP should be: any agency can propose one or suggest they are going to use one, but when that's within a joint decision—making model it means that the other two can either agree that is what they are going to use or determine something different and everybody knows what's happening.
Q. An advantage of everyone knowing that is that, if from the police point of view, they need to know where they are first going to be able to speak to the Ambulance Service, if they know where the Ambulance Service are rendezvousing, they know that's where someone from the police service can be to speak to them, so co—locating?
CHRISTIAN COOPER: Yes, but I think for a situation like

this it's more likely that the operational commander will arrive. If they look around and they can't see a police commander and a fire commander, and they make the assumption they're the only one there, they would say, "I'm here, this is the FCP, can you tell the other agencies that this is where the FCP is?" if they haven't been notified in advance that another agency has already created an FCP. That's not necessarily the same as an RVP. It may well be, but either way, both require a conversation among all three agencies.

Q. Is it still your position, as you put it in your third report, that the lack of an FCP was the greatest obstacle to effective inter-agency liaison at the arena?

CHRISTIAN COOPER: That's our view, yes.

Q. If you were wanting to see JESIP working, you would see an FCP where the commanders were co-located?

CHRISTIAN COOPER: Yes, and physical co-location is always the preference. It could hypothetically be done via a radio link or some other link, but the most effective at incidents like this is physical co-location.

Q. Because there may be aspects of any response that the different services may have different views on and an assessment of risk may well be one of them?

CHRISTIAN COOPER: Yes.

Q. But in terms of dealing with that and resolving those

disagreements, you're much more likely to be able to do that if you're speaking to each other face to face?

CHRISTIAN COOPER: Yes, and it's my experience that when those conversations happen, those disagreements are overcome.

Q. And they need to be -- you need to resolve these disagreements so everyone is doing the same thing?

CHRISTIAN COOPER: Yes.

Q. So anything that will help that process needs to be done?

CHRISTIAN COOPER: Yes.

Q. If conversely, you are not sure what the risks are because you're on your own and trying to deal with it, then the need to change that position so that you can be co-located and speaking becomes obvious, doesn't it?

CHRISTIAN COOPER: Yes.

Q. So really, from when he arrived at the arena, Mr Smith -- and the same would apply to the other emergency services -- but Mr Smith, when he arrived at the arena, should have been looking for the FCP, and if he couldn't find one, establishing one and telling the others where he was?

CHRISTIAN COOPER: Yes.

Q. Because for it to work, that had to happen and had to happen quickly?

CHRISTIAN COOPER: Yes.

Q. And it didn't?

CHRISTIAN COOPER: It didn't.

Q. In terms of deployment of NWAS to the arena, would you agree there's a difference between getting sufficient resources to that part of Manchester on the one hand and getting the right resources to the right places within the arena complex on the other?

CHRISTIAN COOPER: Yes.

Q. So statistics about numbers of ambulances, for example, are only a part of the assessment of deployment and you need to look at who was where and whether they were where they needed to be?

CHRISTIAN COOPER: Yes.

Q. Can I understand with you a little more about some answers you gave to Ms Roberts on Friday afternoon about the half-hour gap. That's the half hour between the bomb going off, the first 999 call coming in on the one hand, and the first ambulances arriving at the arena on the other.

It may have seemed on Friday that you were suggesting that that was acceptable, that there would be a half-hour delay. Is that what you were saying?

CHRISTIAN COOPER: It depends on the demand, the pressures and the location of ambulances and availability within

NWAS at the time. We would expect a rapid mobilisation of specialist resources and there are degrees of protection afforded to those resources that mean they maintain a greater state of readiness than wider ambulances that may well be committed with patients, delayed at hospital.

As I articulated on Friday, the Ambulance Service does not have any spare capacity within its front line operational response, quite the contrary. They are normally stacking emergencies with multiple emergencies waiting to be assigned to a particular ambulance.

So ideally we would expect a large number of front line resources to be at a major incident as quickly as possible, but you don't find a response time standard for a major incident because it depends what that incident is, where it is, and what's needed. You do have response time standards and state of readiness standards for the specialist assets like HART, for example, to make sure that, regardless of the incident type, if it's thought they're needed, early mobilisation of that assets needs to occur. But there isn't an on-scene time requirement for those assets because it depends where it is. If you have got -- the HART base is located where they are located and something happens a long, long way away, the response time is naturally

going to be longer than if it were around the corner.
Q. Can I unpack that slightly? I think by the end of 2017, the ambulance response programme had introduced targets for how quickly the Ambulance Service would respond to different categories of emergency. So life-threatening incidents, category 1, the target was that they'd respond within 7 minutes?
CHRISTIAN COOPER: Yes.
Q. And that's the Ambulance Service more generally rather than a particular Ambulance Service or a particular unit of an Ambulance Service?
CHRISTIAN COOPER: Yes.
Q. And that within nine out of 10 occasions, they would respond within 15 minutes?
CHRISTIAN COOPER: Yes.
Q. So if you were applying that as your test for whether the Ambulance Service responded quickly enough on this occasion, they wouldn't have done, would they?
CHRISTIAN COOPER: Not on the face of applying that particular test, but of course that test is for individual 999 calls to individual patients, not major incidents with lots of patients.
Q. But the need to get to lots of patients at a major junior is no less than it is to get to an individual?
CHRISTIAN COOPER: Not at all. I suppose the need to get to

a severely trauma-injured critical patient within a tight window, if graded category 1, within 7 minutes, then yes, that is an expectation.
Q. In terms of the deployment of specialist units such as HART, there needs to be a recognition that they need to be deployed immediately that news comes in of something where they might be needed?
CHRISTIAN COOPER: Yes.
Q. Rather than that being a consideration some way down the track from when the 999 calls start coming in?
CHRISTIAN COOPER: Yes, there is an expectation that the control rooms have some system in place to identify which types of call would benefit from a HART response and that the HART response is then mobilised very quickly to those types of incidents.
Q. Ms Roberts took you to some of the 999 conversations earlier, whether it was reports of a shooting incident or whether reports of a bomb going off or reports of the two, HART were a resource that was designed for those kind of situations?
CHRISTIAN COOPER: Yes.
Q. And the need to deploy HART should have been obvious as soon as that information had come in?
CHRISTIAN COOPER: Yes.
Q. Given that the speed with which HART can respond will

very much depend on where they are at the time, here we have them beyond Stockport and so, as it turned out in the case of Ms Vaughan, about 20 minutes away from the arena, from the time she left Stockport, and so there was going to be something of a delay in that HART team getting there. Is that an argument for there needing to be more than one HART team for Manchester?
CHRISTIAN COOPER: There is a provision in the contractual standards in relation to the state of readiness of HART and particularly their mobilisation times that gives a dispensation if HART are already committed on an incident that requires their specialist skill set. It's relatively unusual. The types of jobs that HART go to are nowhere near as frequent as the type of jobs a front line ambulance will go to on a daily basis. So it's unfortunate that HART happened to be dealing with a job already that required their specialist skill set and that may or may not have led to a short delay in them being extracted from that incident and being sent on.
Our conclusion, when looking at those timings and looking at how NWAS proactively contacted the HART units to tell them this was going on, the HART team themselves were then able to extract themselves from that and mobilise, the response was well within the expectations that we would have expected.

We would, however, have expected, with the control room knowing that they're deployed on that incident, more rapid deployment of the Liverpool HART team early on, ideally at the same time given the magnitude of the incident.
Q. The Liverpool HART team, from when they were finally allocated to attend, took half an hour to get to the arena. If they had been deployed at the same time that the Manchester HART team was contacted, they wouldn't have got there quite as quickly, but there would have been a matter of minutes between those two HART teams on site and that would have made a difference, wouldn't it?
CHRISTIAN COOPER: Yes. It's particularly important for HART and AIT assets to be mobilised very quickly and it then be a proactive decision to stand them down because they are a limited resource and they are the only assets you've got that can operate in a hazardous area.
And patients -- I'm not thinking of Manchester Arena right now, I'm thinking more of their normal core business, HART teams nationally are dealing with in excess of 300 incidents a week. Most of those jobs require early medical interventions inside a hazardous area very quickly, but because of the limited number of HART staff and the limited places in which they are based, that means early activation and response is

critical to get them there as quickly as possible.
Now, that obviously applies here to that Liverpool HART asset and the Manchester Arena situation.
Q. So really, what needed to happen was as soon as the calls came into the control room, the control room ought to have deployed both HART teams and AIT and SORT?
CHRISTIAN COOPER: The SORT question, I think we've certainly indicated in our reports, and I think I indicated it on Friday, is a little more complex for us to deal with. I absolutely agree with that for HART and for commanders.
In relation to AIT, at that time -- SORT staff -- so SORT staff are the ones that deal with CBRN situations and particularly where decontamination is required. You would need an indicator to suggest that they were needed and there wasn't an indicator at that stage for this incident. So we understand and accept why they may not have been deployed, but that's not to say that those same staff couldn't have assisted. So if there were consideration to proactively deploy them we would have absolutely supported that but we can see why perhaps they weren't initially deployed.
AIT, that really does depend what was in the contemplation of the control room or the commanders very early on in this incident. If they thought it was an

Operation Plato or a firearms related incident, or there was any question as to whether it was or it wasn't, the same applies to that AIT group of staff as applies to HART, that early identification of them and early mobilisation of them is essential.
Q. So the fact that there were calls coming in, as Ms Roberts quoted this morning, that were suggesting that shooting was taking place in the context of this terrorist incident, whether that was right or wrong, would have entirely justified a control room deploying AIT at the same time they deployed HART?
CHRISTIAN COOPER: Yes.
Q. And they could have cancelled it?
CHRISTIAN COOPER: Yes.
Q. But all of that would have resulted in there being, at the very least, two HART teams on site, effectively not long after the time that the one HART team did actually arrive?
CHRISTIAN COOPER: Yes.
Q. And potentially AIT as well?
CHRISTIAN COOPER: Yes.
Q. So you'd have had a significant number of staff who were absolutely trained to go into the City Room, whatever the non-MTA assessment of its zoning, and we'll come back to that after lunch. But you'd have had

a significant number of those staff much more quickly?
CHRISTIAN COOPER: You would have had them more quickly.
I think it's important to understand the context of those staff rather than HART. AIT staff, specialist as they are and trained and equipped as they are, they are only trained and -- they're front line paramedics, they do that job. In relation to their AIT role, that is to specifically to operate in an Operation Plato, a marauding terrorist firearms attack. That is their role.
Now, the situation has changed since 2017 and there is a significant investment being made to make that group of staff more readily available, higher in number and increase the response time for them. But at the time of this attack in 2017, it was a relatively small cohort of staff that were deployed on normal front line ambulances that would have to be identified, the entire ambulance, including their other person would have to then be mobilised directly to scene.
We did try to do some analysis, it's quite challenging to work out just how many would have been available and how quickly they would have got there. I absolutely agree that early identification of them and mobilisation of them, if you suspected you might be dealing with a firearms-type incident, should have

happened.
To go further and say you would have had a greater number of AIT staff at the scene, we are unable to draw that conclusion.
Q. But certainly so far as HART is concerned, given that there was this staggered arrival of the Manchester HART team for the reasons that we all understand, if you could have had the Liverpool HART team there by the time the last of the Manchester HART team were able to get there, so you could have had two teams by that point available with all their kit and their skills, that would have made a difference?
CHRISTIAN COOPER: Yes, and early notification potentially of other HART units because they're all on a 30-minute notice to move.
MR ATKINSON: That would be a convenient moment, sir, unless you have any...
SIR JOHN SAUNDERS: No, no, provided you're all agreed, that's a good time for lunch. So 1 hour. Thank you very much.
(12.50 pm)
(The lunch adjournment)
(1.50 pm)
SIR JOHN SAUNDERS: Mr Atkinson.
MR ATKINSON: Can I just draw some threads together, to use

a great man's phrase, before moving on.
SIR JOHN SAUNDERS: Which great man did you have in mind, Mr Atkinson? I didn't recognise that.
MR ATKINSON: I never name my sources, sir!
In relation to site plans, I think it's right to say that there was a one−page site information sheet that NWAS had, which I think you have seen.
CHRISTIAN COOPER: Yes.
Q. That is not the kind of joined−up plan for a specific site that we've been talking about, is it?
CHRISTIAN COOPER: No.
Q. In relation to deployment to an incident such as this, the public, would you agree, would have a concern, hearing it be said that it would be almost to be expected that there could be a half−hour delay before ambulances would attend a major incident at a major venue?
CHRISTIAN COOPER: I see that concern, yes.
Q. Is it your position that the public should understand that for half a hour, following an incident like this, they should expect effectively to be on their own?
CHRISTIAN COOPER: I don't know if that's a bit of a stretch. I think there would be certain incidents that will occur at certain times that would get a much faster response. We talked earlier on about PDAs. They

are not mandatory at the moment, we're going to give some thought to that and potentially produce something for the chair about whether or not on the declaration of a major incident, a starting point should be rapid mobilisation of normal front line assets as well as specialist assets.
Some trusts already do that for certain sites, but perhaps there's more that can be done there. I think we would agree that in any event, for a major incident, there will be some delay in professional ambulance resources attending that scene, yes.
Q. So that creates an imperative, does it not on the one hand for venues acknowledging the risks and building into their own planning a competent level of medical cover on site?
CHRISTIAN COOPER: Yes.
Q. Be that through their own medical provider or be that through having ambulances on site for events?
CHRISTIAN COOPER: That trigger a certain threshold, yes.
Q. In relation to risk assessment, a good deal of time was spent, not a criticism at all, on Friday on the question of zoning. There is potentially a difficulty in relation to terminology because hot, cold and warm zones feature in MTA planning but they also feature in, from the NWAS point of view, their major incident planning −−

CHRISTIAN COOPER: Yes.
Q. −− and they don't mean the same thing.
CHRISTIAN COOPER: Yes.
Q. So from a multi−agency point of view, the fact that there is that double meaning of zoning creates a risk of confusion, does it not?
CHRISTIAN COOPER: There's a potential for confusion, yes. I think it's a trade−off between having common terms that are understood by everybody that you then adapt to certain circumstances versus having a completely different set of terminology so everybody is crystal clear about the different types of incident. I think a balance has to be struck. So in the case of hot/warm/cold, I can't remember it came out on Friday, but it was suggested for a normal major incident terminology used by ambulance services for more generic major incidents is often inner cordon and outer cordon, which is quite correct.
So you could use that terminology but it's fairly common practice now, regardless of the incident type, to be using hot/warm/cold because it could be a CBRN incident with a hot zone, it could be an MTA incident with a hot zone. But I think everybody is clear, certainly within the Ambulance Service, that a hot zone is something you need to be very, very careful about and

likely to be the preserve of very specialist responders, it just happens to be the case that if it's a firearms−related incident and the hot zone represents an exchange of gunfire, the Ambulance Service will not deploy into that area because they don't have armed assets.
But I think it is well understood that, even if it has not got firearms in it, a hot zone is something that requires very specialist responders and anything other than firearms is something that they would commit HART staff, for example, to.
But yes, I totally accept that there is scope for some confusion in the way things are phrased at the moment.
Q. Particularly in conversations between the emergency services, if a police officer talks about somewhere being a hot zone to an ambulance officer, they may not be talking and understanding it to be the same thing?
CHRISTIAN COOPER: Yes, I think that's fair.
Q. And for JESIP to work they need to be talking the same language, do they not?
CHRISTIAN COOPER: Yes.
Q. Another example of why being in the same place and able to talk to each other rather than getting messages from each other is important, so you actually make sure

you're actually talking about the same thing?
CHRISTIAN COOPER: Yes. It is worth highlighting that JESIP in its different doctrines -- so there is specific JESIP principles for how to deal with a CBRN event, specific ones to deal with an MTA event, and more general principles. All three are clear about what type of zonings there should be, there's multi-agency agreement on that. But if they're not communicating within that envisaged JESIP joint way, then absolutely there is a risk of which type of zone: are we talking about CBRN, MTA or a general one? Those principles were written by JESIP assuming that the joint commanders would do that. I don't think it was envisaged that you try and apply those doctrines without that joint approach which is where the confusion comes in.

So the point I'm trying to make is the principles are very clear at the moment on the different types of zone and everybody should be clear on that, but it does require a joint understanding of which ones you're using.

Q. Is another aspect of that which can potentially complicate things the position that applied here of an IED and the risk of there being secondary devices and what that means in terms of an emergency response?
CHRISTIAN COOPER: Yes.

Q. Clearly, in the MTA context it was thought a good idea that you would have agreed in advance who could go into what areas in relation to such an incident?
CHRISTIAN COOPER: Yes.
Q. Is it your view that it would be a good idea for there to be a similar kind of in advance agreement as to who can go where in a bomb incident?
CHRISTIAN COOPER: Yes. Some attempts have been made to do that. I think we need to be careful about some of the sensitivities because when we're talking about predetermined responses to certain risks like an IED, we also need to be cognisant of not giving information to actors that might act against us to affect our response.

But I think we're on safe ground agreeing that, yes, in the absence of a bit more work being done, different agencies will have a different risk tolerance of things like the potential hypothetical presence of a secondary device, yes.

Q. And again, we don't need to go into the detail of it for the reasons you gave at all, but certainly that needs to be thought through, does it not?
CHRISTIAN COOPER: Yes.
Q. Not only in terms of individual response services identifying what their tolerance levels are, but understanding what that means in terms of the overall

response and the ability to get the right people into the right locations?
CHRISTIAN COOPER: Yes, I agree, yes.
Q. Because in terms of the risk assessment, does it not come down to identifying what the risks are, what is needed in a particular location, and therefore who can and can't go there?
CHRISTIAN COOPER: Yes.
Q. Because it is never just a question of, "There are these risks and therefore certain people can't go in", there always has to be an assessment of, "But there are people in there who need help"?
CHRISTIAN COOPER: Yes.
Q. And clearly, the most effectively way of dealing with that is for there to be a joint discussion between people, pooling their knowledge, pooling their assessments of risk to come to an overall view as to what needs to be done and who can do it?
CHRISTIAN COOPER: Yes and it's envisaged within that doctrine that that joint approach to risk accepts the fact that you cannot mitigate risk to zero, effectively. You're going to have to tolerate a certain degree of risk.

When you've got different individuals and different organisations whose risk tolerance may differ, it's

critically important that a joint assessment, understanding and hopefully agreement on that risk results from that joint approach of sharing your concerns, sharing what your understanding of the risk is, and coming up with a common way forward.

Q. So taking an MTA example, certain emergency services arriving at a location, the police able to inform the Ambulance Service, the Fire Service, "This is the area where there are casualties, we have armed police securing all the doors in and out of that location, there is no shooter in there", so that the other services can understand who they can then send in?
CHRISTIAN COOPER: Yes.
Q. And equally, with an IED, "This is what's happened, this is what we've been able to do in terms of checks, this is our assessment", and then people can come to a view?
CHRISTIAN COOPER: Yes.
Q. If you don't have that pooling, there is a very clear risk that an individual service will get its assessment wrong?
CHRISTIAN COOPER: Yes.
Q. And people who need help will not get help as a result?
CHRISTIAN COOPER: Yes.
Q. And to an extent that's what happened here, isn't it?
CHRISTIAN COOPER: I agree.

Q. There was a good deal of discussion about Mr Ennis in this context on Friday and what the significance was of Mr Smith allowing him back into the room. Is this again what that comes down to: that if this was a location where non-specialist paramedics could not work safely, then Mr Ennis should not have been there?
CHRISTIAN COOPER: Yes.
Q. It should have been HART?
CHRISTIAN COOPER: Yes. An operational commander is not necessarily going to be able to guarantee the safety, as you would normally expect under the Health and Safety at Work Act, of an employee like Patrick Ennis. It needs to be something considered by the operational commander. If the operational commander is content to send a person into that situation because they are satisfied that it is not necessarily safe but that the risks have been suitably mitigated and controlled and that there's a safe system of work in place that is not devoid of risk, it's down to what the operational commander thinks and whether they reached that point where the risk is tolerable, it's manageable. I think a lot of the discussion on Friday was led by the fact that the operational commander was content to send Mr Ennis back in. That gives us an indication of what the level of risk was in their mind.

Q. Because if it was safe enough for Mr Ennis, then it was safe enough for paramedics like Mr Ennis, subject to a consideration of overall numbers?
CHRISTIAN COOPER: Yes.
Q. And any analysis of the number of casualties in the City Room indicated that a number larger than three was the right number for paramedics/NWAS employees to be in that room?
CHRISTIAN COOPER: Yes, that's the conclusion we came to.
Q. So either you get as many HART in as you can to make up that number, if it's a warm zone where Mr Ennis can't go, or if it's safe enough for Mr Ennis you get other paramedics in there with him to make up that number?
CHRISTIAN COOPER: Yes.
Q. But just leaving it at three is not the right answer?
CHRISTIAN COOPER: We agree.
SIR JOHN SAUNDERS: We've talked about all these questions in relation to the forward command post and the importance of the forward command post. If you're going to get operational knowledge or if you're going to get sufficient knowledge to decide who to send into the City Room, don't you really have to have your forward control point just outside the doors to the City Room or very close to them?
CHRISTIAN COOPER: It could have been there, but we would

normally expect either the HART team leader, a sector commander, somebody that is right on that gateway that you describe, sir, to be the one that is passing that information back to the operational commander to inform their assessment of risk and resources, because they may also request that -- they may say, "I need more people in this area".
SIR JOHN SAUNDERS: Okay. In practice, on this particular night, not what ideally may be the position, but the only hope Mr Smith had of talking to police commanders was actually to be by the City Room because there he would have been able to find Inspector Smith and he would have been able to find -- they'd have to be got out, but a firearms commander as well. It seems to me he needs to be speaking to them as well as Mr Ennis, he needs to have some idea what's actually going in the City Room, the number of unarmed people who are already operating in there, in order to come to the sort of decision which I think you came to on Friday of saying, actually, had you been there and had full situational awareness, you would have sent unarmed paramedics in or paramedics without any protective equipment.
CHRISTIAN COOPER: Yes, I think that's fair, sir. Taking the FCP right up to the doors of the City Room might be a little close, but yes, there's no doubt that that

would have given the situational awareness that was really needed for the operational commander, yes, sir.
SIR JOHN SAUNDERS: Assume you get to the doors or fairly close to it, that would bring Mr Smith quite a long way away from where the patients are being treated, wouldn't it?
CHRISTIAN COOPER: Yes, but the purpose of sector commanders and functional roles is that all the distinct features of the major incident should be taking place and the commander has to freedom either to step back or indeed, in this case, step forward to an FCP. They're not supposed to be supervising any individual actions, they're overall in charge of that incident -- at the scene, rather.
SIR JOHN SAUNDERS: Thank you.
MR ATKINSON: Following on from that, would another way of dealing with that have been to appoint a sector commander for the City Room, so have the HART team leader almost certainly being the person who went up that and provided that essential link between the FCP downstairs and the City Room upstairs to ensure that there was that situational awareness flowing from the room, which someone in the position of Mr Ennis, for example, dealing with triage at the same time, couldn't provide?

CHRISTIAN COOPER: Yes, and I think we've been clear in our report that where you have people deployed into an area such as the City Room and an operational commander quite rightly locating themselves on the concourse, albeit ideally in an FCP, that didn't happen here, you would normally expect some sort of forward sector commander overseeing the response in the City Room. That would have been our expectation.
Q. In terms of HART as a resource -- I think this is something that's very clear from your reports and your evidence on Friday -- realistically, given the situation where you had at least a warm zone at the top of the stairs where there were significant numbers of casualties, HART were best placed being there rather than elsewhere?
CHRISTIAN COOPER: I agree, yes.
Q. That's what they're trained for, what they're designed to work with other HART teams on, and that's what should have happened here?
CHRISTIAN COOPER: Yes.
Q. A concern, for example, that there might be a need for HART elsewhere than the arena during the course of that evening, isn't that why HART teams from other parts of the country are also on 30 minutes' standby?
CHRISTIAN COOPER: Yes. If you need additional HART

resources at the scene to do functions other than operate in the hazardous area, then at the very least you should be using the six -- the only six that you've got in the hazardous area and then backfill that requirement as best you can.
But there aren't any functions, as far as I know -- while HART can perform those functions and support the Ambulance Service, there are no specific HART functions only they can perform outside of the hazardous area, if that makes sense. In other words, for all of those functions outside of the hazardous area the expectation is that there are other paramedics that can also undertake those functions.
Q. So the challenge then for an operational commander in consultation with others such as his safety officer, such as his equipment officer, is, "If we send HART in then we'll need someone else to do X", rather than, "Someone needs to do X so we can't send HART in"?
CHRISTIAN COOPER: That's what you would expect, yes.
Q. Moving on to a different topic, and that is triage. Again, very fully covered by you already. But in terms of the -- going back to basics, because that's the level on which I can function, the whole point of triage is working out who needs the most urgent help?
CHRISTIAN COOPER: Yes.

Q. Having them in their categories and then responding to that?
CHRISTIAN COOPER: Yes.
Q. In terms of understanding who is in which category, triage cards play a very important role, do they not?
CHRISTIAN COOPER: Depending whether we're talking about triage sieve, triage sort, primary triage, secondary triage. An indicator is certainly necessary. The reason why I draw the distinction is because in the very initial phase of triage sieve, you may not have sufficient time to undertake an assessment of and fill in a card. You can use the card because you can just select the colour you need initially as part of your initial assessment, but there are other things -- some ambulance trusts use a slapper band, a quick band that indicates -- but you are making an initial indication with something, first, to put that person in a category and then a more comprehensive assessment under secondary triage may take place and then sometimes you get the more detailed cards appearing.
Q. Is it in part because there's various elements to it, that it's recommended you triage in teams of two rather than doing it on your own?
CHRISTIAN COOPER: Yes.
Q. For triage to work, do you really need to have the

back-up available very quickly after you start the process of people who can provide the immediate treatment that is necessary, particularly for P1s, while you move on to the next person?
CHRISTIAN COOPER: That would be ideal, but I think it's recognised that certainly in the sieve process, you're aiming to achieve things within the triage process which would be a basic airway manoeuvre, stem catastrophic haemorrhage, determine your categorisation, and move on quickly. And then, yes, once categorised, you would hope that more resources come in behind to support the extrication particularly of the P1s.
Q. So to cover a space where there are a number of casualties who will need to go through that process, better to have more than one team doing it at a time?
CHRISTIAN COOPER: Yes, absolutely.
Q. And if they are working with cards to identify at least their initial assessment of people then the other team will know who has been assessed and who hasn't?
CHRISTIAN COOPER: Yes.
Q. As part of that process, and it's an issue that has come up with a number of witnesses, as you'll have seen here, there is the fact that, for the very best of intentions, a number of those who were injured, or more particularly those who appeared to have died, were covered over by

members of the public, by police officers.
CHRISTIAN COOPER: Yes.
Q. In terms of good practice, triage should not exclude those who have been covered, should it?
CHRISTIAN COOPER: No, quite the opposite. Paramedics are trained within their triage process that whatever else has been done to that casualty, it's their job to conduct their assessment of that casualty and to categorise them accordingly.
Q. In fairness, NWAS's major incident plan makes that very point, does it not ——
CHRISTIAN COOPER: It does.
Q. —— in the context of triage?
There was, as you will have seen, differences of approach between the three who were in the room doing triage as to their approach to people who were covered over. Mr Hargreaves, by way of example, had presumed, he explained, that the covering over had been done by Mr Ennis, who had been there first ——
CHRISTIAN COOPER: Yes.
Q. —— and said in terms, if he had appreciated it had been done by anybody else, he'd have gone in and checked again.
CHRISTIAN COOPER: Yes. I think to give some credit there, I think part of the problem was that Mr Ennis didn't

have the initial triage labels or cards that were used to grade. So it's a reasonable assumption of Mr Hargreaves that in the absence of having those cards, Mr Ennis has still performed some triage functions, but he's then not to know how Mr Ennis has categorised those casualties. Arguably, in the face of such confusion, if you do have the cards with you and you have a way to mark the casualty properly, assess and mark the casualty. You certainly shouldn't be marking the casualty with a formal card without undertaking the assessment for yourself.
Q. So in terms of learning points, firstly the importance of having the cards if you're going to undertake triage because it produces that certainty as to the assessment of who has been assessed and what they've been assessed as?
CHRISTIAN COOPER: Yes.
Q. And secondly, perhaps in terms of the action cards that address triage and the ready reckoners that address triage, they don't, perhaps because of space, include that contemplation of those who are covered that the major incident plan has —— do you think that it would be helpful, just because people are dealing with these things under pressure, for it somewhere to be said on those kind of action cards: if someone is covered over,

you still need to check unless they have a label on?
CHRISTIAN COOPER: I agree. I think it would be beneficial for that to be explicit, yes.
Q. The next stage in the process is then to identify what needs to be done in relation to those who have been triaged and to devise a scheme that makes sure that those who need to be got out the most are the ones who leave first.
CHRISTIAN COOPER: Yes.
Q. Again, is that a responsibility primarily for the Ambulance Service in dealing with a situation such as this?
CHRISTIAN COOPER: Yes, and that was in our contemplation when we considered additional HART numbers in the room. You could argue that any number of resources is not going to be enough to assist you to deal in that room quickly, and would a small increase in the number of HART staff have really made much difference? In our conclusion we say yes because in addition to that triage process, there is the requirement in those circumstances to robustly manage the extrication of casualties because a number of different people were making best efforts and what that was perhaps crying out for was a confident, coordinated approach to the extrication of those casualties.

Now, that is something that HART, perhaps more than any other group within the Ambulance Service, train regularly to do. They are very confident in that regard. They are used to operating within a team of six and it's our view that if you had five HART operatives within that room and then a sector commander, their team leader, right at the edge overseeing that overall response, we think the management of the extrication of those casualties, even if that was being facilitated by other people, police, members of the public, that that would have been more coordinated and more robustly managed and more closely aligned to the triage system being put in place by the Ambulance Service, by those two initial HART paramedics that were moving through.
I think that's what we envisaged when we said that's the real difference that would have been made by the relatively small increase in HART staff had they been deployed into that room.
Q. Potentially you'd have had more of them able to do the triage in the first place?
CHRISTIAN COOPER: Yes.
Q. Secondly and importantly, you'd have had the identifiable people there who were in charge of saying, "This is the person who needs to leave next"?
CHRISTIAN COOPER: Yes. And HART staff, unlike other front

line ambulance personnel, don't only do training, they do very, very realistic training in that regard. They set up scenarios involving people pretending to be casualties, large numbers of them in difficult circumstances, like trains, aircraft, buildings that have collapsed, and they run that through regularly in terms of how do you robustly get those people out. So we know that that group of people, better than any, are good at managing that extrication.

Q. The analysis that we undertook with Mr Ennis when he gave evidence for the second time -- sir, for your note, Day 110, page 21 {Day110/21:1} -- was that of the first four casualties to be moved from the City Room, only two of them were P1s and of the first nine, only five were P1s, and there were 21 P1s in all. So it's clear, would you agree, that the system was not working as it should have done to get the P1s out first?

CHRISTIAN COOPER: No, I agree. With the caveat that some people will leave of their own volition, some people will leave because they have close relatives, they're able to assist them. So it's not the case that there's an absolute rule that it has to be only P1s that leave that scene first. If you can get out by whatever means possible, of course get out. So it's often the case that actually a large number of P3s are evacuated from

the area quicker because they either do it of their own volition or they are assisted by others to do it.

But from the professional Ambulance Service response, particularly once the triage system has been applied, then of course the preference is you manage those P1s because that's precisely why you have graded them as such and they are your priority for extrication.

Q. There were other aspects of the process, would you agree, that the Ambulance Service were the specialists to help with, the second being to identify more effective ways of extricating people from the room than were being used by volunteers?

CHRISTIAN COOPER: Yes.

Q. And to provide the necessary stretchers and to send up the necessary people to help with that, not necessarily having to go into the room but being able to take people from outside it?

CHRISTIAN COOPER: I agree. But that is not to suggest that the Ambulance Service should have stopped the extrication process that was underway. I think the evidence of Dan Smith among others said: but a movement of casualties was occurring, that was a good thing, let that continue. I think that's right. I think the missed opportunity is: but how can that be better augmented?

Q. You don't want to stop what's happening, you want to add to it, to make it work more effectively and quicker?

CHRISTIAN COOPER: Yes.

Q. And the other area, we've already covered, where things could have been done better in that regard is in relation to the walking wounded, the P3s, and there being a more organised approach to dealing with them once they had left the City Room and getting them help?

CHRISTIAN COOPER: Yes.

Q. In relation to each of those, the managing of those in a warm zone, the extrication of people from a warm zone, dealing with those who had been triaged as P1s and P2s, the Fire Service had skills that they could have brought to that, did they not?

CHRISTIAN COOPER: Yes.

Q. But in fact they didn't?

CHRISTIAN COOPER: No.

Q. And that was another deficit in terms of this being an efficient and effective extrication of those who needed help?

CHRISTIAN COOPER: Yes. So to add to the position that we've just articulated, if you'd had five HART staff operating in that City Room with their sector commander but you also had Fire and Rescue Service personnel operating with them, again HART, more than other groups

in the Ambulance Service, train regularly with Fire and Rescue colleagues, they are well used to working together and have practised to specifically extricate casualties from situations like this. So I think there's little doubt, and we certainly conclude that in our reports, that had the Fire Service been available earlier in that room to support the Ambulance Service to extricate those casualties, that would have led to a far more efficient and effective extrication, particularly of the priority patients from that area.

Q. Final topic, you'll both be relieved to hear, from me. This is going back to the overall assessment of preparation for a major incident at a major venue. It's something you touch on in a number of your reports and focus on briefly in your most recent report, which is the role that licensing has to play in relation to ensuring that a venue has medical provision in place to the necessary standard.

It is at present little dealt with in premises licences, would you agree?

CHRISTIAN COOPER: I would agree.

Q. And in terms of ensuring that venues have thought about their medical provision in the event of an incident and something they ought to be thinking about as any number of things that are dealt within premises licences?

CHRISTIAN COOPER: Yes.
Q. In terms of checking whether a venue is operating appropriately, something that can be checked on in the same way as checking whether they're selling alcohol in the right way or not?
CHRISTIAN COOPER: Yes, I think that's an important point.
Q. Equally, do you consider that the Care Quality Commission could do more in terms of checking that those who are providing medical care at such venues are qualified to do it?
CHRISTIAN COOPER: We're not talking about a role for the Care Quality Commission in licensing now, we're talking about their role in terms of existing medical providers?
Q. Let's take it in stages. In relation to the licensing provision, do you think the Care Quality Commission could do more to help local authorities in relation to that?
CHRISTIAN COOPER: Potentially, but I think the Ambulance Service is probably better placed to help with -- I know we're going to consider that in a bit more detail and I'm only being hesitant because I'm aware of all of the potential implications, not least the resourcing requirement for the Ambulance Service, but if you're asking me whether or not the Ambulance Service or the Care Quality Commission, which one is better placed to

look at the proposals for an event and whether or not the medical cover is appropriate for that, my view would be that the Ambulance Service is better placed than the Care Quality Commission to have a role there, subject to us having to work out exactly how that might work.
Q. Again, without trespassing on the work you're yet to do, given that we identified this morning that the Ambulance Service has a role to play in assessing and helping with the preparations for the readiness of a venue for such an incident anyway, it wouldn't be a completely new thing for them to be doing?
CHRISTIAN COOPER: It would be a natural extension of that role to then have some sort of say in the licensing, yes.
Q. In relation to other area that the Care Quality Commission could help with, which is the adequacy and competency of a medical provider for a venue, is there more that could be done in that regard in your view?
CHRISTIAN COOPER: I think there's more that could be done now. There's a role for them to play now, of course, and that is within their jurisdiction. But is it something that needs to be looked at in terms of them having a greater role? I think that is worthy of further exploration, yes.
MR ATKINSON: Thank you, gentlemen, very much. Thank you,

sir.
MR GREANEY: Sir, it's a good deal earlier than normal, but we will need to have a short break at this stage, following which Mr Cooper will ask his questions on behalf of the families that he represents. Ten minutes will suffice.
SIR JOHN SAUNDERS: Ten minutes, thank you very much.
(2.30 pm)
(A short break)
(2.48 pm)
SIR JOHN SAUNDERS: Sorry to keep you waiting.
MR GREANEY: I'm going to ask Mr Cooper to pose his questions next, please.
Questions from MR COOPER
MR COOPER: Thank you. Indeed, we have a proliferation of Mr Coopers here.
So Mr Cooper, can I refer the questions to you, but obviously to both of you. You've been given advance notice of this short area that I'm going to be asking you about. Let me firstly deal with the witness statement, the third witness statement of Mrs Figen Murray. It's {INQ041919/1}. It's typed with a date of August 2020, and probably needs to be amended; in fact it was made in August 2021. But that's just so we can get the dates clear. In fact, it's a statement

of 9 August 2021.
What I'm going to do, Mr Cooper, is read it, it's only a short statement and ask you to make any comments you feel appropriate:
"I, Figen Murray, make this statement pursuant to the request made by my legal representative, Slater & Gordon, to assist with the Manchester Arena Inquiry.
"I am the mother of Martyn Hett who was a victim in the Manchester Arena terrorist attack on 22 May 2017. I make this statement to provide details of bleed control kits, which I have become very familiar with due to the work I have been doing in respect of the Protect duty and Martyn's Law.
"The matters contained within paragraphs 1 to 16 of my witness statement are within my knowledge, information and belief, except where stated otherwise.
"The work I am doing around Martyn's Law (Protect duty) has resulted in me having built a very wide network of professionals and experts within the private security industry. I am heavily involved in many discussions with the various individuals and groups around the government-led public consultation of Martyn's Law and the impacts of this on the private security sector.
"During the various discussions the subject of

training and preparedness inevitably features as one of the topics. The discussion around training often leads to reflection on first aid training, in part because it has been acknowledged by now across most of the private security industry that private security personnel and other civilian staff are likely to be the first on the scene of a major incident or mass casualty type event before any of the emergency responders arrive from either the police, fire or ambulance.

"The Manchester Arena Inquiry has highlighted the importance of the need for bleed control kits, sometimes referred to as emergency trauma packs, essentially life-saving kits with the resources to potentially stop catastrophic haemorrhaging and significantly reduce a casualty's blood loss.

"The inquiry heard that the application of such medical provisions in the first few minutes to a casualty with a significant bleed can literally mean life or death for that person [as read].

"We know that time is critical for those casualties who suffer with catastrophic haemorrhaging or an otherwise significant bleed to prevent them bleeding to death before emergency responders arrive, therefore these emergency kits are a way to mitigate the time lost by the late or hampered response of the emergency

responder, hampered by declaration of zones, be that from a declaration of a major incident or terrorist incident slowing the movement of emergency responders into area where casualties lie injured or bleeding, and provide additional resources of private security personnel and civilians to use to assist in life-saving medical interventions, such as the correct application of tourniquets until such time as the emergency services are able to tend to the casualty.

"Equally, these kits can be made available as an additional resource to those emergency responders who are on scene and need to deal with catastrophic life-threatening injuries. Anyone can find themselves in a situation where they may need to help another human being who may be severely injured, eg a road traffic collision, a knife attack, industrial accident or a simple fight resulting in severe injury. Anyone can find that they themselves are in need of that life-saving help. There is not only a social responsibility but a need for both private and public confidence in organisations to be prepared not only in terms of training staff and providing first aid courses but also in ensuring that they have the adequate resources and equipment that would be needed in that critical time following an incident.

"After hearing the evidence in the inquiry so far, there is arguably a very strong case for these types of kits and equipment to be as readily available to the public as defibrillators are throughout town centres. Even my tiny Cheshire village benefits from seven defibrillators. However, it is important to have these bleed control kits available in pubs, clubs, restaurants -- there could even be an unfortunate incident in the kitchen -- sports centres, schools, arenas, industrial companies where machinery is operated, major breaches, the list is endless. It is encouraging to see that there are now kits available that include both a defibrillator and a bleed control kit.

"Deaths through bleeding out or catastrophic bleeding could be significantly reduced if these kits were available at as many venues as possible. I personally carry on kit in the back of my car. It gives me reassurance that if I was, for instance, a witness or indeed to be involved in a serious road traffic incident that I have the kit available or I or someone else could use it.

"Bleed control kits are not the same as first aid kits. Bleed control kits are also known as trauma kits or emergency trauma packs. First aid kits treat minor

injuries, scrapes and cuts, et cetera, whereas bleed control kits can be used to treat life-threatening bleeding caused by injuries sustained in traffic collisions, from gunshots and stabbings to name but a few scenarios.

"There are also a lot of 'Stop the Bleed' courses offered free of charge. Members of the public should be encouraged to take part in this training. It is my intention to attend one of these courses as soon as the inquiry has come to an end as I think it is an essential skill to learn and I would encourage others to do the same.

"The inquiry emphasised the issue around lack of tourniquets and it should be noted that most bleed control kits contain these. There is a big debate on whether a layperson should apply a tourniquet or not. As I am not a medical person, I am unable to comment further on the use of tourniquets. However, I guess most people would be inclined to try and improvise something to try and stop the blood loss or in fact try and use a tourniquet if one was available. Most of us would attempt to help rather than stand by and watch a person bleed to death.

"I recently participated in a virtual conference run by the City of London Crime Prevention Association and

an emergency trauma kit scheme was mentioned. Essentially, the City of London Police have emergency trauma kits located at various points around London and these are recorded on their mapping system contained within the control room. A number of officers are trained to use these kits and these are hidden at key locations around London and to be used in major incidents. When allocating officers to attend the incident as part of the response, the control room will task dedicated patrols to attend the specific locations to collect these emergency trauma kits and then take them to the scene. These kits cost just under £500, and as of 2018, London Police have purchased 100 of these packs.

"It was interesting to note that this scheme has been raised with all other Home Office police forces, but very few have taken up the scheme. Though my knowledge is limited on this and I would have to defer to the City of London Police to detail further about the scheme and how it has been received, adopted or implemented by other police forces, I do believe that schemes like this should be considered in further detail for the emergency services, not just the police, and feature as a recommendation by the inquiry.

"There are, however, similar packs at much reduced

price. I have been sent some of these kits to pass on to the inquiry team for examination and have done so to Mr Cooper Queen's Counsel and CTI Mr Paul Greaney Queen's Counsel. These range in price from £20 to £78.

"For example, the Rapaid charity offer a pack at £20 and although this pack does not contain tourniquets, it has pressure bandages with a clip that can act as a semi−tourniquet until a proper one arrives.

"Researching online at alternative options, there are many companies offering similar products which vary in price and provision."

I pause for a moment. You've had an opportunity of looking at two examples of these?

CHRISTIAN COOPER: Yes, we have, three.

MR COOPER: "I can share with the inquiry that a local company is in touch with representatives of City−Co Manchester to pull some figures together on knife crime, stabbings and puncture wounds in Manchester city centre versus the use of the public AED defibrillators in Manchester to help evidence the need for trauma bleed control kits around the city. This company is also in negotiation with a few big Manchester−based hotels regarding the provision of trauma kits.

"GM Business Connect are also supporting the introduction of these kits. It is good to see

Manchester−based organisations showing a keen interest in progressing the introduction of these kits but more needs to be done. More need to be taking action and improving their preparedness and the chair's recommendations could play a key role in this area of both public and private sector preparedness.

"I emphasise again these kits save lives and I will wholeheartedly support any positive move to introduce them as widely as possible. Yes, there may be a cost to these kits, but there is no greater cost than losing a loved one. Any cost spent in preparedness is an investment worth making so that other families do not have to experience what my family and the families of 21 other innocent victims have had to endure."

Gentlemen, I know you've both had an opportunity of reading what Figen Murray has said there and perhaps, Mr Cooper, if I could turn to you first. Do you endorse wholeheartedly and totally what she says?

CHRISTIAN COOPER: I do endorse it and I support all of the content. I think in terms of the practicalities of how this is achieved, some things need to be worked through, but I can't take issue with any of the principles articulated in there or indeed the intent.

Q. Are you aware, for instance, you may not be −− and that's obviously no criticism of you −− are you aware,

for instance, of other police forces, for instance in London and elsewhere, providing places where these kits can be used by officers in times of crisis?

CHRISTIAN COOPER: Yes, I was aware of that and I'm aware that a number of other police forces at the moment are looking at what level of training either their specialist police officers have or their front line officers have in relation to trauma and first aid. So that's an ongoing piece of work. I think it's variable at the moment.

And in terms of the security industry mentioned in here, again I am aware −− I'm not an expert on the security industry but I'm aware, because of some of the interactions some have had with the Ambulance Service, that they too were trying to look at what they can equip their people with.

I think it's quite right to make the observation in here that a lot of existing first aid kits that might be around are not suitable for major catastrophic haemorrhage and the use of a tourniquet, notwithstanding the concerns there are at the moment and the conflicting views within the medical profession about that, but I think there's less concern about pressure dressings and certain types of gauze that can be used to stop catastrophic haemorrhage.

I think the more widely available that sort of kit is —— and if we can change the mindset and people can start to think that a first aid kit should include provision to deal with catastrophic hemorrhage, I think that would be an entirely positive thing.

Q. In terms of the projected costs of these packs you have both seen two examples of them. Would you accept, for what they do, particularly those starting nearer the £20 price range, they are cheap at the price?

CHRISTIAN COOPER: I am not at all surprised at the cost and I think that's reasonable. I think what did strike me, and I don't want to stray in any way into some kind of endorsement here, but what I was struck by, looking at those packs —— and I've seen similar packs before, perhaps not as recently as that, is the instruction cards within that now for both the CAT tourniquet and the pressure dressing —— I mean, myself and Mike had a good play with those outside earlier today and I think most members of the public with those sorts of basic instruction cards would be able to successfully apply a pressure dressing and a CAT tourniquet. So there's clear attempts there within those kits to cater for a complete novice to be able to put one on.

Looking at what's in those two packs, as an example, I think that is probably achievable.

Q. I wonder if you would like to add anything or endorse what you've heard ——

MICHAEL HERRIOT: Thank you very much for introducing this initiative to us, of which clearly we're both very supportive.

I think it might be worth just exploring some other background information. For example, if you call 999 for an ambulance, as you know, you'll get pre—arrival advice. So I would certainly think it would be beneficial exploring the opportunity for ensuring that a person could get signposted to one of these kits in the same way as they would be signposted to a defibrillator, so that's something perhaps to explore.

And also ensuring there's a standard specification. Certainly the way the Ambulance Service approaches these things is to take a specification and then get someone to figure out how to make it. Obviously part of that would be the cost of the individual piece of kit. So it may be worth having conversations again around how that could be achieved rather than buying an off—the—shelf solution, for example.

Q. Before you go on to any other points you'd like to raise, we are obviously concerned primarily here with the tragedy that occurred at Manchester Arena. How do you think these particular kits could be used and

made available to the public in the context of the arena situation and in particular the City Room situation?

MICHAEL HERRIOT: Of course we're aware that members of the public did a fantastic job, a really commendable and brave job, trying to assist in those circumstances, but of course they were hampered by the status of the equipment that was available to them. Many mentioned that the first aid kits were inadequate. And whilst the Ambulance Service did have suitable equipment, quite rightly it's mentioned in the paper that they weren't to arrive immediately, so there's that therapeutic vacuum for a time.

Q. Thank you.

MICHAEL HERRIOT: As I say, because the Ambulance Service is able to give advice as well, that is another feature perhaps that could be explored.

I think clearly, when we look at public access defibrillators, there are various mechanisms in place to look at the expiry date and whether the machine is working properly and that sort of thing. There's no reason why this couldn't be built into that sort of regime, I wouldn't have thought, so perhaps that's worth exploring as well.

Finally from me, training. I absolutely welcome training in this aspect. But I think it would be good

if that could be built in around simple, immediate life—saving training and not just in isolation around stopping the bleed. I hope that's helpful.

Q. That's very helpful, I'm sure the inquiry finds it helpful. In many respects ——

SIR JOHN SAUNDERS: As you've asked whether I find it helpful, let me interrupt: I do find it helpful. It is clearly something I would consider as a recommendation. There was suggested there may be difficulties and practicalities. Can I invite both the experts to give me something in writing, not only dealing with what the advantages are but also what other things need to go with it, what needs to be considered with it and what the difficulties are as to practicalities? Of course, I would invite anybody else with the medical knowledge to do the same and help me if they can. So thank you very much for the idea and I will certainly take it on board.

MR COOPER: Sir, I didn't mean to usurp your function when I said the inquiry finds it helpful. I rather made an assumption.

SIR JOHN SAUNDERS: I would never believe for a moment you'd usurp my function, Mr Cooper. It didn't enter my mind.

MR COOPER: Being such a simple pack, it could be taught in schools, couldn't it?

MICHAEL HERRIOT: Yes, without a doubt.
Q. And young people brought into it at a very early stage?
MICHAEL HERRIOT: And as we discussed on Friday, we certainly believe that is a very important initiative to ensure people have basic life-saving skills of which this would be part.
MR COOPER: Thank you. Can I ask one final question, please, on a totally different topic of which you have both been made aware of. It's a matter that I have raised on a number of occasions.
It is about -- this is no criticism of the police, I emphasise that, it's happened. It's about the police coming to conclusions, I use my words carefully, that life was extinct, that someone had died, and then covering them up.
Do either of you or both of you think that the police should be provided with perhaps specific and detailed training on recognising those sad features to ensure that mistakes, aren't made? Perhaps I can ask you first, Mr Cooper.
CHRISTIAN COOPER: I think we need to be very careful here and this is a somewhat problematic area. The ability to recognise life extinct is something that is reserved for a very small select bunch of registered medical professionals, obviously for the problems that might

occur if it's not done correctly. The profession that recognises life extinct needs to be very carefully regulated because of the risk of mistakes that might happen.
So as a result, at the moment, paramedics, doctors and registered nurses are among the very few people who are able to formally recognise life extinct. There are some practicalities with the emergency services, particularly police or fire arriving at a situation -- if we just deal with an individual situation rather than the arena for the moment -- where to start a resuscitation that is obviously not going to be productive and that may lead to risk to those responders means there's an established practice at the moment that if there are signs that are unequivocally associated with death, it would be appropriate for those emergency services not to act until the Ambulance Service came. But that is not the same as recognising life extinct. The recognition of life extinct would be done when a paramedic then attended that scene.
So it makes me very nervous, particularly in circumstances such as these, if an agency is taking upon itself the ability to make decisions about who has survivable life and who doesn't. We have clear triage processes that have been through medical efficacy, there

are governance processes around that, and they're designed to make sure that -- the triage process is not ideal, it is about trying to do the most for the most and get the priority people out first.
So what we need to do is be careful about expanding that even further and that then leading to people being categorised as dead who might actually have injuries that are survivable if a full resuscitation could be completed, which is going to be challenging in these circumstances. So I think it's a matter that is well rehearsed and there is a general reluctance, certainly across the medical profession, to allow other non-medically regulated professions to be able to recognise life extinct. That brings with it some serious concerns.
Q. None of us are criticising the actions of people -- I don't know whether I saw you indicating something, sir?
SIR JOHN SAUNDERS: I did, if you don't mind. Let me ask the other Mr Cooper something about that, just a further explanation.
Mr Cooper, clearly covering somebody up is an indication of life being extinct. That's why people do it. If in fact police officers are not properly equipped to do that and therefore others should not take

any notice if a police officer covers somebody up, what is the point of them doing it and wouldn't it be better simply to give directions to police not to cover people up even if they consider that life is extinct?
CHRISTIAN COOPER: It's certainly the case, sir, that for a paramedic conducting triage they are not to read anything into whether or not a patient may have been covered, they are to conduct that assessment for themselves and apply the correct triage category. So arguably, it should make no difference to the paramedic response. But for reasons I think we explored this afternoon, there are certain circumstances that perhaps you would not have foreseen prior to the tragic events of Manchester, where that in itself can lead to confusion even among the paramedics. So I think some sort of clear understanding among the emergency services as to how this to be done I think would be helpful.
It is probably worth recognising that I don't believe any individual police officer has done this for anything other than thinking it's the right thing to do and it's a natural thing for people to do as well.
MR COOPER: Of course. In fact, the chair's question was going to be my next question. Let me just take it one stage further, if I can, on that latter question. Should there be a directive that the police, or any

other emergency services not so qualified as to recognise life extinct, should not cover up?
CHRISTIAN COOPER: I think in circumstances where there are multiple casualties in a situation like this, yes, I think that's right, because of the risks involved. If it's a single casualty and the scene is well controlled and it's in the public gaze, I can understand why for dignity reasons they may choose to do that, not with the intention of confusing anybody, purely as a temporary measure until a paramedic can make an assessment, then maybe. So some thought would need to have to be given to the parameters of that directive, but I don't think it's helpful in major incident scenarios where there are multiple casualties.
Q. You don't think it's helpful, what, to cover in major ——
CHRISTIAN COOPER: To cover, that's correct, sir.
Q. Is there anything you would like to add?
MICHAEL HERRIOT: I would agree with Mr Cooper.
MR COOPER: Thank you.
I have no further questions, thank you, sir.
SIR JOHN SAUNDERS: Thank you very much, Mr Cooper.
MR GREANEY: I have no additional questions. Do you have any, sir?
SIR JOHN SAUNDERS: I don't, thank you.
MR GREANEY: Sir, could we begin at the end of today by

thanking everyone for sticking to their time estimates. There is no further questioning for these experts.
SIR JOHN SAUNDERS: Thank you.
MR GREANEY: The timetable hereafter is that we will not sit tomorrow for good reason, about which everyone is aware, and we will resume as near to 11 o'clock on Wednesday as is possible.
SIR JOHN SAUNDERS: Can I, first of all, say I'm sorry not to be with you today, but I have been able to follow everything and it has had the benefit that I've asked fewer questions than I normally do.
Secondly, I am the one who's causing the —— I am the reason why we can't sit tomorrow and indeed why we won't sit until later on Wednesday. I'm sorry for any inconvenience that causes anybody. I hope I can say, as you would, Mr Greaney, that it is for good reason.
Can I then say thank you very much to the experts, whose evidence I have found illuminating and very clear in its nature, so I'm grateful to both of them for the work that they have done and I look forward to seeing what they have to say about recommendations. So thank you both very much.
MR GREANEY: Thank you, sir. So as near to 11 o'clock on Wednesday as we can achieve, please.
SIR JOHN SAUNDERS: Thank you all very much.

(3.15 pm)
(The hearing adjourned until 11.00 am on Wednesday, 15 September 2021)

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