

OPUS2

Manchester Arena Inquiry

Day 145

September 13, 2021

Opus 2 - Official Court Reporters

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Monday, 13 September 2021

1
2 (9.30 am)
3 MR CHRISTIAN COOPER (continued)
4 MR MICHAEL HERRIOT (continued)
5 Questions from MS ROBERTS (continued)
6 SIR JOHN SAUNDERS: Good morning.
7 MR GREANEY: Good morning, sir, we can see and hear you
8 fine.
9 SIR JOHN SAUNDERS: I can simply see the Manchester Arena
10 Inquiry screen: I can't actually see anybody else, which
11 is slightly disconcerting.
12 MR GREANEY: Mr Suter is going to leave the room to sort
13 that out.
14 SIR JOHN SAUNDERS: That's been sorted out. I'm sorry not
15 to be with you today. If I appear not to be here, it's
16 because I am walking around, but I am listening to
17 everybody and I will tell everybody if I'm going to
18 leave the room.
19 Mr Greaney, if you will please keep a check on the
20 fact that we're keeping to the timetable as far as week.
21 MR GREANEY: I'll do that, sir, thank you very much. I will
22 now turn to Ms Roberts and ask her to resume her
23 questioning.
24 MS ROBERTS: Good morning, gentlemen.
25 Could we have on look, please, at the role of

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

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

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

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1 clear—cut, because they may have been the result of the
 2 incident itself and some of the other multi—agency
 3 failings at the incident.
 4 So the point we make is he was not a designated
 5 operational commander at the time, he doesn't appear to
 6 have maintained specific CPD at the operational
 7 commander level, but we were comfortable that he was
 8 both qualified and competent to operate at the tactical
 9 level. And the fact he'd been an operational commander
 10 in the past with that experience, it's often our finding
 11 that tactical commanders and operational commanders can
 12 dual function.
 13 Q. Yes. Would you agree that that's in fact what he
 14 appeared to be doing on the evening in question?
 15 CHRISTIAN COOPER: Yes, in general, yes.
 16 Q. Thank you. Save for the omissions that you have told us
 17 about and which I think we agreed on Friday he had
 18 readily accepted both in his evidence and in his written
 19 statements?
 20 CHRISTIAN COOPER: Yes.
 21 Q. Thank you.
 22 I would like now to focus on the decision by
 23 Dan Smith to be the operational commander as opposed to
 24 Derek Poland, who arrived just seconds afterwards and
 25 who, we remind ourselves, was the on—call operational

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1 commander for that evening.
 2 I think you said that in general, it was, I think
 3 this is something you said on Friday, his prerogative,
 4 in other words it was Dan Smith's prerogative at the
 5 time if he felt he were better able, able to inspire
 6 that level of confidence that I think you agree he
 7 obviously did inspire in others, to take the lead and to
 8 take operational command on the evening.
 9 Is my understanding correct that you are not overly
 10 critical of the fact that he, as opposed to
 11 Derek Poland, took that role?
 12 CHRISTIAN COOPER: We've expressed a concern for the reasons
 13 I think I've previously articulated about Dan Smith's
 14 detailed level of operational practice at that stage.
 15 But yes, we agree, it would have been his prerogative as
 16 an experienced commander to have a conversation with
 17 Mr Poland at the scene and for them to determine who the
 18 most appropriate person was to take operational command.
 19 Q. Thank you. If we could just go back to your third
 20 report, {INQ035306/28}, please, Mr Lopez.
 21 You deal with this at paragraphs 142 and in summary
 22 at 143, you say this:
 23 "In his statement, Dan Smith indicates that the
 24 other potential operational commander was Derek Poland
 25 and he showed a reluctance to take on the role.

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1 Derek Poland was an experienced and qualified
 2 operational commander. Derek Poland's statement
 3 suggests that Dan Smith assumed the role of operational
 4 commander."
 5 As we reminded ourselves on Friday, Derek Poland
 6 then immediately began to undertake the important role
 7 of parking officer, which you told us on Friday
 8 benefited the response to the incident greatly. I think
 9 that was your evidence on Friday; is that right?
 10 CHRISTIAN COOPER: Yes.
 11 Q. Thank you. If we look at what Dan Smith himself said
 12 about this when he gave evidence. Transcript, Day 110,
 13 please, Mr Lopez, at page 103 {Day110/103:3}.
 14 Mr Smith was asked a question by Mr Greaney at the
 15 top of the page:
 16 "Question: Was there any discussion between the two
 17 of you about who was best suited to that role or did you
 18 just decide it should be you?
 19 "Answer: I'm not convinced I would describe it
 20 perhaps as a discussion, but we certainly — my
 21 recollection — I'm aware it's not Mr Poland's because
 22 we've spoken about it since the incident — my
 23 recollection is that I did say to him, 'Do you want to
 24 take this', and I sort of pointed at the tabard."
 25 Pausing there, there's a specific tabard, isn't

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1 there, that operational commanders wear at scene so as
 2 to identify them to others within their own organisation
 3 and others from other organisations that they are the
 4 operational commander; correct?
 5 CHRISTIAN COOPER: Yes.
 6 Q. And he wore that tabard, didn't he, Mr Smith?
 7 CHRISTIAN COOPER: He did.
 8 Q. And again would you agree that the wearing of a tabard
 9 in itself, however minor a point it seems, did again
 10 enhance the response because everybody knew immediately
 11 who the operational commander was?
 12 CHRISTIAN COOPER: I think that's a very important point and
 13 the use of the tabard is important to communicate not
 14 only to other ambulance staff but to other agencies who
 15 that commander is. It is very important.
 16 Q. I suppose to members of the public as well, should they
 17 need to speak to him, he's easily identifiable: it's the
 18 man — it's black and white cross—checked, is it not,
 19 the operational commander tabard?
 20 CHRISTIAN COOPER: The operational commander is yellow
 21 above, but yes.
 22 Q. Thank you. So that deals with that point:
 23 "Answer: ... I sort of pointed at the tabard
 24 invariably meaning: do you want to take operational
 25 command? And from that moment on he said, no, so I was

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

5 Then Sir John asked towards the bottom of the page:
 6 "SIR JOHN SAUNDERS: You're the lead paramedic in
 7 Manchester; is that right?
 8 "Answer: Yes."
 9 So far as his clinical abilities and his competence
 10 is concerned there can have been little doubt on the
 11 night that he was one of the best people within the
 12 organisation?

13 CHRISTIAN COOPER: I think clinical seniority is not
 14 necessarily something that would dictate whether or not
 15 the person was appropriate for a command role. We would
 16 ideally expect to see a more decisive and robust
 17 handover or confirmation of command, but I think the
 18 fact that a discussion of whatever magnitude did — but
 19 the discussion that is articulated there took place
 20 meant it was properly considered.
 21 The fact that both of them deemed themselves both
 22 competent to do the role is the key bit and then they've
 23 made a decision as to who is going to undertake that
 24 role so I don't think we take issue with that.
 25 Q. Over the page, please, to 104 {Day110/104:1}, Mr Lopez.

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1 He says:
 2 "Answer: In rank it does, but we're not an
 3 organisation that really focuses much on rank but
 4 officially yes —
 5 "SIR JOHN SAUNDERS: No, maybe not, but if it was
 6 going to be the senior person who took the operational
 7 commander job, that would have been you?
 8 "Answer: It would be me, yes."
 9 To page 191, please, Mr Lopez {Day110/191:11}.
 10 Mr Gozem Queen's Counsel was asking questions on
 11 behalf of the families. He began by saying:
 12 "Question: Can I begin by saying to you that I have
 13 no doubt, and I'm sure nobody has any doubt, that
 14 absolutely you wanted to do the very best you could on
 15 that night, not just for yourself but for all of the
 16 people who were there and your efforts are much
 17 appreciated. But as you know, I think as you foresaw in
 18 some of the interviews that you underwent, this process
 19 is one that is necessary for learning.
 20 "Answer: Absolutely.
 21 "Question: Can I begin by asking you this: had you
 22 acted as an operational commander before?
 23 "Answer: Had I performed the role before?
 24 "SIR JOHN SAUNDERS: Yes.
 25 "Answer: Yes, I had, yes."

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1 So he confirmed it at that stage. Over the page,
 2 please, Mr Lopez. He talks at the top of the page, and
 3 I think we've looked at this before, about his
 4 operational command pre—NARU around 2004 through to 2009
 5 and then towards the bottom much the page a question
 6 from Mr Gozem {Day110/192:21}:
 7 "You're quite right, your statement does say that
 8 you had never undertaken any and that is why I wanted to
 9 ask you about it."
 10 He clarified the statement was in fact incorrect and
 11 he had undertaken some in the past:
 12 "Question: Derek Poland was perhaps a more recently
 13 trained operational commander than you, wasn't he?
 14 "Answer: Yes. In fact, actually, we started on
 15 operational command at the same time, so had been doing
 16 it the same length of time as me. I moved on to
 17 tactical commander or had training to enable me to do
 18 tactical command. Derek had remained at operational
 19 commander level, yes."
 20 Just finally in relation to this point, if we could
 21 look at a different document, please. It's the NARU
 22 National Ambulance Service command and Control guidance
 23 in force in October 2015 and therefore in force at the
 24 time of the incident. {INQ013227/40}, first of all,
 25 please.

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1 It sets out what is expected of a tactical
 2 commander. There are eight bubbles surrounding the
 3 centre. If we go, please, to the next page,
 4 {INQ013227/41}, "Operational", with seven bubbles around
 5 the centre circle. As I look at those two diagrams, the
 6 only difference seems to be, if we go back to tactical
 7 on the page before {INQ013227/40}, please, Mr Lopez,
 8 tactical — the qualities and the abilities of the
 9 tactical commander demanded an ability at D11 to lead
 10 meetings which, if we go back to operational command on
 11 {INQ013227/41}, is something that the operational
 12 commander it seems wasn't required to do. So there's
 13 that extra step up to tactical command level of the
 14 ability to lead meetings. I'll be corrected if I'm
 15 wrong. Other than that, the other seven bubbles appear
 16 to be identical skills, do they not?
 17 CHRISTIAN COOPER: Yes, and they are very similar. There's
 18 certainly a lot the overlap between the operational
 19 commander's competence and the tactical commander's
 20 competence. It is just worth keeping in mind that
 21 whilst those are generic competency provisions, they
 22 apply differently at the two levels and we would expect
 23 an operational commander to be practising and applying
 24 those competencies within the operational arena and
 25 a tactical commander in the tactical arena.

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

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

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

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

1 provided an RVP and confirmed that the GMP RVP is
 2 Hunts Bank.
 3 So would you agree that there's no — there isn't
 4 that definitive clarity that you and no doubt others
 5 seek at a very early stage for an RVP?
 6 CHRISTIAN COOPER: Yes, I agree.
 7 Q. Ideally who should call it? Who should say where the
 8 RVP is going to be?
 9 CHRISTIAN COOPER: The preference for the ambulance would
 10 always be the police.
 11 Q. So the preference is that the police call it and say,
 12 "This is where the RVP is going to be", but would you
 13 agree from those calls to which I have drawn your
 14 attention that by 22.51, and certainly by 22.53 or
 15 thereabouts, there was an understanding by NWAS that GMP
 16 had said, or they'd understood them to say, that it was
 17 going to be Hunts Bank?
 18 CHRISTIAN COOPER: Yes.
 19 Q. Thank you.
 20 SIR JOHN SAUNDERS: Ms Roberts, my recollection of the
 21 evidence is that Inspector Smith, having initially
 22 declared the cathedral car park, was the person who
 23 changed the RVP to Hunts Bank. So the police
 24 (inaudible: distorted) from then on and no doubt we have
 25 the timing of it.

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1 MS ROBERTS: Yes. Thank you.
 2 MICHAEL HERRIOT: I think the Ambulance Service declared
 3 Thompson Street as the RVP very early on in the
 4 proceedings.
 5 Q. Yes.
 6 MICHAEL HERRIOT: And whilst Cathedral Gardens was
 7 corrected, that wasn't actioned because the
 8 Ambulance Service was sending its resources initially to
 9 Thompson Street and then on the request from the police
 10 to go to Hunts Bank, clearly Hunts Bank was adopted for
 11 a period of time.
 12 Q. Right. So they reacted to that which they were told by
 13 the police?
 14 MICHAEL HERRIOT: Yes.
 15 Q. From whom they would expect the lead to be taken so far
 16 as an RVP is concerned?
 17 MICHAEL HERRIOT: Yes.
 18 Q. Thank you.
 19 FCP, next topic, please, and I start by prefacing my
 20 questions to you with this: the failure to have an FCP
 21 or the failure by Dan Smith to specifically announce
 22 where the FCP was going to be in his view has long been
 23 accepted by him, has it not?
 24 CHRISTIAN COOPER: It has.
 25 Q. Both within his written statements and the evidence he

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1 gave to the inquiry?
 2 CHRISTIAN COOPER: Yes.
 3 Q. Thank you.
 4 Where in your view was the ideal place for an FCP?
 5 CHRISTIAN COOPER: We would normally expect an FCP to be
 6 located as close as possible to a warm or hot zone,
 7 depending on the type of the incident, but not within
 8 it. So it's very much a forward point where the three
 9 operational commanders from the three respective
 10 services are gaining enough situational awareness to be
 11 able to command the response forward of that point. In
 12 the case of Manchester Arena, the concourse at the
 13 bottom of the stairs would have been an appropriate
 14 point.
 15 Q. So before the CCS?
 16 CHRISTIAN COOPER: Ahead of the CCS. The forward control
 17 point we would normally expect to be forward of the CCS,
 18 but not in the City Room.
 19 Q. Okay. We know now, and I suppose once the decision had
 20 been made to get those seriously injured people out of
 21 that bomb zone as quickly and as effectively as
 22 happened, that they were being brought down the stairs.
 23 You're not suggesting right at the bottom of the stairs,
 24 are you, for the FCP?
 25 CHRISTIAN COOPER: No.

19

1 Q. Whereabouts then?
 2 CHRISTIAN COOPER: It needs to be a decision by the
 3 commanders that are there as to where they feel it's the
 4 most appropriate place for them to co-locate. But
 5 you've got a large station concourse area, you've got
 6 the stairs, you've got the mezzanine area at the top of
 7 the stairs that leads to the City Room, which is wide in
 8 itself.
 9 So somewhere within those confines where they're not
 10 obstructing the flow of patients but where they feel
 11 it's a suitable location for them to co-locate and
 12 command the incident would have been appropriate.
 13 Q. Right. So what is your view then of the area outside
 14 the war memorial entrance, so just outside the station
 15 where there appears to have been discussions between,
 16 for example, Chief Inspector Dexter and Dan Smith?
 17 What's your view about the suitability of that
 18 particular area as an FCP?
 19 CHRISTIAN COOPER: Well, that's not an ideal location for
 20 an FCP given the amount of activity that's happening
 21 ahead of it. But if three commanders from three
 22 agencies have co-located somewhere, that's better than
 23 nothing, so we wouldn't quibble over the precise
 24 location of where they're standing. I go back to —
 25 that really is a judgement call for those commanders

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1 based on their understanding of risk and where the most
 2 effective place is for them to co-locate to achieve
 3 their role.
 4 Q. All right. My recollection of the evidence is that the
 5 discussion between Chief Inspector Dexter — when he saw
 6 Dan Smith, there was an assumption on his part that that
 7 was the FCP, I think, where that discussion took place.
 8 You seem to be suggesting that that wasn't the ideal
 9 place for one?
 10 CHRISTIAN COOPER: It's not an ideal place for one, but it's
 11 better than —
 12 Q. Better nothing?
 13 CHRISTIAN COOPER: Better than nothing, quite.
 14 Q. I want to go back now to the PDA, which we've touched on
 15 earlier, and again quite right, as you know, NWAS have
 16 always accepted there wasn't a PDA at the time for the
 17 arena.
 18 Is it your evidence that a PDA kicks in once a major
 19 incident has been declared?
 20 CHRISTIAN COOPER: Yes, that would be ideal. So I think
 21 with a PDA, the PDA — I think the point we were trying
 22 to explore on Friday with the benefits of a PDA is not
 23 so much that you would have a specific PDA for a whole
 24 host of different specific incidents, it's more
 25 something that gets a predetermined set of assets

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1 rolling towards that incident on the declaration of
 2 a major incident because it takes some of the pressure
 3 off the operational and tactical commanders of
 4 requesting specific assets that are needed before
 5 they've got a full understanding of the situational
 6 awareness because in effect those assets are already
 7 coming and it places the operational and tactical
 8 commanders in the easier position of standing them down
 9 if they're not required. I think that's the main
 10 benefit we were seeking to describe on Friday.
 11 Now, as Mike alluded to earlier, you will have
 12 certain sites that, based on the risk assessment and the
 13 unique features of that site, the PDA will be more
 14 specific. An airport is a good example because you know
 15 in advance if an aircraft is coming in in distress,
 16 there are particular assets that you will always want to
 17 have available to you at that scene, so that would be
 18 included within the predetermined attendance.
 19 For more general major incidents, the suggestion
 20 from us is that best practice would be to have a general
 21 predetermined attendance for a major incident of
 22 multiple casualties and then the commanders can adapt
 23 that predetermined attendance as needed once they gain
 24 more situational awareness. But the lack of a PDA in
 25 this case and the lack of a predetermined critical mass

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1 of assets being deployed by the control room in the very
 2 early stages of the major incident declaration, we think
 3 that's just something that could have been improved.
 4 Q. All right. I think one of the things you said on Friday
 5 was because it might have meant that the ambulances got
 6 there rather sooner than they did?
 7 CHRISTIAN COOPER: Yes, we think that ambulances probably
 8 would have, yes.
 9 Q. We'll look at that in a moment or so, but just so I'm
 10 absolutely clear, does the PDA only come into effect
 11 once the major incident is declared?
 12 CHRISTIAN COOPER: That would be the usual trigger for
 13 activating one, yes.
 14 Q. All right. I think picking up on the evidence that you
 15 gave on Friday that the absence of a PDA may — and to
 16 be fair to you gentlemen, you put it no higher than that
 17 at the time — it may have slowed the deployment of the
 18 ambulances and HART. So I just want to explore the
 19 timings that unfolded on the evening in question to see
 20 whether in fact it did slow the ambulances and the
 21 arrival of HART in the way that it might otherwise have.
 22 We are going to look at some calls, please,
 23 Mr Lopez, the first of which is {INQ023884T/1}.
 24 It's at 22.39, and this is NWAS — NWAS Control to
 25 all crews:

23

1 "Golf Mike to all crews. Golf Mike to all crews.
 2 Any crews can clear for a priority incident. That's any
 3 crews can clear for a priority incident."
 4 So no specific numbers given, but a clear direction
 5 or so it seems at that stage at 22.39.16.
 6 Next one, please, Mr Lopez, {INQ015025T/1}.
 7 I preface this with saying it appears to be in identical
 8 terms to the previous one, but it has a different INQ
 9 and the call is of a different length in duration the
 10 first one was 10 seconds and this is 17 seconds. I'll
 11 read it:
 12 "Golf Mike to all crews. Golf Mike to all crews.
 13 Any crews can clear for a priority incident. That's any
 14 crews can clear for a priority incident."
 15 Next one, please, Mr Lopez, {INQ015353/1}. This is
 16 control and Annemarie Rooney. This is a call which
 17 begins at 22.38:
 18 "Operator: What information have we got? Can
 19 anybody update me? Shot in the leg?
 20 "AR: Hello?
 21 "Operator: Annemarie, hi it's Nicola, erm, we are
 22 getting reports of a bomb gone off at the Manchester
 23 Arena.
 24 "AR: Right.
 25 "Operator: We are getting quite multiple calls, erm,

24

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

25

1 "AR: Identify your AIT on duty, if you've got that.
 2 "Operator: Right, sorry, Annemarie, yeah.
 3 "AR: You've got your Plato cards out?
 4 "Operator: Yeah, I'm just updating them now.
 5 Obviously I didn't know it was --
 6 "AR: Go through your Plato card.
 7 "Operator: Yeah, yeah.
 8 "AR: I'll grab mine and see where they are up to.
 9 Do we know who is on at the arena?
 10 "Operator: [Speak to someone else] Is it Take That
 11 today? Does anybody know? [To AR] Ariana Grande.
 12 "AR: Ariana Grande, okay. Right, I'll notify Gold
 13 now.
 14 "Operator: Right.
 15 "AR: You start making...
 16 "Operator: Yeah, I'll go through the Plato cards.
 17 "AR: Yeah, all right.
 18 "Operator: All right then, thank you.
 19 "AR: I'll speak to you shortly."
 20 It's a call that begins at 22.38, during which
 21 Annemarie Rooney is apparently already asking for HART
 22 and the services of the AIT commander; do you agree?
 23 CHRISTIAN COOPER: Yes.
 24 Q. Next one, please, {INQ015082/1}, NWS Control and 304.
 25 304 is the call sign for Chris Hargreaves who was one of

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1 the HART operatives who did go into the City Room as we
 2 know. A call at 22.40 lasting just 43 seconds:
 3 "304: 304.
 4 "NWS Control: Apologies, we're going reports of
 5 a large-scale incident in the city centre. We're asking
 6 if we can redirect you to that, over."
 7 Pausing there, HART, as we know -- Chris Hargreaves
 8 with the HART team are on the other side of the
 9 Stockport receiving this call:
 10 "304: Yeah, have you spoken to the team leader...
 11 currently I'm just liaising with the fire on this job."
 12 Because the fire were at, obviously, the fire
 13 incident on the other side of Stockport as well.
 14 "NWS Control: Roger, no problems, I'll try and get
 15 hold of him, I couldn't a second go.
 16 "304: Yeah, no problem what's the incident?
 17 "NWS Control: We're getting reports of an ongoing
 18 either shooting or bombing at the arena with 30 patients
 19 reported up to now, over.
 20 "304: Yeah, all received. I'll try and get hold of
 21 him.
 22 "NWS Control: Thank you."
 23 Finally, please, Mr Lopez, if we could look,
 24 please -- and just before we do, HART in fact cleared
 25 and left or asked to leave the incident at 22.46 and we

27

1 know that from the HART timeline, which you have looked
 2 at, gentlemen, as I understand. Thank you. Finally,
 3 please, {INQ015335T/1}.
 4 Declaration of major incident at 22.45, the call
 5 starts .
 6 "NWS Control: Hello, Julie speaking.
 7 "HC: Hi Julie, it's Chloe on Health Control. Just
 8 a quick one: is this a major incident standby or is it
 9 declared?
 10 "NWS Control: It's not yet been declared yet, love,
 11 I don't know, just bear with me a second.
 12 "HC: All right.
 13 "NWS Control: [Speaking to colleague] Nicola, have
 14 we declared this or is it still standby? Reply
 15 [inaudible] -- speaking to colleague -- if we haven't
 16 declared this then it's still stand by until we get
 17 things on scene is it? Reply: Yeah, might just declare
 18 it]. Yeah, right, we will call it declared as from now
 19 22.46.
 20 "HC: 22 -- you're declaring it at 22.46?
 21 "NWS Control: Yeah.
 22 "HC: Yeah, okay.
 23 "NWS Control: thanks.
 24 "HC: Bye, thanks."
 25 So we've got the major incident declared there at

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1 22.46. So just pausing there, and accepting as we do
 2 the deficiencies in not having a PDA, it seems, does it
 3 not, from the transcripts that we've looked at, all of
 4 which are timed before the declaration of the major
 5 incident at 22.46, that not only had all ambulances
 6 crews been told to clear for the priority incident but
 7 also HART had been contacted, told to clear from the
 8 incident they were at, and were making their way to the
 9 arena, and all that is before the major incident was
 10 declared? Would you agree with that?

11 CHRISTIAN COOPER: Yes.

12 Q. Next topic, please, equipment. On Friday, you talked
 13 about the potential -- and I think within your reports
 14 as well -- the deficiencies, or so it was perceived, as
 15 to potentially a lack of equipment at the scene. I just
 16 want to understand what your evidence is about that.
 17 Are you saying that there was insufficient equipment
 18 generally or are you pointing to specific items of
 19 equipment that were lacking, leaving aside the vehicles
 20 at the moment or perhaps incorporating those if they
 21 contained the equipment? Perhaps Mr Herriot, if you'd
 22 like to tell us or Mr Cooper.

23 CHRISTIAN COOPER: I think it's specific items that we would
 24 have expected to be at an incident of that type that
 25 weren't that were our concern rather than a general

1 observation that there was generally a lack of
 2 equipment.

3 Q. I see. Are you able to help us in understanding what
 4 the specific items were that were lacking?

5 CHRISTIAN COOPER: I think there was some indication in the
 6 debrief reports that paramedics felt they could have
 7 benefited from more mass casualty--related pharmaceutical
 8 drugs, those are carried on the national mass casualty
 9 vehicle, so that would have been of benefit.

10 Q. Yes.

11 CHRISTIAN COOPER: We've done analysis, to the best of our
 12 ability, on stretchers because we know that's a key
 13 issue and we feel there were more stretchers wither
 14 available there and not used or that could have been
 15 mobilised to scene.

16 Those were the two main ones we had. I'm looking at
 17 you, Mike, if there are others.

18 MICHAEL HERRIOT: Certainly there was a great deal of
 19 equipment available at the scene because the HART team
 20 brought a number of vehicles that contained a lot of
 21 different items of equipment that would have been of
 22 value, not only to the paramedics but also to members of
 23 the public. It was really a matter of: they were there
 24 but the equipment could have been distributed better at
 25 least.

1 Q. Right, let's just break that down. So the equipment was
 2 there on the HART vehicles. You've identified,
 3 Mr Cooper, the deficiencies and I'm not going to
 4 challenge you in relation to that.

5 But as a general concept, there was a large amount
 6 of equipment present, wasn't there?

7 MICHAEL HERRIOT: There was.

8 Q. I think you say, Mr Herriot, a lot of which was carried
 9 on the HART vehicles and there were a number of them in
 10 attendance. Is it right that that equipment was removed
 11 from the HART vehicles or a lot of it was removed from
 12 the HART vehicles -- I think it's called a kit dump,
 13 where they effectively plonk the equipment on the floor
 14 for anyone to use. Is that right in your understanding?

15 MICHAEL HERRIOT: Certainly some of it was but in the
 16 absence of an equipment officer that probably wasn't
 17 done in a systematic way.

18 Q. Yes, and you have made your observations about that and,
 19 again, I am not going to challenge you in relation to
 20 that. That is accepted by Mr Smith as one of then
 21 deficiencies.

22 So I think you said it could have been distributed
 23 or deployed better? What do you mean by that?

24 MICHAEL HERRIOT: Well, equipment could have been deployed,
 25 for instance to the City Room, including triage packs,

1 perhaps a little earlier. Similarly, equipment could
 2 have been deployed for use by the public -- in fact
 3 there was a vehicle there that was designed for that
 4 specific purpose.

5 Q. Right. Which was?

6 MICHAEL HERRIOT: The public support unit.

7 Q. Yes. There's a little confusion, isn't there, in terms
 8 of whether that was a PSU, as one understands it to be,
 9 or whether it was a vehicle that had been swapped with
 10 other one because of there being -- as you heard,
 11 I think the other day, from Mr Blezard one of the
 12 vehicles was out of action at the time?

13 CHRISTIAN COOPER: Yes and I think it's good that the
 14 equipment was put to good use. I think we recognise
 15 that. I think in terms of our expectations, the HART
 16 equipment, the cubes that they carry that contain quite
 17 a lot of consumable items, some of their special drag
 18 stretchers and various other items of HART equipment,
 19 including in fact the mass oxygen delivery system, have
 20 all been given to HART for the purpose of using it
 21 within a hazardous area, a warm zone.

22 So our starting point, not the mass oxygen, that
 23 would have been appropriate necessarily, but certainly
 24 the cubes and some of those stretchers carried by HART
 25 which ended up in the equipment dump outside of

1 Victoria Station, our expectation would have been the
 2 starting point for that equipment would have been --
 3 that should have been up in the City Room.
 4 For the wider walking wounded, the people that found
 5 themselves on the concourse but not receiving medical
 6 treatment, for all of those people, and indeed to
 7 provide equipment to the CCS itself, we would expect
 8 that to all come from these major incident support
 9 vehicles.
 10 In the event, it looks like most of the additional
 11 equipment that didn't come from a front line ambulance
 12 has been provided from this vehicle that HART brought.
 13 And as I say, better that that's got out and used
 14 regardless of where than not at all.
 15 So I don't think we're overly critical in that
 16 regard, but the deployment of the equipment didn't quite
 17 meet our expectations.
 18 Q. Right. Just a brief touch, if we may, in relation to
 19 operational plan. There was plainly an operational plan
 20 to extricate those seriously injured from the City Room
 21 as rapidly and as effectively as could be achieved
 22 in the circumstances, accepting, as we do, that the
 23 manner in which they were extricated was not ideal, and
 24 I make that plain.
 25 Do you agree as a general principle that that

1 priority, that operational plan, the priority to move,
 2 was the right operational plan?
 3 CHRISTIAN COOPER: Yes.
 4 Q. Thank you. Next topic, please, in relation to TAC
 5 advisers. Within your most recent report you talk about
 6 the roles and Steve Taylor and Jon Butler took on the
 7 evening.
 8 Within your final report, we don't need to turn it
 9 up, but I'll give the reference to those who want to
 10 know where I am within the document. I'm at page 21 of
 11 your document, and it's {INQ041856/21}. It doesn't need
 12 to go on the screen, Mr Lopez, thank you.
 13 Within that document, at page 21, you say this --
 14 in relation to the direct question you were asked:
 15 "Did Jon Butler discharge his duties as TAC AD/NILO
 16 adequately?"
 17 You say this:
 18 "As there was a failure of JESIP..."
 19 We can't lay that at the feet of Mr Jon Butler,
 20 I think, can we?
 21 MICHAEL HERRIOT: No, only inasmuch as their role is to
 22 contribute to that multi-agency response.
 23 Q. All right. So:
 24 "As there was a failure of JESIP, we must conclude
 25 that the NILO/TAC adviser role was not discharged

1 adequately. Although not a role stipulated expressly in
 2 action cards we suggest that Mr Butler's expertise may
 3 have been of greater value at the scene or as an Airwave
 4 tactical adviser at the EOC."
 5 You caveat that criticism, however gentle it is,
 6 with:
 7 "Although not a role stipulated expressly in the
 8 action cards."
 9 We take it from that that what he did and the
 10 actions he took that night were stipulated in the action
 11 cards and he complied with what he was meant to do.
 12 MICHAEL HERRIOT: Yes, he was asked initially to respond to
 13 the scene and he was diverted to police headquarters,
 14 which was a role that would be expected, yes, of
 15 a tactical adviser.
 16 Q. Yes. You say here that his expertise may have been of
 17 greater value at the scene and those of us who heard his
 18 detailed evidence, he appeared to have a good knowledge
 19 of both the plans and the procedures and what was
 20 required of him, he appeared to be a very competent
 21 individual, would you agree?
 22 MICHAEL HERRIOT: Yes.
 23 CHRISTIAN COOPER: Yes.
 24 Q. Thank you. Is that one of the reasons that you say his
 25 expertise may have been of greater value at the scene?

1 CHRISTIAN COOPER: I think we would absolutely expect that
 2 a tactical adviser makes their way to support the
 3 tactical commander --
 4 Q. And she was at GMP?
 5 CHRISTIAN COOPER: She was at GMP, yes. I think what we're
 6 saying is the operational commander would have benefited
 7 from tactical advice as well, not necessarily from this
 8 individual, but from a TAC adviser role. So if this
 9 individual made their way to the scene to support the
 10 operational commander, the other tactical adviser could
 11 potentially have supported Annemarie Rooney in police
 12 force HQ. But either way we think it would have been of
 13 benefit for both the operational and the tactical
 14 commanders to have had a tactical adviser. That's the
 15 point we make.
 16 Q. Thank you. That's helpful. So in terms of -- I'll just
 17 ask directly: what did he do wrong, what did Jon Butler
 18 do wrong, anything or nothing?
 19 CHRISTIAN COOPER: I think a key concern is that of all the
 20 people, the person that is perhaps the most familiar
 21 with JESIP and how it should work and the person best
 22 placed to recognise when it's not is the NILO and
 23 tactical adviser. So I think we would have expected --
 24 that's another cross-check that was perhaps missed where
 25 that tactical adviser could have said, "Things don't

1 appear right here from the way that's happening".
 2 So I think when we say:
 3 "As there was a failure of JESIP we must conclude
 4 that the NILO and tactical adviser role was not
 5 discharged adequately."
 6 It's because we would have expected that role
 7 particularly to have supported JESIP and to have
 8 insisted on some sort of corrective action to get JESIP
 9 up and running more effectively and sooner.
 10 Q. And just dealing with Steve Taylor, we know he remained
 11 at home. I don't think you're critical of that in
 12 itself. In fact, is that where he should have been?
 13 CHRISTIAN COOPER: It's not inappropriate for him to remain
 14 at home. I think for this particular incident, and this
 15 is I would say with the benefit of hindsight, it would
 16 have been better for a NILO or tactical adviser to be
 17 supporting the operational commander as well as the
 18 tactical commander. But if you've got two and an
 19 incident is unfolding, it's my experience that it's not
 20 uncommon for one of them to remain at home with access
 21 to materials, to be looking things up immediately, to be
 22 maybe making some communications whilst another
 23 mobilises to a location, wherever that may be. That is
 24 fairly common practice.
 25 Q. Triage, next topic. Would you agree that the better the

1 primary triage, in fact the better the triage process as
 2 a whole at scene, the better the chances of the mass
 3 casualty distribution plan working and the better the
 4 chances of the outcome for the patient?
 5 CHRISTIAN COOPER: I'd agree, yes.
 6 Q. Thank you. I would like us, please, with that in mind,
 7 to look at the statement, and it's a statement that's
 8 been recently served, I referred to it on Friday, and
 9 I think I described Mr Smith as an ambulance consultant.
 10 He's not, he's a hospital consultant, so we're going to
 11 look at his statement now, please.
 12 It is {INQ041974/1}, please. Mr Smith tells us he's
 13 employed at the Salford Royal Hospital as a consultant
 14 in emergency medicine and he has held the position for
 15 about 18 years. He tells us a little of his
 16 qualifications, tells us also that he's the clinical
 17 director of the Greater Manchester Major Trauma Network,
 18 appointed to that post in 2015. In that role, as the
 19 clinical director of the trauma network, he has been
 20 involved in a number of projects linking EPRR, emergency
 21 planning resilience and response, and the major trauma
 22 network in the years running up to the Manchester Arena
 23 attack. He has provided this statement to assist the
 24 chair in relation to the development of the
 25 Greater Manchester mass casualty dispersion plan.

1 {INQ041974/4}, please, Mr Lopez. It's paragraph 20
 2 dealing with the specifics of the incident on 22 May:
 3 "Although the plan had been agreed, tested and
 4 received broad approval, final sign-off had not occurred
 5 by the night of the arena bombing. However, crucial
 6 personnel present at scene and within the incident
 7 command had knowledge of and had been involved in its
 8 development. They were also aware of the Socrates
 9 Report."
 10 Pausing there, that's the training exercise that
 11 happened a month or so before which you told us on
 12 Friday had gone well:
 13 "... aware of the Socrates Report and its
 14 recommendations. The decision which those individuals
 15 made to enact the casualty distribution plan was crucial
 16 and positively contributed to the care of victims that
 17 night."
 18 Page 5, please, Mr Lopez {INQ041974/5}.
 19 Paragraph 23:
 20 "I wish to highlight the summary provided by
 21 Professor Moran in consideration of the pre-planning and
 22 prior exercising of the dispersal plan. When he
 23 reflected on the whole system response, he felt that the
 24 planning, desktop exercises and rehearsal were
 25 enormously beneficial and made a great difference to the

1 response on the day. He thought the rehearsal meant
 2 that many staff were familiar with the major incident
 3 plan. The presence of a regional mass casualty plan
 4 identifying receiving units, their capability and their
 5 capacity in advance was invaluable for casualty
 6 distribution. Accurate triage and casualty distribution
 7 directly to the appropriate hospitals greatly
 8 facilitated patient care and minimised secondary
 9 transfer. Indeed [he concluded], each region must have
 10 a patient dispersal framework and a casualty capability
 11 chart."
 12 Just picking up on that last sentence, are we to
 13 understand therefore, and I think Mr Smith talks about
 14 this earlier in his statement, that this particular plan
 15 and the way it worked on the night was seen thereafter
 16 as somewhat of a beacon to others?
 17 CHRISTIAN COOPER: Yes.
 18 Q. Others who hadn't got this type of plan in place at the
 19 time?
 20 CHRISTIAN COOPER: No, at this point in time there was quite
 21 a lot of work being done by NHS England at the national
 22 level, led by Professor Moran, looking at the management
 23 of mass casualties in general and more specifically how
 24 the overall NHS system would cope and the dispersal
 25 plans from scene were part of that work. But the

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

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

20 "The EMJ paper..."

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

23 MICHAEL HERRIOT: The Emergency Medical Journal, yes.

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

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

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

24 {INQ041974/9}, please. Paragraph 44:

25 "Note was made of the care given by bystanders and

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

9 Gentlemen, just finally, if I may, please.

10 Inevitably this process looks at, and quite correctly
 11 this process looks at, the inadequacies of a response.
 12 You say in your third report that you could not state
 13 that the overall response by NWAS was adequate in all
 14 the circumstances because some aspects were less than
 15 adequate. Your evidence over the last day and a half or
 16 so has gone some way to show us and the organisation
 17 what those inadequacies were.

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

25 CHRISTIAN COOPER: Yes.

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1 Q. You agreed on Friday that you had seen the documents
 2 submitted by NWAS over a year ago which set out a number
 3 of key issues that you had drawn to the organisation's
 4 attendance (sic) in the three reports that you had
 5 submitted at that stage. You have seen that document
 6 and you noted and agreed with me on Friday that of the
 7 16 key areas, all were either accepted in whole or in
 8 part.

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

12 CHRISTIAN COOPER: Yes.

13 MICHAEL HERRIOT: Yes.

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

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

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

20 Questions from MR TAYLOR

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

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

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

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

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

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

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

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

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1 Industry Body?
 2 MICHAEL HERRIOT: Yes, I have read of that.
 3 Q. Do you know anything about this organisation?
 4 MICHAEL HERRIOT: I'm not familiar with its work.
 5 Q. Then I'll leave that there. Thank you.
 6 You'll know of Brigadier Hodgetts' evidence on
 7 Day 68 of the oral evidence hearings. He said at
 8 page 22, line 21 {Day68/22:21}:
 9 "Within the civilian community, the prevailing
 10 narrative at the time of the arena attack would have
 11 been: don't use tourniquets and first aid because they
 12 may cause harm."
 13 Do you agree with that comment as it relates to the
 14 content of first aid training at the time?
 15 MICHAEL HERRIOT: I'm aware that at that time some
 16 first aiders were being taught the use of tourniquets.
 17 It wasn't universal by any means.
 18 Q. Thank you. I'll move on. Mr Cooper, you're nodding,
 19 thank you.
 20 On Friday, Mr Herriot, you were asked a discrete
 21 question about numbers of first aiders at the arena on
 22 22 May 2017. You were asked in your view whether there
 23 was an adequate number of ETUK first aiders. Your
 24 answer:
 25 "From my standpoint no, but the counterargument to

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1 that is that there is guidance and it could be argued
 2 that the provision was in keeping with the guidance. My
 3 issue with that is more about skills mix. So it's not
 4 just about number, it's about what skills those
 5 individuals have."
 6 MICHAEL HERRIOT: That's correct.
 7 Q. A comment you have recently made?
 8 MICHAEL HERRIOT: Yes.
 9 Q. Is it right to say that your focus throughout this
 10 process has actually been on the skills mix rather than
 11 the numbers as a discrete issue?
 12 MICHAEL HERRIOT: I think that the provider is required to
 13 carry out a risk assessment, which should lead them to
 14 the type of cover, the type of skills mix, and number of
 15 providers that are present. So provided that risk
 16 assessment has been carried out competently, then that
 17 would give them an idea about the number of first aiders
 18 and other staff that would be required to cover that
 19 particular event.
 20 Q. The reason I ask the question, maybe I'm wrong about
 21 this, but is it right that you have not in any of your
 22 written documents specifically said the numbers were
 23 insufficient, the focus has always been on the
 24 competencies?
 25 MICHAEL HERRIOT: It does and of course different versions

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1 of the guidance give a slightly different interpretation
 2 of the numbers that would be required, and that's the
 3 reason why, in the 1999 guidance, the expert group
 4 specifically tried to move away from the formula of so
 5 many first aiders per so many audience and that was
 6 because we believed that organisers were focusing
 7 primarily at looking at the numbers they had and saying,
 8 "Well, X number needs X number of first aiders", when
 9 clearly that wasn't the case because evidence was
 10 showing that there are a lot of other factors that
 11 should influence that cover rather than purely numbers.
 12 Q. The 1999 guide did still have that approach to numbers.
 13 MICHAEL HERRIOT: The 1999 guide was the first guidance
 14 anywhere that looked at a thorough risk assessment,
 15 including the different relevant factors, to arrive at
 16 the number and the skill mix of first aiders, ambulance
 17 personnel, et cetera whereas, as the guidance has become
 18 an industry code of practice, a table has been
 19 reintroduced which, on the face of it, looked a little
 20 more simplistic. So the proposal in the 1999 guidance
 21 around moving to a risk assessment-based approach
 22 probably hasn't been carried through to the same degree.
 23 Q. Thank you. That's where I was going. You have referred
 24 to what we believe to be the 2015 table, and that is
 25 defined between small, medium and large events.

1 MICHAEL HERRIOT: That's correct.
 2 Q. And the medium event is 10,000 to 50,000 attending and a
 3 large event is over 50,000 attending?
 4 MICHAEL HERRIOT: That's right, yes.
 5 Q. I read out to you what you said on Friday about the
 6 numbers and you in summary fairly said it could be
 7 argued that the provision met the guidance. Can I just
 8 try to understand that for a moment? Are you saying
 9 that there is a reasonable range of responses to the
 10 guidance and that what there was fell within it?
 11 MICHAEL HERRIOT: There is, yes.
 12 Q. Thank you.
 13 SIR JOHN SAUNDERS: I am sorry, I don't understand what that
 14 answer means. There were two questions there. Can we
 15 separate them off and I will find out whether the
 16 answers were yes to both?
 17 MR TAYLOR: Thank you, sir. I'll try that.
 18 There was the guidance and are you saying that the
 19 guidance can be interpreted in different ways as it was
 20 in 2015?
 21 MICHAEL HERRIOT: I think, as you have postulated, the table
 22 in the recent guidance covers a wide variation, events
 23 from 20,000 to 50,000. Now, clearly, there will be
 24 a wide range of different hazards and risks within
 25 a population covering that magnitude of difference. So

1 clearly, a competent risk assessment is required to
 2 enable the provider to ascertain the correct number and
 3 skill mix of staff, so in that respect there is
 4 a variation, and it is open to some interpretation.
 5 Q. Is that why you said on Friday, arguably it met that
 6 guidance?
 7 MICHAEL HERRIOT: Exactly.
 8 MR TAYLOR: Sir, does that clear up the question?
 9 SIR JOHN SAUNDERS: Yes, thank you.
 10 MR TAYLOR: A slightly related topic is historical data. In
 11 your note at ETUK5, which is on page 30 if anyone is
 12 following it, you say that:
 13 "Providers/medical providers should keep records of
 14 patients seen."
 15 MICHAEL HERRIOT: Yes.
 16 Q. It seems like a rather obvious comment to make, but
 17 perhaps it needs stating. Do you agree the evidence has
 18 shown there was a log being kept at the arena?
 19 MICHAEL HERRIOT: Certainly that has been published. The
 20 ratio of patients seen at events seems to have been
 21 recorded, yes.
 22 Q. That's been calculated and it comes from a log. Perhaps
 23 to be clear, I won't put it up but I'll read a very
 24 short part of Mr Allen's eighth witness statement. For
 25 those who would like a reference it is {INQ040488/2}:

1 "This log sets out data per show including the
 2 number of people in the audience, the number of EMTs and
 3 first aiders on duty, the number of individuals seen by
 4 the medics at the event, whether an ambulance was
 5 called, the types of medical incident reported."
 6 And as you've observed, Mr Herriot, there has been
 7 statistics which have been quoted so far that come from
 8 that data. Do you agree that the guidance in part
 9 referred to the importance of looking at your own data
 10 from previous events?
 11 MICHAEL HERRIOT: That's correct. As a means of learning
 12 from previous events, that would include not just
 13 looking at the numbers, looking at the cause of the
 14 incident, if there was an incident, or the types of
 15 conditions seen that could be then contrasted against
 16 the activity at the time. Again it's well-known that
 17 different types of act, different types of audience, the
 18 different make-up of audience makes a big difference in
 19 the number of people that seek medical assistance.
 20 Q. The Purple Guide aims to educate those putting on a wide
 21 range of events and maybe, for the first time, some may
 22 be only periodic events?
 23 MICHAEL HERRIOT: That's correct.
 24 Q. Not everyone who reads the guide will be putting on
 25 several events a week, hundreds of events a year?

1 MICHAEL HERRIOT: That's right.
 2 Q. So in the case of the arena, with data from every show
 3 going back over a decade, would you agree in that
 4 context they had very good data about past medical
 5 incidents?
 6 MICHAEL HERRIOT: They should have, yes.
 7 Q. No comments on that topic, Mr Cooper?
 8 CHRISTIAN COOPER: I have nothing further to add, thank you.
 9 SIR JOHN SAUNDERS: Sorry, can we stop for a moment? I am
 10 not quite sure of the significance or what is going to
 11 be said to be the significance of the last series of
 12 questions. So is that to say: well, we look at the past
 13 data of what's been required, and from that we get some
 14 sort of indication of the sort of medical service
 15 provision we need to supply? If that were the case then
 16 we would simply ignore anything such as happened on
 17 22 May. Is that the argument?
 18 MR TAYLOR: Not so much an argument, sir, but it's right to
 19 say that the table in the 1999 Purple Guide — one of
 20 the scores depends on how good the past data is.
 21 Is that right, Mr Herriot?
 22 MICHAEL HERRIOT: Yes. The past data is one element to be
 23 considered. Not the most important element, I would
 24 say, but one in a wide range of factors that need to be
 25 taken into consideration.

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

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

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

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

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

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

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

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

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1 Ambulance Service?
 2 MICHAEL HERRIOT: It would require the police to pass that
 3 message. But it didn't contain the sort of information
 4 that the Ambulance Service would require to inform their
 5 response earlier. The Ambulance Service was purely
 6 relying on, at that stage, the information from the
 7 general public: 30 calls, I think, in the first
 8 10 minutes.
 9 Q. I don't mean to say that Mr Johnson's call is alone
 10 amongst all the calls that were being received and
 11 providing information about what was happening, but for
 12 Mr Johnson's call there is information as to there
 13 having been an explosion, the type of incident; yes?
 14 MICHAEL HERRIOT: But not to the Ambulance Service, that's
 15 the point.
 16 Q. So you would make a criticism that the Ambulance Service
 17 weren't requested to the 999 operator or that it wasn't
 18 passed on to the Ambulance Service from the
 19 999 operator?
 20 MICHAEL HERRIOT: No, my criticism is there is a plan that
 21 details the fact that that call will be made to the
 22 Ambulance Service and that call was not made.
 23 Q. So no criticism of the efforts that were made to contact
 24 999 by the control room?
 25 MICHAEL HERRIOT: No, but it didn't meet the requirement.

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1 Q. Because they didn't reach NWS or because --
 2 MICHAEL HERRIOT: Yes, because they didn't contact NWS, as
 3 had been stipulated in their plan.
 4 Q. The way to contact NWS would be to dial 999?
 5 MICHAEL HERRIOT: Yes.
 6 Q. I'm going to finish that topic. Mr Cooper, I give you
 7 the opportunity if you have anything to add.
 8 CHRISTIAN COOPER: I don't think so. The key thing we have
 9 to look at is what the plan says that they should do.
 10 The plan says that that METHANE message needs to be
 11 passed to NWS. Yes, of course, you do that via the
 12 999 system and then you ask for the Ambulance Service
 13 and you pass the METHANE message. That is our
 14 expectation and that didn't happen, absolutely agreeing
 15 that the main responsibility for that in the plan and
 16 our expectation would be that that would be done by
 17 ETUK. I think the other thing we were considering here
 18 with the "or SMG" bit in brackets was if there's
 19 a control room operating or something of that nature
 20 that SMG have control over, perhaps there's an
 21 opportunity there to make sure that that message has
 22 gone in. I think that was why we were saying ETUK, or
 23 more broadly SMG, but we do recognise that the -- that
 24 METHANE message particularly should have been passed by
 25 ETUK to NWS.

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1 MR TAYLOR: Thank you, gentlemen, thank you, sir, those are
 2 my questions.
 3 SIR JOHN SAUNDERS: Thank you very much, Mr Taylor.
 4 MR GREANEY: Sir, that would be a convenient moment for our
 5 15-minute morning break.
 6 SIR JOHN SAUNDERS: Okay. Thank you very much. Quarter of
 7 an hour.
 8 (11.05 am)
 9 (A short break)
 10 (11.20 am)
 11 MR GREANEY: Sir, we have heard from Mr Wood, on behalf of
 12 Sexton and Dexter, and from Mr Horwell on behalf of GMP,
 13 and Mr Warnock and on behalf of GMCA, that they no
 14 longer have any questions and so I am going to turn
 15 straight to Mr Atkinson to ask his questions on behalf
 16 of the families.
 17 SIR JOHN SAUNDERS: Mr Greaney, I understand we're well up
 18 to time?
 19 MR GREANEY: We are ahead of time, sir, yes. We will
 20 certainly finish the evidence of these witnesses today.
 21 SIR JOHN SAUNDERS: Thank you. Don't take that as an
 22 invitation to be longer!
 23 Questions from MR ATKINSON
 24 MR ATKINSON: Perish the thought, sir, good morning.
 25 Gentlemen, as you understand, I ask questions on

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

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

10 CHRISTIAN COOPER: Yes.

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

15 CHRISTIAN COOPER: That's correct, yes.

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

19 CHRISTIAN COOPER: Yes.

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

23 CHRISTIAN COOPER: Yes.

24 Q. And they all needed to plan for it?

25 CHRISTIAN COOPER: Yes.

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

2 CHRISTIAN COOPER: Yes.

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

5 CHRISTIAN COOPER: Yes.

6 Q. And that did not happen?

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

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

13 CHRISTIAN COOPER: In part, yes.

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

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

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

25 CHRISTIAN COOPER: Yes.

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

4 CHRISTIAN COOPER: That's correct, yes.

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

9 CHRISTIAN COOPER: Yes.

10 Q. And that didn't happen?

11 CHRISTIAN COOPER: It did not.

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

15 CHRISTIAN COOPER: Yes.

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

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

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

24 CHRISTIAN COOPER: Yes.

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

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

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

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

7 CHRISTIAN COOPER: Correct.

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

11 CHRISTIAN COOPER: No.

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

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

17 Q. Or trained together with?

18 CHRISTIAN COOPER: Indeed not.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 This is something you were referring to earlier
 2 today, I think, Mr Herriot, the recommended minimum
 3 number of first aiders at small events where no special
 4 risks are considered likely is 2:1,000 for the first
 5 3,000 attending.
 6 MICHAEL HERRIOT: Yes.
 7 Q. Do we understand that the point you were making is that
 8 that is only the first step in identifying who you
 9 actually need as your medical cover for an event, it is
 10 not the answer?
 11 MICHAEL HERRIOT: Yes, and this is really referring to the
 12 smallest, simplest events.
 13 Q. Because if we go on, please, to {INQ001452/134}, and
 14 again it's the bottom of the page, there are then set
 15 out in the 1999 version a series of tables that identify
 16 what the resources actually you're going to need for
 17 your event are by reference to the nature of the event,
 18 using table 1; available history and pre--event
 19 intelligence, table 2; various additional elements that
 20 are set out in table 3; and resource requirements set
 21 out in table 4.
 22 I took Mr Parry through, using this version, because
 23 that was the version he was familiar with, and he and
 24 I didn't reach entire agreement as to the score, but
 25 we were on a score over 30.

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

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

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

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

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

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

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

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

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

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1 functional role, then it is all the more important that
 2 you follow that action card so the key things that are
 3 envisaged that that role should complete are done.
 4 Q. You make the point in each of your reports, but perhaps
 5 most clearly in your most recent response to the series
 6 of questions — this is {INQ041856/16}, topic NWAS25,
 7 the top of that page of that document, gentlemen, if
 8 you have it — where you say:
 9 "Major incident action cards have been designed so
 10 they can be quickly and easily utilised during the most
 11 complex and stressful phases of an incident. They are
 12 simple checklists that are easy to read in seconds and
 13 convey the key actions that need to be taken to ensure
 14 an effective response."
 15 And then you give the analogy, as you did on Friday,
 16 of the emergency checklist for a pilot.
 17 CHRISTIAN COOPER: Yes.
 18 Q. The reality, would you agree, is, looking at what
 19 various of those who had roles on behalf of NWAS at the
 20 arena are concerned, what they had to say about it and
 21 what you could say that they did, there was not
 22 effective use of action cards by a number of those with
 23 roles?
 24 CHRISTIAN COOPER: Yes.
 25 Q. The operational commander, Mr Smith, we'll come back to

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1 in a moment, he was a key example of that, would you
 2 agree?
 3 CHRISTIAN COOPER: Yes.
 4 Q. But also those who were given particular jobs, like
 5 Mr Poland and the parking officer, the loading officer,
 6 the CCS medical lead, did not happen to be using their
 7 cards?
 8 CHRISTIAN COOPER: Yes.
 9 Q. And nor did it appear Mr Ennis, as the first ambulance
 10 on scene, used his?
 11 CHRISTIAN COOPER: Yes.
 12 Q. With each of those people, clearly Mr Ennis, you are
 13 understandably at pains to stress the considerable
 14 things that he did do given what he was confronted with,
 15 but critical things that he could have and should have
 16 done as first ambulance on scene were spelt out for him
 17 on the action card?
 18 CHRISTIAN COOPER: They were.
 19 Q. Such as an RVP?
 20 CHRISTIAN COOPER: Yes.
 21 Q. In relation to the operational commander, in particular
 22 in that respect — and Mr Lopez, it's {INQ013422/6},
 23 please.
 24 This is the operational commander action card, so
 25 the one that was available to Mr Smith. Just as

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1 a preliminary question in relation to this: clearly, the
 2 first ambulance on scene, and that action card, gives
 3 that person the effective role of operational commander
 4 until an actual operational commander turns up.
 5 CHRISTIAN COOPER: Yes.
 6 Q. That card lists things such as RVPs as things to be
 7 considered?
 8 CHRISTIAN COOPER: Yes.
 9 Q. Less so on this card. Is that because this card is
 10 predicated on those things already having been done by
 11 the first ambulance on scene?
 12 CHRISTIAN COOPER: Yes.
 13 Q. But without a reminder on this card: check that they've
 14 been done?
 15 CHRISTIAN COOPER: Yes, that's fair.
 16 Q. Would that be an improvement, if the things that anyone
 17 adopting the operational commander role should do ought
 18 to be set out on this card, it would make it a little
 19 bit longer but not a lot?
 20 CHRISTIAN COOPER: Yes, I think that's fair.
 21 Q. But in terms of assessing what needs to be done, we can
 22 see number 12 on this list, the need to consider other
 23 specialist assets that need to attend. That should
 24 already have been addressed by the first ambulance on
 25 scene, but something spelt out that the operational

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1 commander needs to that address again when they're on
 2 scene?
 3 CHRISTIAN COOPER: Yes.
 4 Q. Which in the case of Mr Smith would have meant
 5 considering SORT and AIT as well as HART, and Liverpool
 6 as well as Manchester when it comes to HART?
 7 CHRISTIAN COOPER: Yes.
 8 Q. Over the page, please {INQ013422/7}:
 9 "Consideration of [number 2 on the list] forward
 10 control point (FCP)."
 11 And then a series of locations and roles, including
 12 safety officer and equipment officer and HART team
 13 leader.
 14 So if Mr Smith had gone through this and checked it
 15 off, he would have realised that he didn't yet have
 16 a safety officer?
 17 CHRISTIAN COOPER: No. You don't have to appoint every
 18 functional role for every incident. But the purpose of
 19 this is to give a very quick reference to an operational
 20 commander to — rather than having them in a position
 21 where they've got to think about what they might need,
 22 to speed things up and in the interests of efficiency,
 23 it gives them a list of what they need to consider and
 24 then effectively proactively reject what is not required
 25 from that list.

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

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

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

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

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

1 commander in charge of that whole scene, it is all the
 2 more important then to make sure you've got all of the
 3 functional roles you need to give that operational
 4 commander the span of control they need to be able to
 5 step back and manage that incident effectively. When
 6 you don't have certain roles appointed and things start
 7 to not go particularly well, it is even more challenging
 8 for that operational commander to deal with it and
 9 manage it effectively.
 10 So the fact that the tactical commander went to
 11 consider it is no surprise and where it is expected they
 12 should have gone, it does mean that we are in a position
 13 where we recognise in our analysis that it was more
 14 important then for as many functional roles as possible
 15 to have been appointed in this case to make sure that
 16 that operational commander — because the functional
 17 roles are not only about going away, following the
 18 action cards, and discharging those duties; it means
 19 you've got somebody who is focusing on that particular
 20 issue, that particular problem — an equipment officer,
 21 for example, can devote all of their effort and energy
 22 to working out when there might be an equipment
 23 shortfall, what might be needed, what else is not here
 24 that perhaps should be here, which takes that
 25 responsibility away from the operational commander.

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

1 operational commander was filling in all the roles that
 2 needed filling and was getting the resources that were
 3 needed to the scene, is essential, isn't it?
 4 CHRISTIAN COOPER: Yes.
 5 Q. Because you can't expect the operational commander to do
 6 it all on their own?
 7 CHRISTIAN COOPER: No, and when you are a tactical commander
 8 remote from that scene, and I've been in that position
 9 myself, you don't have the same situational awareness of
 10 what's going on. I use situational awareness in
 11 a slightly different context here. That's not just
 12 situational awareness about what's going on in the
 13 City Room, what's needed for members of the public and
 14 casualties, it's the situational awareness that the
 15 tactical commander needs to have on how effectively is
 16 this incident being managed by the Ambulance Service.
 17 So if you have a remote tactical commander, you
 18 would expect far more questions from that commander of
 19 the operational commander to cross-check that there was
 20 the relevant grip and focus of incident at the scene.
 21 Q. The other thing that those higher up the command chain
 22 and/or remote from the scene can do perhaps more than
 23 someone who is in the heat of it is identify whether
 24 JESIP is working or not?
 25 CHRISTIAN COOPER: Yes.

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

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

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

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1 paragraph that begins:
 2 "As there was a failure of JESIP we must conclude
 3 that the NILO tactical adviser role was not discharged
 4 adequately."
 5 CHRISTIAN COOPER: Yes.
 6 Q. Is it appropriate perhaps to read that in the context of
 7 the paragraph before it, which reads:
 8 "The fundamental role of the NAWAS NILO tactical
 9 adviser is to bring together the commanders of the
 10 responding emergency services to ensure that liaison is
 11 taking place, confirm that the appropriate plans have
 12 been initiated and are working effectively, provide
 13 specialist emergency procedural advice, and to ensure
 14 effective inter-agency working as required by JESIP?"
 15 If that is the job of a tactical adviser, and that
 16 was not happening, then there has then -- does it not
 17 inevitably follow that the tactical adviser was not
 18 discharging their role adequately?
 19 CHRISTIAN COOPER: That was our finding, yes.
 20 Q. Because making JESIP happen was what they were there
 21 for?
 22 CHRISTIAN COOPER: Yes.
 23 Q. And it didn't happen?
 24 CHRISTIAN COOPER: No.
 25 Q. In terms of particular aspects of JESIP, clearly the

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

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

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

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

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1 this it's more likely that the operational commander
 2 will arrive. If they look around and they can't see a
 3 police commander and a fire commander, and they make the
 4 assumption they're the only one there, they would say,
 5 "I'm here, this is the FCP, can you tell the other
 6 agencies that this is where the FCP is?" if they haven't
 7 been notified in advance that another agency has already
 8 created an FCP. That's not necessarily the same as
 9 an RVP. It may well be, but either way, both require
 10 a conversation among all three agencies.
 11 Q. Is it still your position, as you put it in your third
 12 report, that the lack of an FCP was the greatest
 13 obstacle to effective inter-agency liaison at the arena?
 14 CHRISTIAN COOPER: That's our view, yes.
 15 Q. If you were wanting to see JESIP working, you would see
 16 an FCP where the commanders were co-located?
 17 CHRISTIAN COOPER: Yes, and physical co-location is always
 18 the preference. It could hypothetically be done via
 19 a radio link or some other link, but the most effective
 20 at incidents like this is physical co-location.
 21 Q. Because there may be aspects of any response that the
 22 different services may have different views on and an
 23 assessment of risk may well be one of them?
 24 CHRISTIAN COOPER: Yes.
 25 Q. But in terms of dealing with that and resolving those

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1 disagreements, you're much more likely to be able to do
 2 that if you're speaking to each other face to face?
 3 CHRISTIAN COOPER: Yes, and it's my experience that when
 4 those conversations happen, those disagreements are
 5 overcome.
 6 Q. And they need to be — you need to resolve these
 7 disagreements so everyone is doing the same thing?
 8 CHRISTIAN COOPER: Yes.
 9 Q. So anything that will help that process needs to be
 10 done?
 11 CHRISTIAN COOPER: Yes.
 12 Q. If conversely, you are not sure what the risks are
 13 because you're on your own and trying to deal with it,
 14 then the need to change that position so that you can be
 15 co-located and speaking becomes obvious, doesn't it?
 16 CHRISTIAN COOPER: Yes.
 17 Q. So really, from when he arrived at the arena,
 18 Mr Smith — and the same would apply to the other
 19 emergency services — but Mr Smith, when he arrived
 20 at the arena, should have been looking for the FCP, and
 21 if he couldn't find one, establishing one and telling
 22 the others where he was?
 23 CHRISTIAN COOPER: Yes.
 24 Q. Because for it to work, that had to happen and had to
 25 happen quickly?

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1 CHRISTIAN COOPER: Yes.
 2 Q. And it didn't?
 3 CHRISTIAN COOPER: It didn't.
 4 Q. In terms of deployment of NWSAS to the arena, would you
 5 agree there's a difference between getting sufficient
 6 resources to that part of Manchester on the one hand and
 7 getting the right resources to the right places within
 8 the arena complex on the other?
 9 CHRISTIAN COOPER: Yes.
 10 Q. So statistics about numbers of ambulances, for example,
 11 are only a part of the assessment of deployment and you
 12 need to look at who was where and whether they were
 13 where they needed to be?
 14 CHRISTIAN COOPER: Yes.
 15 Q. Can I understand with you a little more about some
 16 answers you gave to Ms Roberts on Friday afternoon about
 17 the half-hour gap. That's the half hour between the
 18 bomb going off, the first 999 call coming in on the one
 19 hand, and the first ambulances arriving at the arena on
 20 the other.
 21 It may have seemed on Friday that you were
 22 suggesting that that was acceptable, that there would be
 23 a half-hour delay. Is that what you were saying?
 24 CHRISTIAN COOPER: It depends on the demand, the pressures
 25 and the location of ambulances and availability within

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1 NWSAS at the time. We would expect a rapid mobilisation
 2 of specialist resources and there are degrees of
 3 protection afforded to those resources that mean they
 4 maintain a greater state of readiness than wider
 5 ambulances that may well be committed with patients,
 6 delayed at hospital.
 7 As I articulated on Friday, the Ambulance Service
 8 does not have any spare capacity within its front line
 9 operational response, quite the contrary. They are
 10 normally stacking emergencies with multiple emergencies
 11 waiting to be assigned to a particular ambulance.
 12 So ideally we would expect a large number of front
 13 line resources to be at a major incident as quickly as
 14 possible, but you don't find a response time standard
 15 for a major incident because it depends what that
 16 incident is, where it is, and what's needed. You do
 17 have response time standards and state of readiness
 18 standards for the specialist assets like HART, for
 19 example, to make sure that, regardless of the incident
 20 type, if it's thought they're needed, early mobilisation
 21 of that assets needs to occur. But there isn't an
 22 on-scene time requirement for those assets because it
 23 depends where it is. If you have got — the HART base
 24 is located where they are located and something happens
 25 a long, long way away, the response time is naturally

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

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

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

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

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

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

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

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1 happened.
 2 To go further and say you would have had a greater
 3 number of AIT staff at the scene, we are unable to draw
 4 that conclusion.
 5 Q. But certainly so far as HART is concerned, given that
 6 there was this staggered arrival of the Manchester
 7 HART team for the reasons that we all understand, if you
 8 could have had the Liverpool HART team there by the time
 9 the last of the Manchester HART team were able to get
 10 there, so you could have had two teams by that point
 11 available with all their kit and their skills, that
 12 would have made a difference?
 13 CHRISTIAN COOPER: Yes, and early notification potentially
 14 of other HART units because they're all on a 30-minute
 15 notice to move.
 16 MR ATKINSON: That would be a convenient moment, sir, unless
 17 you have any...
 18 SIR JOHN SAUNDERS: No, no, provided you're all agreed,
 19 that's a good time for lunch. So 1 hour. Thank you
 20 very much.
 21 (12.50 pm)
 22 (The lunch adjournment)
 23 (1.50 pm)
 24 SIR JOHN SAUNDERS: Mr Atkinson.
 25 MR ATKINSON: Can I just draw some threads together, to use

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

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

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

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

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1 you're actually talking about the same thing?
 2 CHRISTIAN COOPER: Yes. It is worth highlighting that JESIP
 3 in its different doctrines -- so there is specific JESIP
 4 principles for how to deal with a CBRN event, specific
 5 ones to deal with an MTA event, and more general
 6 principles. All three are clear about what type of
 7 zonings there should be, there's multi-agency agreement
 8 on that. But if they're not communicating within that
 9 envisaged JESIP joint way, then absolutely there is
 10 a risk of which type of zone: are we talking about CBRN,
 11 MTA or a general one? Those principles were written by
 12 JESIP assuming that the joint commanders would do that.
 13 I don't think it was envisaged that you try and apply
 14 those doctrines without that joint approach which is
 15 where the confusion comes in.
 16 So the point I'm trying to make is the principles
 17 are very clear at the moment on the different types of
 18 zone and everybody should be clear on that, but it does
 19 require a joint understanding of which ones you're
 20 using.
 21 Q. Is another aspect of that which can potentially
 22 complicate things the position that applied here of an
 23 IED and the risk of there being secondary devices and
 24 what that means in terms of an emergency response?
 25 CHRISTIAN COOPER: Yes.

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1 Q. Clearly, in the MTA context it was thought a good idea
 2 that you would have agreed in advance who could go into
 3 what areas in relation to such an incident?
 4 CHRISTIAN COOPER: Yes.
 5 Q. Is it your view that it would be a good idea for there
 6 to be a similar kind of in advance agreement as to who
 7 can go where in a bomb incident?
 8 CHRISTIAN COOPER: Yes. Some attempts have been made to do
 9 that. I think we need to be careful about some of the
 10 sensitivities because when we're talking about
 11 predetermined responses to certain risks like an IED, we
 12 also need to be cognisant of not giving information to
 13 actors that might act against us to affect our response.
 14 But I think we're on safe ground agreeing that, yes,
 15 in the absence of a bit more work being done, different
 16 agencies will have a different risk tolerance of things
 17 like the potential hypothetical presence of a secondary
 18 device, yes.
 19 Q. And again, we don't need to go into the detail of it for
 20 the reasons you gave at all, but certainly that needs to
 21 be thought through, does it not?
 22 CHRISTIAN COOPER: Yes.
 23 Q. Not only in terms of individual response services
 24 identifying what their tolerance levels are, but
 25 understanding what that means in terms of the overall

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1 response and the ability to get the right people into
 2 the right locations?
 3 CHRISTIAN COOPER: Yes, I agree, yes.
 4 Q. Because in terms of the risk assessment, does it not
 5 come down to identifying what the risks are, what is
 6 needed in a particular location, and therefore who can
 7 and can't go there?
 8 CHRISTIAN COOPER: Yes.
 9 Q. Because it is never just a question of, "There are these
 10 risks and therefore certain people can't go in", there
 11 always has to be an assessment of, "But there are people
 12 in there who need help"?
 13 CHRISTIAN COOPER: Yes.
 14 Q. And clearly, the most effectively way of dealing with
 15 that is for there to be a joint discussion between
 16 people, pooling their knowledge, pooling their
 17 assessments of risk to come to an overall view as to
 18 what needs to be done and who can do it?
 19 CHRISTIAN COOPER: Yes and it's envisaged within that
 20 doctrine that that joint approach to risk accepts the
 21 fact that you cannot mitigate risk to zero, effectively.
 22 You're going to have to tolerate a certain degree of
 23 risk.
 24 When you've got different individuals and different
 25 organisations whose risk tolerance may differ, it's

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1 critically important that a joint assessment,
 2 understanding and hopefully agreement on that risk
 3 results from that joint approach of sharing your
 4 concerns, sharing what your understanding of the risk
 5 is, and coming up with a common way forward.
 6 Q. So taking an MTA example, certain emergency services
 7 arriving at a location, the police able to inform the
 8 Ambulance Service, the Fire Service, "This is the area
 9 where there are casualties, we have armed police
 10 securing all the doors in and out of that location,
 11 there is no shooter in there", so that the other
 12 services can understand who they can then send in?
 13 CHRISTIAN COOPER: Yes.
 14 Q. And equally, with an IED, "This is what's happened, this
 15 is what we've been able to do in terms of checks, this
 16 is our assessment", and then people can come to a view?
 17 CHRISTIAN COOPER: Yes.
 18 Q. If you don't have that pooling, there is a very clear
 19 risk that an individual service will get its assessment
 20 wrong?
 21 CHRISTIAN COOPER: Yes.
 22 Q. And people who need help will not get help as a result?
 23 CHRISTIAN COOPER: Yes.
 24 Q. And to an extent that's what happened here, isn't it?
 25 CHRISTIAN COOPER: I agree.

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

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

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

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

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

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

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

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

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1 members of the public, by police officers .

2 CHRISTIAN COOPER: Yes.

3 Q. In terms of good practice, triage should not exclude

4 those who have been covered, should it?

5 CHRISTIAN COOPER: No, quite the opposite. Paramedics are

6 trained within their triage process that whatever else

7 has been done to that casualty, it's their job to

8 conduct their assessment of that casualty and to

9 categorise them accordingly.

10 Q. In fairness, NWS's major incident plan makes that very

11 point, does it not --

12 CHRISTIAN COOPER: It does.

13 Q. -- in the context of triage?

14 There was, as you will have seen, differences of

15 approach between the three who were in the room doing

16 triage as to their approach to people who were covered

17 over. Mr Hargreaves, by way of example, had presumed,

18 he explained, that the covering over had been done by

19 Mr Ennis, who had been there first --

20 CHRISTIAN COOPER: Yes.

21 Q. -- and said in terms, if he had appreciated it had been

22 done by anybody else, he'd have gone in and checked

23 again.

24 CHRISTIAN COOPER: Yes. I think to give some credit there,

25 I think part of the problem was that Mr Ennis didn't

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1 have the initial triage labels or cards that were used

2 to grade. So it's a reasonable assumption of

3 Mr Hargreaves that in the absence of having those cards,

4 Mr Ennis has still performed some triage functions, but

5 he's then not to know how Mr Ennis has categorised those

6 casualties. Arguably, in the face of such confusion, if

7 you do have the cards with you and you have a way to

8 mark the casualty properly, assess and mark the

9 casualty. You certainly shouldn't be marking the

10 casualty with a formal card without undertaking the

11 assessment for yourself.

12 Q. So in terms of learning points, firstly the importance

13 of having the cards if you're going to undertake triage

14 because it produces that certainty as to the assessment

15 of who has been assessed and what they've been assessed

16 as?

17 CHRISTIAN COOPER: Yes.

18 Q. And secondly, perhaps in terms of the action cards that

19 address triage and the ready reckoners that address

20 triage, they don't, perhaps because of space, include

21 that contemplation of those who are covered that the

22 major incident plan has -- do you think that it would be

23 helpful, just because people are dealing with these

24 things under pressure, for it somewhere to be said on

25 those kind of action cards: if someone is covered over,

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1 you still need to check unless they have a label on?

2 CHRISTIAN COOPER: I agree. I think it would be beneficial

3 for that to be explicit, yes.

4 Q. The next stage in the process is then to identify what

5 needs to be done in relation to those who have been

6 triaged and to devise a scheme that makes sure that

7 those who need to be got out the most are the ones who

8 leave first.

9 CHRISTIAN COOPER: Yes.

10 Q. Again, is that a responsibility primarily for the

11 Ambulance Service in dealing with a situation such as

12 this?

13 CHRISTIAN COOPER: Yes, and that was in our contemplation

14 when we considered additional HART numbers in the room.

15 You could argue that any number of resources is not

16 going to be enough to assist you to deal in that room

17 quickly, and would a small increase in the number of

18 HART staff have really made much difference? In our

19 conclusion we say yes because in addition to that triage

20 process, there is the requirement in those circumstances

21 to robustly manage the extrication of casualties because

22 a number of different people were making best efforts

23 and what that was perhaps crying out for was

24 a confident, coordinated approach to the extrication of

25 those casualties.

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1 Now, that is something that HART, perhaps more than

2 any other group within the Ambulance Service, train

3 regularly to do. They are very confident in that

4 regard. They are used to operating within a team of six

5 and it's our view that if you had five HART operatives

6 within that room and then a sector commander, their team

7 leader, right at the edge overseeing that overall

8 response, we think the management of the extrication of

9 those casualties, even if that was being facilitated by

10 other people, police, members of the public, that that

11 would have been more coordinated and more robustly

12 managed and more closely aligned to the triage system

13 being put in place by the Ambulance Service, by those

14 two initial HART paramedics that were moving through.

15 I think that's what we envisaged when we said that's

16 the real difference that would have been made by the

17 relatively small increase in HART staff had they been

18 deployed into that room.

19 Q. Potentially you'd have had more of them able to do the

20 triage in the first place?

21 CHRISTIAN COOPER: Yes.

22 Q. Secondly and importantly, you'd have had the

23 identifiable people there who were in charge of saying,

24 "This is the person who needs to leave next"?

25 CHRISTIAN COOPER: Yes. And HART staff, unlike other front

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

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

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

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

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

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

13 CHRISTIAN COOPER: Yes.

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

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

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

3 CHRISTIAN COOPER: Yes.

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

9 CHRISTIAN COOPER: Yes.

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

15 CHRISTIAN COOPER: Yes.

16 Q. But in fact they didn't?

17 CHRISTIAN COOPER: No.

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

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

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

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

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

21 CHRISTIAN COOPER: I would agree.

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

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

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

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1 sir.
 2 MR GREANEY: Sir, it's a good deal earlier than normal, but
 3 we will need to have a short break at this stage,
 4 following which Mr Cooper will ask his questions on
 5 behalf of the families that he represents. Ten minutes
 6 will suffice.
 7 SIR JOHN SAUNDERS: Ten minutes, thank you very much.
 8 (2.30 pm)
 9 (A short break)
 10 (2.48 pm)
 11 SIR JOHN SAUNDERS: Sorry to keep you waiting.
 12 MR GREANEY: I'm going to ask Mr Cooper to pose his
 13 questions next, please.
 14 Questions from MR COOPER
 15 MR COOPER: Thank you. Indeed, we have a proliferation of
 16 Mr Coopers here.
 17 So Mr Cooper, can I refer the questions to you, but
 18 obviously to both of you. You've been given advance
 19 notice of this short area that I'm going to be asking
 20 you about. Let me firstly deal with the witness
 21 statement, the third witness statement of
 22 Mrs Figen Murray. It's {INQ041919/1}. It's typed with
 23 a date of August 2020, and probably needs to be amended;
 24 in fact it was made in August 2021. But that's just so
 25 we can get the dates clear. In fact, it's a statement

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

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

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

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

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

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

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

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

15 "Deaths through bleeding out or catastrophic
16 bleeding could be significantly reduced if these kits
17 were available at as many venues as possible.

18 I personally carry on kit in the back of my car. It
19 gives me reassurance that if I was, for instance,
20 a witness or indeed to be involved in a serious road
21 traffic incident that I have the kit available or I or
22 someone else could use it.

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

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

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

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

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

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

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

25 "There are, however, similar packs at much reduced

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

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

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

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

14 CHRISTIAN COOPER: Yes, we have, three.

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

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

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

7 "I emphasise again these kits save lives and I will
 8 wholeheartedly support any positive move to introduce
 9 them as widely as possible. Yes, there may be a cost to
 10 these kits, but there is no greater cost than losing
 11 a loved one. Any cost spent in preparedness is an
 12 investment worth making so that other families do not
 13 have to experience what my family and the families of
 14 21 other innocent victims have had to endure."

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

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

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

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

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

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

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

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1 I think the more widely available that sort of kit
 2 is — and if we can change the mindset and people can
 3 start to think that a first aid kit should include
 4 provision to deal with catastrophic hemorrhage, I think
 5 that would be an entirely positive thing.
 6 Q. In terms of the projected costs of these packs you have
 7 both seen two examples of them. Would you accept, for
 8 what they do, particularly those starting nearer the £20
 9 price range, they are cheap at the price?
 10 CHRISTIAN COOPER: I am not at all surprised at the cost and
 11 I think that's reasonable. I think what did strike me,
 12 and I don't want to stray in any way into some kind of
 13 endorsement here, but what I was struck by, looking at
 14 those packs — and I've seen similar packs before,
 15 perhaps not as recently as that, is the instruction
 16 cards within that now for both the CAT tourniquet and
 17 the pressure dressing — I mean, myself and Mike had
 18 a good play with those outside earlier today and I think
 19 most members of the public with those sorts of basic
 20 instruction cards would be able to successfully apply
 21 a pressure dressing and a CAT tourniquet. So there's
 22 clear attempts there within those kits to cater for
 23 a complete novice to be able to put one on.
 24 Looking at what's in those two packs, as an example,
 25 I think that is probably achievable.

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1 Q. I wonder if you would like to add anything or endorse
 2 what you've heard —
 3 MICHAEL HERRIOT: Thank you very much for introducing this
 4 initiative to us, of which clearly we're both very
 5 supportive.
 6 I think it might be worth just exploring some other
 7 background information. For example, if you call 999
 8 for an ambulance, as you know, you'll get pre-arrival
 9 advice. So I would certainly think it would be
 10 beneficial exploring the opportunity for ensuring that
 11 a person could get signposted to one of these kits
 12 in the same way as they would be signposted to
 13 a defibrillator, so that's something perhaps to explore.
 14 And also ensuring there's a standard specification.
 15 Certainly the way the Ambulance Service approaches these
 16 things is to take a specification and then get someone
 17 to figure out how to make it. Obviously part of that
 18 would be the cost of the individual piece of kit. So it
 19 may be worth having conversations again around how that
 20 could be achieved rather than buying an off-the-shelf
 21 solution, for example.
 22 Q. Before you go on to any other points you'd like to
 23 raise, we are obviously concerned primarily here with
 24 the tragedy that occurred at Manchester Arena. How
 25 do you think these particular kits could be used and

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1 made available to the public in the context of the arena
 2 situation and in particular the City Room situation?
 3 MICHAEL HERRIOT: Of course we're aware that members of the
 4 public did a fantastic job, a really commendable and
 5 brave job, trying to assist in those circumstances, but
 6 of course they were hampered by the status of the
 7 equipment that was available to them. Many mentioned
 8 that the first aid kits were inadequate. And whilst the
 9 Ambulance Service did have suitable equipment, quite
 10 rightly it's mentioned in the paper that they weren't to
 11 arrive immediately, so there's that therapeutic vacuum
 12 for a time.
 13 Q. Thank you.
 14 MICHAEL HERRIOT: As I say, because the Ambulance Service is
 15 able to give advice as well, that is another feature
 16 perhaps that could be explored.
 17 I think clearly, when we look at public access
 18 defibrillators, there are various mechanisms in place to
 19 look at the expiry date and whether the machine is
 20 working properly and that sort of thing. There's no
 21 reason why this couldn't be built into that sort of
 22 regime, I wouldn't have thought, so perhaps that's worth
 23 exploring as well.
 24 Finally from me, training. I absolutely welcome
 25 training in this aspect. But I think it would be good

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1 if that could be built in around simple, immediate
 2 life-saving training and not just in isolation around
 3 stopping the bleed. I hope that's helpful.
 4 Q. That's very helpful, I'm sure the inquiry finds it
 5 helpful. In many respects —
 6 SIR JOHN SAUNDERS: As you've asked whether I find it
 7 helpful, let me interrupt: I do find it helpful. It is
 8 clearly something I would consider as a recommendation.
 9 There was suggested there may be difficulties and
 10 practicalities. Can I invite both the experts to give
 11 me something in writing, not only dealing with what the
 12 advantages are but also what other things need to go
 13 with it, what needs to be considered with it and what
 14 the difficulties are as to practicalities? Of course,
 15 I would invite anybody else with the medical knowledge
 16 to do the same and help me if they can. So thank you
 17 very much for the idea and I will certainly take it on
 18 board.
 19 MR COOPER: Sir, I didn't mean to usurp your function when
 20 I said the inquiry finds it helpful. I rather made an
 21 assumption.
 22 SIR JOHN SAUNDERS: I would never believe for a moment you'd
 23 usurp my function, Mr Cooper. It didn't enter my mind.
 24 MR COOPER: Being such a simple pack, it could be taught in
 25 schools, couldn't it?

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

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

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

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

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

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1 (3.15 pm)
 2 (The hearing adjourned until 11.00 am
 3 on Wednesday, 15 September 2021)

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

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