

THE SOUTHPORT INQUIRY

WITNESS STATEMENT OF DANIEL AINSWORTH

I, **Daniel Ainsworth**, will say as follows:

Introduction

1. I am employed by North West Ambulance Service NHS Trust ("**NWAS**" or "**the Trust**") as Director of Operations. I have been employed by NWAS since 2014 joining as an Operations Manager for the 111 service. I held a number of senior management roles before I took up my role as Area Director of Integrated Contact Centres ("**ICC**") in May 2022. I became the Director of Operations on 1 July 2024.
2. As Director of Operations, I am also the Accountable Emergency Officer. In that position I am accountable for ensuring that the Trust is properly prepared for any relevant emergency and that the Trust complies with the requirements relating to emergency preparedness in its service contracts with the NHS Commissioning Boards.
3. This statement is provided to assist the Southport Inquiry (the "**Inquiry**") in response to the matters set out in the Rule 9 Request dated 8 July 2025. I was not involved in the NWAS response to the attack that took place in Southport on 29 July 2024. This statement is intended to provide a factual narrative of the NWAS response to that attack. I confirm that this statement has been prepared with the assistance and benefit of contributions from others across the Trust including colleagues from the Emergency Operations Centre, clinical colleagues and those from the Resilience and Contingency Planning Team.

4. I would firstly like to take this opportunity to offer my most heartfelt condolences to the families of Alice, Elsie and Bebe for their loss. My thoughts remain with them and all those who were injured or have been affected by the horrific events that occurred in Southport on 29 July 2024.
5. Before I detail any matters pertaining to the 29 July 2024 itself, in order to assist the Inquiry I will set out a background of how emergency calls are received and managed and how resources are allocated and dispatched to an incident.

Management of Emergency Calls

6. NWAS has three Emergency Operation Centres (“**EOC**”) located across the North West, all of which are staffed 24 hours a day, 365 days a year. In general terms, the EOC is a call receiving and resource dispatch centre which manages emergency and other health related calls.
7. 999 call handling is managed virtually across the three EOC sites, meaning each EOC receives and manages 999 calls for patients across the North West, with calls automatically routed to an available Call Handler regardless of their geographical location. This provides resilience in managing high call demand across the region. Virtual call handling is standard across all English ambulance services and indeed, it allows ambulance services to take emergency calls for each other in certain circumstances. All of the emergency calls in relation to the Southport incident were managed by NWAS.
8. When an emergency 999 call is made by the public, callers will be connected to BT Operations and asked to state the emergency service(s) that they require. When a call is identified for the ambulance service, BT connects the caller to their local ambulance service.
9. As soon as the call connects to NWAS, it generates a record within the NWAS C3 Nexus system. C3 Nexus then electronically searches through the Enhanced Information Service for Emergency Calls (a BT managed database), historical data on C3 and an Advanced Mobile Locator to find a location for the call. This process takes a matter of seconds and can occur by the time the emergency call has been answered by the NWAS Call Handler.

10. Once answered, the Call Handler asks the caller some pre-triage questions to establish if the patient is breathing, conscious and if they have noisy breathing. This is in line with NHS England (“**NHSE**”) Ambulance Response Programme national standards and helps to identify patients who need the fastest response, before a full triage commences.
11. Once these initial pre-triage questions have been asked and answered, in order to confirm the location of the emergency the Call Handler will ask the caller for the address of the emergency. The information provided is matched with the automatically generated information as described in paragraph 9 above. The Call Handler will then ask the caller to tell them exactly what has happened before commencing the triage of the call.
12. NWAS uses the NHS Pathways telephone triage system which is one of two triage systems licenced and authorised by NHSE for use in the UK. The other licensed triage system is the Medical Priority Dispatch System (known as “**MPDS**”). NWAS previously used MPDS but undertook a phased introduction to NHS Pathways during 2022 as this system supports the remote assessment of urgent calls made to 111 and emergency calls made to 999, both of which are managed by NWAS in the North West region.
13. The NHS Pathways system was developed by and continues to be maintained by a group of experienced NHS clinicians, most with an Urgent or Emergency Care background. The system supports the remote assessment of over 16 million calls per annum. NHS Pathways is owned and managed by the Department for Health and Social Care (“**DHSC**”).
14. The NHS Pathways system presents a series of questions to the Call Handler to determine the most appropriate clinical response or disposition. A disposition will specify the level of care and response time frame that a patient needs. Questions are presented to the Call Handler according to clinical hierarchy; meaning that life threatening scenarios are enquired about at an early stage of the call, through to less urgent symptoms as the call progresses. The NHS Pathways system is an interlinked series of algorithms/pathways which link questions and items of care advice leading to clinical endpoints, known as a ‘disposition’.

15. The NHS Pathways system is broadly divided into three modules: Module 0, Module 1 and Module 2. The system is symptom-based and not diagnostic.
16. Module 0 provides a rapid means of assessing immediately life-threatening cases such as unconsciousness, not breathing, choking and fitting as well as serious conditions based on a caller's declaration such as heart attack, stroke, anaphylaxis or blood sugar problems. If symptoms are sufficiently serious, answers to Module 0 questions will trigger dispatch of an emergency ambulance. No further questions or consideration of conditions or body areas is needed at this point.
17. Module 1 contains a body map of a gender and age relevant human body which presents the Pathway related to that body area or body system. The Pathway which is selected by the Call handler is determined by the caller's report of the main or worst symptom. Where there is no easily identifiable main or worst symptom, the Call Handler should seek clinical advice.
18. The NHS Pathways system will then present various questions to be asked about the patient. Each answer will determine the next question asked until a disposition is reached, the call is ended early or the call is handed over to a Clinician. The questions continue in a hierarchical order and so generally speaking the more questions asked the less severe the symptoms.
19. Emergency calls may also be presented from other sources, including other emergency services. For calls from other emergency services, NWAS uses the NHS Pathways Attend Incident function. This presents differently and the Call Handler will record the nature of the incident and then select the categorisation based on the information provided. For a medical or trauma related incident, the options available are a Category 1 for an immediate threat to life, a Category 2 for major trauma, a medical incident involving an unconscious adult, heavy bleeding or someone fighting for breath for example, and a Category 3 response for any other medical or trauma related incidents.
20. NWAS has a dedicated line for calls from Police control rooms. This separate, dedicated line prevents Police calls from taking up 999 call handling capacity and facilitates the

direct flow of information between the two services, for example providing updates from scene or requests for additional information such as estimate arrival times etc.

21. NHS Pathways dispositions have unique codes which are mapped to the national Ambulance Response Standards dispatch categories, which are set by NHSE. There are four response categories as detailed below: -
 - a. Category One – life-threatening calls. We aim to respond to these calls on average within seven minutes, and at least nine out of ten times within 15 minutes. These calls represent a time critical life-threatening event needing immediate intervention and/or resuscitation e.g. cardiac or respiratory arrest; airway obstruction; ineffective breathing; unconscious with abnormal or noisy breathing; or hanging.
 - b. Category Two – emergency calls. We aim to respond to these calls on average within 18 minutes and at least nine out of ten times within 40 minutes. These calls are potentially serious conditions that may require rapid assessment, urgent on-scene intervention and/or urgent transport.
 - c. Category Three – urgent calls. We aim to respond to these calls within 120 minutes at least nine out of ten times. These patients may be treated by ambulance staff at the scene. Category Three calls represent an urgent problem (not immediately life-threatening) that needs treatment to relieve suffering (e.g. pain control) and transport or assessment and management at scene with referral where needed within a clinically appropriate timeframe.
 - d. Category Four – less urgent calls. We aim to respond to these calls within 180 minutes at least nine out of ten times. These calls are for problems that are not urgent but need assessment and possibly transport within a clinically appropriate timeframe. Onward management is locally agreed and may include a referral to an alternative appropriate service.
22. The mapping of the NHS Pathway disposition to the NHSE approved response category is undertaken and nationally approved by the Emergency Call Prioritisation Advisory Group (“ECPAG”) which is made up of representatives from across the urgent and

emergency care system who have oversight of such mapping for both NHS Pathways and MPDS.

23. Call Handlers should seek to use local policies in conjunction with the triage system. Call Handlers also have access to remote support via the Non-Clinical and Clinical Hunt Advice Line should they need further support and guidance whilst dealing with a 999 call.
24. Each 999 call received into NWS is logged within the Computer Aided Dispatch (“CAD”) system. Each call is assigned a unique incident number. Subsequent calls in relation to a patient are also recorded as a new incident as are duplicate calls for the same incident/event.
25. Within each incident record there is a Sequence of Events (“SOE”). This is an electronic record of all activity within that particular incident, including but not limited to: answers and information inputted by a Call Handler, location information, manual information entries into the incident notepad, searches for available resources, information passed to allocated resources electronically and activity relating to resources attached to the incident.
26. Where there are multiple calls received, NWS Supporting Dispatch Guidance [EOC-BAU-15D] (Exhibit DA/01 – NWS000011) directs dispatchers to allocate against the first call received in the system. However, where a duplicate call received within the system is of a higher categorisation than the first call, allocation should be made on the highest category of call.

Allocation and dispatch of emergency response resources

27. Once the 999 call has been received, it is available to the Dispatch team who are collectively responsible for the allocation of emergency response resources. Individual Dispatchers are allocated to specific geographical areas for which they are then responsible during any one shift. Dispatchers are responsible for ensuring that vehicles are moved in accordance with demand and that the crews on responding vehicles in that area are given appropriate rest breaks.

28. Dispatchers have access to a list of incidents and the emergency response resources signed on duty within their dispatch area. All incidents and resources are colour coded to help the Dispatchers identify the category of incidents, the call sign of the resource that has been assigned to the incident and the resources which are available/not available for allocation.
29. Dispatchers are able to view all resources within the NWS operational area in order to support identification of the nearest available vehicles, including those which may be outside of their dispatch area.
30. To allocate a resource, the Dispatcher will identify the incident they wish to allocate a resource to and then perform a resource check, which is a system-based check that will display resources in order, with the closest resource to the incident presented at the top, ascending in terms of estimated time of arrival and distance from the call. Dispatchers are also able to see the category of call that resources are allocated to which allows them to make decisions to divert crews to higher acuity calls if required.
31. During normal business, the Dispatchers work to identify the longest waiting and highest priority incident on their list of unallocated incidents. For Category 1 calls, if appropriate to do so, the dispatch system will automatically allocate or divert the nearest available ambulance. The Dispatcher will then review this allocation to ensure appropriateness.
32. Following allocation by the Dispatcher, the ambulance crew will receive information via their Mobile Data Terminal (“MDT”) and radio to alert them to the incident. They will receive location and incident details, including the type of call they have been allocated to. In addition to this, the Dispatcher will select information available within the notepad to pass to the crew, i.e. notes from the call triage, further patient or scene safety information. There is also a further option to transmit important information via the radio to provide updates or ask questions.
33. In order to co-ordinate NWS resources in line with the Ambulance Response Programme, NWS has set allocation guidance across all EOCs. This provides guidance to Dispatch teams around the allocation of ambulance resources to patients.

It is expected that EOC Managers and Dispatchers within the Dispatch environment will also use their experience and autonomy, in conjunction with clinical support, to make decisions to ensure that no patients are kept waiting unnecessarily. In the main, incidents should be allocated in time and category order [EOC-BAU-15D].

34. The management of Complex Incidents across the North West, such as major trauma, clinically complex and critical incidents, is managed by the Complex Incident Hub (“**CIH**”). The CIH is based within the Lancashire & Cumbria EOC, with oversight and management of incidents across all EOCs. The CIH is made up of a Team Leader, Dispatcher, Helicopter Emergency Medical Service (“**HEMS**”) Critical Care Paramedic, HEMS Dispatcher and Advanced Paramedic. The CIH team are responsible for the management of clinically complex patients and the deployment of specialist resources such as HEMS, the Hazardous Area Response Team (“**HART**”) and Advanced Paramedics.

Factual narrative of the NWAS response

35. NWAS received ten emergency calls from members of the public in relation to the attack on 29 July 2024 and deployed a total of 37 resources, including emergency ambulances, Advanced Paramedics, Commanders, including National Inter Agency Liaison Officers (“**NILO**”) and HEMS in response to the attack. Over 100 personnel attended to the incident.
36. I provide a chronology of the emergency calls received below.

Call	Incident Number	Time	Information	Category
1	29439224	11:47:56	999 call to attend Norwood Business Centre, 34A Hart Street Southport PR8 6BX. The call was received into the Parkway EOC in Manchester. The call was made by a male looking out onto the street, he was calling for a girl, approximately [redacted] I&S [redacted], who he could see and who was described as	2

			<p>I&S and being carried by another person. The caller was not with the girl and was unable to confirm if she was conscious and breathing. The line disconnected during the triage following some shouting in the background for people to call 999.</p> <p>The Call Handler made 2 attempts to re-contact the informant without success and documents this at 11:54.</p>	
2	29439228	11:48:00	<p>Call received into Cheshire & Merseyside EOC and logged against the incident. The call was from a female who was in her car outside 110 Hart Street, Southport, PR8 6DS. The call was for a I&S child who was inside the car and had been stabbed. It was initially reported that the patient was conscious with further information received that the child was "going unconscious". The caller reported that a male had run into a children's play area and stabbed children, the child had run out of the club and into the car, which had now moved down the street away from the scene.</p> <p>The nearest available ambulance was automatically diverted from a Category 2 incident by the Dispatch system at 11:50, with a 4-minute estimated time of arrival to the location.</p> <p>The Call Handler remained on the line to provide advice on how to control the patient's bleeding (as outlined by the NHS Pathways</p>	1

			<p>system), and continued to monitor the patient's condition, who could be heard talking whilst the Call Handler was on the line.</p> <p>During the call, the caller stated they were able to see ambulances further down the road and someone had gone down the street to inform the crew this patient was further up the road. 19 minutes into the call, the Call Handler asked the caller to drive back down the road as Police and ambulances were there. After 21 minutes, the caller indicates that there is a medic with the patient and the call ends after 25 minutes.</p>	
3	29439229	11:48:49	<p>Call received from Merseyside Police into the Cheshire & Merseyside EOC. The location was given as Master Vehicle Body Repairs, 36A Hart Street, Southport, PR8 6BT. The Police reported numerous people had been stabbed, it was unknown if people were breathing or awake. Information was received that 25 people had been stabbed, approximately 8-9 people had heavy bleeding with 2 children not breathing; this information was entered into the notepad of the call and an informant's name and number were taken.</p> <p>Following an attempt to call back the informant, the Call Handler launched the NWS internal questionnaire for a suspected Marauding Attack or Major Incident [EOC-MI-01] (Exhibit DA/02 – NWS000014). Based on information known at the time from the Police, the Call</p>	1

			Handler inputted notes in relation to the attack, location and identified target.	
4	29439230	11:48:53	<p>Call is received into the Greater Manchester EOC. A request was made to attend 43 Hart Street, Southport, PR8 6BT. The call was from a female who had multiple children (approximately 15) within her house. It is understood that there were 3 patients with stab wounds. The call was triaged using NHS Pathways, with the Call Handler applying local NWS guidance on the triage of multiple patients [EOC-BAU-06C] (Exhibit DA/03 - NWS000008). The Call Handler made attempts to triage the highest priority patient then triaged the youngest patient.</p> <p>Advice on how to control bleeding was provided over the phone. There were difficulties in the delivery of this advice due to the number of children and support being provided by the caller to them.</p> <p>During the call it was established that parents were entering the property and taking children out to the ambulance crews outside. The Police arrive within the property 21 minutes into the call cycle and the call comes to an end.</p>	2
5	29439232	11:49:12	Call received into the Cheshire & Merseyside EOC to attend 44 Hart Street, Southport, PR8 6BT. The caller initially stated that he thought a female had been hit by a car, then confirmed that she had been stabbed in the chest. During the call further information indicated there were 3 children who had	1

			<p>been stabbed, with 1 not breathing. Information was provided that the attacker was possibly still inside the Norwood Business Centre on Hart Street. Basic Life Support (“BLS”) was being delivered six minutes into the call when the caller was next to the patient. Seven minutes into the call the Police arrived on scene. Eight minutes into the call the caller advised the ambulance had arrived and the Call Handler remained on the line to ensure BLS continued until a Police Officer and a Paramedic took over care for the patient nine minutes into the call.</p>	
6	29439235	11:49:49	<p>Call received from Merseyside Police into the Cheshire & Merseyside EOC. Attendance was requested by the Police at 34A Hart Street, Southport, PR8 68X. The Police advised a male child approximately 8 or 9 had been stabbed and 2 females had been injured. Information developed throughout the call to update that 3 children had been stabbed, and 2 children were not breathing. It was unknown if the attacker was still on scene.</p> <p>The Police passed an RVP as Southport Police station 5 minutes into the call and confirmed that Police were at the RVP.</p> <p>The call handler wrote information into the incident notes at 11:55. At 11:58 the call handler applied a warning to alert the dispatcher to the RVP, which was noted by the dispatcher at 12:03:56 by which point, NWAS resources were already on scene.</p>	1

7	29439240	11:50:21	Call received into the Greater Manchester EOC. The call was to attend Calculus Legal Costs within Norwood Business Centre, PR8 6BX. The call was to attend a 59-year-old male who had been stabbed in the leg, he was conscious and breathing during the triage. The caller also reported a further patient they could see, namely a girl that had also been stabbed outside. During the call it was advised that someone was outside and had smashed a glass door, advice was provided to move to a safe place, it was unknown if this was the attacker and it was confirmed by the caller that those on scene were locked in the office. A tourniquet was in place on the leg and advice was provided to leave that in place along with bleeding control instructions. Six minutes into the call it was established that the Police were on scene	2
8	29439245	11:52:02	Call received into the Greater Manchester EOC. The call was to attend Maple Street, junction with Hart Street, Southport, PR8 6BT. The caller was on Maple Street and advised they had heard shouting about a stabbing and provided further information that indicated a potential deceased child; they were not with the patients.	2
9	29439266	11:57:38	Call was received into the Lancashire & Cumbria EOC. The call was from a female who was on FaceTime to her husband who was on Hart Street by the Hart Space in Southport. The address was given as 34A Hart Street, Southport, PR8 6BT. The caller advised her husband was with one of her	2

			<p>children and was unable to locate their other child, the caller understood that there had been an attack and the youngest child, a [I&S] [I&S] female, had blood on her clothes but was not hurt. The caller wanted to ensure that the Ambulance Service had been informed.</p> <p>During the call the ambulance could be seen on scene by the caller and the call ended after 2 minutes and 49 seconds.</p>	
10	29439311	12:09:23	<p>Call was received into the Cumbria and Lancashire EOC. The call was from Merseyside Police asking for further ambulances to attend 50 Hart Street, Southport, PR8 6BT. Details were provided that there was a female with slash wounds and the Police were on scene</p>	2

37. NWAS has audited all of the emergency calls it received in relation to the Southport incident to establish whether they were handled in line with the expectations of NHS Pathways. The NHS Pathways audit checks for strict compliance against the Pathway. Whilst some of the calls handling did not meet the NHS Pathway audit standard, that did not impact on the NWAS response to the incident; resources were allocated and dispatched to the incident on a continuing basis on receiving the first and second calls.

Call	Audit outcome	Audit comments
1	Safe and appropriate	Call correctly managed and coded as a Category 2 response.
2	Call handling did not achieve standard with identified learning in relation to scene safety	The Category 1 response was safe although the call did not achieve the overall standard with learning identified in relation to the management of scene safety. Although it was known that the Police were on scene, the overall scene safety could not be confirmed, there was also a

		delay in inputting notes regarding the attack into the incident notepad, which is available for the Dispatcher to read. Overall, this did not impact the care to this patient; or delay the response of NWS resources.
3	Safe with learning	The Category 1 response was correct, with learning for the Call Handler in relation to the flow and pace of the call. During the call, the Call Handler is trying to process a lot of information; but it has resulted in some longer gaps and time taken before being able to ring back the informant. It may also have been more appropriate to ask further questions to identify if the 'terrorist incident' or 'threat of terrorism' response within the Attend Incident Module was a more suitable pathway than the "medical or trauma" route that was used. This absence of probing or questions, however, does not impact the overall outcome of the call as the same safe categorisation was reached.
4	Not achieved safe standard	The Call Handler correctly identified and followed the local policy for triaging multiple patients and identified the youngest child. However, it was heard on the audio there was another older child described as ' <i>slumped on a chair</i> ' and best practice would have been to further establish their condition and ensure appropriate care advice was being delivered. This triage appeared more complex due to the situation and number of patients on scene.
5	Safe and appropriate	The Category 1 response was correct and appropriate.
6	Safe and appropriate	The Category 1 response was correct and appropriate.
7	Not achieve a safe standard	Although the Call Handler correctly triaged the patient who was with the caller, it would have been appropriate to establish if the girl outside was conscious and breathing to ensure the categorisation was appropriate.

		The identified learning did not impact or delay the overall response.
8	Safe standard not achieved	Learning has been identified that it would have been appropriate to establish if the any of the patients had stopped breathing, in order to ensure the most appropriate categorisation. It would have also been appropriate to negotiate with the caller in order to assess the patient's conditions if it was safe to do so.
9	Safe and appropriate	The Category 2 response was correct and appropriate.
10	Safe standard not achieved	The call did not achieve a safe standard as a contact number should have been obtained for someone on scene in order to call back in line with NWS local policy.

Deployment and Communication

38. Across the UK, Ambulances Services do not usually have spare capacity within their frontline resources and the vast majority of ambulances which are signed on duty will be allocated and travelling to or in attendance with patients. On 29 July 2024, NWS had a total of 375 ambulances signed on for duty, of which 123 were within the entire Cheshire and Merseyside region which covered.

39. On 29 July 2024, NWS was operating under moderate operational pressures. In order to respond to variations in demand and pressure, NWS operates a Clinical Safety Plan (“CSP”) which provides escalatory measures to support the response to and the safety of patients and is to be utilised in situations where NWS is receiving an excessive volume of calls or there is a reduction in available staff numbers. The CSP allows NWS to respond dynamically to increased service pressure as soon as certain triggers are met. There are 4 levels of escalation within the CSP in addition to ‘Business as Usual’ and each level has its own triggers and actions to be considered to alleviate pressure and communicate with the wider NHS system, for example local hospitals.

40. At the time NWS received the first 999 call in relation to the attack, they were operating within 'Business as Usual'. At 10:00 it was recorded that there were 80 calls awaiting allocation across the NWS geographic footprint, with only 1 call waiting outside of the Ambulance Response Programme response times.
41. Having seen an increase in demand between 10:00 and 13:00, a decision was made to escalate to Level 2 of the CSP with 153 calls waiting, exceeding the trigger of 150 calls.
42. Despite seeing some low-level demand overall, CIH had been managing a number of complex incidents throughout the late morning on 29 July 2024. Between 08:00 and 13:00, the CIH were involved in the management of twenty-seven incidents, of which eight were received between 11:00 and 12:00, excluding the attack in Southport. These included incidents such as an electrical fire with a patient burnt, a multi-vehicle road traffic collision on the motorway, a road traffic collision involving a pedestrian, a further fire reported incident and a further complex electrocution incident involving a multi-agency response.
43. Despite the operational pressures and the number of incidents that were being managed by the CIH, NWS deployed a total of 37 resources to the incident at Hart Street.
44. I set out below a narrative timeline of allocation and communication with the early resources deployed to the incident in Southport, along with information pertaining to decision making with respect to Rendezvous Points ("**RVP**") and stand-off instructions.
45. Following receipt of the first 999 call at 11:50:09, the local Dispatcher allocated Senior Paramedic Team Leader ("**SPTL**") Paul Smith in R646, a solo crewed Rapid Response Vehicle ("**RRV**"), who was on base at Southport Ambulance Station. Upon allocation the Dispatcher passed details via the radio to R646 to advise that the incident was for a young person who had been stabbed in the back. A further update was provided at 11:52:43 to confirm that back up had also been mobilised.
46. At 11:50:47 and on receipt of the second call and the Category 1 coding, A664 (Paramedic Gemma March-Jackson and Emergency Medical Technician ("**EMT**") Katie Johnson) was auto allocated by the CAD system. At the time of allocation this ambulance had been mobile and making its way to another unconnected patient on a Category 2 response and were located at the junction of Church Street and Houghton Street in Southport. Their estimated time of arrival to the scene at Hart Street was 4 minutes.

47. At 11:51 A664 (Paramedic Gemma March–Jackson and EMT Katie Johnson) contacted the Dispatcher via the radio to ask if it was safe to attend scene. The Dispatcher advised that the Police were aware and in attendance but they should stand-off until further information was provided.
48. EOC holds two standard operating procedures that cover the process of ‘standing off’ and attending an RVP; Violent and Aggressive Incidents [EOC-BAU-33D, issued 2023] (Exhibit DA/04 – **NWAS001084**) and Firearms Incidents [EOC-BAU-16D, issued 2023] (Exhibit DA/05 **NWAS001085**). The Violent and Aggressive Incident procedure outlines the actions required by EOC in the event operational staff could potentially be or are at risk whilst attending any incident. This allows operational colleagues to make an informed risk assessed decision on whether they are required to operationally ‘stand-off’ when attending an emergency call.
49. ‘Standing off’ is different to attending an RVP. An RVP is a location where resources arriving at an outer cordon are directed for logging, briefing, equipment issue and deployment or a location where two or more agencies arrange to meet prior to moving forward to an incident location. In contrast, ‘standing off’ involves responders making way to a safe location which is close to but away from the incident location where NWS responders may arrive and spend time gathering additional information or carrying out a risk assessment prior to attending an incident scene.
50. The location provided for the second call was outside 110 Hart Street which is slightly different from the initial incident location, as that caller had driven up the road away from scene.
51. As the second call received a higher category of response, at 11:51 R646, SPTL Paul Smith, was re-allocated from the first call to the second call in line with NWS deployment guidance, which ensures attendance to the highest category of subsequent call. This re-allocation was made by the CIH Team Leader who also allocated the nearest Advanced Paramedic, Gary Fitzpatrick and Paramedic Amy Spicer in RRV QX617. QX617 was allocated at 11:51 from Bootle Ambulance Station which was 12.66 miles from the incident scene with a 25-minute estimated time of arrival. QX617 was requested to make their way to Southport and information relating to the incident was provided to them. QX617 asked

for an open talk group and the Dispatcher advised that they would let them know the details of this once confirmed.

52. Open talk groups are used for incidents that require a high level of radio traffic and are opened at the discretion of the EOC Duty or Performance Manager. All radio traffic for responders on the talk group is broadcast on the channel to allow for monitoring. This ensures that business as usual talk groups are kept clear from incident specific communications.

53. In addition to the NWS major incident open talk group, EOC also operates on the Emergency Services Inter Control Talk-Group (“**ESICTRL**”), along with 7 police forces within the North West; North West Fire Control, North West Motorway Patrol Group, Merseyside Fire and Rescue and HM Coastguard. The ESICTRL talk group is monitored by all 3 NWS EOCs on a 24/7 basis and is used to pass and receive information including ETHANE and METHANE messages.

54. At 11:51 the CIH contacts the North West Air Ambulance (“**NWAA**”) Blackpool airbase to inform them of the ongoing incident in Southport. Information was provided that there were multiple calls for 8-9 people who had been stabbed. NWAA confirmed with CIH that they could be mobile in 5 minutes. At 11:54 NWAA H08 (Caroline Duncan, Senior HEMS Paramedic Team Leader/Critical Care Paramedic and Simon Stephens, Critical Care Paramedic) confirmed they were mobile to scene travelling from Blackpool airbase.

55. At 11:52, the Dispatcher contacted R646 (SPTL Paul Smith) who was on his way to scene. R646 was advised that the attacker could still be on scene and to stand-off.

56. At 11:52 QX616 (Advanced Paramedic Paul Brennan) was allocated from Whiston Ambulance station by the CIH with an estimated time of arrival of 35 minutes and a travelling distance of 17 miles to the incident location. QX616 was asked to make their way to Southport for a multi-call incident.

57. At 11:53 R646 (SPTL Paul Smith) was advised that Police were in attendance.

58. At 11:54 Emergency Ambulance A603 (Paramedic Richard Krcmer and EMT David Baxter) was allocated and mobilised to scene from Southport Ambulance Station with a 4-minute estimated time of arrival.
59. At 11:54 the Great North Air Ambulance Service (“**GNAAS**”) resource H58 (Dr Ally Hog and Terry Sharp, Critical Care Paramedic) were allocated to the incident by CIH. They were confirmed as mobile from their base in the Penrith area at 11:55.
60. At the same time, the CIH contacted NWAA helicopter H72 (Dr Ollie Harrison and Mikey Foster, Critical Care Paramedic) who had recently arrived on scene at another incident in Macclesfield, Cheshire. H72 were asked by the CIH if they could confirm if they were needed at that incident in Macclesfield or whether they were available for potential re-allocation to Southport. At the time, the crew confirmed they had not reached the patient yet but would provide an update in due course. At 11:58 the crew confirmed that they were required to remain at scene in Macclesfield with their patient who was critically injured, requiring blood products and onward transportation to Manchester Royal Infirmary.
61. Further information in relation to the allocation and deployment of HEMS assets, including details of the clinical skills and equipment available to them is provided from paragraph 112 onwards.
62. At 11:55 an Operational Commander, call sign BX1792, Andrew Patton was mobilised by Cheshire & Merseyside EOC from Chaloner Street in Liverpool, which was 17 miles away from the scene with a 34-minute estimated time of arrival.
63. At 11:56, a Dispatcher passed further information to R646 Paul Smith to update that there were reports of armed men in the Norwood Business Centre and to stand-off. Paul Smith confirmed to the Dispatcher that he was on scene. Paul Smith parks his vehicle at scene at 11:57:25, as confirmed by the dashcam recording for R646.
64. The response to the Southport Incident met the Ambulance Response Programme standards. It was 9 minutes (1 minute as a Category 2 response and 8 minutes as a Category 1 response) from the time of the first call to R646 (SPTL Paul Smith) arriving on scene.

65. At 11:57, a Dispatcher updated R646 Paul Smith to confirm that Police were on scene, that a Doctor was attending with blood and a Bronze Commander was enroute, in addition to two HEMS resources. Paul Smith responded to advise that he was on scene with four children with deep lacerations/major stab wounds.
66. At 11:58 Emergency Ambulances A664 (Paramedic Gemma March- Jackson and EMT Katie Johnson) and A603 (Paramedic Richard Krcmer and EMT David Baxter) arrived on scene.
67. None of the initial NWAS resources were deployed to an RVP. They were mobilised to scene though they were advised by the Dispatchers to 'stand-off' as there were unconfirmed reports that the perpetrator was still on scene. All resources were mobilised directly to scene or to a landing site to collect HEMS crew, unless they were being moved into the Cheshire and Mersey region to provide support and resilience to ensure that NWAS was able to meet the needs of the wider public.
68. NWAS' first communication with Merseyside Police was at 11:48 during which they confirmed that they were present at scene. The Police first passed information regarding an RVP at 11:55 (during the sixth call). This was noted by the Call Handler in the incident details and a warning applied to alert the Dispatcher. At 12:03 the Dispatcher turns off the warning as R646 (SPTL Paul Smith) was already on scene with a clear Police presence on scene.
69. At 11:58 three HART resources (Z608, Z604 and Z607) were mobilised by the CIH from Merseyside Fire and Rescue Service Training Centre, Storrington Avenue, Liverpool with a 27-minute estimated time of arrival.
70. At 11:59 Dispatch provided information to R646 (SPTL Paul Smith) of the dedicated major incident radio channel for the incident.
71. As additional resources were allocated to the incident, Dispatch asked them to switch their radio to the dedicated major incident channel. As identified in the NWAS Structured Debrief, recent changes to the national radio system has removed the ability for NWAS EOC to 'push' allocated resources onto certain radio channels and so NWAS Dispatch

therefore have to request that crews manually change the channel on the radio handsets themselves.

72. At 12:00 a further call was received on the Police line from Merseyside Police seeking an ETA. Merseyside Police were informed that the ETA was one minute and confirmed there was 3 Ambulances, 1 RRV, 2 Advanced Paramedic, HART team, Helimed and a Dr on their way to the incident. Mersey Police passed further information regarding deceased children on scene and that there were different reports as to the number of other casualties ranging between 5 or 6 to 25. It was during this call that Merseyside Police were informed that NWAS were on scene.
73. At 12:01 the CIH allocated a BASICS Doctor, Dr Eimhear Quinn, call sign MX5877 from Eccles, Manchester with a 57-minute estimated time of arrival. Further detail is provided in relation to BASICS doctors within the section of this statement titled 'Helicopter Emergency Medicine/Enhanced Pre Hospital Care'.
74. At 12:02, Dispatchers allocated two further emergency ambulances, A645 (Paramedic Chelsea Phillips and Paramedic Matthew Bousfield) from Southport Ambulance Station with a 4-minute estimated time of arrival; and A611 (Paramedic Gillian McKenna and Paramedic Catherine Jones) from Lord Street Southport with a 5-minute estimated time of arrival to scene.
75. At 12:03 a further HART resource (Z602) was allocated by the CIH to attend from Merseyside Fire and Rescue Training Centre, Storrington Avenue, Liverpool with an estimated time of arrival of 26 minutes.
76. At 12:04 Dispatch allocated emergency ambulance A640 (Paramedic Guy Halsall, Paramedic and EMT Ian Carville). They were dispatched from Formby and had a 14-minute estimated time of arrival to scene.
77. At 12:04 information was provided via the radio from Merseyside Police to NWAS EOC to advise of a Major Incident Standby with ETHANE pneumonic format:-

- **E:** Exact location of the incident given as 30 Hart Street, PR8 6BT.
- **T:** Type of incident, advised that circumstances were unclear but appeared to be a large volume of children being stabbed at the location, including children who were deceased.
- **H:** Hazards were updated as blood, victims, traffic making to the incident and broken glass at scene.
- **A:** Access was provided as Southport Police Station, however NWAS and Police were noted as having gone straight to scene in a first aid capacity.
- **N:** Number of casualties was given as 2 deceased children.
- **E:** Emergency services required was given as Police, NWAS and Merseyside Fire and Rescue if they had first aid capacity to attend scene.

78. Further information was passed to QX617 (Advanced Paramedic Gary Fitzpatrick) at 12:04 whilst mobile to this incident to confirm a Major incident had been declared.

79. At 12:05 Dispatch updates QX616 (Advanced Paramedic Paul Brennan) that this was a major incident and provided an update in relation to the two deceased children at scene with further children with stab wounds.

80. At 12:05 emergency ambulance A611 (Paramedic Gillian McKenna and Paramedic Catherine Jones) arrived on scene.

81. At 12:06, RRV R627 (Senior Paramedic Simon Boardman) was allocated to attend, with a 20-minute estimated time of arrival.

82. At 12:06 the Merseyside Police confirmed they had one offender detained and in possession of a knife and were awaiting confirmation if there were any additional offenders.

83. At 12:07 this message was acknowledged by Merseyside Fire and Rescue.

84. At 12:07 emergency ambulance A125 (Paramedic Stephen Lloyd and EMT Sarah Thompson) was allocated from the Skelmersdale area with a 21-minute estimated time of arrival to scene. A125 had already been asked by Dispatch to start making their way to Southport Ambulance Station at 12:05.

85. At 12:07 emergency ambulance A102 (Paramedic Benjamin Houghton and Apprentice EMT Emma Heron) was allocated to attend having become available on Town Kew Lane in Southport with a 3-minute estimated time of arrival. Whilst on route to scene the crew were asked to divert to the Southport landing site to collect HEMS H08 staff.
86. At 12:08 R646 (SPTL Paul Smith) contacted Dispatch to request further support at scene. Dispatch confirmed seven ambulances were enroute, three of which were 1 minute away, with the others having an estimated time of arrival of between 13 - 20 minutes.
87. The NWS Incident Response Plan (“**IRP**”) contains local guidance as to the resources to be deployed in the event of a major incident standby or major incident declaration, known as a Pre-Determined Attendance (“**PDA**”). The PDA guides a Dispatcher as to the number of resources that should be allocated to the incident. This guidance is contained within EOC-MI-01. The guidance states that there should be 5 x Emergency Ambulances, 1 x RRV, 2 x Advanced Paramedics and 1 x HART resources allocated. At the time of the major incident standby being made, by Merseyside Police at 12:04 all of the recommended resources had been allocated to this call.
88. At 12:08 H08 (Caroline Duncan, Senior HEMS Paramedic Team Leader/Critical Care Paramedic and Simon Stephens, Critical Care Paramedic) were informed that the GNAAS H58 (Dr Ally Hog and Terry Sharp, Critical Care Paramedic) were inbound and estimated to be flying above Hart Steet at approximately 12:25. Thereafter the helicopter would need to land at the landing site and the crew make their way to scene. It was advised that they would need to be met at a secondary site (KGV College), due to challenges in identifying a landing site close by.
89. At 12:09 a further call was received from Merseyside Police requesting that further ambulances attend.
90. At 12:12 CIH informed QX617 (Advanced Paramedic Gary Fitzpatrick) that two HEMS assets H08 (Caroline Duncan, Senior HEMS Paramedic Team Leader/Critical Care Paramedic and Simon Stephens, Critical Care Paramedic and H58 (Dr Ally Hog and Terry Sharp, Critical Care Paramedic) had been allocated with a further HEMS resource (H75 Mike Southworth and Steve Millar, both Critical Care Paramedics) coming clear in Chester. NWS CIH requested that QX617 (Advanced Paramedic Gary Fitzpatrick) provide a full

assessment to CIH directly once they arrived on scene (rather than on the major incident channel) in order to confirm whether the third helicopter was needed.

91. At 12:12 BX1792 Operational Commander Andrew Patton arrived on scene.

92. At the same time Dispatch requested that emergency ambulance A097 (Paramedic Andrew Smallman and EMT Angela Nolan) which was located in the Preston area, start making their way to Southport Ambulance Station. A097 had not yet been formally dispatched to the incident and so they were asked to make their way on a cold response, without lights and sirens.

93. Within the NWAS Hot Debrief it is noted that some crews felt that this practice caused a delay in their attending scene. It is understood that these were emergency ambulances who had either made contact with Dispatch to state they were available or who were identified by EOC as being able to be moved into the Cheshire and Mersey area in order to provide additional support and resilience. These emergency ambulances were mobilised on a cold response (travelling without lights and sirens), before being formally deployed to scene further into the incident timeline. Dispatch managed their allocation in this way so to ensure all resource allocations were coordinated and necessary, as allocating ambulances unnecessarily could overwhelm the scene and result in a lack of ambulances for allocation to other patients within the North West.

94. At 12:12 QX617 arrives on scene (Advanced Paramedic Gary Fitzpatrick and Paramedic Amy Spicer).

95. At 12:14 Merseyside Police confirmed via the ESICTRL radio that the incident has been had been updated and was a confirmed Major Incident.

96. At 12:15, the crew from emergency ambulance A604 (EMT Amanda Owen and EMT Charlotte Womersley) who were unavailable at the time due to a tyre issue on the ambulance advised they could render aid on foot with kit. They made their way on foot to Hart Street from Town Lane Kew.

97. At 12:16 HEMS H08 (Caroline Duncan, Senior HEMS Paramedic Team Leader/Critical Care Paramedic and Simon Stephens, Critical Care Paramedic) is confirmed as having landed at the secondary landing site at KGV High School in Southport, having flown overhead and been unable to identify a suitable landing site at Meols Park. Emergency Ambulance A102 was requested to make their way to the landing site to collect the crew with kit. At this time, GNAAS H58 (Dr Ally Hog and Terry Sharp, Critical Care Paramedic) had an estimated time of arrival to scene of 12:25. It is usual practice for an emergency ambulance/RRV to be asked to make their way to the a helicopter landing site to collect the HEMS crew and their equipment, particularly if the landing site was some distance away from the scene of the incident.
98. Between 12:17 and 12:18, a further three ambulances were allocated, A097 (the emergency ambulance from the Preston area that had initially been mobilised on a cold response, being Paramedic Andrew Smallman and EMT Angela Nolan) A502 (EMT Caitlin Donohue and Paramedic Leah Worrall) and A536 (EMT Linda Spencer and Paramedic Arthur Morris). A536 had been informed of the incident at 12:09 and had been stood by whilst Dispatch confirmed the number of resources required. Upon allocation they were advised to go straight to scene.
99. At 12:19 QX616 Paul Brennan arrived on scene. Emergency ambulance A640 (crewed by Paramedic Guy Halsall and EMT Ian Carville) arrived on scene at 12:20.
100. At 12:23 emergency ambulance A102 (EMT Sarah Thompson and Paramedic Stephen Lloyd) arrives at scene having collected the crew from H08, as per paragraph 97 above.
101. At 12:24 A125 were asked to stop at Southport Hospital enroute to scene to collect the GNAAS crew from the landing site. At 12:28 the crew queried the landing site being the hospital with knowledge there was no Helipad at the hospital. The local Dispatcher asked the crew to standby whilst this information was being confirmed.
102. At 12:24 a Safety Officer UX3799 (Paramedic Matthew Dugdale and Paramedic Chris Marsden) was allocated to attend along with a NILO TX2973 (Thomas Maloney) at 12:25.

103. Information obtained from the Hot Debrief indicated that NWAS declared a major incident at 12:25, however, I have been unable to confirm this timing on with the NWAS radio logs. Upon declaration of a Major Incident, guidance states there should be 10 x Emergency Ambulances, 2 x RRVs, 1 x HART, 3 x Advanced Paramedics deployed. Whilst I have not been able to confirm the timing of the major incident declaration, I can confirm that at that time, the resources allocated to the incident met these criteria with further doctors enroute to scene instead of a third Advanced Paramedic.
104. At 12:27 a further HEMS asset H75 (Critical Care Paramedic Mike Southworth and Critical Care Paramedic Steve Miller) were allocated to attend this incident from the Cheshire area, this being a category 1 incident, a male fallen from a ladder. At the time, they had cleared from another incident where they were being supported on scene by the Midlands Air Ambulance (“MAA”) H03 (Doctor Ben Taylor and Trainee Critical Care Paramedic Rob Davies). This crew were also requested to assist in Southport and attended together from the previous call to the Southport secondary landing site arriving at 12:51.
105. At 12:31, GNAAS H58 (Dr Ally Hogg and and Terry Sharp, Critical Care Paramedic) confirmed that they had landed at the secondary landing site at KGV College. A125 were then mobilised from Southport Hospital to collect the crew at the KGV landing site by CIH. Upon review of the incident, they leave the grounds of KGV College at 12:38 and arrive at the scene at 12:40.
106. At 12:34 both H03 and H75 confirmed their estimated time of arrival overhead would be 17 minutes.
107. At 12:40, CIH requested that emergency ambulance A502 (EMT Caitlin Donohue and Paramedic Leah Worrall) who were approaching the Southport area to attend the helicopter landing site to collect the crew from H03 and H75 who landed at 12:51.
108. At 13:09 a further RVP was nominated by the Police (via the ESICTRL radio) at Meols Cop High School PR8 6JS. This was to be utilised as a muster point for further additional resources that were required to be brought forward. The EOC Duty Manager confirmed via

the radio to NWS crews that this was to be used for any further additional resources to wait to be brought forward. All crews already in attendance had proceeded directly to scene.

109. Multiple further resources were allocated to this incident, for both patients and family members. In total there were 17 ambulance attendances to scene along with 3 RRVs, 2 Advanced Paramedics, 4 HART resources, 2 Operational Commanders, 2 x Critical Care Paramedics, 5 Doctors (including 2 on HEMS assets). Further Commanders were also mobilised to other EOCs.

110. Following a review of calls from Southport Hospital, I can confirm that NWS did not receive a call to transfer a patient to Alder Hey on either the 29 July or 30 July 2024.

111. On review of all resource allocations for this incident, I am satisfied that all available resources were allocated in line with guidance and that it was the nearest available resources that were dispatched.

Helicopter Emergency Medicine/Enhanced Pre Hospital Care

112. Air Ambulance or HEMS as they are also known, are not part of the commissioned service of the statutory/NHS ambulance service. All twenty-one HEMS in the UK and volunteer British Association for Immediate Care (“**BASICS**”) Doctors are provided by the charity sector. NHS Ambulance Trusts are not commissioned, funded or legislated to maintain a specific level of coverage for specialist resources, including provision of enhanced prehospital care and advanced (paramedic) practitioners, with the exception of national Emergency Preparedness Resilience & Response assets such as HART.

113. NWS does however, work in partnership with NWAA to provide a HEMS service to the population of the North West. I have set out an overview, from an NWS perspective, of the services that NWAA, BASICS and the other HEMS provide but should the Inquiry require further or specific information as to the nature of their services and operation, that information would be best obtained directly from those organisations.

114. NWAA oversees the delivery of Enhanced & Critical Care across the region with a hybrid model consisting of Paramedic Emergency Services, which include Advanced Paramedics, Critical Care Paramedics and Doctors. They operate by helicopter or RRV.
115. NWAA does not operate on a 24/7 service. NWAA operates seven days per week. The helicopters operate during daylight hours with the RRV operating between 6pm to 2am.
116. Enhanced Doctor led support is also available via BASICS. There are two BASICS schemes within the North West, North West Pre Hospital Critical Care Charity and BEEP Doctors Cumbria. Both organisations are registered charities and are volunteer responders. Volunteers who are available to respond will be allocated and dispatched to an incident by CIH or Dispatch.
117. GNAAS supports the delivery of HEMS in the northern part of the North West. In situations where further HEMS capability is required, there is an established mutual aid process in place to request support from neighbouring services such as MAA.
118. The deployment and oversight of HEMS and BASIC assets is co-ordinated by the NWAS CIH which is located within the NWAS EOC at Broughton, Preston.
119. The HEMS resources of NWAA, GNAAS and MAA are located as follows: -

	Call sign	Crew skill mix
NWAA		
Barton Airbase (Manchester)	H72	Doctor and Critical Care Paramedic
	H75	Double Critical Care Paramedic
Blackpool	H08	Double Critical Care Paramedic
GNAAS		
Langwathby (North Cumbria)	H58	Doctor and Critical Care Paramedic

MAA		
Shropshire	H03	Doctor and Critical Care Paramedic

120. Before setting out the detail in relation to the HEMS support provided to NWS, I set out below a summary of the clinical capabilities amongst the HEMS responders.

Critical Care Paramedics

121. Critical Care Paramedics have a very similar skill set to that of an NWS Advanced Paramedic, though they have some additional skills which they may use when working alongside HEMS Doctors:-

- a. Airways skills including endotracheal intubation;
- b. Advanced analgesia, ketamine;
- c. Procedural sedation, ketamine & midazolam;
- d. Surgical skills, open thoracostomy, front of neck access; and
- e. When working alongside Doctors on the air ambulance, Critical Care Paramedics are also trained Rapid Sequence Induction (“RSI”) assistants and work in partnership with the doctor to facilitate surgical interventions including resuscitative thoracotomy, resuscitative hysterotomy and limb amputation.

122. At the time of the Southport incident, NWSA Critical Care Paramedics were only able to provide pre-hospital blood transfusions when working alongside an NWSA Doctor. Plans have been in place since January 2023 to support and facilitate NWSA Critical Care Paramedics being able to autonomously administer prehospital blood products. Training commenced on 30 August 2024, followed by an initial launch on 4 September 2024 on the night car platform when crewed by two Critical Care Paramedics working together. This was followed by rollout on to the two air assets, H08 and H75 on 17 September 2024 before a full launch on 7 October 2024.

HEMS Doctors

123. All four HEMS response doctors are Consultant level practitioners and share the same skill set including: -
- a. Prehospital Anaesthesia (“PHEA”) / RSI;
 - b. Surgical skills: Open thoracostomy, resuscitative thoracotomy, amputation, resuscitative hysterotomy;
 - c. Advanced vascular access and invasive arterial blood pressure monitoring; and
 - d. Blood product transfusion.
124. The BASICS response doctors had the capability to provide PHEA and surgical skills but do not carry the equipment necessary for invasive monitoring, advanced vascular access or blood product transfusion.

Blood Product Transfusion

125. At the time of this incident, pre-hospital blood products were available to both H58 and H03. H72 also had blood products but were at the time committed to other incidents in the North West (please see further explanation below) which required enhanced care intervention, including blood product transfusion

Allocation of HEMS resources to the incident

126. At the time of the Southport incident, H72 was unavailable to attend having been dispatched at 11:28 to attend a critically injured patient in the Macclesfield area of Cheshire (incident number 29439115). Once aware of the Southport Incident and before H72 arrived at their patient, NWAS CIH made contact with them to request an update once they had arrived at the patient’s side as to whether their assistance was required. This patient did require enhanced care, including blood products. They were accompanied by the H72 crew and transported via land ambulance to Manchester Royal Infirmary arriving there at 12:28.
127. As such, H72 was unavailable to respond immediately to the Southport incident and subsequent to handing over the care of their patient at hospital and clearing from that particular incident at 12:40, H72 were allocated to another separate incident in Birkenhead

(incident number 2943981), arriving on scene at 13.15. This patient had fallen from height and again required enhanced pre-hospital care, including the administration of pre-hospital emergency anaesthesia. This patient was also transferred by road ambulance with the H72 crew accompanying them, arriving at Aintree Hospital at 14.25.

128. During the duration of the Southport incident, H72 were committed to separate incidents within the North West where both patients required and received enhanced care interventions. H72 were therefore unavailable for the entirety of the Southport incident.

129. Similarly, at the time of the Southport incident occurring, H75 were also committed to an incident in Chester. H75 had been allocated and dispatched to that incident (29439112) at 11:32, arriving on scene at 12:01. After an initial assessment the H75 crew requested assistance from a HEMS Doctor asset and as H72 were committed elsewhere, mutual aid assistance was requested from the MAA.

130. MAA H03 was duly dispatched to support H75 in Chester. Subsequently, both H75 and H03 cleared from the Chester incident at 12:26 and were both then allocated to the Southport incident. NWAA H75 was allocated to the Southport incident at 12:27, lifted off at 12:35 and landed at the helicopter landing site at 12:51.

131. Helicopters need sufficient space in which to land safely, usually in large open spaces such as playing fields. The landing site used for the Southport incident was Meols Park which also serves as the landing site for Southport Hospital. I have set out at Figure 1.0 a Google Map image which details the location of the incident, helicopter landing site and Southport Hospital.



Figure 1.0 - Google Map image which details the location of the incident, helicopter landing site and Southport Hospital

132. H75 was crewed by two Critical Care Paramedics who were collected by a passing Police vehicle and transported to scene.

133. As the NWAA and MAA Doctor led HEMS teams were already committed to incidents at the time that the Southport incident occurred, NWAS CIH contacted GNNAS at 11:55 to request their support at scene. GNAAS H58 lifted off at 11:59 from their base in Langwathby in North Cumbria (73 miles from Southport as the crow flies), landing at the helicopter landing site at 12:31. The crew were transported to scene from the helicopter landing site by a Police car and are timed at being with a patient at 12:40.

134. H58 was the first HEMS resource to arrive on scene at 12:40 with a clinical team and equipment to be able to administer blood products and able to perform a resuscitative thoracotomy.

Timing of NWAS treatment and transport of Alice da Silva Aguiar

135. In order to provide assistance to the Inquiry in relation to the triage, treatment and transport of Alice, NWAS has been assisted by a range of resources including the NWAS SOE the Electronic Patient Report Form (“ePRF”) and some video footage provided to us by the Inquiry Legal Team. I set out below NWAS’ interaction with Alice.

136. On viewing the relevant video footage, Alice can be seen running from the building alongside a number of other children and an adult female at 11:47. This coincides with the time of the first 999 call received by NWAS. The time stamp from the CCTV appears incorrect but the time of 11:47 has been identified after triangulating other confirmed time-stamped evidence.
137. Alice, the adult and other children initially gather around a car parked outside. Alice can be seen to be unsteady on her feet before seemingly collapsing to the ground next to the rear offside of the vehicle. She is mainly out of sight but her right foot is visible and appears motionless.
138. At 11:51, the video footage provided to NWAS by the Inquiry identifies that Alice had been moved from the car park onto Hart Street. At 11:58, a member of the public is with Alice and can be heard saying she is breathing in answer to a question from a Police Officer. On viewing this footage, Alice appears to be motionless and no signs of life are seen.
139. Alice's first contact with an NWAS Paramedic is at 11:59 where her injuries were noted. Chest compressions are seen being delivered at 12:08, suggesting that traumatic cardiac arrest had ensued prior to this point.
140. At 12:21 Alice is seen on the video footage being attended to by an NWAS Advanced Paramedic, Paul Brennan. She is noted to be in traumatic cardiac arrest as a result of her injuries. Within the ePRF, Alice was identified as a 9 year old female who had sustained two "large incised wounds" to the mid-thoracic area of her back as a result of an attack from a bladed article. Evidence of major haemorrhage was noted, as was bleeding "PV" (per vagina). It was noted that Alice was not breathing and had no palpable pulse. The initial cardiac rhythm identified on the monitor was Pulseless Electrical Activity ("PEA"). PEA describes a situation in which there is evidence of cardiac electrical activity but there is no pulse present. This clinical picture is consistent with Traumatic Cardiac Arrest ("TCA") and would trigger clinical management in line with well-established protocols for the management of TCA. These include guidance from the European Resuscitation Council and Resuscitation Council UK.
141. It is possible that Alice was in a clinical condition known as Low Outflow State in Trauma ("LOST") in which such major haemorrhage has occurred that there are no signs

of life and no pulses are present but yet there is still (minimal) cardiac activity. LOST and TCA would be clinically indistinguishable to the clinicians managing Alice's care and the treatment priorities would be identical irrespectively. The relatively low End Tidal Carbon Dioxide ("ETCO₂") recorded of 1.1kPA and 0.9kPA would, be more suggestive of TCA than LOST.

142. The clinical interventions provided to Alice included the following in addition to ongoing chest compressions:

- i) An iGel device was inserted to assist with airway management and delivery of oxygen and ventilation.
- ii) Bilateral needle thoracocentesis. This is a procedure in which a cannula (needle) is inserted through the chest wall to treat an underlying lung injury. A large release of air was noted on the right side of Alice's chest which would be suggestive of an underlying tension pneumothorax. This is a pathology in which the lung has collapsed and a high-pressure environment is created in the chest cavity which exerts pressure on the heart and main central blood vessels. This in isolation is a recognised cause of cardiac arrest.
- iii) Bilateral thoracostomies. This is a procedure only available to advanced clinicians and involves using a scalpel to create an incision in the chest wall which is then opened using a combination of surgical forceps and the operator's finger. This procedure allows either air, blood or both to be released from the chest cavity and facilitate re-expansion of the underlying collapsed lung. Again, a large release of air was noted on performing this procedure on the right side of Alice's chest, indicative of an underlying tension pneumothorax.
- iv) Intraosseous ("IO") access was gained in Alice's right lower leg. IO access involves inserting a needle into the bone marrow cavity to enable the administration of drugs and fluid as part of the resuscitation process. IO is often used in cases of critically ill or injured patients where intravenous access is either not possible or would represent a delay in administering treatment.

- v) IO fluid was administered, totalling 435ml in volume during the course of Alice's treatment.
 - vi) 450mg - weight/age adjusted dose of IO tranexamic acid ("TXA") was administered at 12:26. TXA is a drug used to help preserve/promote blood clot formation in the context of significant haemorrhage.
 - vii) 300mg – weight/age adjusted dose of IO adrenaline was given twice, with documented times of 12:24 and 12:40.
 - viii) A single episode of ventricular fibrillation ("VF") was experienced enroute to hospital. This was identified and appropriately managed with the delivery of an age/weight adjusted DC shock of 120J at 12:38 from the NWS defibrillator.
143. A decision was made at 12:28 by Advanced Paramedic Paul Brennan to transport Alice to the Emergency Department at Southport District General Hospital ("SDGH").
144. At 12:29, Alice is moved onto an NWS stretcher and taken from the scene to a nearby emergency ambulance A640. She is moved into the ambulance at 12:31.
145. A pre-alert radio transmission was made at 12:35 by Advanced Paramedic Paul Brennan to NWS EOC, who then in turn telephone this through to SDGH Emergency Department, to inform them of the transport of Alice to them for ongoing care. Emergency ambulance A640 is moving at this point. At 12:36 a Dispatcher working in NWS CIH calls SDGH to pass on the pre-alert. During this call an error was made by the CIH Dispatcher when passing on the detail of the clinical procedures that had taken place. Instead of confirming "*bilateral thoracostomies*" the CIH Dispatcher says that the patient has "*bilateral incisions to the knees*". This error was identified and corrected by the person receiving the call.
146. Whilst it is accepted that there should not have been any error in conveying the pre-alert from scene to the hospital, the error was identified and corrected by the person receiving the pre-alert. The relevant and pertinent information i.e. the nature of the injuries and that Alice was in traumatic cardiac arrest was provided in clear terms to the receiving team at SDGH Emergency Department.

147. After initiating all appropriate interventions within their skill set, Advanced Paramedic Paul Brennan accompanied the patient on the short journey from scene to SDGH. Their time of departure from scene was 12.35 with arrival at SDGH at 12:41 and into the resuscitation bay at 12:42, upon which a handover is given by Advanced Paramedic Paul Brennan to the attending trauma team.

148. Traumatic cardiac arrest ensues as a result of one, or a combination of four underlying pathologies. These form the basis of treatment priorities in cases of traumatic cardiac arrest and are often referred to as the 'HOTT principles':-

H – Hypovolaemia. In the context of trauma, this is as a result of significant blood loss.

O – Oxygenation. An injury that inhibits the body's ability to provide sufficient oxygen to sustain life.

T – Tension Pneumothorax. A pathology usually associated with trauma in which one or both lungs collapse leading to a build up of pressure that impairs the ability of the heart to fill and empty adequately, leading to cardiac arrest.

T – Tamponade (cardiac). As a result of cardiac trauma, usually from a penetrating injury but sometimes associated with blunt force, blood is lost from the heart through a wound and collects in the pericardial space between two membranes that surround the hearts surface. This blood is stagnant and clots leading to an inability for the heart to fill & empty, leading to cardiac arrest.

149. The treatment provided to Alice by the NWAS clinical teams included addressing each of these underlying causes. Where further intervention was deemed necessary, a clinically based decision was made to convey Alice to the nearest facility capable of delivering these interventions. At NWAS, Advanced Paramedics provide a core function in the delivery of care to patients who have sustained major trauma. This includes an in-depth knowledge of the major trauma systems, both within the area in which they operate but also across the North West region as a whole when undertaking their role within the NWAS CIH.

150. It is within NWAS guidance, supported by all adult Major Trauma Networks in the region and the North West Paediatric Major Trauma Network, that patients in traumatic cardiac arrest are transported to the nearest Trauma Unit unless a fully capable enhanced care resource is delivering care & treatment on scene.

151. Alice is the first patient to be conveyed away from scene at 12:35 reflecting her being attributed the highest triage category and prioritisation.
152. Transporting Alice to SDGH Emergency Department which is the nearest Trauma Unit was the only viable option available to the team caring for Alice. At the time of her departure from scene, H08 was the only HEMS resource on scene and that team were involved in delivering care to other patients affected by the incident. Similarly, the skill set of the Critical Care Paramedics were the same as those of the attending Advanced Paramedic, Paul Brennan, and so transferring care to the H08 team would have conferred no clinical benefit.
153. By the time that the first HEMS resource with full Doctor led capability (H58) arrived at their first patient's side it was 12.40, at which time Alice was already arriving at SDGH Emergency Department.
154. The decision to convey Alice to hospital via road ambulance is fully supported and in line with expectations. Transfer via road ambulance is often preferred to an air ambulance transfer due to the restrictions on delivering ongoing critical care to patients in air ambulances in flight, as opposed to the space afforded within the back of the ambulance, which also has the ability to stop to undertake time critical intervention if required. This would include the rapid identification and defibrillation of ventricular fibrillation as occurred with Alice.
155. The primary purpose of an air ambulance resource is to deliver the team and equipment to the patient. Patient transport is a secondary function and often not utilised because the benefits of doing so are outweighed by the risks and restrictions.
156. Transferring Alice by air to Alder Hey Children's Hospital was not feasible for several reasons. Firstly, it is not possible to deliver the full care required for a patient in traumatic cardiac arrest in flight. Second, the logistics of an air transfer would have constituted an unacceptable delay to the delivery of the immediate care that Alice required which included the administration of blood products, securing a definitive airway and ventilation and if appropriate, the performing of emergency surgical intervention, namely a resuscitative thoracotomy. These interventions are available at designated Trauma Units, such as SDGH Emergency Department as part of the Major Trauma Network system, in accordance with the NHS Major Trauma specification for Trauma Units.

157. H08 was later utilised to transport a patient from the incident to Alder Hey Children's Hospital. The documented times of H08 leaving scene at 13:02 and arriving at hospital at 13:17 only constitute part of the overall time for their patient's transfer time. The time of 13:02 is the time the aircraft would have lifted from the hospital landing site – prior to this, the patient would have been loaded on to a road ambulance, transferred from scene to the hospital landing site and then loaded on to the aircraft. A series of mandated safety checks would then have been undertaken before the aircraft lifted. Similarly, once arriving at the helipad at Alder Hey Children's Hospital, the aircraft would shut down and the patient unloaded on to a stretcher to be taken into the Emergency Department. In total, a conservative estimate of the time taken for the patient to leave the incident scene and arrive in the Emergency Department at Alder Hey Children's Hospital is a minimum of 30 minutes.

158. If these timings are applied to Alice's care, not only would her clinical condition of traumatic cardiac arrest preclude air transfer as an option, a transfer time of at least 30 minutes is in contrast to the 6 minutes taken to transfer her to SDGH Emergency Department by road.

Reflection on Events

159. NWAS is providing the Inquiry with its full co-operation and assistance and sees the Inquiry as an opportunity for further learning and improvement. NWAS is committed to addressing any issues/areas for improvement and will continue to do so as the Inquiry progresses.

160. NWAS has established processes in place which are designed to identify issues arising from incidents and to learn from them.

161. The Hot Debrief took place immediately after this incident with the Cold/Structured Debrief taking place some weeks later. The Cold Debrief brought groups of responders together to reflect on the incident and to identify what elements of the response could have been better.

162. The NWAS Debriefing Policy sets out that the debrief should be conducted in accordance with the College of Policing format. However, given the recent introduction of

new investigation methodologies with the implementation of the Patient Safety Incident Response Framework (“**PSIRF**”), a different format was used namely After Action Learning (“**AAL**”). Late in the debriefing process it became apparent that the AAL methodology was not meeting the needs of the Trust’s review of the incident and a more blended approach of the recognised College of Policing approach and AAL was adopted. This caused a substantial delay in the delivery of the final debrief report together with associated learning, actions and recommendations.

163. In relation to the use of AAL methodology, I confirm that a clear instruction has been communicated to the NWS team responsible for conducting debriefs, to the effect that only the College of Policing methodology is to be used.

164. NWS has now completed its debrief into the Southport Incident. Areas for learning and change have been identified and action is being taken to ensure learning is embedded within the workforce, as a result of changes to processes and procedures.

165. The NWS debrief identified twelve high level lessons and recommendations and a working group has been formed which meets regularly to distil these recommendations into actions and progress is ongoing in relation to implementation.

166. In relation to the debrief recommendations, I wish to specifically highlight the following elements of the NWS response, which I will then address in turn:

- a. Speed of establishing the command structure at operational level.
- b. Lack of process/action cards to support the actions of NWS CIH.
- c. Provision of paediatric analgesia.
- d. Use of Body Worn Video Cameras (“**BWVC**”).

Operational Command Structure

167. The Operational Command Structure did not establish itself on scene as quickly as would be expected and was incomplete, as was mentioned in the Hot Debrief and later raised within the Structured Debrief process. Having examined the incident timeline, the only Functional Roles allocated were those of Operational Commander, Safety Officer, Primary Triage Officer and an initial Parking Officer. The NWS IRP envisages that roles such as Parking Officer, Casualty Clearing Officer, Casualty Loading Officer and

Equipment Officer would have been appointed by the Operational Commander. Whilst it is accepted that these roles should have been filled and are likely to have facilitated better coordination of the resources at scene, I do not believe that the absence of these roles materially impacted the overall effectiveness of the NWAS response. For example, an Equipment Officer and/or Loading Officer would have been able to ensure that crews had all of the appropriate equipment to hand on vehicles before they left scene as it is understood that one resource (A664) left scene and conveyed a patient to hospital without full equipment available onboard the vehicle.

NWAS CIH

168. CIH played an important and positive role in the NWAS response to the incident including the quick identification and deployment of Advanced Paramedic and HEMS resources to scene. Although CIH was established in August 2022, CIH did not have a defined major incident role with the IRP and Action Cards in place at the time of the Southport Incident. The absence of defined role or Action Card did not prevent the CIH from taking actions, it did however lead to the duplication of some actions which caused confusion. For example, there was confusion over which communication routes crews should be using to provide a pre alert to hospitals for inbound patients; some pre alerts were communicated by CIH and others by Dispatch. Another example is that CIH alerted the receiving hospitals of the major incident which is in fact the role of the Regional Operational Coordination Centre ("**ROCC**").

169. Beyond the contemporaneous notes that were made by one member of the CIH, no formal log was kept by CIH as would be expected from key roles/functions during a major incident.

170. NWAS updated its IRP on 1 June 2025 and I confirm that CIH does now feature within it, although there is an opportunity for its role to be further defined and incorporated by way of a dedicated action card.

Paediatric Analgesia

171. Having undertaken a clinical review for the purposes of the NHSE Clinical Debrief, it was noted that the pain relief administered to paediatric patients was oral paracetamol. Patients with IV access could have received parenteral paracetamol or morphine but

NWAS had also introduced oro-dispersable morphine in November 2023 (with a reminder issued by way of Clinical Bulletin dated 2 July 2024 – **Exhibit DA/06 – NWAS001086**) as an additional means of analgesia however, the clinical review did not identify use of this. Whilst morphine may not have been clinically appropriate in all circumstances, its absence has highlighted a need for further education and awareness amongst NWAS clinicians.

Use of BWVC

172. NWAS introduced BWVC approximately 3 years ago, this was initially part of a national trial to assist in reducing violence and aggression towards staff. In September 2023, NWAS updated its BWVC policy and extended the scope and use of BWVC during a major incident scenario. In line with the policy, there was an expectation that all commanders and clinical leads use BWVC within a major incident to allow the capture of contemporaneous actions and provide situational awareness to assist in incident reviews.
173. Whilst there was some use of the BWVC, it was not as extensively used as would be expected; four cameras were used as against the thirteen that we would have expected. There are several reasons why the cameras were not used for example, issues with how the cameras attached onto uniforms, poor camera battery life and not having the correct ID badge to gain access to the storage cabinet. These are issues and challenges that are encountered by staff on a day to day basis and not just on occasions of a major incident.
174. NWAS is currently undertaking a review into the suitability of our current camera equipment and the matters identified in the Southport Incident are an important consideration.

Actions relating to Alice

175. Alice was one of the first patients to be treated at scene and as has been outlined within this statement, received all appropriate clinical interventions, including enhanced interventions from Paul Brenan, an Advanced Paramedic. She was the first patient to be transported from scene and was taken to a Trauma Unit that was a short distance away from scene, where she received definitive care that was unavailable at scene.
176. Emergency ambulances, RRVs, Advanced Paramedics, BASIC Doctors and HEMs were all dispatched quickly to the scene and were able to provide a clinically led response.

The NHSE Trauma Network review and the NWS Clinical Debrief identified that all appropriate clinical interventions were provided in an appropriate timeframe.

177. Whilst it is accepted that the Debrief report identifies elements of the NWS response that could have been improved, it is not considered that those elements have negatively impacted on the care and treatment Alice received, including the speed at which she received it. The matters identified in the Debrief report are largely focused on the response to the incident as a whole, and the expectations of those responding to a major incident – often for the very first time.

178. There have been a number of changes and improvements to NWS' practices since this incident. Some of the changes were already planned and others have been introduced directly as a result of the learning identified from the incident: -

Duty Officer

179. NWS introduced the new role of Duty Officer in January 2025. The introduction of this role was planned as part of a substantial operational leadership review which commenced in 2022 but was shaped and influenced from learning that was identified from the Manchester Arena Inquiry. Duty Officers are trained operational commanders who operate on a 24/7 basis. There are six Duty Officers on duty 24/7 (two in each part of NWS' operational regions) and their principal role is to provide leadership and command and control at complex or major incidents.

180. We are continuing to extend the remit of Duty Officers and are recruiting an additional eighteen Duty Officers who will work on rotation in the EOC environment. The extended remit of the role will provide a 24/7 interface between Commanders deployed at scene and our EOCs to ensure incidents are managed as effectively as possible.

RVP and Stand-off Procedure

181. Following feedback and learning from incidents, specific and updated guidance has been introduced to support dynamic decisions relating to 'stand-off' from incidents and timeframes for re-assessing that position. The procedure, which can be found at **Exhibit DA/07 – NWS001087** does not change the position in relation to an RVP or stand-off

but provides guidance and a framework to support colleagues with respect to decision-making in this regard.

Updated IRP

182. A number of amendments have been made to the IRP (Version 9.1) to reflect the learning identified from this incident. The updated IRP and Actions Cards can be found at **Exhibit DA/08 – NWAS001088** and **Exhibit DA/09 – NWAS001089**.
183. The IRP has been designed to support the response to any type of incident that needs managing, not just a major incident. The intention is that the important scene management actions are embedded into every day practice so they are familiar when responders are facing a complex incident.
184. The process of Triage Sieve and Sort has been replaced with the NHSE updated Ten Second Triage (“TST”) and Major Incident Triage Tool (MITT). Both of these support rapid initial casualty triage.
185. Following the integration of the call handling functions for the urgent 111, emergency 999 and non-urgent patient transport functions, the EOC is now known as the Integrated Contract Centre (“ICC”). With the integrated call handling function and recognition of the fundamental role ICC plays in responding to a major incident, the updated IRP now includes a specific section for the ICC.
186. The PDA has been updated to increase the number of resources to be dispatched in the event of a major incident standby or major incident declared and also ensure that it reflects the changes to the operational leadership structure.
187. As indicated above, the debrief process identified a number of areas for change and improvement. A task and finish group has been convened to deliver action and change within a managed timescale; the group consists of senior leaders from multiple departments within NWAS to ensure there are collaborative solutions in place to improve the NWAS response. Progress against these actions is being managed via the Trust’s Management Committee and Board.

Commander Training 2026/27

188. NWS's annual command training cycles commence in July each year with the training plan and material being prepared in the period March to May. Regrettably, the delay in concluding the Structured Debrief Report meant that the 2025/26 command training plan had already been set and could not be updated to reflect any matters identified by the Structured Debrief. I confirm that the annual commander training programme for 2026/27 will be heavily influenced by the Southport incident with focus being brought to matters identified in the debrief. For example, the use of BWVC, communication between commanders, contents of action and decision logs, declaration of major incidents and self deployment.
189. The Inquiry has asked me to consider whether the guidance, training and resources available to NWS were adequate for the nature of the incident. As NWS is a Category 1 responder under the Civil Contingencies Act, it is required to have emergency plans in place, share information with other local responders to enhance the co-ordination of a multi agency response and cooperate with other local responders to enhance co-ordination and efficiency.
190. In order to meet the requirements of the Civil Contingencies Act, as well as the national guidance issued by National Ambulance Resilience Unit ("**NARU**"), NWS developed and maintained an IRP which supports and guides the response to an incident such as that at Southport.
191. National guidance is also provided by the Joint Emergency Services Interoperability Programme ("**JESIP**"). In my view JESIP is adequate and provides a framework for the emergency services to work together collaboratively. It sets out agreed approaches to risk and mitigation which all services can follow.
192. It is my view that the emergency services coordinated together on scene and worked well to ensure that patients received the clinical care that they needed.
193. The NWS IRP mentioned above, was in my view appropriate and sufficiently flexible to be adapted to a wide range of incidents. The IRP has been reviewed and updated since the Southport incident and includes a number of the changes to reflect learning from the Southport Incident, as detailed at paragraphs 182 to 187 above.

194. All ambulance commanders undertake a programme of training provided by NARU prior to formally taking up an NWAS command position. Thereafter, NWAS provides training on an annual basis. The annual training is delivered across two days and the programme of training is shaped by changes to national policy, procedure and learning identified through local debriefs. I believe that the national commander training programme delivered by NARU is adequate and appropriate and the NWAS commanders receive sufficient annual training and education to enable them to perform their roles.
195. In relation to our frontline responders, I do consider that they receive appropriate training, education, resources and guidance to be able to treat and care for patients with traumatic injuries. Thankfully, incidents such as those at Southport are rare but I do acknowledge that frontline responders do have limited opportunity to undertake simulated major incident training and exercising.
196. At the conclusion of the Manchester Arena Inquiry, the Inquiry Chair Sir John Saunders, made a number of monitored recommendations, and specifically Monitored Recommendation 20 (“**MR20**”) which stated that: *“North West Ambulance Service should ensure non specialist ambulance personnel are involved in multi-agency exercising”*.
197. Since the publication of the Manchester Area Inquiry Report, NWAS has ensured that mandatory training time in relation to incident management has been allocated to all operational frontline staff by way of classroom and online training. Training has been provided in relation to first resource on scene/Acting Operational Commander actions, recognition of major incidents, specialist capabilities, scene management, major incident triage and the trauma kits now included within the standard NWAS response bags.
198. Whilst NWAS has been able to provide classroom and online learning to our frontline responders, it is a challenge to be able to release them from duty in order to undertake simulated training and exercising. In accordance with MR20, NWAS, along with all other ambulance services, have submitted their individual assessment of need based on the Manchester Arena recommendations, along with corresponding funding requests to commissioners, which are still under consideration by NHSE.
199. NWAS has reflected on the speed of its response to the Southport incident and whether an appropriate level of resource was allocated. Despite the operational pressures, NWAS

was able to quickly allocate and deploy a large number of resources, including enhanced capabilities such as HEMS. Some of those resources, however, including the two Advanced Paramedics who responses and H58, needed to travel some distance to reach the scene.

200. NWAS does have the appropriate level of operational resources to meet the demands of normal activity. Major incidents however, do present significant capacity challenges to NWAS and all other ambulance services. Due to commitments to our normal business, the arrival of resources at a major incident can be slower than the public may expect given most resources are routinely engaged with other patients, as was the case with H72 and H03, the HEMS resources with consultant led teams and blood products.

201. The additional resourcing identified and asked for as part of MR20 would both facilitate capacity to allow enhanced training and an increased exercising regime but also additional capacity to respond in the event of a major incident.

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed:  **Signature**

Dated: 29 July 2025

ANNEX 1

Exhibit Index to the Witness Statement of Daniel Ainsworth

Exhibit No.	Inquiry Reference No.	Document Description
DA/01	NWAS000011	NWAS Supporting Dispatch Guidance [EOC-BAU-15D]
DA/02	NWAS000014	NWAS internal questionnaire for a suspected Marauding Attack or Major Incident [EOC-MI-01]
DA/03	NWAS000008	NWAS guidance on the triage of multiple patients [EOC-BAU-06C]
DA/04	NWAS001084	EOC Procedure for Violent and Aggressive Incidents [EOC-BAU-33D]
DA/05	NWAS001085	EOC Procedure for Firearms Incidents [EOC-BAU-16D]
DA/06	NWAS001086	Clinical Bulletin dated 2 July 2024
DA/07	NWAS001087	Scene Safety Stand Off and RVP Guidance
DA/08	NWAS001088	Incident Response Plan Version 9.1
DA/09	NWAS001089	Action Cards Version 9.1