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Structured Debrief Report

Major Incident

Incident/Event	Major Incident	Date	29/07/24	Incident Reference No.	
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Debrief Location	JCC Silver Conference Room	Date & Time	27/01/2025
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OLH Reference No.	
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Debrief Commissioned by	
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FOI	
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Debriefing Officers			
Facilitator	James Ellerton	Additional	Jay Hannon
Scribe	Jo Ross	Additional	

Debrief Summary	

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Debrief Participant List			
<i>(Order is not indicative of the assigned numbers, participants are listed alphabetically, assigned numbers are randomly allocated)</i>			
Allocated Number	Name	Organisation	Role
1	I&S	Merseyside police	Ch/ Inspector Custody
2		Merseyside police	Response Inspector Sefton
3		Merseyside police	CH/inspector Sefton
4	Neal Arrowsmith	Merseyside police	FIM
5	Andy Hughes	Merseyside police	FIM
6	I&S	Merseyside police	Supt Productivity Programme Lead
7		Merseyside police	Call Taker JCC
8		Merseyside police	Call Taker JCC
9		Merseyside police	Ch/ Inspector Knowsley LP

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Recommendations

No.	Recommendations	Owner	Comments
1	No training can prepare for a call like that. Thought it was run well in the FCC on call handling side. Processes worked. Welfare was considered by supervisors. Consideration of standing staff down if opportunity is there following incident. Check on all of the staff who were in the room, not just ones who dealt with the call.		
2	Having all call handlers in one site will be an advantage due to multiple calls and supervisor managing incident.		
3	Consider training for further calls being documented on the log so can be differentiated on that same log. Consider using different colour text for different calls.		
4	Further training and identify a process to capture information coming in on multiple logs. Use of banner facility. Consider use of warning lights for incidents such as this with multiple logs.		
5	Be more lenient with response times. News and comms team to put out notice of dealing with major incident and consider calling police only if genuine emergency. Trigger plan for major incidents.		
6	Use of major incident plan going forward. Review contents to develop prompts for considerations. Commanders to have ability to divert non-urgent calls.		
7	Identify strand SPOC's for every strand to mobilise officers. Plan needs to be streamlined. Identification of a rota.		
8	Review of bronze POPS deployments / criteria / training. Consideration of accreditation for POPS.		
9	Use of mass messaging service force wide or specific groups depending on needs.		
10	Review of functional model		
11	Consideration of further training for CIM's, review of deployment of bronze's		
12	Good practice re FIM model.		

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No.	Recommendations	Owner	Comments
13	Good practice of sharing workload – is there too much placed on Gold?		
14	Identify who is best placed to take command from CIM at scene during major incidents. If POPs are going to do this, need further training or experience. Consider the FDO role being reinstated alongside the FIMs		
15	Location of ARV's to be reconsidered. Should be more central to force. Review location of Ops Support functions		
16	Investigations to consider who is currently in command of the incident prior to making decisions and communicate. Joint exercises to take place between R&P, command and investigations. Better communication required.		
17	Additional workstation in the FIM's office for control room supervisor and for investigations to consider who is currently in command of the incident prior to making decisions and communicate. Joint exercises to take place between R&P, command and investigations. Better communication required his procedure to be used.		
18	Additional workstation in the FIM's office for control room supervisor and for this procedure to be used.		
19	Have pre-defined RVP locations which are assessed for suitability which is constantly reviewed.		
20	Mobilisation of officers from other strands to cover BAU. Consider inclusion in major incident plan.		
21	Review of command structure resilience and deployment		
22	Consider vehicle for on call bronze with emergency equipment		
23	Keep doing unarmed first responder training. Tabletop exercises rather than e-learning. Consider this as part of first line leaders course. Consider Stay Safe input or scenario on PPST.		
24	Standardise way of record keeping. Utilise loggist for Bronze and FIM's.		
25	Senior leadership follow up and visibility to be improved and better attention to detail on public and internal reports and statements.		
26	Response from RPU brought a lot of capabilities to the scene.		
27	Training for officers on arrival at scene, access and egress right from the start		

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No.	Recommendations	Owner	Comments
28	Consider standardised/realistic approach for exercises. Information to be sent to bronze from TCG for full updates.		
29	Further multi-agency exercises. Consider asking for confidence level on information being provided.		
30	Better knowledge and understanding of resources from all agencies.		
31	Consideration for separate roles for resilience		
32	Consideration of health and safety entering building – face mask and/or gloves if do not know what we will find behind the door.		
33	Better communication around wider exposure		
34	Consider wider impact for debrief invites		
35	Further training required for CBRN search staff		

Areas for improvement

No.	Area for improvement	Identified by	Recommendation Number	Comments
1	Call handler takes call from witness. Obtained details from them, can hear screams from inside premises. Talked the witness through, was handed a dead child. Tried to help witness by keeping calm. Number of 999 calls coming in. Appeared to be enough call handlers to take the calls. All linked to one log for Hart Street. Process in place already for multiple calls coming in and the supervisor is notified.	7,8	1	No training can prepare for a call like that. Thought it was run well in the FCC on call handling side. Processes worked. Welfare was considered by supervisors. Consideration of

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	Supervisor amalgamated the logs and was run off the one. Concern for the officers going to scene. Once officers at scene, call handler terminated the call. Had another teams supervision during the incident due to changeovers. Staff who were not on duty turned up for duty in order to relieve colleagues who had dealt with the incident.			standing staff down if opportunity is there following incident. Check on all of the staff who were in the room, not just ones who dealt with the call.
2	Call handlers were still on two sites – Mather and JCC. Multiple calls coming in.	7 / 8 / 9	2	Having all call handlers in one site will be an advantage due to multiple calls and supervisor managing incident.
3	When log comes in, difficult so follow at times and when multiple calls coming in, have to look at open door numbers to see what information is coming from the same or different calls. Varying styles of how the logs are populated – i.e. capitals.	4 / 5	3	Consider training for further calls being documented on the log so can be differentiated on that same log. Consider using different colour text for different calls.
4	Time it takes to arrange logs, identify all relevant information for ITFCs and other decision makers can make it difficult to make those decisions as information is scattered across logs until a working log is identified.	6	4	Further training and identify a process to capture information coming in on multiple logs. Use of banner facility. Consider use of warning lights for incidents such as this with multiple logs.
5	Calls still coming in for usual business and public getting abusive over the phone due to no police attendance as all resources are already deployed to major incident.	7 / 8	5	Be more lenient with response times. News and comms team to put out notice of dealing with major incident and consider calling police only if genuine emergency. Trigger plan for major incidents.
6	Major incident plan was not in place at the time – one is about to be signed off following MEN inquiry.	4 / 6	6	Use of major incident plan going forward. Review contents to develop prompts for

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No.	Area for improvement	Identified by	Recommendation Number	Comments
				considerations. Commanders to have ability to divert non-urgent calls.
7	Strands had to identify critical functions during covid. Before scaling back services, should ensure efficiency throughout all strands and only critical functions. No strand SPOC's for contacting to put this in motion. Of a weekend, we are easy to move as a force. During the week, this is not the case and we need this flexibility throughout every day. Identify priority of major incident, then calls for service, anything after that needs to be put on hold – such as community events etc, until normal service can resume.	9	7	Identify strand SPOC's for every strand to mobilise officers. Plan needs to be streamlined. Identification of a rota.
8	Some command team officers are dealing with business as usual and are not informed of the incident. Officers dealing with basic functions such as statements etc, will not routinely deploy without instruction. Duty bronze is not necessarily best placed to make to the incident due to geographical nature. Communication was not in place.	3 / 9		See 10
9	Training on bronze POPS course did not link to anything dealt with on the day at the incident. Officer used previous knowledge and experience of how to deal with the incident. Bronze role may not be most appropriate for incidents such as this.	9	8	Review of bronze POPS deployments / criteria / training. Consideration of accreditation for POPS.
10	When major incident is running, resilience direct emails come out with the information available. But not everyone is signed up to this to receive the emails.	2 / 5 / 1	9	Use of mass messaging service force wide or specific groups depending on needs.
11	Force not dealt with incident of this nature before as a force. Functional model for the force does not work in this situation. Sefton previously would have led the incident with support from other areas. However it was geographical and did not run well. Considering savings the functional model is good for the force, however for responding to incidents it does not work.	6	10	Review of functional model
12	Duty Supt is generally used for authorities in PACE.	4/6/9		

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13	Bronze at scene was in charge, was getting phone calls, radio requests and questions in person. Too much for one person to manage and would be better divided up. There is a lot of responsibility initially on the CIM until support arrives – are the CIM's qualified/trained enough to manage this. CIM's can hand over control to CH Insp's etc with less experience, when the CIM's are better placed and experienced to manage the scene and incident.	9	11	Consideration of further training for CIM's, review of deployment of bronze's
14	No major improvement points. 2 FIM/FDO model worked well. Arena enquiry recommended 2 FIMs and does work better. On Call worked well, had a rota but this was during office hours, so was easier to get hold of people who were on duty to inform and deploy. Supt Wilson was Gold and SFC. IM sent for initial notification from FIM to Supt as needed to know straight away. However FDO role no longer exists and may be a gap here.	5 / 9	12	Good practice re FIM model.
15	SFC offered to take command if required from Supt Wilson. This was agreed in order for better focus on tasks. This was from experience of Showcase Cinema incident as knew that the amount the Gold would need to do was a lot on top of SFC.	6	13	Good practice of sharing workload – is there too much placed on Gold?
16	Initial response from CIM was managed. The next rank up then attended scene. During MEN enquiry this was shown not to have happened. We managed this well with the deployment of POPS bronze, however there is no FDO making to scene due to the current model.	5 / 9 / 3 / 6	14	Identify who is best placed to take command from CIM at scene during major incidents. If POPS are going to do this, need further training or experience. Consider the FDO role being reinstated alongside the FIMs
17	Instructions from FIM were unarmd to scene as cant wait due to public safety. Not an option to wait for ARV's to attend. One ARV was carrying out enquiry at the airport. Considered multiple attackers, consideration of Plato.	5 / 4	15	Location of ARV's to be reconsidered. Should be more central to force. Review location of Ops Support functions
18	Length of Sefton area and distances are too far. Lack of staff within Sefton area to provide efficient response. Underestimate the distance between Crosby and Southport.	3		See 17.

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19	FIM's considered Lancs ARV request however our were satisfied could treat as BAU and no further required as one suspect and was detained at scene. Lancs FIM did offer more resources and moved close to border incase required. Did question if this was part of a wider attack, but no information to suggest otherwise.	3		Good practice from neighbouring force and our FIM's
20	Command structure did consider wider picture of MTA, victims at home address of suspect. Protocols in place to assist with deployments of ARVs and cross boarder resources. Investigations wanting to secure house as a scene, but due to unknown information there was still an armed operation ongoing and this was not safe to do so. This also happened following IED at the womens hospital, and there was dangerous items at the address.	6 / 4	16	Investigations to link in with FIM's and consider wider picture. Protocols for command structure worked well.
21	Welfare was considered for ARVs attending and officers came in through good will to backfill. There was nothing in place to ensure this happened to maintain ARV numbers if this good will was not there. Officers in ARVs who dealt with scene were sent to another part of the incident, asked if ok to continue and all said yes. Lancs helped with resources but officers had to deploy to this further matter before returning to OCC.	6		
22	When investigations arrived at scene, Supt level, the operation was still ongoing. None of them identified as SIO	9		See 23
23	Officers being sent to hospitals. Family reception centre set up, bronze was asked for a form of words to use on their arrival. Supt arrived from investigations but did not take control of any of this. Investigations didn't want officers making their own statements but was not enough staff to take all statements. Investigations putting unnecessary pressure on live ongoing incident.	9 / 3	17	Investigations to consider who is currently in command of the incident prior to making decisions and communicate. Joint exercises to take place between R&P, command and investigations. Better communication required.
24	No communication from silver of who has command of incident following the firearms command scaling back.	5	18	Additional workstation in the FIM's office for control room supervisor and for this procedure to be used.

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25	RVP set as Southport police station. Not feasible for this incident.	4	19	Have pre-defined RVP locations which are assessed for suitability which is constantly reviewed.
26	PSU came from Lancs following request and further sent using cross border protocols. Bronze wanted to use them for wider disruption purposes, but they were taken back to Lancs and did not deploy as per this request. They were deployed to Meols Cop and on standby. When wanted to deploy them they were told no.	9 / 2		
27	Model we use has a weakness due to amount of inspectors we have. CIM was deployed to scene. There was no contingency for cover on BAU. This was reflected across all other areas of business. No resilience in R&P at all, so when major incident is factored in it is not feasible.	5 / 9 / 3	20	Mobilisation of officers from other strands to cover BAU. Consider inclusion in major incident plan.
28	Cons deployed to the incident from the force, however command structure above was lacking and there was limited deployment apart from personalities and willingness, rather than as part of the command structure.	9	21	Review of command structure resilience and deployment
29	Duty/on call bronze vehicle. Has own kit in car currently has makes to incidents if required. Other on call have vehicles and there should be the same for the bronze incident commander	3	22	Consider vehicle for on call bronze with emergency equipment
30	Response from ACR, officers on the ground, was very good. Difficult to say what we could have done better that day. If it had been multiple offenders, would it have been as effective as it was. Support that was available from other forces, areas, depts was good. Preparation work prior to the incident before we knew anything about it has been good. Unarmed first responder training was in place. JESIP training vital throughout all services.	2 / 6	23	Keep doing unarmed first responder training. Tabletop exercises rather than e-learning. Consider this as part of first line leaders course. Consider Stay Safe input or scenario on PPST.
31	Difficult to take notes / record of decisions. Different methods of recording information. BWV wouldn't have kept enough battery for length of incident. Bronze needs loggist to take notes. Possible use of high capacity BWV camera.	2 / 3 / 9	24	Standardise way of record keeping. Utilise loggist for Bronze and FIM's.

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32	Welfare was there, but staff have gone off sick without being debriefed. Tried to capture as much as possible. Lack of visibility of senior officers post incident. Meetings now on teams and therefore lack of visibility from leaders. NPCC ranks were there for PM visit, but did not visit first responders. Lack of understanding of involvement and who first responders were from senior officers.	2 / 3	25	Senior leadership follow up and visibility to be improved and better attention to detail on public and internal reports and statements.
33	Roads policing bikes were good, being able to get ambulances out and to hospitals. Only through luck – the road was wide and assisted with access and egress. Smaller terrace type street would have been more difficult to deal with. RPU also brought FLO capabilities which was invaluable at the scene.	2 / 3	26	Response from RPU brought a lot of capabilities to the scene.
34	Police vehicles were just stopped in the street and it could have been thought of better as access and egress was limited.	2	27	Training for officers on arrival at scene, access and egress right from the start
35	Ambulance commander approached bronze provided a wrong casualty list. Stated only 1 deceased. Then Insp [redacted] informed him that there was multiple deceased. Unknown where this had broken down and why the ambulance information was so wrong. Roles were tasked out to other agencies for JESIP / ETHANE principles. This did not happen. Ambulance heavily depend on police for major incident. Extremely difficult scene to deal with due to dynamics, details and people involved.	9	28	Consider standardised/realistic approach for exercises. Information to be sent to bronze from TCG for full updates.
36	No flexibility with MFRS and NWAS and apparent lack of understanding of JDM. There is not enough information to have a JESIP meeting, but they are calling one straight away. Appears that they are very rigid to the manual and do not wait for information to develop. Sometimes need more detail before making command decisions.	4	29	Further multi-agency exercises. Consider asking for confidence level on information being provided.
37	Asked NWAS if had enough trauma kits and never got a straight answer on this. There was enough through multi agency, however NWAS did not provide this information. NWAS also stated that 'Fusion' had been stood up, and it actually hadn't.	2 / 9	30	Better knowledge and understanding of resources from all agencies.

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38	Only 3 CBRN silver commanders. No resilience within the force. Most CBRN commanders within the country are also POPS commanders. CBRN staff are also POL2 or equivalent. Nationally there was no resilience for CBRN staff or commanders.	1	31	Consideration for separate roles for resilience
39	A number of officers had entered suspects bedroom during contain and call out. This exposed them to ricin. Once it was actually identified as ricin and officers were tracked down, one of the officers was shown signs and symptoms of exposure. No CBRN information at all to suggest this prior to the deployment to the house.	1 / 6	32	Consideration of health and safety entering building – face mask and/or gloves if do not know what we will find behind the door.
40	Lack of communication with officers who dealt with suspect and fear of exposure to ricin.	3	33	Better communication around wider exposure
41	CBRN staff were not considered/invited to debrief's	1	34	Consider wider impact for debrief invites
42	CBRN teams worked extended shifts on the scene due to lack of CBRN search staff	1	35	Further training required for CBRN search staff
43	Non declaration of CT incidents caused significant issues. SO15 were not required, but wanted to be involved. They stopped the army assistance. SO15 wanted to run the investigation however as it wasn't a CT incident, were not able to and caused Merseyside Police issues.	1		
44	Handling of ricin from various agencies worked well, from initial identification through to the lab.	1		Good practice identified.
45	Reward and recognition – call handlers often forgotten about	8		All staff to be identified for recognition

Areas of Good Practice

No.	Area of good practice	Identified by	Recommendation Number	Comments
1	Handling of ricin from various agencies worked well, from initial identification through to the lab.	1	1	Good practice identified.

