

Wednesday, 24 September 2025

1
2 (10.00 am)
3 **SIR ADRIAN FULFORD:** Yes, Mr Goss.
4 **MR GOSS:** Thank you, sir. Could the witness be sworn,
5 please.
6 **SIR ADRIAN FULFORD:** Could you stand for this, please.
7 **CI ANDREW ALAN HUGHES (sworn)**
8 **Questioned by MR GOSS**
9 **SIR ADRIAN FULFORD:** Thank you very much. Do have a seat.
10 **A.** Thank you.
11 **MR GOSS:** May it please you sir, could you give the Inquiry
12 your full name, please?
13 **A.** Yes, it is Andrew Alan Hughes.
14 **Q.** You are a Chief Inspector in Merseyside Police?
15 **A.** That is correct.
16 **Q.** Could we have up on the screen, please, MERP007548. Is
17 this a witness statement that you have produced for the
18 Inquiry?
19 **A.** That is right.
20 **Q.** If we go to page 25, please, we can see that, beneath
21 the redaction, you have signed that on 1 August this
22 year?
23 **A.** That is right.
24 **Q.** Would you like to adopt that statement as part of your
25 evidence to the Inquiry?

1

1 it at paragraph 5 in your witness statement, can
2 I summarise it as supervising the response of the Force
3 control room to significant incidents, including the
4 initial firearms response, until a wider command
5 structure can be put in place?
6 **A.** That is right.
7 **Q.** Part of that role then is to decide on the most
8 effective, initial operational police response and to be
9 the tactical commander of an incident until it is handed
10 over?
11 **A.** Yes, correct.
12 **Q.** In terms of practicalities, you are based in the Force
13 control room?
14 **A.** Yes. In Aintree.
15 **Q.** Thank you. You are in a separate office from the main
16 control room; is that right?
17 **A.** That's right, yes.
18 **Q.** Just describe for us your working environment there.
19 **A.** So, the control room is quite a large room, probably
20 something around this size and it is split into
21 different areas. There is a call handling area and then
22 there is the response area where all the operators sit
23 in different pods for different areas around the Force
24 and they have banks of screens that they use the various
25 systems. And then my office is adjacent to the main

3

1 **A.** Yes, please.
2 **Q.** Is it true to the best of your knowledge and belief?
3 **A.** It is.
4 **Q.** Could I start, Chief Inspector, with a little bit about
5 you. You were tested as a Police Constable in 2002?
6 **A.** That is right.
7 **Q.** So as of July 2024 you had been a police officer for
8 some 22 years?
9 **A.** That is right.
10 **Q.** You had previous experience as a firearms officer,
11 including as a Firearms Sergeant?
12 **A.** Yes.
13 **Q.** You are qualified as a Firearms Tactical Adviser?
14 **A.** Yes.
15 **Q.** And as an Initial Tactical Firearms Commander.
16 **A.** That is right.
17 **Q.** Am I right that, also in your career, you have served as
18 a Response Officer and also as a Response Sergeant?
19 **A.** That is right.
20 **Q.** You became a Force Incident Manager, or FIM, in March
21 2023?
22 **A.** Yes.
23 **Q.** You are still in that role now?
24 **A.** I am.
25 **Q.** Just dealing then with the role of the FIM, you describe

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1 control room and we have four different terminals that
2 can accommodate four different people. So, day to day,
3 there are two FIMs in the office and we have desks just
4 next to each other and we have the various screens for
5 the various systems that we use day to day.
6 **Q.** We will come to that in a moment. You say day to day
7 there are two of you. Am I right that you always work
8 in pairs?
9 **A.** There are always two on duty 24/7.
10 **Q.** The pairs are usually but not always drawn from a set
11 group of three, so that there's somebody who can cover
12 for leave, training, those sorts of matters?
13 **A.** Yes, that is correct.
14 **Q.** What's the division of responsibilities between the two
15 of you?
16 **A.** So, in 2023 we changed to a different Force operating
17 model. Prior to that, there would be a Force duty
18 officer, which would deal with, like, resourcing issues
19 across the Force and various administration issues. Due
20 to the change of the operating model, the Force Incident
21 Manager's office absorbed that role, so one FIM, day to
22 day, will be the Force duty officer and will do the
23 Force duty officer duties, such as -- there are various
24 corporate meetings that we chair and we attend
25 throughout the day, just to ensure operational policing

4

1 is fully resourced. And one will be the ITFC, so they
 2 will deal mainly with the logs that come -- that are
 3 referred to the control room.
 4 **SIR ADRIAN FULFORD:** ITFC?
 5 **A.** Sorry, Initial Tactical Firearms Commander.
 6 **SIR ADRIAN FULFORD:** Can you remember to give at least once
 7 the full meaning of an acronym, thank you very much.
 8 **A.** Will do.
 9 **MR GOSS:** Thank you, sir.
 10 In terms of the systems then, you mention the
 11 terminals that you have available to you in that office?
 12 **A.** Yes.
 13 **Q.** You have access to all of the command and control logs
 14 on a system called, I think, Storm?
 15 **A.** Yes, so we have Storm CAD, which is used in the control
 16 room, so we have access to Storm CAD.
 17 **Q.** Computer Added Dispatch?
 18 **A.** Yes.
 19 **Q.** Do you have radio systems?
 20 **A.** Yes, so we have the IC System, which is the integrated
 21 communication system, so that allows a selection of
 22 various radio channels and is also like to take
 23 telephone calls and make telephone calls.
 24 **Q.** So you have a single radio and telephony system?
 25 **A.** Yes, we also have Skype that we use to make internal

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1 by reference to area and "Eastings" and "Northings".
 2 If we come down to "Graded Response/Classification
 3 Details", again, further information there about the
 4 incident and we will come back to some of this in
 5 detail.
 6 Could we go to page 2, please. This is the log
 7 itself isn't it?
 8 **A.** It is, yes.
 9 **Q.** So there are individuals who are making entries onto the
 10 log and we can see there, running from left to right,
 11 you have a date and time, you have a user ID and
 12 workstation, so that is an individual is the user ID and
 13 the workstation is the terminal they are using?
 14 **A.** That is correct, yes.
 15 **Q.** Thank you. There is a category of message and then
 16 there is a message, which is the actual content, which
 17 is either automatically generated, as I suspect that one
 18 is --
 19 **A.** That is, yes.
 20 **Q.** -- or it is something that somebody has entered via
 21 a keyboard?
 22 **A.** That is correct, yes.
 23 **Q.** We will look at a number of those entries but I just
 24 wanted to orient ourselves to that document, so that we
 25 are familiar with it?

7

1 calls.
 2 **Q.** Do you have access to databases of information held by
 3 Merseyside Police and policing generally?
 4 **A.** Yes, so we have access to the Niche database that
 5 contains all the information -- anybody who has any
 6 dealings with the police, it is all recorded on a Niche
 7 system so people who are arrested they report crimes to
 8 us, or there's intelligence held on anybody, it is all
 9 held within that one system.
 10 **Q.** Niche is a Merseyside Police system, rather than
 11 a national system; is that right?
 12 **A.** It is but other Forces -- so we have a tri-service
 13 collaboration with -- I think it's -- I think it is
 14 North Wales and Cheshire Police and I think Lancashire
 15 Police use it but I'm not too sure. But other Forces do
 16 use it and we can get access to other Forces'
 17 information.
 18 **Q.** Could we have on screen, please, MERP000469 and this is
 19 the Storm log for Hart Street on 29 July. I just want
 20 to orient ourselves to that, if that's all right?
 21 **A.** Okay.
 22 **Q.** So we see at the top of the page there are incident
 23 details, it gives a reference number, date opened, date
 24 received, reporting method, a lengthy list of involved
 25 officers. Can we come down -- it also gives a location

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1 **SIR ADRIAN FULFORD:** That's very helpful.
 2 **MR GOSS:** You have mentioned some of the other people
 3 working in the Force control room. You would have 999
 4 and 101 call handlers; is that right?
 5 **A.** That is right.
 6 **Q.** You then have dispatchers who would have a log assigned
 7 to them and then they seek to resource that log with
 8 officers they pass on the information to those on the
 9 ground?
 10 **A.** That is right, they would manage the radio channel day
 11 to day and dispatch officers.
 12 **Q.** You have control room supervisors to deal with any
 13 initial issues as they emerge?
 14 **A.** Yes.
 15 **Q.** Is there also access to any sort of intelligence or
 16 research cell within the control room?
 17 **A.** So we have the Force Intelligence Bureau, they are
 18 located at the OCC, which is the Operational Command
 19 Centre, in Speke. So if we need any intelligence
 20 research done, we can call them and give them the log
 21 number and ask them to carry out some intelligence
 22 research on that.
 23 **Q.** So they are not co-located but it is --
 24 **A.** They are not co-located in that location but they are
 25 available 24/7 to us.

8

1 Q. Then, in terms of your command and control, where we are
 2 dealing with a firearms incident, you were the Initial
 3 Tactical Firearms Commander, the ITFC?
 4 A. That is right.
 5 Q. There would then be an Operational Firearms Commander on
 6 the ground --
 7 A. That is right.
 8 Q. -- to whom you give direction?
 9 A. Yes.
 10 Q. You would report up to a Strategic Firearms Commander,
 11 a SFC?
 12 A. That is right.
 13 Q. Then, as the event matured, you would hand over the
 14 initial TFC responsibilities to a standing TFC?
 15 A. That is correct, yes.
 16 Q. Alongside that, as part of the broader incident
 17 management, you, when an incident is running, would be,
 18 in effect, the initial Silver Commander?
 19 A. That is right, yes.
 20 Q. You then have a number of Critical Incident Managers,
 21 CIMs on the ground for different local policing areas?
 22 A. That's right.
 23 Q. So, again, you would give direction to them. Are those
 24 officers in the rank of Inspector?
 25 A. They are, yes.

9

1 Interoperability Channel, which we sometimes see as
 2 ESIC?
 3 A. That would be one of the routes and also we could call
 4 them direct.
 5 Q. Can we call up NWAS000016, please.
 6 This is the regional standard operating procedure
 7 for that Emergency Services Interoperability Channel.
 8 We can see at the top left it is a document that
 9 Merseyside are party to, isn't it?
 10 A. Correct, yes.
 11 Q. Could we go to page 6, please, and could we look at
 12 paragraph 1.6. It is recognised there that terminology
 13 between different organisations and indeed acronyms can
 14 differ and part of the purpose of this is to ensure
 15 clarity between organisations in terms of this policy,
 16 this operating procedure. It is to ensure clarity
 17 between organisations when sharing information?
 18 A. Yes.
 19 Q. If we could look, please, at page 8 and paragraph 3.2.
 20 The Talk Group, so that is the Channel, effectively:
 21 "... should be used during any spontaneous and
 22 preplanned situation that requires the passage of
 23 immediate safety critical information between police,
 24 fire and ambulance control rooms."
 25 That's the purpose of that Channel?

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1 Q. Do they double as the Response Inspector for that local
 2 policing area?
 3 A. They are, yes.
 4 Q. Then, above you, as the initial Silver, again it is
 5 similar to the firearms chain, there would be a duty
 6 Gold Commander who is stepping in once an incident has
 7 been initiated?
 8 A. Yes, so there's a duty National Police Chiefs' Council
 9 officer on duty and there is also a public order public
 10 safety Gold Commander on duty.
 11 Q. Then, in the same way as you would hand over from being
 12 ITFC to a standing TFC, there comes a point where you
 13 would hand over your initial Silver duties, if I can put
 14 them that way, to a standing Silver Commander?
 15 A. That is correct, yes.
 16 Q. Those then are the links within the control room. Are
 17 there also links outside to other agencies? So,
 18 ambulance, Fire Service, Coast Guard, National Police
 19 Air Service, other police forces, hospitals, Counter
 20 Terrorism Policing?
 21 A. There are, yes. There are on-call people -- for
 22 counter-terrorism we have an on-call number we can call
 23 if we need support from them.
 24 Q. Is one of the main methods of communicating directly
 25 with other emergency services the Emergency Services

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1 A. It is, yes.
 2 Q. Thank you. As well as this, there is a number of other
 3 different relevant policies that I just want to
 4 establish, first of all, if we can, Chief Inspector.
 5 Particularly from within policing, you have national
 6 policies from the College of Policing but then also
 7 local policies within Merseyside Police; is that a very
 8 outline assessment?
 9 A. Yes. The college of Policing produce authorised police
 10 practice, covering various areas of police work.
 11 Q. Could I start with call handling. Could we have
 12 MERP007530, page 11, please.
 13 This is the Merseyside call handling policy. It
 14 sets out there the various grades of call in the table
 15 and also the timings that are supposed to be met for
 16 response --
 17 A. Yes.
 18 Q. -- in particular:
 19 "Emergency response
 20 "Attendance within 10 minutes."
 21 A. Correct.
 22 Q. Just help us please with the mechanics of that. A 999
 23 call doesn't come directly to Merseyside Police, it
 24 first of all goes to a BT control room; is that right?
 25 A. That is correct, yes.

12

1 Q. That is where the caller is asked, "Which emergency
2 service do you require?" --
3 A. Yes.
4 Q. -- and they are then transferred to the relevant control
5 room?
6 A. They are, yes.
7 Q. The call handler within your Force control room will
8 then take initial details and they will grade the call
9 accordingly?
10 A. That's right, yes.
11 Q. Then officers will be dispatched in line with the
12 grading?
13 A. That's right.
14 Q. Can you help us with what point the 10 minutes
15 attendance starts from?
16 A. I think that 10 minutes starts from the initial call
17 coming in.
18 Q. The initial call coming into Merseyside?
19 A. To Merseyside Police, yes.
20 Q. So it isn't the point the call is made and picked up by
21 BT, it comes into Merseyside and then it is 10 minutes
22 from there?
23 A. That's my understanding.
24 Q. If we could look a little bit further down that page,
25 please. You should have the definition of emergency.

13

1 different areas of the Force. So the response time of
2 10 minutes may not get hit in terms of them getting to
3 scene.
4 Q. You refer in your witness statement at paragraph 24 to
5 some learning from the Manchester Arena Inquiry, which
6 is that, in some situations, it may be appropriate, even
7 when there is, for example, a bladed weapon threat, to
8 deploy unarmed officers forward with caution?
9 A. That's correct, yes.
10 Q. That's something that you refer to one of your
11 colleagues having done a good deal of training with FIMs
12 and other responders to help develop thinking after the
13 Manchester Inquiry?
14 A. That's correct, yes.
15 Q. Is that training recorded in any sort of Merseyside
16 policy or procedure at all?
17 A. I'm not entirely sure about that. It would be
18 recorded -- any officers who have attended, it would be
19 recorded as continual professional development.
20 Q. So it is recorded for the officers that they have been
21 to the training?
22 A. Yes.
23 Q. But as a piece of policy, that may not have made it
24 into, for example, the call room response policy yet?
25 A. No. I know there will be a lesson plan for that

15

1 Yes, 3.16. Emergency covers: risk to life; use of or
2 immediate threat of violence; serious injury to
3 a person; or, just over the page, an allegation of
4 criminal conduct which is likely to be serious or in
5 progress?
6 A. Correct, yes.
7 Q. Then at 3.17, call handlers are also instructed to flag
8 certain incidents to the FIM at the earliest
9 opportunity, and that would include cases where the
10 caller has indicated that a firearm or a bladed weapon
11 is involved?
12 A. That's right.
13 Q. You describe at paragraph 24 of your witness statement
14 the purpose of that. It is so the FIM can ensure that
15 the police response is both as quick as possible but
16 also as appropriate as possible?
17 A. That's right.
18 Q. We can see there, in 3.17.1:
19 "Whilst such incidents require an emergency
20 response, it may not be possible to achieve an emergency
21 response time."
22 Is that because officers deployed to that incident
23 may need to hold back, due to the level of risk?
24 A. That is right. Depending on the level of risk, if
25 I deploy firearms officers, they may be travelling from

14

1 training.
2 Q. As part of managing an incident response, a FIM can
3 decide whether to declare a critical or a major
4 incident; is that right?
5 A. That is correct, yes.
6 Q. You defined them in your witness statement in
7 paragraph 13. A major incident is an event or situation
8 with a range of serious consequences which requires
9 special arrangements to be implemented by one or more
10 emergency responder; is that right?
11 A. That is right.
12 Q. A critical incident is where any effectiveness of
13 a police response is likely to have a significant impact
14 on the confidence of the victim, their family and/or the
15 community?
16 A. That's correct, yes.
17 Q. How do these two definitions interact: are they in
18 ascending order of seriousness; do they sit in different
19 spheres in some way?
20 A. So, a critical incident would be mainly for an internal
21 Merseyside function that wouldn't involve the other
22 emergency services. So it is a method of ensuring that
23 there is -- the threat is managed effectively and the
24 response and the investigation is resourced and managed
25 appropriately, and there's a wraparound about all the

16

1 departments working together.

2 There would be various meetings, there would be
3 a critical incident meeting shortly after the incident,
4 to ensure the response was effective and the
5 investigation was progressing, and then probably the
6 next day after the incident, there would be a follow up
7 meeting to ensure that the investigation was
8 progressing.

9 So the critical incident is mainly an internal
10 Merseyside Police mechanism, and then the major incident
11 involves all the other emergency services and would
12 require a tactical coordination group meeting to be held
13 and then that wraparound sort of interoperability with
14 the other services.

15 **Q.** That major incident process, is that where we start to
16 see what is referred to as JESIP, the Joint Emergency
17 Service Interoperability Principles?

18 **A.** That's correct, yes.

19 **Q.** Could we have MERP007533, please, and page 2 in the
20 first instance. Are these the JESIP principles?

21 **A.** They are, yes.

22 **Q.** Then I'm not going to go through them one by one, but
23 then on the previous page, linked to JESIP is the idea
24 of a M/ETHANE report, which is a report designed to
25 create shared understanding between all emergency

17

1 incident. So an RVP in an initial phase is to keep
2 unarmed staff away from a location that might not be
3 safe for them to attend.

4 **Q.** Could we have NWAS001087, page 2, up, please. Again,
5 this is a North West Ambulance Service policy.

6 **A.** Yes.

7 **Q.** Could we have paragraph 2.1, please. I think it will
8 probably be page 5. Yes.

9 This describes a rendezvous point in similar terms
10 as in the APP in the ambulance service doctrine; is that
11 fair?

12 **A.** That's correct, yes.

13 **Q.** Could we just bring up 2.2. This describes the
14 ambulance policy of "standing off". In effect,
15 ambulances moving towards an incident but then waiting
16 a short distance away until they are satisfied the scene
17 is safe for them to approach. Do those two concepts
18 between them cover the two meanings of RVP that you just
19 set out: one for use of the major incident; but one,
20 an area for people to gather while waiting for a scene
21 to be safe to approach?

22 **A.** That's right, yes.

23 **Q.** The ambulance service are clear across those two
24 paragraphs that those are not the same thing; they are
25 different concepts?

19

1 services --

2 **A.** That's correct, yes.

3 **Q.** -- in respect of a major incident or a potential major
4 incident?

5 **A.** That is right.

6 **Q.** It is called a M/ETHANE report, sometimes it is also
7 seen as an ETHANE report, where a major incident hasn't
8 yet been declared?

9 **A.** It is, yes.

10 **Q.** Could we have MERP007548 and paragraph 23 up please,
11 which is page 9. You have set out there some of the APP
12 as regards rendezvous points or RVPs?

13 **A.** Yes.

14 **Q.** Looking at that description -- a rendezvous point is
15 part of that multi-agency response to an incident; is
16 that fair?

17 **A.** That's correct, yes.

18 **Q.** Looking at that description, is it one that is wholly
19 suited to the very early initial operational response to
20 a spontaneous incident? I'm thinking, for example, at
21 the end of the first paragraph, it says "An RVP manager
22 should be appointed", and then in the paragraph
23 beginning, "The location of a RVP", it says it should be
24 searched prior to use.

25 **A.** So, an RVP in that instance is more suited to a major

18

1 **A.** Yes.

2 **Q.** You have used "RVP" a few moments ago to mean both of
3 those things. Is there a risk that the use of RVP to
4 mean two slightly different things could generate
5 a degree of confusion in responding to an incident?

6 **A.** It could be but, as the police service, we don't use the
7 term "standing off", we only use the term "RVP".

8 **Q.** Is it known to the police that the ambulance service do
9 use the term "RVP" in that specific way and use "stand
10 off" for the other meaning?

11 **A.** It wasn't known to me prior to getting the disclosure
12 for the Inquiry and reading the policy of NWAS.
13 I wasn't aware that that was something they did.

14 **Q.** Because one of the implications of the ambulance policy
15 of stand off, which is linked to the meaning of RVP in
16 police but also in ambulance doctrine, is that one of
17 the most important pieces of information to be passed to
18 the ambulance service is when the scene is safe to
19 approach?

20 **A.** That's correct, yes.

21 **Q.** Whose responsibility is it to determine whether the
22 scene is safe to be approached?

23 **A.** Well, for the ambulance service I think the individual
24 crews make their own risk assessment but they would be
25 based on information given by the police at the time,

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1 whether it be police officers on the ground or via the
 2 control room.
 3 Q. Where it has been possible for the police -- and we will
 4 explore how this unfolded on the ground shortly -- where
 5 it has been possible for the police to ascertain that
 6 a scene is safe or is reasonably safe, it would be
 7 helpful, wouldn't it, if that information was passed
 8 promptly and clearly to the ambulance service?
 9 A. It would be, yes.
 10 Q. That effectively enables them to shortcut their own risk
 11 assessment, having to judge it for themselves from some
 12 distance away --
 13 A. Yes.
 14 Q. -- and go, "We know there were police officers on the
 15 ground advising us it is safe, we can come forward"?
 16 A. That is right, yes.
 17 Q. Ultimately, though, it does remain the Ambulance
 18 Service's responsibility but they may well be acting on
 19 the information from the police?
 20 A. That's better information for them.
 21 Q. Would that be the sort of information that could
 22 helpfully be passed over the Emergency Services
 23 Interoperability Channel?
 24 A. It could be, yes.
 25 Q. Can I turn then to 29 July 2024. You were on duty as

21

1 numerous persons, numerous casualties. That led to it
 2 being transferred to a supervisor; is that right?
 3 A. That's right.
 4 Q. They determine that Southport police station should be
 5 the RVP in the event one is required. That's about five
 6 minutes' drive from Hart Street?
 7 A. At normal road speed, yes.
 8 Q. So if driving with blue lights and sirens on, can
 9 probably cut a minute or two off that?
 10 A. Yes.
 11 Q. Again, was this intended to be an RVP in the major
 12 incident JESIP sense or a location to rally before
 13 determining whether the scene was safe to approach?
 14 A. It would be the latter, to gather resources before
 15 I could make a decision on what was going to happen at
 16 the scene.
 17 Q. There were a number of other calls being received around
 18 this time as well, we have heard about some of those
 19 from DCI Pye and they were all being incorporated into
 20 this master log; is that right?
 21 A. Yes.
 22 Q. I don't need to go through those in detail --
 23 A. Okay.
 24 Q. -- other than to ask this: is it fair to say that the
 25 initial stages of any spontaneous incident like this are

23

1 FIM1, so primarily taking the minute-by-minute,
 2 hour-by-hour operational role?
 3 A. That is correct, yes.
 4 Q. Your colleague, Chief Inspector Arrowsmith was FIM2?
 5 A. He was the Force Duty Officer role.
 6 Q. He wasn't one of your usual pod of three. I think he
 7 was covering a shift for somebody else?
 8 A. He was, yes.
 9 Q. You have told us about the FIM room that you are based
 10 in at the Force control room. Could we have
 11 paragraph 30, which is page 11 of MERP007548, please.
 12 You have set out there a summary of the initial 999
 13 call that was received and we know that was received
 14 from Leanne Lucas. She made it at either 11.46.31 or
 15 11.46.33. I think it was first received by MerPol, so
 16 having come through BT at 11.47.08. Does that sound
 17 right?
 18 A. That sounds right.
 19 Q. We see the log is opened at 11.47.
 20 First of all, we can see it's immediately graded as
 21 an emergency response. I don't think anyone would
 22 disagree that that was the appropriate grading?
 23 A. Of course not.
 24 Q. Can we look at paragraph 31, please. In the initial
 25 details received: boy with a knife who had stabbed

22

1 inevitably fast moving and confusing?
 2 A. That would be correct, yes.
 3 Q. You have information, sometimes conflicting information,
 4 coming in from a variety of sources?
 5 A. That's right.
 6 Q. Could we look at MERP008178, please, on page 5 -- sorry,
 7 one page on, thank you. This is a debrief report from
 8 after the incident and, Chief Inspector Hughes, you were
 9 participant 5 in this debrief?
 10 A. Yes.
 11 Q. Can we look at line 3. I should say that Mr Arrowsmith
 12 was participant 4. If we look at line 3:
 13 "When log comes in, difficult to follow at times,
 14 when multiple calls coming in, have to look at open door
 15 numbers to see what information is coming from the same
 16 or different calls. Varying styles of how the logs are
 17 populated ..."
 18 There is a recommendation:
 19 "Consider training for further calls being
 20 documented on the log so can be differentiated ...
 21 possibly different colour text ..."
 22 Both of you then, 4 and 5, raised concerns about the
 23 speed with which information was coming into that log,
 24 multiple calls coming in and have suggested a potential
 25 mitigation for that. Is that something that's being

24

1 taken forward at all?

2 **A.** I don't know whether that's been taken forward.

3 **Q.** Could we go back then, please, to MERP7548,

4 paragraph 35, which is on page 12. We've heard a little

5 bit about this already, Chief Inspector, but I just want

6 to cover the initial deployment of officers to the

7 scene. I think that was done by the supervisors on

8 their initial -- or by the dispatchers and supervisors,

9 on their initial receipt of the call?

10 **A.** That's correct, yes.

11 **Q.** You've set out the call signs there but, in summary, you

12 have BR102, which is Sergeant Gillespie, dispatched at

13 11.48, arrived at 11.56, and he was the first on scene?

14 **A.** That's right.

15 **Q.** You have BM116, that's PC Shakespeare, Taser equipped,

16 dispatched at 11.49, arrived at Southport Police Station

17 at 11.51, and then moved onto the Hart Space 11.52.

18 I think we know they were there no later than 12.00?

19 **A.** Yes.

20 **Q.** Then BM118, PC Carr, Taser equipped, dispatched 11.49,

21 arrived at Southport Police Station at 11.51, collected

22 a defibrillator from there at 11.53 and then, again not

23 quite clear what time they arrived, but relatively

24 shortly after that.

25 Then LKB96, that's Temporary Police Sergeant,

25

1 **Q.** Sad to say, sometimes people do make even very striking

2 false calls to the police?

3 **A.** They do.

4 **Q.** But in this case you had multiple calls coming in and,

5 clearly, genuine sounds of distress on the line, you

6 were able very quickly to determine that this was

7 a genuine call?

8 **A.** I did, yes.

9 **Q.** You went on to determine that the criteria for armed

10 deployment was met?

11 **A.** Yes.

12 **Q.** Was that primarily down to the bladed weapon threat?

13 **A.** To the threat and the number of casualties.

14 **Q.** You decided to deploy unarmed units forward with caution

15 with instructions to deal with the situation if safe to

16 do so?

17 **A.** Yes. My overriding concern was the Article 2, right to

18 life, and we needed to deploy officers straight to

19 scene.

20 **Q.** Can we look at MERP000469, page 3, just to see the

21 instructions you put on the log. This is again back to

22 the Storm log.

23 So it is the bottom quarter of the page, there are

24 a number of entries from workstation FIM1, and we can

25 see those are entries made by you on the log, are they?

27

1 sometimes referred to as PC, Luke Holden and PCSO Parry,

2 PS Holden was Taser equipped, dispatched 11.52 and

3 arrived at the Hart Space at 11.56?

4 **A.** That's right.

5 **Q.** Those are really the initial officers attending in the

6 first few minutes after the --

7 **A.** It is, yes.

8 **Q.** I'm going to return to what they did on arrival shortly

9 but just trying to keep matters in chronological order

10 for the most part.

11 Paragraph 38, on the next page, you deal with the

12 initial notification of you as the FIM. You say that

13 occurred at 11.49, and you accepted the log at that

14 point. Is two minutes, or thereabouts, a normal sort of

15 time before the log is referred to you, a log of this

16 nature is referred to you?

17 **A.** Yes, that would be realistic. All that activity, the

18 call takers, the supervising, it is all happening

19 concurrently. So by the time the log gets to me, the

20 call taker is still on the phone to the informant.

21 **Q.** At paragraphs 39 to 45, you set out your initial review

22 of the log. I'm not going to go through it line-by-line

23 but, in short, you formed the view that this was

24 a genuine call?

25 **A.** Yes.

26

1 **A.** Yes, that's 02 -- 32032, is my open door number.

2 **Q.** They have helpfully been highlighted for us?

3 **A.** Yes, that's correct.

4 **Q.** So we can see:

5 "Deploy unarmed patrols as initial response while

6 [armed response vehicles] en route

7 "ARV assets ... are significant distance away

8 "As there is an immediate duty to protect life

9 [while they are] en route

10 "Deploy unarmed patrols to approach with caution

11 "Assess the situation

12 "If safe deal."

13 So, again, that is you, as you say, having in mind

14 the obligation to try to protect life and also the

15 learning that you referred to earlier from the

16 Manchester Inquiry?

17 **A.** That's correct, yes.

18 **Q.** ARV deployment then: a significant distance away, does

19 that reflect the number and range of roles and tasks for

20 armed response vehicles?

21 **A.** So on a day-to-day basis, the Force identified our

22 threat harm risk areas, where gun crime or violent crime

23 is happening, and we will deploy the ARV officers to

24 those areas and, that day, Southport wasn't one of those

25 areas where they were deployed.

28

1 Q. There wasn't any intelligence or --
 2 A. There was no intelligence to say there was a threat in
 3 Southport.
 4 Q. It isn't always possible to have an ARV always a matter
 5 of minutes away?
 6 A. It's not, no.
 7 Q. Can that lead to an issue of not having an ARV nearby to
 8 deal with bladed weapons threats, for example?
 9 A. Yes.
 10 Q. Some officers, as we have seen, carry Taser, not all?
 11 A. That is right.
 12 Q. That can mitigate that to some extent?
 13 A. It can to some extent but, obviously, there are
 14 limitations on what Taser officers can do.
 15 Q. For an officer who doesn't have Taser, they are likely
 16 to have a stab vest?
 17 A. They will have PAVA spray, which is like a pepper spray
 18 and they will have a baton and a stab vest.
 19 Q. Somebody equipped like that, if they are confronting
 20 someone armed with a knife, who is determined to cause
 21 them harm, is that a very significant risk to their own
 22 life, aren't they?
 23 A. It is but they do have training and they do have some
 24 PPE, although it is limited.
 25 Q. But is that really the reflection of why you have said,

29

1 to brief them.
 2 Q. So you begin to brief them but one of the first things
 3 you say is --
 4 A. "Start making" -- yes.
 5 Q. -- "Start making to Southport".
 6 A. Correct, yes.
 7 Q. They then start making their way and receive the rest of
 8 the briefing en route?
 9 A. That is correct, yes.
 10 Q. They would be making their way there on blue lights and
 11 sirens?
 12 A. Of course, yes.
 13 Q. While this is going on and you are briefing the ARVs,
 14 I think it is right that other officers, including
 15 Mr Arrowsmith, are making arrangements for deployment of
 16 other police assets, as well as further unarmed response
 17 officers, in particular police dogs, and the National
 18 Police Air Service?
 19 A. That is correct, yes.
 20 Q. Both of those have a variety of uses but one particular
 21 capability is the ability to locate and, in the case of
 22 the dogs, potentially detain a fugitive suspect.
 23 A. That is correct. Within an armed operation, requesting
 24 NPAS and a dog would be a standard bolt-on to that
 25 operation.

31

1 "Approach with caution, assess the situation, if safe
 2 deal"?
 3 A. Yes. So my expectation would be, if they could deal
 4 with the situation, they should, and, if they couldn't,
 5 they would place a barrier between members of the public
 6 and the offender and they would begin evacuating members
 7 of the public away to a safe location.
 8 Q. So effectively try to contain the situation, without
 9 tackling the threat head on?
 10 A. Correct, yes.
 11 Q. In terms of deploying the ARVs, I think you provided
 12 them with a verbal briefing that you have set out in
 13 your witness statement from paragraph 47 onwards. We
 14 don't need to look at it.
 15 Later on, I think that's recorded on the log in
 16 writing. Inevitably, much of it is in quite generic
 17 terms; is that fair?
 18 A. It is, yes.
 19 Q. I think it is right that they wouldn't wait for the
 20 briefing and then start making their way to the scene,
 21 they would be being briefed while they are en route?
 22 A. They would, yes, they wouldn't know about this incident
 23 because the areas they were in, they would not be
 24 monitoring the bravo -- the Sefton area radio channel,
 25 so they wouldn't know about the incident until I begin

30

1 Q. At the time you are briefing the ARVs, we know you put
 2 the initial instructions on the log at about 11.51,
 3 briefing to the ARVs followed shortly after, at that
 4 point AR has not yet been detained?
 5 A. No.
 6 Q. From your perspective, it is not wholly clear whether
 7 this is a case of a single attacker or potentially
 8 multiple attackers?
 9 A. No. As you mentioned, the log is quite confusing.
 10 There are various people mentioned and I have assessed
 11 the threat as still quite high until we get that
 12 confirmation.
 13 Q. Was there a possibility at this point that this was
 14 what's known as a Marauding Terrorist Attack?
 15 A. There was a possibility but the attack was located at
 16 the Hart Space and the information, at that time, the
 17 best information was there was one attacker and he was
 18 within the Hart Space.
 19 Q. So the response to a Marauding Terrorist Attack, that is
 20 known as Op Plato?
 21 A. It is, yes.
 22 Q. In outline only, that involves designating different
 23 zones with different levels of risk and different --
 24 only suitably trained and equipped emergency services
 25 responders can enter different zones?

32

1 A. That's correct, yes.
 2 Q. There was a judgement call then that you have to make,
 3 declare Op Plato, that is likely to provide a greater
 4 degree of protection to emergency services responders?
 5 A. Yes.
 6 Q. But it is also likely to delay, particularly, first aid
 7 and medical treatment being provided at the very
 8 earliest opportunity?
 9 A. That's right. We would call in extra ARVs and other
 10 assets. I felt that one offender or possibly two
 11 offenders with edged weapons was within the capability
 12 of the armed response staff I had available, who were
 13 briefed and en route to the incident.
 14 Q. As well as being a difficult judgement call that you
 15 have got to make in terms of you are acting on
 16 potentially imperfect or incomplete information, is it
 17 right it is a decision that has to be made under time
 18 pressure: in essence, if you call Plato, it is difficult
 19 to stop the wheels turning?
 20 A. Yes.
 21 Q. But if you don't call it at the earliest opportunity,
 22 potentially people are going into very high risk without
 23 the proper equipment and support?
 24 A. That's right, yes.
 25 Q. You have talked us through there already your decision

33

1 A. Yes.
 2 Q. Thank you. Can I come on then to communications with
 3 the Ambulance Service. The first call from MerPol to
 4 NWAS was at 11.48. At that point then, the first
 5 officers have been dispatched but they weren't at the
 6 scene yet?
 7 A. That's right.
 8 Q. I think by 11.53, there were calls between the police
 9 and NWAS going both ways?
 10 A. Yes, I think NWAS -- they were receiving 999 calls
 11 themselves about injured people.
 12 Q. These are calls by call handlers or dispatchers. It is
 13 not messages across the ES Channel?
 14 A. No, it wasn't at that stage, no.
 15 Q. There is one call I want to pick up in particular.
 16 Could we have MERP001395, please. This is a call from
 17 a police call handler to NWAS at 11.49, so it is one of
 18 the early ones. You see 11.49.49.
 19 If we can look at page 2. This is at about 11.55.
 20 It is a little bit earlier. First of all, we can see
 21 the caller is being asked there about:
 22 "Call handler: Any hazards present?
 23 "Caller: Not that we're aware of no.
 24 "Call handler: Okay, the attackers have they left?
 25 "Caller: I'm trying to work it out, I'm so sorry the

35

1 not to declare it. Effectively, you thought on the
 2 information you had, this was one, possibly two,
 3 attackers, edged weapons and you were satisfied that
 4 Plato didn't need to be declared?
 5 A. That's right.
 6 Q. In hindsight now, were you satisfied with the training
 7 and experience that you have as a FIM as regards whether
 8 to declare Plato or not?
 9 A. Yes, I am, yes.
 10 Q. Again, with the benefit of time to reflect on what you
 11 knew there and then, I think it follows from what you
 12 have said that you are satisfied that the decision not
 13 to call Plato was the right one?
 14 A. I have reflected on that quite a bit and I'm satisfied
 15 that it was the correct decision not to call Plato. It
 16 would have slowed the police response down. I would
 17 have had to brief other assets, as you said, zone the
 18 location and restrict people going into the hot zone.
 19 So I'm 100 per cent satisfied that not to declare Plato
 20 was the right decision.
 21 Q. You say it would have slowed the police response. It's
 22 broader than that, isn't it: it would have slowed the
 23 whole emergency services response --
 24 A. It would have.
 25 Q. -- including ambulance services?

34

1 log is so confusing ..."
 2 Then a little bit further down:
 3 "Call handler: Okay, you say the attacker has left
 4 the scene?
 5 "Caller: Let me check. I'm sorry, we don't seem to
 6 know. No I've put 'not sure' for that."
 7 Again, at this very early stage, that's an accurate
 8 passage of information at that stage --
 9 A. At that stage, it was, yes.
 10 Q. If we could go on to the next page, please, we can see
 11 towards the top of the page, the caller, so that is the
 12 police caller:
 13 "We have got an RVP point of Southport Police
 14 Station."
 15 We know from the call that that is at about 11.55.
 16 So the caller has taken a few minutes to get to this
 17 point?
 18 A. Yes.
 19 Q. That led to the Ambulance Service putting a marker on
 20 their log for their 999 call or one of their 999 calls
 21 to attend the RVP, rather than go straight to scene.
 22 It is fair to observe that that doesn't then appear
 23 to have necessarily been passed to the ambulance crews,
 24 who did, I think, go straight to scene. It doesn't seem
 25 that the ambulance did muster at Southport Police

36

1 Station. By that point, of course, 11.55, you had given
 2 your direction that officers were to proceed to the
 3 scene with caution. We know that that marker that NWS
 4 put on their log was removed at 12.03, so about eight
 5 minutes later --
 6 **A.** Okay.
 7 **Q.** -- after paramedics reported that they had gone to the
 8 scene -- this is Mr Smith, following PS Gillespie in --
 9 and said, "I'm at the scene, I'm with police officers".
 10 The first point from that, that marker wasn't
 11 removed because police passed information to NWS, "We
 12 are at the scene, the scene is safe, you can approach";
 13 is that fair?
 14 **A.** That's fair, yes.
 15 **Q.** Second point, police there using their language of
 16 "RVP", but the Ambulance Service potentially hearing
 17 RVP, but having different meanings for that in their own
 18 doctrine, potential there for miscommunication?
 19 **A.** There could be, yes.
 20 **Q.** The earliest point you suggest in your witness
 21 statement, at paragraph 61, that the information was
 22 conveyed by police to others that it was safe to come to
 23 the scene, was at 12.06 in the ETHANE message that goes
 24 out over the Emergency Services Channel?
 25 **A.** That's right.

37

1 Forgive me, I think that's my bad reference. One
 2 moment. *(Pause)*
 3 Page 17, paragraph 60. So, again, thinking back to
 4 that structure of M/ETHANE, the "M" is for whether
 5 a major incident has been declared?
 6 **A.** Correct.
 7 **Q.** At this point, it hadn't been but it was indicated that
 8 it might become a major incident shortly?
 9 **A.** That's right.
 10 **Q.** "E", the exact location, and you say the location of the
 11 incident and the address and postcode were broadcast?
 12 **A.** Correct.
 13 **Q.** "T", type of incident. What was reported was the
 14 circumstances are unclear, a large number of individuals
 15 have been stabbed, including children who were deceased?
 16 **A.** That's right.
 17 **Q.** "H", hazards. What's referred to as blood, traffic
 18 making into the incident, broken glass at the scene
 19 access. At that point -- and we will come back to the
 20 arrest in a moment -- but there's no suggestion passed
 21 that there might be any continued risk from --
 22 **A.** No, there wasn't.
 23 **Q.** -- an offender or offenders. "A", access. Gave the RVP
 24 as Southport Police Station but said that police and
 25 ambulance crews had gone straight to scene, due to the

39

1 **Q.** Was that the first message sent over the Emergency
 2 Services Channel?
 3 **A.** The ETHANE message would have been, yes.
 4 **Q.** I just want to deal with one point about this first, and
 5 then look at that report in a little bit more detail.
 6 Could we look at NWS000379 at page 16, please. It is
 7 the paragraph under the underlined heading, "Areas for
 8 improvement". This is part of the NWS debrief report:
 9 "Police had not made any type of declaration
 10 (according to a point in time referenced in the debrief)
 11 and NWS did not receive a M/ETHANE report on ESICTRL."
 12 Subject to what "according to a point in time
 13 referenced in the debrief" might mean, am I right that
 14 you would disagree that NWS did not receive a report on
 15 ESICTRL.
 16 **A.** I would disagree, yes.
 17 **SIR ADRIAN FULFORD:** ESICTRL?
 18 **MR GOSS:** I think that is the Emergency Services
 19 Interoperability Channel.
 20 **A.** It is Emergency Services Interoperability Control
 21 Channel.
 22 **Q.** Thank you. You have set out the content of that
 23 M/ETHANE report that Mr Arrowsmith sent at paragraph 54,
 24 could we have that from your witness statement again,
 25 MERP007548.

38

1 number of casualties?
 2 **A.** That's right.
 3 **Q.** "N", number of casualties -- we are just over the page
 4 now. I think it is reported two children deceased.
 5 Then "E", emergency services. The message is "All
 6 agencies, please go".
 7 **A.** Yes.
 8 **Q.** There's no express instruction there, is there, to come
 9 forward from the RVP to the scene. There is a statement
 10 that police and ambulance have done so already but there
 11 isn't a "It is safe to come forward"?
 12 **A.** No, I could see from looking at the log that there were
 13 multiple ambulance resources landing at scene. The HART
 14 team were being deployed and air ambulances were also en
 15 route.
 16 **Q.** In essence, to some extent, this had been overtaken by
 17 events on the ground --
 18 **A.** It had.
 19 **Q.** -- or the need to pass that information had been
 20 overtaken to some extent by events on the ground?
 21 **A.** That's correct, yes.
 22 **Q.** Would you agree though that it might be better if that
 23 sort of indication that the scene is now safe to
 24 approach was given clearly and at the earliest
 25 opportunity?

40

1 A. I could see that would be a benefit, yes.

2 Q. Again, although, as you say, matters overtaken by events

3 on the ground, if at 12.06 and that ETHANE message was

4 the first point that the fact it was safe to move

5 forward was formally conveyed from police to ambulance,

6 that would be almost 20 minutes after the initial call?

7 A. It would but, as I said, from the log I could see

8 multiple ambulance calls and landing at scene --

9 Q. I'm not for a moment suggesting that this, in fact, was

10 something that delayed ambulances attending the scene.

11 But, nonetheless, 20 minutes before even an inferred

12 message that it is safe to approach is quite a long

13 time, isn't it?

14 A. It is, yes.

15 Q. Is that the sort of thing that could perhaps be

16 addressed by clearer or standardised communication and

17 terms between emergency services?

18 A. It could, yes.

19 Q. Agreed language, agreed approach, shared training,

20 perhaps, between ambulance and police over issues about

21 RVPs and standing off?

22 A. We do joint training with all emergency services. There

23 is JESIP training that everybody attends, so something

24 that could be included in that JESIP training package.

25 Q. Do you think something like that would be a good idea to

41

1 door to the Hart Space at 11.57.04, so about 11 seconds

2 after arriving in his vehicle. As he stood there, he

3 provided some updates over his radio and he said:

4 "We are going to try to detain him."

5 A. Yes.

6 Q. He is warned by Mr Verite, a member of the public, not

7 to go in with only a baton and informed that AR is armed

8 with a knife. Then, very shortly afterwards, PC Holden

9 and PCSO Parry -- PC Holden armed with a Taser --

10 arrive, that's 11.57.50, so some 46 seconds after

11 PS Gillespie arrived at that smashed door and less than

12 a minute after he arrived at the scene.

13 Then very shortly after their arrival, PS Gillespie

14 and PC Holden tell PCSO Parry and Mr Verite to wait at

15 the door, and they go in?

16 A. That's right.

17 Q. That is, I think, about six seconds after Holden and

18 Parry, excuse rank, arrive at the door?

19 A. That's right.

20 Q. So in total then, between PS Gillespie arriving at the

21 door and him entering, now with PC Holden, it is

22 52 seconds. In that time, he is informed that AR has

23 a knife and that he shouldn't go in with only a baton.

24 He's passing updates over the radio and then, when he

25 arrives, as we have just seen, he goes in within six

43

1 ensure that those very early stages -- and making all

2 allowances for quite how difficult, confusing, pressured

3 those very early minutes can be, would it be a good idea

4 for some of that training to try and focus on that area

5 to ensure that you do have that joint understanding?

6 A. Certainly, yes.

7 Q. That would be in keeping with the ESICTRL standard

8 operating procedure that we looked at earlier, about

9 both common understanding and communication but also

10 passing time and safety critical messages at the

11 earliest opportunity?

12 A. Yes.

13 Q. Could I come then to the initial actions of the officers

14 on the scene and, in particular, the detention of AR.

15 We have heard something about this on Monday from

16 DCI Pye, so I will take it relatively quickly.

17 A. Yes.

18 Q. In your witness statement at paragraph 54, so the

19 previous page, you set out the initial arrival timings.

20 PS Gillespie arrived at 11.56.53 and am I right that you

21 have seen his body worn video?

22 A. I haven't seen that body worn video.

23 Q. You haven't seen it?

24 A. No.

25 Q. But we know, I think, that he arrived at the now smashed

42

1 seconds.

2 Drawing on your experience as a FIM, a firearms

3 officer, as a Response Sergeant and Officer, was it

4 reasonable for PS Gillespie to try to gather information

5 about what he was facing before going in to that

6 building?

7 A. It would be, yes. If he is using the national

8 decision-making model, at the top of that is gather

9 intelligence and information, which is exactly what he

10 did, very quickly.

11 Q. Your instructions were for unarmed officers to proceed

12 with caution, to assess and to deal if safe?

13 A. Yes.

14 Q. Communicating over the radio, again, that ensures that

15 he is sharing that information that he has gathered, so

16 that others know what they are facing as well?

17 A. Yes.

18 Q. Then waiting for an officer equipped with Taser, again

19 is that part of mitigating that risk and going in if

20 safe to do so?

21 A. It is. I think he has formulated a plan very quickly,

22 it is highly commendable what he did.

23 Q. Had he gone straight in, before the arrival of the other

24 officers, one possibility is that AR might have

25 surrounded momentarily earlier; another possibility

44

1 might be that, faced with only one officer armed with
 2 a baton, he might have decided to try and attack him?
 3 **A.** He might have, yes.
 4 **Q.** Do you think PS Gillespie got the balance right between
 5 assessment of risk and his duty to protect life and to
 6 protect the public?
 7 **A.** Absolutely.
 8 **Q.** Thank you.
 9 The log was updated to reflect the detention of one
 10 male in possession of a knife at 11.59. At this point,
 11 you have got ARVs making their way to the scene. Does
 12 the fact that you now have an offender detained affect
 13 that decision-making at all?
 14 **A.** It didn't, no, because reports from the scene were still
 15 quite confusing. The amount of casualties, I found it
 16 difficult to understand how one person could inflict
 17 that many injuries to that many people. So
 18 a consideration for me was that there might be more
 19 offenders that we hadn't yet encountered.
 20 **Q.** Did the fact that you now had an offender detained have
 21 an influence in your thinking about Plato at all?
 22 **A.** I was still of a mind that Plato wasn't necessary now
 23 that we have got an offender detained.
 24 **Q.** Effectively, it provides you with a little bit of
 25 reassurance that --

45

1 **Q.** At this point, the next step is to start transitions
 2 from that immediate operational response into a more
 3 considered response in line with JESIP; is that right?
 4 **A.** That's correct, yes.
 5 **Q.** One element of that is the ETHANE or M/ETHANE message
 6 that we have already covered and that was sent at 12.06.
 7 **A.** That's right.
 8 **Q.** Another, though, is the command structure on the ground.
 9 What you say at paragraph 59 is that you could see from
 10 the log that Inspector Cowin was on the ground at 12.05
 11 and that he had declared a critical incident. Could we
 12 look at MERP000268, please.
 13 Just while that comes up, Inspector Cowin was the
 14 policing area response Inspector and therefore also one
 15 of your critical incident managers?
 16 **A.** He was, yes.
 17 **Q.** If we just look at his movement at the bottom of that
 18 page. He first becomes aware of the incident at around
 19 11.50 and he makes his way from the Netherton area where
 20 he is at that time, that's about 14 miles, just over, to
 21 Southport?
 22 **A.** Yes.
 23 **Q.** He sets off at 11.52, so shortly after becoming aware of
 24 the incident, very shortly after you have been notified
 25 of it yourself?

47

1 **A.** It did, yes.
 2 **Q.** -- your assessment that you can manage this without
 3 Plato is starting to be borne out?
 4 **A.** Yes.
 5 **Q.** I'm about to move on to a slightly lengthy topic.
 6 I wonder, sir, if now is a convenient moment for the
 7 mid-morning break?
 8 **SIR ADRIAN FULFORD:** Certainly. Thank you very much indeed,
 9 Mr Goss. I will sit again at 11.25 am.
 10 **(11.09 am)**
 11 **(A short break)**
 12 **(11.27 am)**
 13 **MR GOSS:** Thank you, sir. Chief Inspector Hughes, I want to
 14 move on to deal with the command and control at the
 15 scene and how that evolved.
 16 **A.** Okay.
 17 **Q.** I want to pick matters up at about 12.05. At this
 18 point, we are just under 15 minutes after you have been
 19 notified of the log. You have received confirmation
 20 that one suspect is in custody, you have unarmed police
 21 officers on the scene dealing, ARVs are on the way and
 22 you are aware that paramedics and ambulances are both on
 23 the scene and en route and, as you have mentioned, also
 24 Helimed capability as well?
 25 **A.** Yes.

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1 **A.** That's right.
 2 **Q.** It takes him 17 minutes and, if we could just go down
 3 slightly to the top of the next page, we can see that,
 4 while en route, he declares it a critical incident and,
 5 in fact, he arrives on scene at about 12.09?
 6 **A.** That's right.
 7 **Q.** What's then the significance of that declaration by him,
 8 en route to the scene, that this is a critical incident;
 9 does that change the way that this incident is being
 10 managed at this stage?
 11 **A.** No, it doesn't change how it is managed at that stage,
 12 the critical incident process is more about the
 13 investigation and managing any ongoing threat from
 14 an incident like that and to make sure that there's
 15 adequate coordination between the various police
 16 departments to manage that incident.
 17 **Q.** So would that then start processes like having the
 18 criminal investigation departments warned that there
 19 was --
 20 **A.** It would, yes.
 21 **Q.** Perhaps other departments as well, family liaison?
 22 **A.** Yes, it would.
 23 **Q.** If Inspector Cowin's timing is right, there is no reason
 24 to think he isn't, he arrived at 12.09, having set off
 25 from just over 14 miles away at 11.52. That means the

48

1 first officer of Inspector rank attended just over 20
 2 minutes after the initial call and about 10 minutes
 3 after AR was detained?
 4 **A.** That's right.
 5 **Q.** Is that an appropriate sort of timeframe, bearing in
 6 mind the breadth and composition of the Force area that
 7 he is covering?
 8 **A.** That's realistic. Specifically, Sefton geographically,
 9 it's quite a long sort of strip of area from the Bootle
 10 area up to Southport, so geographically it is quite
 11 large, so that is a realistic arrival time for him.
 12 **Q.** Could we have a look at MERP008178, this is the debrief
 13 report, and page 10, please.
 14 Just reminding us that you were participant 5 in
 15 this debrief. At line 27, you say:
 16 "The model we use has a weakness due to amount of
 17 Inspectors we have. CIM [that is Inspector Cowin] was
 18 deployed to scene. There was no contingency cover on
 19 BAU."
 20 Is that business as usual?
 21 **A.** Correct, yes.
 22 **Q.** "This was reflected across all other areas of business.
 23 No resilience in R&P at all ..."
 24 **A.** Response and patrol, Response Officers.
 25 **Q.** Thank you.

49

1 **A.** It was.
 2 **Q.** -- rather than it being a pre-planned capability for
 3 somebody to step in?
 4 **A.** Yes.
 5 **Q.** Is this something -- this potential gap for dealing with
 6 other matters, is this something that's been looked at
 7 separately following this debrief?
 8 **A.** I don't know how that's been progressed.
 9 **Q.** Before Inspector Cowin arrived on the scene, who was
 10 acting as Ground Commander if anyone?
 11 **A.** It would have been the most senior police officer at the
 12 scene. I'm not aware whether there was another
 13 supervisor. I know Sergeant Gillespie had arrested AR
 14 and was transporting him to custody. So I'm not -- if
 15 there was another Sergeant at scene, they would have
 16 taken command.
 17 **Q.** We have also got Temporary Sergeant Holden as well?
 18 **A.** Yes, yes.
 19 **Q.** I think it is just worth reminding ourselves of the
 20 timings here, with apologies for going over old ground.
 21 As you say, the first officer on scene was a Sergeant at
 22 11.56, AR detained 11.59 and the officers involved
 23 then -- the officers there at the time were then
 24 involved in extracting Ms Little and Child X, that's at
 25 12.03, and in assisting Mr Hayes, who they found at

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1 "... so when major incident is factored in, it is
 2 not feasible."
 3 Just picking that a little bit, is what this is
 4 saying, the concern you raised in this debrief, that
 5 when the Response Inspector for that area is committed
 6 to a critical incident, subsequently became a major
 7 incident, there's no cover for anything else going on in
 8 that area, at that level?
 9 **A.** No, there isn't. I mean, these incidents are so rare,
 10 there isn't anything built into our sort of model that
 11 allows for that.
 12 **Q.** In terms of dealing with what was going on on Hart
 13 Street, there was an Inspector there, you say, in
 14 a realistic timeframe?
 15 **A.** Yes.
 16 **Q.** It isn't that the response to Hart Street was
 17 under-resourced but that left a gap in the coverage
 18 elsewhere in Sefton?
 19 **A.** That's correct, yes.
 20 **Q.** I think another Inspector actually volunteered to take
 21 on those business as usual duties as Inspector Cowin was
 22 committed to that incident?
 23 **A.** She did, yes.
 24 **Q.** But that was essentially down to their availability and
 25 their goodwill --

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1 12.04 and 12.05, and then Inspector Cowin then arrives
 2 four minutes after that?
 3 **A.** Yes.
 4 **Q.** So it is a short gap, would you say --
 5 **A.** I would say, yes.
 6 **Q.** -- between, in particular, the detention of AR but also
 7 the evacuation of that building and moving casualties
 8 out of that building?
 9 **A.** Yes, there is.
 10 **Q.** Can I deal shortly with a related point here. One of
 11 the tasks for police in responding to an incident such
 12 as this is to secure, protect and preserve the scene.
 13 Primarily, or one of the reasons for that, is for the
 14 purpose of the future investigation.
 15 **A.** That's right.
 16 **Q.** Ideally, any crime scene shouldn't have members of the
 17 public entering it after police have arrived?
 18 **A.** That's right. Preservation of life is always a priority
 19 overriding any crime scene contamination.
 20 **Q.** I think you may have shortcut the further questions
 21 I was going to ask on that point, Chief Inspector. In
 22 effect, in this case, when Sergeants Gillespie and
 23 Holden entered the building, they had left PCSO Parry at
 24 the front door. We heard this from DCI Pye. He then
 25 enters the building when he hears shouts of "Knife!" and

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1 members of the public, including parents of a number of
 2 the girls who had attended the dance class, were then
 3 able, for entirely understandable reasons, to enter the
 4 Hart Space. The officers did then make efforts to move
 5 them back out of the building; is that your
 6 understanding?
 7 **A.** That's my understanding.
 8 **Q.** What DCI Pye said was:
 9 "In a textbook scenario, you would have had someone
 10 on that door and you would have stopped anybody going
 11 in. This was far from textbook."
 12 As you say, preservation of life and the need for
 13 officers to deal with what was going on in that
 14 building, in your view, it was reasonable for that to
 15 take priority over controlling access to the scene?
 16 **A.** It is and also leaving somebody at the door also has the
 17 effect of creating a barrier between members of the
 18 public and the offender and preventing him from leaving
 19 that location.
 20 **Q.** We don't need to bring it up but I think we can see on
 21 the log at 12.03 the message is passed that no one is to
 22 be allowed in and out of the scene, so that was
 23 something that was in the officers' minds?
 24 **A.** It would have been one of the golden hour principles of
 25 securing the scene.

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1 a message that that's where it will meet Inspector
 2 Cowin, rather than a formal redesignation of the
 3 rendezvous point?
 4 **A.** I think that was a redesignation of the rendezvous point
 5 because Meols Cop School is more suited to a JESIP type
 6 RVP because it has a bigger area for more vehicles and
 7 it is nearer the location to Hart Street than it is --
 8 than Southport Police Station would have been.
 9 **Q.** There certainly came a point when Meols Cop High School
 10 was designated as the RVP, I'm not sure it was at this
 11 point, if I can suggest that. Inspector Cowin doesn't
 12 seem to think that he took that decision at that point
 13 by reference to his statement and I'm just wondering if
 14 you may have misinterpreted that line in the log and
 15 moved the timing of the redesignation of the RVP forward
 16 slightly?
 17 **A.** In the early stages, it was quite confusing.
 18 **Q.** You then declared a major incident at 12.14.
 19 **A.** Correct.
 20 **Q.** You deal with that at paragraph 66 to 68 of your
 21 statement. Again, I don't think there's going to be any
 22 dispute that what was occurring or had occurred met the
 23 definition of a major extent. So we don't really need
 24 to explore the basis for your decision, this was clearly
 25 a major incident?

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1 **Q.** Thank you. Staying then with Inspector Cowin, and
 2 apologies for returning to the topic of rendezvous
 3 points, you say at paragraph 65 of your statement that
 4 your understanding is at 12.13, Inspector Cowin took the
 5 decision to relocate the RVP to Meols Cop High School?
 6 **A.** That is correct, yes.
 7 **Q.** What you say is it would appear there was still some
 8 discussion about the RVP for a period after this was put
 9 on the log. Can we just look at the log. MERP000469
 10 and page 11.
 11 If we could have the entry at 12.13 from 49598,
 12 about a quarter of the way up the page, enlarged please.
 13 49598.
 14 "HR24 will RVP ..."
 15 In fact, I think it may be the one slightly above
 16 that. 40264:
 17 "Will rv with bo01 ..."
 18 BO01 is Inspector Cowin?
 19 **A.** Bravo Oscar, yeah.
 20 **Q.** Bravo Oscar 01, Inspector Cowin:
 21 "HR24 will rvp bo01 entrance Meols Cop High."
 22 A little further down the log, we can look at it in
 23 a moment, when the M/ETHANE report is put up on there,
 24 the RVP is still said to be Southport Police Station.
 25 Do you think that entry might just be a unit passing

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1 **A.** Yes.
 2 **Q.** Why make that declaration at 12.14?
 3 **A.** I think from reviewing my body worn footage and looking
 4 at the log, we were waiting to see how many
 5 casualties -- confirmed number of casualties -- because
 6 reports from the scene were still quite confusing. So
 7 I think the delay between the ETHANE message and the
 8 M/ETHANE message was waiting for that and, also, I had
 9 deployed the armed officers, so I had not -- my
 10 attention had been drawn away from the log and the radio
 11 channel. So I think I was trying to catch up with the
 12 information on the log and listen to the radio
 13 transmissions of what was happening at scene.
 14 **Q.** Do you think it would have been possible to have
 15 declared a major incident earlier, perhaps at the time
 16 Inspector Cowin also declared a critical incident, for
 17 example?
 18 **A.** It could have been, yeah, completely.
 19 **Q.** Because if you declared it at that point, that would
 20 have allowed the first ETHANE message to go out as
 21 a M/ETHANE message?
 22 **A.** It could have, yes.
 23 **Q.** Of course, when that message did go out, it did say,
 24 "Likely to be declared major incident shortly". So
 25 clearly there was already some consideration of that, at

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1 that point?

2 **A.** Yes, the ETHANE message is a major incident standby.

3 **Q.** Even when making your initial assessment, you had

4 a report of multiple stabbings and the log recorded

5 "potentially involving 25 children", which was a detail

6 you checked and at least one of those was reported as

7 "not breathing". Would that not meet the definition of

8 a major incident?

9 **A.** It would at that stage, yes, but that's one report that

10 I wanted clarifying.

11 **Q.** Could we look at your statement, paragraph 66, it is

12 MERP007548 at page 19.

13 I'm just looking at the last sentence of that and

14 I wonder if you could help us with that because I think

15 the syntax may have become a little confused there.

16 Is your meaning of that sentence that earlier

17 declaration of a major incident would not have made any

18 difference to the emergency response?

19 **A.** From looking at the log and dealing with the incident,

20 then the amount of police patrols that we had going to

21 the scene and the amount of ambulances would be

22 consistent with a major incident, and they were already

23 in place.

24 **Q.** When you declare a major incident, is that a declaration

25 for the police only or does that have the effect of

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1 **Q.** This wasn't a systematic issue of an inability to speak

2 to the Ambulance Service NILO, it was simply that at

3 that particular moment, when that entry was being made

4 on the log, contact hadn't been able to be made?

5 **A.** No. They may have been travelling to the scene or they

6 may have already been at the scene and dealing with

7 patients, so that could be a reason why they didn't

8 answer the phone.

9 **Q.** When you say that in paragraph 67, that's not intended

10 as a criticism of either the NILO or indeed

11 Mr Arrowsmith?

12 **A.** No.

13 **Q.** It is simply observing what you see recorded on the log?

14 **A.** Yes.

15 **Q.** Then at paragraph 69, you deal with the Force Silver

16 Public Order Public Safety Commander for the day, making

17 his way -- Chief Inspector Riley -- making his way to

18 the joint control room. Is this one of the things that

19 is triggered by declaration of a major incident, that

20 a standing Silver, I think I referred to it earlier, is

21 designated to eventually take over Silver Command of it

22 from you?

23 **A.** That's correct. In our building, there is a Silver room

24 which is another control room, which is on standby for

25 incidents like this and can be opened up quite rapidly

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1 declaring it for other agencies as well?

2 **A.** It declares it for the police and it is for the other

3 emergency services to declare their own major incident.

4 **Q.** If it were suggested that declaring a major incident

5 earlier would have enabled perhaps a faster conclusion

6 to be reached about there being only one offender, do

7 you think that would be right?

8 **A.** I don't think that would have made any difference.

9 **Q.** What about the faster deployment of resources or

10 deployment of more resources to Hart Street, would it

11 have enabled those resources to get there or more

12 resources to get there faster?

13 **A.** I don't think that would have made -- they all deployed

14 on an emergency response, which is consistent with the

15 type of incident it was.

16 **Q.** Thank you.

17 At paragraph 67, you note that Mr Arrowsmith, FIM2,

18 had been attempting to speak to NWAS via the National

19 Inter-Agency Liaison Officer. That's somebody who works

20 within the Ambulance Service, the NILO?

21 **A.** That is correct, yes.

22 **Q.** You note that he had been unable to speak with them.

23 I think later on there is direct contact about

24 12.35/12.36?

25 **A.** That's right, yes.

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1 to take command of the incident.

2 **Q.** So this is, effectively, the consequence of your major

3 incident declaration, that the joint control room is

4 being stood up and the Silver Commander is beginning to

5 prepare to take command?

6 **A.** That's correct, yes.

7 **Q.** Another significant step in the response here is the

8 ARVs arriving on scene. I just want to explore that

9 a little bit. PC Lloyd is the Operational Firearms

10 Commander for this incident and he arrives at 12.15; is

11 that right?

12 **A.** That's correct, yes.

13 **Q.** What's the role for the ARVs at this point? You have

14 already got a suspect in custody. What's the ARVs'

15 role?

16 **A.** The ARV role would be to ensure that the Hart Space is

17 clear of any other offenders. At this stage, it was

18 still quite confusing whether we had any offenders

19 outstanding. So my direction to them was to carry out

20 an emergency search of the Hart Space to ensure there

21 were no outstanding offenders.

22 **Q.** Firearms officers have a high level of first aid

23 training and equipment, don't they?

24 **A.** They do, yes.

25 **Q.** If I can put it this way, higher than unarmed response

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1 officers but not to the same level as paramedics; this
 2 is still in the realms of first aid rather than trauma
 3 care?
 4 **A.** Yes. They are trained to a level of pre-hospital trauma
 5 care.
 6 **Q.** Thank you. At paragraph 70, you record that they were
 7 seeking permission to assist with first aid. Did that
 8 suggest to you at all that there was a lack of first
 9 aiders or a need for more first aiders at the scene?
 10 **A.** It would suggest to me that there were multiple
 11 casualties and there were still people who needed help,
 12 and then the Armed Response Officers with their training
 13 and equipment could render that help.
 14 **Q.** But as you have said you took the view that what was
 15 necessary first was for the Hart Space to be cleared by
 16 armed officers?
 17 **A.** Their primary function is to manage the threat and
 18 that's what I wanted to happen first.
 19 **Q.** As well as confirming that there are no further
 20 offenders in there, does a systematic clearance of the
 21 Hart Space also enable confirmation that there are no
 22 further undiscovered casualties?
 23 **A.** Correct it would, yes.
 24 **Q.** So, notwithstanding that the firearms officers on
 25 arrival are saying, "Can we be released to help with

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1 **Q.** You can see from the log, and no doubt also from your
 2 conversations with Mr Arrowsmith in the FIM room that
 3 the Gold Officer, ACC Wilson, is aware of the incident
 4 and there's a briefing to ACC Wilson from FIM2,
 5 Mr Arrowsmith.
 6 **A.** That's right.
 7 **Q.** Then 12.25 we have the first JESIP meeting. Can we
 8 look, again, at MERP000268, Inspector Cowin's statement,
 9 at page 4, please. So, in that central paragraph:
 10 "At approximately 12.25 hours I [that is Inspector
 11 Cowin] was present when the first JESIP meeting took
 12 place near to the entrance to the access road leading to
 13 the offence location."
 14 He describes the multi-agency meeting -- addresses
 15 that meeting as a meeting between all of the emergency
 16 services present at the scene; is that right?
 17 **A.** That's one of the JESIP principles, yes, to co-locate
 18 and communicate.
 19 **Q.** So one feature of this meeting is that there was
 20 reassurance across that meeting that there are
 21 sufficient first responders in place at this point in
 22 time; do you see that?
 23 **A.** Yes.
 24 **Q.** That takes into account, we can see, the assistance that
 25 is available from firearms officers, as well as the Fire

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1 first aid?", you are satisfied that clearing the Hart
 2 Space first was the appropriate use of those firearms
 3 officers?
 4 **A.** It was. From looking at Constable Lloyd's statement,
 5 I think two officers carried out that emergency search
 6 of the Hart Space, which is entirely consistent with
 7 their tactical training and then the other officers were
 8 able to begin that first aid care.
 9 **Q.** So, in fact, you have two officers carrying out the
 10 search but the other firearms officers do then become
 11 involved in providing first aid to casualties?
 12 **A.** That's right.
 13 **Q.** I think we can see on the log, again no need to bring it
 14 up, but the confirmation that the Hart Space is clear,
 15 it comes at 12.20, so about five minutes after the
 16 Operational Firearms Commander has arrived on scene.
 17 You then start -- if we can look at paragraph 72 on
 18 the next page -- again, as part of the -- in fact
 19 paragraph 71 first. The ETHANE message that has been
 20 passed goes onto the log, now as a M/ETHANE message
 21 because a major incident has been declared. That wasn't
 22 an updated message, save for the fact that it now has
 23 the "M", that was the recording of the earlier message;
 24 is that right?
 25 **A.** It was, yes.

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1 and Rescue Service and obviously paramedics?
 2 **A.** Yes.
 3 **Q.** There is also a search directed of the outside areas
 4 along Hart Street, again to ensure no further previously
 5 unidentified casualties?
 6 **A.** That's correct, yes.
 7 **Q.** Could we return to your statement then. At 12.36,
 8 I think the log reflects that there is now communication
 9 between the FIMs and the NILO in the Ambulance Service?
 10 **A.** Yes.
 11 **Q.** So, having tried to make contact some 20 minutes or so
 12 earlier, there is now that line of communication opened?
 13 **A.** That's right, yes.
 14 **Q.** Again, does the fact that there was some delay in
 15 that -- again, you have made clear you aren't
 16 criticising the fact that they weren't available
 17 earlier --
 18 **A.** No.
 19 **Q.** -- does the fact that there was any delay have any
 20 impact on the ability to respond to the incident?
 21 **A.** I don't think it has any bearing on the response.
 22 **Q.** At 12.41, you describe at paragraph 74, the Coast Guard
 23 offering support, and they said that they can mobilise
 24 10 to 15 first aiders within 15 minutes. Am I right
 25 that that message is then relayed to those on the

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1 ground?

2 **A.** That's right, yes. I think I spoke to John Lloyd, who

3 was the firearms OFC, asked whether they would be useful

4 at scene and the message was that there was sufficient

5 ambulance staff at scene giving first aid and they

6 weren't required.

7 **Q.** That's consistent with what we have just seen from the

8 JESIP meeting, where it was agreed there was sufficient

9 first responders?

10 **A.** Yes.

11 **Q.** Is there a challenge in managing an incident like

12 this -- as well as having too few people, is there

13 a challenge in having too many sometimes?

14 **A.** That's correct and that's one of the purposes of the RVP

15 is to keep resources that you may need away from the

16 location to manage the congestion with emergency

17 services vehicles that might be there.

18 **Q.** If we could go back to the log now, please, at

19 MERP000469 and page 16, and the 12.43 the entry that

20 begins with asterisks and then RVP. Do you think that

21 may be the point where the Meols Cop High School is, in

22 fact, formally designated as the RVP for everyone?

23 **A.** Yes, so that entry, you can see there it is "SILVER33",

24 so that would be the terminal that is in the Silver

25 control room.

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1 So very shortly after that call has ended,

2 information has been put on the log from that call.

3 **A.** That's right, yes.

4 **Q.** That gives you an address, 10 Old School Close. Because

5 AR hasn't given any details when asked who he is at the

6 scene, that's the first identifying detail that MerPol

7 received; is that right?

8 **A.** That is correct, yes.

9 **Q.** What we can see is there is a précis of the call entered

10 there by 33767. That address is then researched by

11 those in the control room or by the Force Intelligence

12 Bureau?

13 **A.** I think that would have been the control room.

14 **Q.** If we could go ahead, please, to page 19 now. We can

15 see at 13.04, there is -- in fact just making good

16 a point from earlier -- at 13.04, FIM2 covers off the

17 fact that another Inspector is covering for Inspector

18 Cowin and then, just below that, we have the taxi driver

19 on the log has given the suspect's address, 10 Old

20 School Close. From a Niche check of this address, there

21 was a male, AR, gives his date of birth, warning marker

22 for carrying knives. That, I think, is the first

23 identification of AR by Merseyside Police; is that

24 right?

25 **A.** That's my understanding, yes.

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1 **Q.** Meols Cop is about two minutes' drive from Hart

2 Street --

3 **A.** Yes.

4 **Q.** -- and you have already explained it is more suitable as

5 a JESIP RVP than Southport Police Station is?

6 **A.** It is, yes.

7 **Q.** I think on the ground at this point, about 12.45, Chief

8 Inspector Ruane -- excuse pronunciation -- is taking

9 over as the Bronze Commander in the same way as Chief

10 Inspector Riley is starting to stand up to take over

11 from you as the Silver Commander?

12 **A.** That is correct, yes.

13 **Q.** Can I turn then, please, to the call or the

14 identification of 10 Old School Close as an address of

15 interest. If we could look, please, at page 19 of the

16 same document.

17 In fact, if we could go back one page, please, thank

18 you. At the top of that page, we see at 12.54 there

19 were details of a call from Mr Poland -- he has been

20 ciphered there but that is Mr Poland -- the taxi driver

21 for One Call Taxis. We have heard from DCI Pye that

22 that call was, in fact, received at 12.36. For your

23 note, sir, the transcript is at MERP000647.

24 **SIR ADRIAN FULFORD:** Thank you.

25 **MR GOSS:** That records that the call ended at 12.54.

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1 **Q.** That's about 10 minutes after the data is put on the

2 log?

3 **A.** That's right.

4 **Q.** If we look a little further down towards the bottom of

5 what we can see on the screen, you can see some of the

6 intelligence -- sorry, next page, please.

7 So, the next entry provides some of the intelligence

8 that's held about AR, in particular the point about him

9 logging on to school websites, involving school mass

10 shootings, talking about guns and beheadings?

11 **A.** That is right. Looking at that log now and the terminal

12 it has come from, I would consider that that was from

13 the Force Intelligence Bureau.

14 **Q.** I think we can see slightly further down "SILVER34":

15 "DS Moran, requesting FIB to view info on ..."

16 I think that should be 13.04. Do you think perhaps

17 that's an initial search and then the Force Intelligence

18 Bureau develop it a little further?

19 **A.** That would be my understanding.

20 **Q.** That's the perfectly normal way --

21 **A.** Yes.

22 **Q.** -- for a piece of intelligence to come in on the log and

23 then to be developed?

24 **A.** That's right.

25 **Q.** But what that intelligence leads you to do is to decide

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1 that you need to search that address of 10 Old School
 2 Close?
 3 A. Yes.
 4 Q. You decide that that should be a search by firearms
 5 officers rather than unarmed conventional response
 6 officers?
 7 A. That's correct.
 8 Q. Am I right that your concern was, first of all, that
 9 there might be other offenders?
 10 A. There were a number of scenarios that I was considering.
 11 Q. Talk us through them.
 12 A. One, that there could be other offenders, this is part
 13 of a -- some sort of planned operation to lure police in
 14 and there could be a threat to the officers when they
 15 arrive; there could be -- he could have injured family
 16 members; there could be injured people at that location;
 17 and there could, you know, still be a threat to police
 18 officers when they arrive.
 19 Q. I think you gave direction on the log, therefore, that
 20 other officers weren't to approach that address, it was
 21 to be a firearms deployment?
 22 A. Yes, I just felt we needed to pause operations, get our
 23 foot on the ball and then formulate a plan what we were
 24 going to do with Old School Close.
 25 Q. Old School Close is in Lancashire, rather than

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1 A. That's right, yes.
 2 Q. There was then a short period where you remained in
 3 charge of the firearms officers but you reached the view
 4 shortly after handover that there was no ongoing need
 5 for a firearms authority to be in place?
 6 A. Yes, I had reviewed the necessity for the authority. We
 7 neutralised the threat, or the threat had been
 8 neutralised, at Hart Space and we'd found no threat at
 9 Old School Close, so reviewing the need for the
 10 continued authority, I rescinded the authority then.
 11 Q. I think there was a minor typo on the log about who you
 12 handed over to but it was to Chief Inspector Riley --
 13 A. It was, yes.
 14 Q. -- as the Silver Commander. So from that point on, you
 15 are no longer involved in the decision-making about how
 16 to handle this incident because what had happened is the
 17 longer term enduring command structure has stood up to
 18 take over management of it?
 19 A. That's right, yes.
 20 Q. So going through that. Now, instead of the local
 21 policing area Inspector, as Bronze Commander on the
 22 ground, you have the Public Order Public Safety Bronze
 23 Commander, Chief Inspector Ruane in command on the
 24 ground --
 25 A. That's right.

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1 Merseyside?
 2 A. That's right.
 3 Q. But I think you directed that, given the urgency, you
 4 were going to deploy your ARVs cross border?
 5 A. There are cross-border protocols and for me to have
 6 a command structure in place and deploy Merseyside armed
 7 officers into Lancashire is a well understood principle
 8 of the cross-border understanding.
 9 Q. So the effect of that is that, I think at 13.28,
 10 Merseyside armed officers attend and secure 10 Old
 11 School Close and we know they found AR's family safe and
 12 well there and they then preserved that house as
 13 a further scene?
 14 A. That's correct, yes.
 15 Q. We have heard already from DCI Pye about the searches
 16 that took place there and what was recovered. Your role
 17 was not on that side of things?
 18 A. No.
 19 Q. It was simply the immediate response in securing that
 20 location?
 21 A. That's right, yes.
 22 Q. Thank you. Just then to round off your role on the day
 23 Chief Inspector, you transferred command of the log to
 24 the designated Silver Commander, Chief Inspector Riley,
 25 I think, at 13.34 hours?

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1 Q. -- you have Chief Inspector Riley established in the
 2 Silver command centre as Silver Commander?
 3 A. Yes.
 4 Q. Then you have a Gold structure coming into place above
 5 that, for the strategic direction?
 6 A. That's right and the tactical coordination group
 7 meetings would have taken place subsequently following
 8 on.
 9 Q. The tactical coordination group, that is the
 10 multi-agency Silver level --
 11 A. It is, yes.
 12 Q. -- response?
 13 A. And there was also strategic coordination group meetings
 14 taking place at the same time.
 15 Q. Those are there to deal with the longer-term management
 16 of the incident, the recovery and bringing matters
 17 ultimately back to as normal a situation as can be
 18 achieved?
 19 A. That's right, yes.
 20 Q. Can I just briefly take you through the strands of work
 21 that were then going on from a Merseyside Police
 22 perspective at the point you handed over.
 23 By this point, I think you have CID attendance at
 24 the scene?
 25 A. That's right, yes.

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1 Q. You have AR in custody and he has been taken to
2 a custody suite?
3 A. That's right.
4 Q. Is there forensics, crime scene investigation work
5 beginning to be stood up?
6 A. There would need to be a forensic strategy, which would
7 come from the investigation team.
8 Q. There was obviously work going on to manage the scene at
9 Hart Street, including the members of the public who had
10 gathered there, collection of witness details, cordons,
11 all of the work going on there?
12 A. Yes.
13 Q. There was the scene at 10 Old School Close. I think,
14 having been secured by Merseyside firearms officers, it
15 is now Lancashire officers who have taken responsibility
16 for that scene?
17 A. They have, yes.
18 Q. Family liaison is beginning to be put in place,
19 including officers deployed to hospitals?
20 A. That's right.
21 Q. And media and communications is then also again starting
22 to stand up for outward communications about what has
23 happened?
24 A. That's right.
25 Q. No doubt I have missed some but is that a reasonable

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1 landed on you with no warning whatsoever but I felt able
2 to discharge my duties effectively.
3 Q. Did you have sufficient resources available for you to
4 put your decisions into effect?
5 A. Yes. In an incident like that then, you know, all hands
6 to the pump. So, there were sufficient resources
7 available.
8 Q. How helpful was having the assistance of Chief Inspector
9 Arrowsmith as a second FIM in managing this incident?
10 He's obviously come up a number of times as we have gone
11 through the narrative of what's happened.
12 A. Absolutely essential, yes.
13 Q. I think you had experience as a FIM before the two-FIM
14 model was introduced. You talked to us about the
15 absorption of the Force duty officer role. Was it
16 a better model having two of you available to manage the
17 duties of a FIM?
18 A. Yes, 100 per cent, yes.
19 Q. Do you know if that's a model that's been adopted by all
20 Forces?
21 A. I don't know about all Forces. I know a lot of Forces
22 have introduced extra support for Force Incident
23 Managers. I don't know whether all have two trained and
24 accredited FIMs on duty all the time. But I know it is
25 certainly a recommendation of the Kerslake Report that

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1 overview of the kind of strands of activity that you
2 were handing over?
3 A. That's a fair assessment, yes.
4 Q. I think you then carried on in your role as a FIM until
5 about 7.00 pm that night?
6 A. That's right, yes.
7 Q. So it was back to business as usual, while obviously
8 also being aware that this incident was being properly
9 managed by others?
10 A. Yes.
11 Q. So your involvement lasted just under two hours?
12 A. Yes.
13 Q. No doubt an extremely busy and demanding two hours?
14 A. It was.
15 Q. Like anything you had had to deal with before as a FIM?
16 A. Nothing like that before, no.
17 Q. How well do you feel your training as a FIM and your
18 experience in general had prepared you for handling this
19 sort of incident?
20 A. I think it equipped me well to deal with the incident.
21 Q. At paragraph 93, you make clear that you didn't feel
22 overwhelmed in any way. Did you ever feel that you were
23 simply receiving too much information to make effective
24 decisions?
25 A. No. It was a very chaotic, horrific incident which gets

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1 FIM should have extra support to deal with incidents
2 like this.
3 Q. You mention the Kerslake Report. That, I think, was
4 a review commissioned by the Mayor of Greater
5 Manchester, following the Manchester Arena bombing. It
6 came ahead of the Public Inquiry --
7 A. Yes.
8 Q. -- but nonetheless made early recommendations?
9 A. It did, yes.
10 Q. I think you attended a debriefing or reflections event
11 with a Detective Superintendent at some point after,
12 could we have MERP008199. Do you recall this debriefing
13 or reflections conversation?
14 A. Yes.
15 Q. Can you help us with when it took place?
16 A. It may have been about six months after the incident.
17 Q. I don't want to go through all of the questions and
18 answers and it is not wholly clear whether all of them
19 are attributable to you, although some are. Is it fair,
20 to summarise, to say that, in the main, your view was
21 that JESIP, first of all, had been applied --
22 A. Yes.
23 Q. -- and that it had operated effectively?
24 A. Yes, it had.
25 Q. So we see, for example, just below the lines on "Shared

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1 situational awareness", it says:

2 "In Andy Hughes' opinion, the incident was managed
3 in line with the principles. The principles are
4 scalable and are often employed in various incidents
5 involving a multi-agency response and as a result are
6 well embedded in our working."

7 A. Yes.

8 Q. So we have drawn out some points, for example, around
9 clarity of communications and shared understanding today
10 but, overall, you feel that JESIP operated effectively
11 in this case?

12 A. It did, yes.

13 Q. We have looked already at a number of the structured
14 debrief comments and I haven't gone through them all but
15 I have gone through some of the ones attributable to
16 you. You haven't been able to help us on what has been
17 done to implement those recommendations particularly; is
18 that fair?

19 A. That's fair, yes.

20 Q. Can I come on then to a final topic, and this really is
21 just drawing on your experience as a FIM, not about what
22 did happen but about what might have happened in some
23 hypothetical scenarios. The first one goes back to
24 22 July, when we know that AR's father, Alphonse,
25 prevented him from getting into a taxi at about

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1 been?

2 A. If he was already en route, it would be to deploy to the
3 Range High School in an attempt to intercept him before
4 he got there. Perhaps we would have advised the school
5 that there was a threat to the pupils and they might
6 want to consider making sure nobody could get on site
7 and we probably would have deployed a patrol to his home
8 address.

9 Q. If the information given was that AR had returned to the
10 home address and was no longer making his way to the
11 Range High School, what do you think the result might
12 have been -- or the response?

13 A. We probably would have deployed to his home address to
14 investigate what was going on.

15 Q. As part of that investigation, you would have expected
16 officers to speak to AR?

17 A. Yes.

18 Q. To speak to his parents?

19 A. Yes.

20 Q. We know that, by that point, Alphonse seems to have been
21 aware of AR's purchase of some of the weapons that he
22 had been trying to buy. So that might well have come to
23 police attention?

24 A. It may well have, I would expect police officers to ask
25 some -- be professionally curious, ask some questions

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1 12.46 pm. Alphonse believed he was going to the Range
2 High School in Merseyside and that he was carrying
3 a knife, and we know he didn't call 999 or 101 on that
4 occasion.

5 If he had done so, I just want to explore what might
6 have happened.

7 A. Yes.

8 Q. Am I right that, because of where Old School Close is
9 located, that 999 or 101 call would have been received
10 not by the Merseyside control room but by Lancashire?

11 A. It would have, yes.

12 Q. But because of the link to Range High School as
13 a potential target, Merseyside would likely have been
14 notified?

15 A. They would have, yes.

16 Q. That would probably have led to the information that was
17 found on the log quite quickly on the 29th about AR
18 being identified?

19 A. That's right, yes.

20 Q. So, for example, the fact that he had previously
21 attended Range High School in 2019 with a hockey stick
22 and knife and assaulted another pupil with the hockey
23 stick, that would have been identified quite quickly?

24 A. It would have been, yes.

25 Q. What would the MerPol response to that information have

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1 when they get there and find out what's going on.

2 Q. What powers do police have in that situation, where they
3 are told you have a child, they may be in possession of
4 weapons, potentially very dangerous weapons, but they
5 are in their home address?

6 A. Very limited, in terms of police powers. We may well
7 speak to the father to see whether he would surrender
8 any weapons and we could get them handed in and
9 destroyed but, with it being in a private premises, he
10 has not left the location, it is very limited police
11 powers. I don't know whether the weapons would fit the
12 "zombie knife" definition at that time, I don't think
13 the legislation was in place then but should they be of
14 that style of weapon, then we could take action.

15 Q. One of the things that was in the home address was
16 either ricin or the materials preparatory to making
17 ricin. If that was identified, that would be an offence
18 in and of itself, wouldn't it?

19 A. It would, yes.

20 Q. One option you have set out there then, potentially,
21 short of dealing with any offences that might be
22 disclosed, would be effectively trying to engage through
23 the parents and say, "We want you to get those off him
24 and hand them in"?

25 A. Yes.

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1 Q. Probably making sure that that was in fact done --
 2 A. Yes.
 3 Q. -- rather than simply leaving it for the parents to
 4 decide whether to do it or not?
 5 A. I would expect the police to take those items away but
 6 it would be a voluntary surrender.
 7 Q. If I can put it this way: a voluntary surrender but it
 8 might well be one that a police officer wasn't going to
 9 leave the scene until that had been voluntarily
 10 surrendered.
 11 A. I am sure they would be persuasive to make sure that
 12 happened.
 13 Q. *In extremis*, through a child, there is a power for
 14 police to remove them from an address, isn't there?
 15 A. There is, yes.
 16 Q. That depends on a reasonable belief that the child may
 17 be at risk of significant harm?
 18 A. Yes, if we felt the parents weren't able to look after
 19 him, then we could activate a Police Protection Order.
 20 Q. Then you touched briefly on what would have happened if
 21 AR had travelled to the Range High School: deployment of
 22 officers. Do you think you would have had enough for
 23 officers to carry out, for example, a stop and search
 24 under Section 1 of PACE?
 25 A. Yes.

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1 police, the fact that he had attended Range High School
 2 previously with weapons and committed an offence there?
 3 A. Yes.
 4 Q. Again, that call would be received by Lancashire, in the
 5 first instance?
 6 A. It would have been, yes.
 7 Q. We can deal with Lancashire officers, how they might
 8 have responded to that. But would you have thought that
 9 would have been again flagged to Merseyside Police?
 10 A. With the link being made to Range High School, I would
 11 expect that to be made, yes.
 12 Q. Likely to be graded as an emergency?
 13 A. Likely, yes.
 14 Q. So a 10-minute response time. Merseyside officers
 15 again, similarly as you have described with the 22nd,
 16 likely to be deployed to Range High School?
 17 A. That's right, yes.
 18 Q. Nothing, sadly, to indicate a threat to the Hart Space
 19 that might lead to them being deployed there?
 20 A. No.
 21 Q. Circulation of his description likely, potentially
 22 cueing up a stop and search?
 23 A. I would expect that to happen, yes.
 24 Q. But to the extent he was still in the vicinity of his
 25 home address, that's within the Lancashire area of

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1 Q. That would have identified any weapon and led to
 2 an arrest?
 3 A. It would have.
 4 Q. Would that also probably led to a search of the home
 5 address?
 6 A. Yes, well, the arrest, he would be taken into custody
 7 and then authority for a Section 18 search would have
 8 been sought and his home address would have been
 9 searched.
 10 Q. You would have expected that to turn up the weapons and
 11 potentially also the ricin or its constituent parts?
 12 A. Yes.
 13 Q. Thank you. That's all I want to ask about the 22nd.
 14 Could I ask, again, a hypothetical scenario about
 15 29 July. AR left the house, we know, on foot at about
 16 11.10. If a member of the family had called police at
 17 that point, can we just consider what they might have
 18 said? They could have raised the history of weapons;
 19 they could have raised the possibility that he had been
 20 purchasing weapons online; they could have flagged how
 21 unusual it was for him to leave the house; they could
 22 have flagged his attempt the week before to travel to
 23 Range High School, when they believed he was taking
 24 a weapon there, it seems, to do harm; and they could of
 25 course raise, or it would become rapidly apparent to

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1 operations, rather than Merseyside?
 2 A. The incident would be owned by Lancashire Police.
 3 I would expect Lancashire officers to deploy to the area
 4 to carry out a search -- for a stop/search. With him
 5 having left on foot, then they would search the
 6 immediate streets around his home address because, at
 7 that stage, they still think he has left on foot and not
 8 in a vehicle.
 9 MR GOSS: Yes. One moment, please, Chief Inspector.
 10 Sir, I think that is all the questions for Chief
 11 Inspector Hughes.
 12 Chief Inspector, thank you very much for answering
 13 my questions.
 14 SIR ADRIAN FULFORD: I'm very grateful to you, Chief
 15 Inspector, you have covered an enormous amount of ground
 16 during your evidence. It has been very clear and very
 17 helpful to me. Thank you very much indeed. You can
 18 withdraw now.
 19 A. Thank you.
 20 MR GOSS: I'm in your hands, sir, as to whether you rise for
 21 five minutes and we just swap the witnesses over or
 22 a slightly early lunch.
 23 SIR ADRIAN FULFORD: So Mr Ainsworth is the outstanding
 24 witness for today?
 25 MR GOSS: He is, sir.

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1 **SIR ADRIAN FULFORD:** A rough approximation as to how long he
 2 is going to take?
 3 **MR GOSS:** Probably around two hours, sir.
 4 **SIR ADRIAN FULFORD:** Then I think we will rise now for lunch
 5 and we will sit again at 1.30 pm, and then take a break
 6 during the course of his evidence this afternoon.
 7 **MR GOSS:** Thank you, sir.
 8 (12.25 pm)
 9 (The short adjournment)
 10 (1.32 pm)
 11 **SIR ADRIAN FULFORD:** I'm afraid you are going to have to
 12 stand again, Mr Ainsworth. Thank you.
 13 **DANIEL AINSWORTH (sworn)**
 14 **Questioned by MR BOYLE**
 15 **SIR ADRIAN FULFORD:** Please have a seat.
 16 Yes, Mr Boyle?
 17 **MR BOYLE:** Sir, a slightly inauspicious start but, in moving
 18 my chair, I just had my screen go blank. I don't need
 19 it immediately but if someone could look at that,
 20 I would be grateful. I'm just going to move this back.
 21 **SIR ADRIAN FULFORD:** If you need me to rise at any stage,
 22 Mr Boyle, you only have to say.
 23 **MR BOYLE:** I think I have a few minutes to play with yet.
 24 Mr Ainsworth, could you give your full name to the
 25 Inquiry, please?

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1 2014; is that right?
 2 **A.** That's correct.
 3 **Q.** Thank you. You became Director of Operations shortly
 4 before the attack on 1 July 2024, correct?
 5 **A.** I did, yes.
 6 **Q.** Thank you. Can you just explain that role as Director
 7 of Operations?
 8 **A.** Yes. So as Director of Operations, I have overall
 9 responsibility for the delivery of our three core
 10 services, so that is our 999/111/patient transport
 11 service. I also am the accountable emergency officer
 12 for the organisation and that role requires me to be
 13 responsible and ensure that the organisation is prepared
 14 to respond to all incidents, including major incidents,
 15 and that we are trained and ready to do so.
 16 **Q.** Thank you. In terms of your roles with NWAS up until
 17 taking that position of Director of Operations, were
 18 those roles within the Emergency Operation Centre field
 19 of NWAS work?
 20 **A.** Yes, so my two previous roles for the two prior years to
 21 taking up Director of Operations, I was the Director of
 22 Integrated Contact Centres, of which the Emergency
 23 Operations Centre is a part of that Directorate. Prior
 24 to that, I was the Strategic Head of Emergency
 25 Operations for NWAS.

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1 **A.** Yes, it is Mr Daniel Ainsworth.
 2 **Q.** Thank you. Could we have up, please, your witness
 3 statement. That is NWAS001083 and just the first page
 4 to start with, please. Thank you.
 5 Do you recognise that document as your witness
 6 statement?
 7 **A.** I do.
 8 **Q.** Thank you. Could we go to the last page, please, it is
 9 page 47 -- sorry, penultimate, I think. Thank you very
 10 much. Your signature has been redacted there but can
 11 you confirm that that statement is true to the best of
 12 your knowledge and belief?
 13 **A.** Yes, I can. I would -- you may want to address now --
 14 there is one minor inaccuracy in the timing of the
 15 second 999 call.
 16 **Q.** Yes, we will come to that.
 17 **A.** Thank you.
 18 **Q.** I will correct that with you. In addition, NWAS has
 19 provided a helpful chronology of their response. That
 20 is NWAS001090. That's not part of your statement but
 21 are you able to confirm that that is accurate to the
 22 best of your knowledge?
 23 **A.** I can, yes.
 24 **Q.** Thank you very much. We will refer to that.
 25 You joined North West Ambulance Service, or NWAS, in

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1 **Q.** Thank you. Is it right that you are not trained as
 2 a clinician?
 3 **A.** I'm not, no.
 4 **Q.** Thank you. But at the Inquiry's request, you have
 5 discussed certain topics with your clinical colleagues;
 6 is that right?
 7 **A.** That's correct.
 8 **Q.** Thank you. You have also spoken with colleagues from
 9 the Emergency Operations Centre and those from the
 10 Resilience and Contingency Planning team; is that
 11 correct?
 12 **A.** Yes.
 13 **Q.** Thank you very much. Is it also right to say that you
 14 were not involved in the response to the attack on the
 15 day?
 16 **A.** I was not.
 17 **Q.** Thank you very much.
 18 Moving on to a term we have already used, the
 19 Emergency Operations Centre and related centres. First
 20 of all, can you just explain what the Emergency
 21 Operations Centre is?
 22 **A.** Yes, so the Emergency Operations Centre has two core
 23 aspects, which is a 999 call handling team, who answer
 24 and assess 999 calls; and a dispatch team who have
 25 overall to dispatch appropriate ambulatory resources to

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1 patients. Within the North West we have three Emergency
2 Operations Centres, they are geographically located one
3 in Lancashire, one in Greater Manchester and one within
4 the Merseyside region. Alongside those core roles there
5 is a significant number of clinical roles as well but
6 the predominant two responsibilities of the team are the
7 call handling and the dispatch aspects.

8 **Q.** Thank you, that's helpful, and we might explore that
9 a bit further shortly. You said that there are three
10 different EOCs located in the North West. Can you help
11 us to understand when multiple calls come in about the
12 same event, is it right that the call handlers dealing
13 with those calls may not be in the same place?

14 **A.** That's correct. We operate a virtual call handling
15 pool, so call handlers across the region answer the next
16 waiting call. It is industry standard approach these
17 days. What that does is give us the greatest resilience
18 and ability to answer calls as quickly as possible.
19 Where those calls have then been answered due to the
20 computer systems we use, the information that they
21 capture will be available across the region.

22 **Q.** Thank you. So you perhaps anticipate my follow up
23 question, which is how the EOC is able to get a grip or
24 oversight of multiple calls coming into different
25 locations?

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1 **Q.** Thank you. I might just break those down?

2 **A.** Sure.

3 **Q.** Looking at your paragraph 112, you address the
4 Helicopter Emergency Medical Service, or HEMS, which
5 I think in your region is delivered by the North West
6 Air Ambulance; is that correct?

7 **A.** That is.

8 **Q.** Thank you. The NWAA, that is a registered charity; is
9 that correct?

10 **A.** That's correct.

11 **Q.** So it isn't part of NWS but you work closely together,
12 including through the CIH?

13 **A.** That's correct, yes. The dispatch function is
14 co-located within the CIH.

15 **Q.** Thank you. Just to understand who is on a helicopter,
16 part of the HEMS service, some but not all helicopters
17 have response doctors that are consultant level
18 practitioners who have additional skills including
19 pre-hospital anaesthesia, surgical skills and blood
20 product transfusion; is that right?

21 **A.** That's correct.

22 **Q.** Thank you. No need to put it up but, looking at
23 paragraph 121 of your statement, they also have critical
24 care paramedics. Could you just explain the difference
25 in skills between a critical care paramedic and a HEMS

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1 **A.** Yes, so how that would work is that the computer system
2 will identify, both through the call and through the
3 information provided by the caller, the location of that
4 call. That creates a record within the computer system
5 that is then visible to the dispatch team, the dispatch
6 leadership, and the wider leadership team as well.

7 **Q.** What is the Integrated Contact Centre?

8 **A.** So, the Integrated Contact Centre is the new terminology
9 for the Emergency Operations Centres. So historically,
10 within the North West, our 111 and 999 teams work
11 separately, we are in the process of bringing those
12 teams to co-locate and work together. So the Integrated
13 Contact Centre is the naming convention for the 111
14 patient transport and Emergency Operations Centres.

15 **Q.** We are obviously not concerned with the 111 issue, so if
16 we use the term "Emergency Operations Centre" will that
17 capture the structure that we need to address?

18 **A.** Absolutely.

19 **Q.** Thank you. What about the Complex Incident Hub?

20 **A.** So the Complex Incident Hub is part of the EOC. The
21 Complex Incident Hub is a joint dispatch and clinical
22 function. They have responsibilities both for
23 identifying potentially complex clinical cases and the
24 dispatch of some of our specialist resources, such as
25 helicopters and our hazardous areas response teams.

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1 response doctor?

2 **A.** Yes. So critical care paramedics can perform a number
3 of clinical roles, over and above a paramedic. There
4 are some functions the critical care paramedics at the
5 time were unable to do without the supervision of
6 a doctor, so one of those, as an example, is blood
7 transfusion.

8 **Q.** Thank you. Again, just for reference, at paragraph 116
9 of your statement, you address the British Association
10 for Immediate Care or BASICS. Is that, again,
11 a charitable organisation?

12 **A.** It is, yes.

13 **Q.** Are the capabilities of BASICS doctors similar to those
14 of response doctors in HEMS?

15 **A.** The capabilities are but the equipment they carry do
16 vary, which will narrow the -- for example, they would
17 not necessarily be able to provide a blood transfusion
18 as they do not have the equipment to do so, but the
19 clinical skillsets/medical are the same.

20 **Q.** Thank you. We will come to consider in overview blood
21 products but is it right then that, at the time of the
22 attack, it was only a helicopter with a response doctor
23 that would have been able to deliver a blood product?

24 **A.** That's correct.

25 **Q.** Thank you. Moving on to the types of resource at NWS.

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1 First of all is, without meaning this pejoratively, but
 2 a regular ambulance; is that right? That would be
 3 crewed by normally a paramedic and an Emergency Medical
 4 Technician; is that correct?
 5 **A.** That's correct.
 6 **Q.** Thank you. Emergency Medical Technicians, again not
 7 meant pejoratively, but they are not trained to the same
 8 level as a paramedic?
 9 **A.** No, they are not.
 10 **Q.** Thank you. A rapid response vehicle, who would crew
 11 a rapid response vehicle?
 12 **A.** Within our organisation, we have two separate types of
 13 crewing for that vehicle. So one would be a paramedic;
 14 the second would be an advanced paramedic.
 15 **Q.** Thank you. Before we come onto advanced paramedics, is
 16 a rapid response vehicle crewed by one practitioner
 17 only?
 18 **A.** Normally. At times, we may have a second crew member,
 19 who generally would be doing some shadowing or clinical
 20 practice with the primary paramedic or advanced
 21 paramedic.
 22 **Q.** The rapid response vehicle can't transport a patient; is
 23 that correct?
 24 **A.** That's correct.
 25 **Q.** You mentioned an advanced paramedic; is there

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1 **Q.** But they are trained in their role to ask a series of
 2 questions and triage calls that come in, correct?
 3 **A.** Correct.
 4 **Q.** What level of supervision does a call handler have?
 5 **A.** So within a room, generally the ratio of supervision
 6 would be around 1:8, when somebody is fully trained and
 7 has been deemed to be competent.
 8 **Q.** What is the role or rank above a call handler?
 9 **A.** Call handling supervisor.
 10 **Q.** Thank you. Moving on to dispatches. Can you just
 11 explain their role please?
 12 **A.** I can. So within each dispatch suite that are
 13 geographically located, a region, so Cheshire, Mersey,
 14 would be divided up geographically and each dispatcher
 15 will be responsible for that area, both in terms of the
 16 ambulatory resources and the waiting incidents within
 17 that area. They are supervised by performance managers
 18 and the overall responsibility within each dispatch
 19 suite sits with the duty manager.
 20 **Q.** Can you help us as to how a dispatcher works in
 21 practice, so what they have in front of them and how
 22 they dispatch resources?
 23 **A.** Yes, I can. So they will have a screen with
 24 a hierarchical list of patients who are awaiting
 25 an ambulance. So they are ranked in category and length

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1 a difference between the skills and treatment that can
 2 be delivered by an advanced paramedic and a critical
 3 care paramedic?
 4 **A.** They are -- at the time, they were very similar, broadly
 5 the same.
 6 **Q.** What is it that an advanced paramedic can deliver that
 7 a paramedic cannot?
 8 **A.** They can deliver a wider range of drugs to patients and
 9 they can also perform a wider range of clinical
 10 interventions with patients that they are trained to
 11 a higher level.
 12 **Q.** Finally, the HART team or the Hazardous Area Response
 13 Team, is the clue in the name there: the HART team have
 14 specialist abilities to deploy to more challenging
 15 scenes?
 16 **A.** They do, yes, both in terms of their training that they
 17 go through and the equipment that they carry. They are
 18 able to, as an example, work at height or water, so they
 19 have a wider -- not a wider clinical skillset
 20 necessarily but a wider skillset in terms of how and
 21 where they could respond.
 22 **Q.** Can I move on to roles in the EOC. So you have
 23 mentioned a call handler. I assume that a call handler
 24 isn't clinically trained; is that right?
 25 **A.** That's correct.

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1 of time waited. So as an example, a category 1 patient
 2 would appear at the top of the list. They are then able
 3 to utilise the computer system that will identify the
 4 nearest appropriate resources that they would then
 5 allocate to that incident.
 6 **Q.** Then can you help us with the structure that sits above
 7 the call handlers and the dispatchers. So I think you
 8 have addressed the performance managers for a dispatcher
 9 and the supervisors for a call handler. There are, in
 10 addition, EOC managers and a duty manager as well. Can
 11 you just explain how they work together?
 12 **A.** Yes, I can. So the duty manager has the overall
 13 responsibility within that Emergency Operations Centre.
 14 So they are a 24/7, in-the-room resource. So they have
 15 the responsibility, fundamentally, for our response and
 16 our patient care within any kind of given shift, so they
 17 are in overall charge within the room.
 18 **Q.** If it is safe to draw an analogy, in the police field,
 19 we have the Force Incident Manager, whom we heard from
 20 this morning, Chief Inspector Hughes, who deals with the
 21 incident; is it an analogous position to that?
 22 **A.** It is similar. They have an operational level command
 23 responsibility within the EOC.
 24 **Q.** Having mentioned the police, can I just deal with
 25 communications between the EOC and the police. Is it

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1 right that there is a dedicated line for calls between
 2 the EOC and police control rooms?
 3 **A.** That's correct.
 4 **Q.** There's also the joint radio channel, which I think was
 5 the Emergency Service Interoperability Control Channel;
 6 is that right?
 7 **A.** That's correct.
 8 **Q.** I want to move on to the progress of a typical 999 call
 9 and I'm looking at paragraph 8 which is on page 2 of
 10 your statement. When someone makes a 999 call, they are
 11 first connected to BT Operations and asked to state the
 12 emergency service that they want to speak to, correct?
 13 **A.** That's correct.
 14 **Q.** If they say "ambulance", they are then connected to
 15 their local Ambulance Service?
 16 **A.** Yes.
 17 **Q.** They speak to a call handler who will ask them a series
 18 of questions to triage and categorise the call?
 19 **A.** That's correct.
 20 **Q.** Is that a correct summary?
 21 **A.** Yes.
 22 **Q.** Thank you very much. In terms of the documentation that
 23 will lie behind that, a 999 call is logged within a NWAS
 24 computer aided dispatch, or CAD, log; is that right?
 25 **A.** Yes.

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1 minutes and nine out of ten times within 40 minutes.
 2 **Q.** Categories Three and Four are urgent and less urgent
 3 calls, which we are not concerned with in the response
 4 to this incident, correct?
 5 **A.** Yes.
 6 **Q.** You have given the response times for each category: how
 7 are those set?
 8 **A.** Those are set by NHS England.
 9 **Q.** So are the response times given there consistent with
 10 those of other ambulance services?
 11 **A.** Yes, all English ambulance services work to the same
 12 categories and the same response targets.
 13 **Q.** Is the expectation that a response to a Category One or
 14 Two call will be done under blue lights and sirens?
 15 **A.** Yes.
 16 **Q.** At paragraph 26 of your statement, you talk about the
 17 position where there are multiple calls to the same
 18 incident. Could you just explain that for us in your
 19 own words?
 20 **A.** Yes, there are often occasions where we will receive
 21 more than one call that relates to the same incident.
 22 So, in the context of Southport, as an example, what we
 23 will do is we will dispatch on the highest category. So
 24 if, for example, the first call we receive is Category
 25 Two and, moments later, we see the second call is

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1 **Q.** Within each incident record, there is also a sequence of
 2 events, which is an electronic record of all activity
 3 within that particular incident?
 4 **A.** Yes, that's correct.
 5 **Q.** So each individual resource, so, for example,
 6 an individual ambulance, would also have a record kept
 7 of their response to an incident?
 8 **A.** Yes.
 9 **Q.** Moving on then to categories of 999 call, paragraph 21
 10 of your statement, please. You explain the definition
 11 and response times for the various different categories.
 12 So first of all we have Category One. Could you just
 13 explain what a Category One call is?
 14 **A.** I can. So a Category One call is a life-threatening
 15 call, which make up around 10 per cent of the calls that
 16 we deal with.
 17 **Q.** The response time for that is, on average, within seven
 18 minutes and, at least nine out of ten times, within 15
 19 minutes?
 20 **A.** Yes.
 21 **Q.** Category Two calls, could you explain those?
 22 **A.** Yes. Category Two would be deemed as emergency calls.
 23 They are the largest kind of proportion of categories,
 24 around half of calls would be categorised as
 25 an emergency. We have a mean response time of 18

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1 Category One, we will link those two records and we will
 2 dispatch on the highest category of response.
 3 **Q.** So, we will come on to see that certain later calls, as
 4 well as the example you have just given, in this case
 5 were categorised as Category Two?
 6 **A.** Yes.
 7 **Q.** Is it right that that shouldn't have impacted the way in
 8 which resources were dispatched to the incident?
 9 **A.** No, it won't have. So, firstly, with call 2 being
 10 a Category One call, that call then takes primacy but,
 11 in addition to that, when we have established that there
 12 is a multiple-patient need, then that will then be set
 13 and the additional calls, while they will provide
 14 potentially additional information, the decisions around
 15 the dispatch will have been driven by one of the first
 16 original calls.
 17 **Q.** Moving on please to the information received by
 18 an ambulance crew or resource when they are dispatched.
 19 I'm looking over the page, I think, at paragraph 32 of
 20 your statement. When allocated an ambulance crew will
 21 receive information via their mobile data terminal, or
 22 MDT.
 23 **A.** That's right.
 24 **Q.** What details will they receive?
 25 **A.** They will receive the location, brief details of the

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1 incident itself, and then the dispatcher can make
 2 a decision as to whether there is any other really
 3 important key information to share with the crew and
 4 they may then paste those additional information in.
 5 **Q.** So that additional information will come through as text
 6 on the MDT?
 7 **A.** It will depend. So some will come through on text and,
 8 at times, that will come through on voice, through
 9 radio.
 10 **Q.** The second way a dispatcher can pass information on to
 11 an ambulance or any other resource is via radio?
 12 **A.** Yes.
 13 **Q.** Could you help us with that. Would that be a direct
 14 message transmitted only to the ambulance concerned or
 15 to a wider talk group that can be heard by others?
 16 **A.** It would dependent on the information. If you had
 17 specific information to a crew, who were, say, en route
 18 to a job, that would go direct. If you were looking for
 19 support for a Category One patient that may go across
 20 the wider network.
 21 **Q.** So there might be a wider call to say, "I have
 22 a Category One call in X location, is anyone able to
 23 dispatch to it in the near future"?
 24 **A.** Yes, exactly.
 25 **Q.** Moving on to terminology in relation to dispatch and now

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1 where we would request the crews to attend the scene but
 2 proceed with caution and they would proceed with
 3 caution, they would make a dynamic risk assessment as
 4 they proceed to scene, as to whether it would be safe to
 5 continue forward.
 6 **Q.** And I think you refer in your statement to examples when
 7 that might be used, which include violent and aggressive
 8 incidents and firearms incidents, correct.
 9 **A.** That's correct.
 10 **Q.** In terms of deciding when to use an RVP or standing off,
 11 one can see that there might be overlapping situations
 12 where one would be considering using one or the other.
 13 Are you able to help with how a decision is made as to
 14 which of those two to use?
 15 **A.** So, predominantly, we would look to advise crews to
 16 stand off unless there was a very clear instruction that
 17 there was a necessity for an RVP, so the cordon had
 18 already been established, which negates the crew's
 19 possibility to enter, would be the reason for that. We
 20 generally try to take the approach of standing off
 21 because the crew or whomever attends is in a better
 22 position with that eyes on to be able to make a decision
 23 as to the safety of the scene.
 24 **Q.** Is that to avoid the circumstances where the crew is
 25 held back at an RVP and unable to establish whether it

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1 please looking at paragraph 48 and 49, which is at
 2 page 18 of your statement. In paragraphs 48 and 49, you
 3 explain "rendezvous point" and "standing off". Just in
 4 your own words for us today, can you, first of all,
 5 explain what is meant by a rendezvous point?
 6 **A.** Yes, a rendezvous point would be a location within
 7 reasonable proximity of an incident that we would
 8 dispatch our crews to. They can be used for a range of
 9 reasons. But an example would be if it was determined
 10 that the scene was definitively unsafe, or there was
 11 a chemical spill or something of that nature.
 12 **Q.** So, in that example, I think you say that there might be
 13 an outer cordon and an RVP would be set at some point on
 14 the outer cordon for resources to go to, before it's
 15 safe for them to then deploy onto the scene?
 16 **A.** It does. It gives an exact location, a safe location
 17 and it allows you to bring your resources together.
 18 **Q.** There may be an overlap between these two concepts but
 19 I think you say additionally that you might set an RVP
 20 to meet with another emergency service, such as the
 21 police or the Fire Service?
 22 **A.** That's correct.
 23 **Q.** Again, in your own words, can you just explain what the
 24 concept of standing off means to NWAS?
 25 **A.** So standing off is different to an RVP. Standing off is

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1 is safe to go forward or not?
 2 **A.** That's exactly right.
 3 **Q.** Are you aware of any differences in terminology in
 4 relation to rendezvous points and standing off between
 5 NWAS and MerPol?
 6 **A.** I don't have a detailed understanding of their
 7 procedures. I know under JESIP rendezvous point is
 8 an established, consistent application and there will be
 9 instances where Mersey police will establish
 10 a rendezvous point. I couldn't say whether they have
 11 a standing-off or equivalent procedure.
 12 **Q.** That's helpful. We heard from Chief Inspector Hughes
 13 this morning that they don't have a term "standing off"
 14 and they might use the term RVP in a way which was
 15 referring to the concept of standing off, where
 16 resources are expected to go to the RVP and deploy
 17 forward perhaps in short time. Were you aware of that?
 18 **A.** I was aware that they had an RVP and I'm aware that they
 19 would make a decision and utilisation of RVP. In terms
 20 of those potential differences, no.
 21 **Q.** Do you think, for example, the EOC duty managers would
 22 understand the differences in terms of response between
 23 MerPol and NWAS in this area?
 24 **A.** I think they would have a clear common understanding of
 25 RVP and I think I'm confident that the duty managers for

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1 NWAS have a clear understanding of where standing off
 2 would be applied.
 3 **Q.** Standing off would be applied by NWAS?
 4 **A.** NWAS, yes.
 5 **Q.** Is that an area, do you think, where either shared
 6 terminology, or greater training on understanding of how
 7 MerPol would respond to this type of incident, would
 8 help NWAS?
 9 **A.** So I think it is always helpful, where possible, to use
 10 common language and a shared understanding. I think
 11 there would be scenarios that a NWAS stand off would be
 12 different to police approaching with caution, given that
 13 may be a violent offender as an example. But actually
 14 having common understanding in anything that we deal
 15 with is always advantageous, yes.
 16 **Q.** Moving on to the concept of major incident and major
 17 incident on standby. Could we have please the incident
 18 response plan, which is NWAS000734. I think this is
 19 a postdated version of the incident response plan but
 20 please tell us if there has been any material changes to
 21 the sections that we go to, when we --
 22 **A.** I will.
 23 **Q.** Could we have, please, page 14. Thank you. So we have
 24 a definition there of the major incident as defined by
 25 the Cabinet Office and JESIP. That is in the green box:

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1 we have the definition at the top, in the green box, of
 2 major incident and on standby:
 3 "This alerts the NHS that a major incident may need
 4 to be declared. Major incident standby is likely to
 5 involve the participating NHS organisations in making
 6 preparatory arrangements appropriate to the incident,
 7 whether it is a rapid onset or a rising tide or
 8 a pre-planned event."
 9 If we could just zoom out from there, can we then,
 10 please, look at that red box in the middle of the page:
 11 "Remember, it is easier to stand down from
 12 a potential major incident than it is to escalate when
 13 it is too late -- it is better to bring the plan into
 14 operation early, rather than to delay doing so with
 15 a consequent risk to casualties."
 16 Is that capturing the idea that it is easier to wind
 17 down a major incident or an even a major incident on
 18 standby declaration than it is to wind one up?
 19 **A.** Yes, it is.
 20 **Q.** If we then look, please, at section 3.5. The bottom
 21 half of the page. We have the green box, the
 22 instruction where a major incident has been declared.
 23 The line below:
 24 "Should the EOC consider that a major incident has
 25 occurred from initial calls, they should not hesitate to

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1 "An event or situation, with a range of serious
 2 consequences, which requires special arrangements to be
 3 implemented by one or more emergency responder
 4 agencies."
 5 Could we turn, please, to page 15 now. If we look
 6 at section 3.2.3. We have there a different definition
 7 for major incident for the NHS, so:
 8 "Any occurrence that presents serious threat to the
 9 health of the community or causes such numbers or types
 10 of casualties as to require specialist arrangements to
 11 be implemented."
 12 Is the reason for a distinction there that the
 13 latter definition is for hospitals to make preparations
 14 for patients to come to them or can you help with why
 15 there are two definitions?
 16 **A.** The NHS definition has, as you can sort of see within
 17 the terminology, a clearer consideration around
 18 casualties, patients and, as you have suggested, sort of
 19 capacity within the NHS itself. So it has a health
 20 focus within its terminology.
 21 **Q.** At NWAS, does the fact that there are two different
 22 definitions cause any sort of confusion?
 23 **A.** Not in terms of the definitions, no. I think it is well
 24 understood in terms of both.
 25 **Q.** Can we turn, please, over the page to page 16 and there

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1 declare a major incident."
 2 Can you help us with this, can a major incident be
 3 declared by the EOC or anyone from NWAS that is on the
 4 scene?
 5 **A.** Either. Either can.
 6 **Q.** Thank you very much. Again, at the bottom of the page,
 7 in the red box, we see:
 8 "If in doubt, declare a major incident."
 9 Could we turn over the page again, just for one more
 10 point, which is again at the bottom of this page, now,
 11 3.8. We have there, "Major incident declared by another
 12 agency", and the response to that.
 13 Sorry to jump around but, if we could now go over to
 14 the next section of this, which is at the top of
 15 page 18, the first line says:
 16 "It must be noted that a major incident for another
 17 agency may not necessarily be a major incident for
 18 NWAS ..."
 19 It goes on to say that NWAS has a responsibility to
 20 support other responders. So if you were to receive
 21 a major incident declaration from the police, this tells
 22 us, does it, that that doesn't automatically lead to
 23 a major incident declaration from NWAS but presumably it
 24 is an important consideration?
 25 **A.** It is. So, the information that would be presented from

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1 whichever of those organisations such as the police,
 2 would need to be considered and a decision would then be
 3 taken as to whether it would meet the criteria for
 4 a major incident for NWAS.

5 **Q.** Thank you. Turning back to your statement, please, and
 6 looking at paragraph 87, which is on page 24. You note
 7 that a declaration of major incident on standby leads to
 8 what's called a predetermined attendance or PDA.
 9 I think we can see there that the guidance says it's
 10 five emergency ambulances, one rapid resource vehicle,
 11 two advanced paramedics and one HART resource allocated;
 12 is that right?

13 **A.** That is correct.

14 **Q.** For a major incident there is a higher PDA or
 15 predetermined attendance; is that correct?

16 **A.** It is, yes.

17 **Q.** Thank you. We have that at paragraph 103, which is
 18 three pages on, at page 27, the top paragraph: 10
 19 emergency ambulances, two RRVs, one HART and three
 20 advance paramedics deployed.

21 Mr Ainsworth, thank you. Having got that
 22 terminology and concepts evidence from you, I'm now
 23 going to move on to the attack and seek to draw out with
 24 you the facts so that we have a record of NWAS's
 25 response to the attack.

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1 is it right to say that all of the 999 calls received by
 2 NWAS have been audited?

3 **A.** They have, yes.

4 **Q.** Could you just explain what that process involved?

5 **A.** Yes. So we audit a proportion of all of our calls. We
 6 utilise the NHS Pathways framework for audit. That
 7 framework would involve listening to the entirety of the
 8 call and then reviewing the call under a set of criteria
 9 as to its safety and procedural compliance.

10 **Q.** Thank you. We see from that section that this call was
 11 a Category Two call. But is it right that that was
 12 deemed to be an appropriate categorisation for the call?

13 **A.** It was, yes, and there will be two primary reasons for
 14 that, in terms of the nature of the call. So the first
 15 would be the caller is remote to the patient, so they
 16 are not with the patient directly and with the
 17 presentation that is described within that call, the
 18 Category Two outcome would be seen to be appropriate.

19 **Q.** We know, with the benefit of hindsight, that there were
 20 very serious and fatal injuries on the scene but your
 21 audit is obviously looking at what was known to the call
 22 handler through the call and, based on that, it is your
 23 view that this was correctly deemed -- it was the
 24 audit's view that this was correctly viewed an emergency
 25 call and not a life-threatening call, correct?

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1 You will, I think, no doubt be aware that the
 2 Inquiry obtained a report from an expert in emergency
 3 medicine, Professor Lyon, and that report has been
 4 summarised in open court yesterday, who I think, in
 5 broad terms, called the response timeframe commendable.

6 In exploring these issues, I'm not seeking to
 7 undermine the overall findings of his report but you
 8 will understand that the Inquiry is tasked with making
 9 recommendations, and so I seek to explore issues to see
 10 if there might be lessons learned for the future.

11 I'm going to start, please, with the first 999 call
 12 and, looking at your paragraph 36, you gave a table of
 13 the 999 calls and when they were received, which is at
 14 page 8 of the statement.

15 So looking at the top of that box, the first 999
 16 call that NWAS received was at 11.47.56, correct?

17 **A.** That's correct, yes.

18 **Q.** This wouldn't have been known to NWAS but we have heard
 19 other evidence in the Inquiry that this was a called
 20 received from Jonathan Cape, who was a costs lawyer
 21 looking from Calculus Legal Offices -- which were next
 22 to the Hart Space -- into the carpark at the Hart Space
 23 studios in the Norwood Business Centre.

24 We have heard evidence about this, so I don't
 25 propose to go into the details of the call in depth but

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1 **A.** Yes, that is correct.

2 **Q.** This was a call in which, at some stage, a disturbance
 3 can be heard in the background, which is arising from
 4 Jonathan Hayes having been stabbed by AR, and then the
 5 call cuts out. So is it right this call cuts short and
 6 so further information about what was happening at the
 7 scene was not obtained by the call handler?

8 **A.** It was not. The call handler did attempt to call back,
 9 I think, on two occasions but unsuccessfully.

10 **Q.** Thank you. We will move on now to call 2. Now, I think
 11 you wanted to make a correction to this and I believe
 12 that it is the call was received rather than at 11.48.00
 13 it was in fact 11.48.34?

14 **A.** Yes.

15 **MR BOYLE:** Sir, we don't need to pull this up but, for your
 16 note, the transcripts of the call can be found at
 17 MERP000558?

18 **SIR ADRIAN FULFORD:** Thank you very much.

19 **MR BOYLE:** So this call comes 38 seconds after Mr Cape's
 20 call and it is from a female in her car outside 110 Hart
 21 Street, correct?

22 **A.** Correct.

23 **Q.** Again, from evidence now known to the Inquiry but not to
 24 the call handler, we know that this call was made by the
 25 mother of C5.

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1 The stabbing was reported in this call, as you will
 2 see from six lines or so -- seven lines from the top,
 3 and this call, as we can see in the top right-hand
 4 corner, was correctly categorised as a Category One
 5 call, correct?
 6 **A.** That's correct, yes.
 7 **Q.** The audit noted issues around scene handling and also
 8 inputting on notes but that didn't impact the care to
 9 this patient or delay the response of NWAS resources.
 10 Are you able to explain why that was?
 11 **A.** Yes. So there are different categorisation in terms of
 12 the call assessment. So "Safe", as with call 1, would
 13 be absolutely everything was exactly as we would expect.
 14 "Safe with learning" would mean that the outcome and the
 15 assessment was appropriate and safe but there will be
 16 elements of process that sit outside of influencing the
 17 outcome of the call that may not have been followed
 18 fully.
 19 **Q.** Thank you. I think that the issue with the scene was
 20 that C5's mother was instructed to go back to the scene
 21 where ambulance and police had gathered and, based on
 22 the information known to the call handler, it couldn't
 23 be determined whether the scene was safe but I think,
 24 with the benefit of hindsight, we do know that, by the
 25 time that instruction was given, there were a lot of

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1 opportunities to gather further information from the
 2 caller by the call handler, which might have raised the
 3 category of the call?
 4 **A.** Yes, that is the case.
 5 **Q.** So, in both cases, there were small amounts of
 6 information which suggested there might be other
 7 patients who were more seriously injured than the ones
 8 that were being triaged on the call; is that fair?
 9 **A.** Yes, there is guidance in terms of multiple patients and
 10 how they should be assessed in order.
 11 **Q.** How challenging is it for a call handler to address and
 12 keep track of and triage a telephone call with multiple
 13 different patients?
 14 **A.** I think the most complex point is making the decision of
 15 whom you would triage first and, in the scenario of one
 16 of the calls, with 15 children, that can become
 17 incredibly difficult. The guidance that we would give
 18 to -- or the pathways prescribed, more accurately, is
 19 either the most unwell or the youngest and this
 20 presented true complexity in terms of the presentation
 21 for the call handler.
 22 **Q.** Is this right that the youngest child was the one that
 23 was triaged --
 24 **A.** Yes.
 25 **Q.** -- but information had been given which suggested that

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1 police and ambulance on the scene; is that right?
 2 **A.** That's correct, yes.
 3 **Q.** I don't propose to go through the remaining eight calls
 4 in depth. Can I summarise them as follows, and you will
 5 let me know if you disagree. There were three further
 6 Category One calls and five further Category Two calls,
 7 correct?
 8 **A.** That's correct.
 9 **Q.** Summarising the audit of the further calls, four were
 10 found to be safe and appropriate, and one case with
 11 learning, and four were found not to achieve a safe
 12 standard, and I think you have defined what is meant by
 13 that.
 14 But it was considered that none of those four calls
 15 which didn't achieve a safe standard impacted on the
 16 overall response; is that correct?
 17 **A.** It did not, no.
 18 **Q.** Is that because at the time those calls were being
 19 addressed, we already had a Category One call and the
 20 resources were being dispatched against that Category
 21 One call?
 22 **A.** That is correct, yes.
 23 **Q.** In relation to the four that didn't achieve a safe
 24 standard, do I summarise it fairly where I say that, for
 25 at least two of these, that related to missed

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1 an older child might have been more seriously injured?
 2 **A.** That's exactly right, correct.
 3 **Q.** Does the number of calls that were below the required
 4 standard, so half, suggest a wider cause of concern for
 5 you?
 6 **A.** It does not, no. There is two reasons for that: our
 7 call handling teams have the highest level of audit and
 8 assurance of anyone within our organisation. We work
 9 with a Pathways framework and Pathways licence, which
 10 prescribes audits at three or five for every call
 11 handler per month, and we have a very good record.
 12 I think what I would present is that this was a very
 13 complex and a very difficult scene and some of those
 14 calls were very difficult to manage. So I could give
 15 assurance and can give assurance that we do not have
 16 an issue with the audits in general but we did see that,
 17 in some of these circumstances, some of the procedural
 18 challenges that were borne out of what was presented to
 19 the call handler.
 20 **Q.** As you say, a challenging situation and perhaps one that
 21 is -- a major incident is not a common one either. But
 22 does NWAS have safeguards in place to allow call
 23 handlers to deal with these challenging calls, as best
 24 they can?
 25 **A.** We do, we have guidance for a range of major incident

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1 types, be that marauding terrorists, a bomb. We have
 2 guidance for the team and they do have, with the
 3 physical presence of supervision in the room, the
 4 ability to escalate concerns as well.

5 **Q.** Were concerns suitably escalated indeed this case?

6 **A.** I have not seen evidence that there was an immediate
 7 escalation to call the supervisor. I think some of the
 8 procedural errors within the calls will not have been
 9 known by the call handler at that point in time.

10 **Q.** You have addressed the guidance. Can I ask you, please,
 11 about training and exercising for call handlers in these
 12 challenges situations. Is there training for these
 13 difficult type calls and exercising for call handlers?

14 **A.** So call handlers through their induction go through
 15 a prescribed NHS Pathways and NWS training programme,
 16 which is six weeks classroom based. That then moves
 17 into around four weeks of direct -- so somebody plugged
 18 in with you listening -- and indirect supervision.
 19 Through the course of that training, the training team
 20 will take them through familiarisation with all Range of
 21 calls of, which some will be related to major incident
 22 or potential major incident.

23 So in terms of the training, yes, we do. In terms
 24 of them being involved in a true exercise, no, we do not
 25 and we are unable to release the staff sufficiently,

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1 I think you explain that the Complex Incident Hub, the
 2 CIH, had been managing 27 incidents that morning. Was
 3 that a higher than normal amount?

4 **A.** It would fluctuate significantly, the scale and level of
 5 their involvement will also vary. So their involvement
 6 in one incident, for an hour, could take up all of their
 7 bandwidth, for want of a better description, whereas
 8 they may just be having a watching eye on multiple. So
 9 it's difficult to say but, certainly, they had been
 10 active and busy that morning.

11 **Q.** I don't propose to get into the depths of the deployment
 12 of HEMS but that's obviously a very limited resource in
 13 terms of the number of helicopters. That is something
 14 presumably that can be quite impacted by a small number
 15 of incidents in the area which ensures that helicopters
 16 are taken up by other incidents and not able to deploy
 17 immediately to the scene, is that right?

18 **A.** Yes, with the number of helicopters and the scale and
 19 number of incidents we deal with, availability can be
 20 an issue, which is why we work to a very strict criteria
 21 for allocation and why that is clinically led through
 22 the Complex Incident Hub.

23 **Q.** I want to move, please, to the allocation of the first
 24 two resources and their route to the scene.

25 The first resource allocated was Mr Paul Smith, who

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1 given the kind of operational pressures that we have.

2 **Q.** I will pick up on this at a later stage but can
 3 I summarise it this way: that NWS is seeking further
 4 resources to be able to take staff out of active duty
 5 and engage in exercising from NHS England?

6 **A.** Yes.

7 **Q.** I'm going to move on now to the dispatching side of the
 8 response. But to try and pull from A to B, or connect A
 9 to B, those categorised calls will then be seen by
 10 a dispatcher who will then dispatch against those calls;
 11 is that correct?

12 **A.** They will and, in fact, they will see the calls prior to
 13 categorisation as well. So they will see those as soon
 14 as the calls come in.

15 **Q.** What level of information will the dispatcher be seeing
 16 as those calls are on going?

17 **A.** They will see demographics, location, category and
 18 a brief statement as to the nature of the call.

19 **Q.** Just to give context, in your statement at paragraph 39,
 20 which is page 16, you address the operational pressures
 21 that were on NWS at the time of the attack, and you
 22 describe that, I think, as "moderate operational
 23 pressures".

24 If we go over the page and look at paragraph 42, you
 25 describe I think the overall demand as low level but

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1 is a senior paramedic team leader. Can you explain the
 2 role of a senior paramedic team leader, please?

3 **A.** I can. So a senior paramedic team leader has the same
 4 clinical skills as a paramedic but they have
 5 a leadership role. So often they will be the line
 6 manager for a team of paramedics and Emergency Medical
 7 Technicians.

8 **Q.** He was in a solo-crewed rapid response vehicle and he
 9 was, at the time he was dispatched, at Southport
 10 Ambulance Station, correct?

11 **A.** Yes.

12 **Q.** We see at paragraph 45, he was dispatched to the scene
 13 at 11.50.09; is that right?

14 **A.** Yes.

15 **Q.** I think we also see that he was initially allocated
 16 to -- in a different section -- to the first 999 call,
 17 the Category Two call?

18 **A.** He was, yes.

19 **Q.** But he deployed under blue lights and sirens to that
 20 call, as is expected?

21 **A.** Yes.

22 **Q.** In fact, although it didn't affect his response, he was
 23 later reallocated to that second Category One call; is
 24 that right?

25 **A.** He was, yes.

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1 Q. Thank you. Moving to the second resource. That is
 2 A664, which we see at paragraph 46, that was a regular
 3 ambulance crewed by Paramedic Gemma March-Jackson and
 4 Emergency Medical Technician Katie Johnson; is that
 5 right?
 6 A. Yes.
 7 Q. We see they were allocated at 11.50.47, which was 38
 8 seconds after Paul Smith?
 9 A. Yes.
 10 Q. At the time of allocation, they had been mobile to
 11 another incident and were located at the junction of
 12 Church Street and Houghton Street in Southport. So they
 13 deployed from a different location to Paul Smith, didn't
 14 they?
 15 A. They did.
 16 Q. I don't know how familiar you are with the geography of
 17 Southport but would you agree with me that they were
 18 similar distances from Hart Street, Mr Smith and
 19 Ms March-Jackson's ambulance?
 20 A. Yes, I would say similar.
 21 Q. I think they were probably both between a mile and
 22 a mile and a half from Hart Street, depending on the
 23 route that they chose to take?
 24 A. Yes, that's correct.
 25 Q. Looking at the next paragraph of your statement, so over

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1 Q. I think we have heard from police evidence that that
 2 wasn't, in fact, the case. Could that relate to
 3 a misunderstanding in terms of the way that the police
 4 would deploy or the terminology that they use. Are you
 5 able to help with that?
 6 A. I couldn't definitively say but I think it has the
 7 potential.
 8 Q. Having been advised to stand off, the policy was that
 9 that ambulance would proceed towards the scene under
 10 blue lights and sirens but stop a safe distance away; is
 11 that right?
 12 A. That is correct.
 13 Q. But we have dashcam footage of that ambulance's
 14 deployment and is it correct to say that, from the
 15 dashcam footage, we can see that the ambulance drove
 16 towards Hart Street but did not use blue lights and
 17 sirens in so doing?
 18 A. Yes.
 19 Q. We will explore the impact of this on the chronology.
 20 It doesn't appear to have had a significant impact on
 21 their time of arrival but, just to clarify how you
 22 became aware of this: was this identified through your
 23 process of preparing to give evidence?
 24 A. Yes, it was.
 25 Q. Is it right to say that NWAS proactively raised this

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1 the page. At 11.51 Paramedic March-Jackson's ambulance
 2 contacted the dispatcher via the radio to ask if it was
 3 safe to attend the scene. Do you know what would have
 4 prompted that question to be asked?
 5 A. I would suspect, when they saw the information that was
 6 presented to them relating to a stabbing, it would be
 7 something that a crew would routinely want to know.
 8 Q. They were told by the dispatcher that the police were
 9 aware and in attendance, that they should stand off
 10 until further information was provided. Firstly, that
 11 advice by the dispatcher, was it consistent with the
 12 violent and aggressive incident procedure of NWAS?
 13 A. Yes.
 14 Q. Are you able to say why the dispatcher thought the
 15 police were in attendance or what, in fact, that meant?
 16 A. So what the dispatch will have been advising the crew is
 17 that, with the police being on scene, when they arrived,
 18 they would be able to, in partnership with the police,
 19 make a dynamic risk assessment as to whether they could
 20 proceed forward.
 21 Q. So in the work that you have done to prepare this
 22 witness statement, did you understand the message to
 23 Paramedic March-Jackson to be that the police were
 24 actually on scene at 11.51?
 25 A. Yes.

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1 issue with the Inquiry?
 2 A. We did, as soon as we became aware.
 3 Q. At this stage, have you been able to establish why they
 4 didn't drive to Hart Street under blue lights and
 5 sirens?
 6 A. We have not been able to definitively. There is
 7 an ongoing investigation within the organisation.
 8 Q. Will that investigation not only look to understand why
 9 that happened but also whether any issues arising out of
 10 it can be addressed for future deployments to major
 11 incidents?
 12 A. Absolutely. I think we seek to understand, we have
 13 a learning culture within the organisation wherever we
 14 can and we seek to take learning from whatever
 15 opportunity presents.
 16 Q. I might suggest this might be another example which
 17 relates to exercising, although we don't know the full
 18 background yet. But, in terms of policies and
 19 procedures, are you satisfied that the standing-off
 20 policy is sufficiently straightforward and accessible
 21 for paramedics to understand?
 22 A. We have -- we constantly review our policies, often
 23 annually or by annually. On review, we have enhanced
 24 the policy, so we have added greater guidance for staff.
 25 Having said that, standing off is something that a crew

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1 would be asked to do relatively routinely and is
 2 understood.
 3 **Q.** So it is not necessarily a major incident instruction?
 4 **A.** No, no, not at all. It would happen far more
 5 frequently.
 6 **Q.** Does the policy specify that someone standing off should
 7 deploy to their standing-off point under blue lights and
 8 sirens?
 9 **A.** It does.
 10 **Q.** Turning back then to the chronology. Paul Smith was en
 11 route, following his dispatch at 11.50; is that correct?
 12 **A.** Yes.
 13 **Q.** Thank you. I think we pick up on the chronology here at
 14 paragraph 55, so over the page, please.
 15 At 11.52 Paul Smith was contacted by a dispatcher as
 16 he was on his way to the scene and advised that the
 17 attacker could still be on the scene and to stand off.
 18 Was that a direct message that was passed to Mr Smith?
 19 **A.** Yes.
 20 **Q.** So it wasn't a wider message passed to all resources,
 21 for example, in the Southport area?
 22 **A.** No.
 23 **Q.** We see at paragraph 57 that at 11.53 Paul Smith was
 24 advised that police were in attendance. Again, it's the
 25 same point that we made before: that wasn't yet the
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1 closer.
 2 "The controller from the EOC, who I know as Andrew,
 3 advised me to stand off until we had been assured the
 4 scene had been made safe. I decided to continue to the
 5 scene, as I was aware that the police were also at the
 6 scene, so I was confident that I would be okay."
 7 Just related to this, I think we see in your
 8 statement at paragraph 63, if we could have that down
 9 please, that, at around the same time, a dispatcher
 10 passed information to Mr Smith to update that there were
 11 reports of armed men in the Norwood Business Centre and
 12 to stand off again.
 13 We know that that report of armed men wasn't
 14 accurate. Is it unusual for this kind of false or
 15 conflicting information to be passed in the early stages
 16 of an incident such as this?
 17 **A.** No, it is often common in the early onset of a major or
 18 a complex incident that the information we are receiving
 19 will be conflicting at times and can be confusing.
 20 **Q.** Thank you. As we can see there, Paul Smith simply
 21 confirmed to the dispatcher that he was on scene in
 22 response to this information, parked his vehicle at
 23 11.57.25. So that is the time of the first responder
 24 arriving on the scene; is that correct?
 25 **A.** Yes.
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1 case. Are you able to assist in why that false
 2 information might have been passed to Mr Smith?
 3 **A.** I can't say definitively.
 4 **Q.** Moving away from your statement and just by reference to
 5 the dashcam footage, Paramedic March-Jackson's ambulance
 6 shows it pulling over to allow Paul Smith to pass at
 7 a junction, I think, a bit of a way away from the scene.
 8 If I were to say that the dashcam footage camera shows
 9 that at 11.55, does that sound accurate to you?
 10 **A.** It does.
 11 **Q.** It is right then that they proceed to scene behind
 12 Mr Smith but, as discussed, not under blue lights and
 13 sirens?
 14 **A.** Yes.
 15 **Q.** Can I now please deal with Paul Smith's approach to the
 16 scene. Please could we have up his witness statement,
 17 which is MERP000723 and could you just please show
 18 page 3 and the middle two paragraphs.
 19 So Mr Smith entered Hart Street from St Luke's Road
 20 but, as he reached the scene, he stopped to let a police
 21 car over take him, and he says:
 22 "The police car pulled up alongside me and I spoke
 23 to the Sergeant who was driving the vehicle. He asked
 24 me if I knew where the scene was and I recall telling
 25 him that it would probably become apparent as we got
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1 **Q.** Thank you.
 2 The instruction that Mr Smith received on two
 3 occasions, that he should stand off, that again was as
 4 per the NWAS policy; is that right?
 5 **A.** Yes.
 6 **Q.** Would it be fair to say that Mr Smith went beyond the
 7 call of duty in heading to the scene, despite that
 8 instruction?
 9 **A.** I think Mr Smith, Paul, made a brave decision, based
 10 upon what he observed when he attended at scene but
 11 I think his decision to go forward was commendable and
 12 brave.
 13 **Q.** Thank you. The way Professor Lyon put this -- and
 14 I don't seek to bring up his report because it contains
 15 sensitive information -- but he says:
 16 "It is normal practice for emergency medical
 17 services to be held at an RVP until the scene is
 18 declared safe. NWAS paramedics should be commended for
 19 performing a dynamic risk assessment and attending the
 20 scene without considering significant delay or holding
 21 an RVP."
 22 Do you agree with that?
 23 **A.** I do completely.
 24 **Q.** Moving on then to Paramedic March-Jackson, her ambulance
 25 was also under the same stand-off instruction but she
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1 decided to follow her senior, Mr Smith, to the scene; is
 2 that right?
 3 **A.** It is.
 4 **Q.** We have discussed the issue about the blue lights and
 5 sirens but is it right that, in going forward to the
 6 scene behind Mr Smith, she was making a dynamic risk
 7 assessment that she was surpassing the expectations of
 8 the policy?
 9 **A.** I think it was an equally dynamic and brave decision.
 10 Policy does require that our crews make the decision
 11 based upon what they see and what they appraise but
 12 I certainly think that they clearly -- they actually
 13 took -- minimised any delay.
 14 **Q.** So I shouldn't denigrate policy to say that it doesn't
 15 allow practitioners to make dynamic assessments and make
 16 their own decisions but that they chose to deploy in
 17 those circumstances?
 18 **A.** I think with any dynamic assessment, there will be
 19 a range of decisions that are taken dependent on what
 20 they face. I certainly think with both of the
 21 individuals that you have described, they did make
 22 a dynamic assessment and they did proceed to scene
 23 bravely.
 24 **Q.** The arrival time was 11.58.00. So they actually arrived
 25 35 seconds behind Mr Smith; is that correct?

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1 **A.** Yes.
 2 **Q.** We have seen that from the table, which was at
 3 paragraph 36. As we have discussed, Paul Smith parks
 4 his vehicle at 11.57.25, so that's 9.5 minutes, give or
 5 take a second, within the call being made. Is that the
 6 correct timeframe to be measured from the moment the
 7 call connects to NWAS to the arrival of the first
 8 resource?
 9 **A.** Principally, yes.
 10 **Q.** Thank you. So that 9.5 minutes was within the target of
 11 nine out of ten calls -- let me word this right. There
 12 was a 15-minute target for 90 per cent of calls; is that
 13 right?
 14 **A.** Yes. The added complexity with Paul's response is the
 15 first minute he is responding to a Category Two
 16 incident. He is then reallocated to a Category One. So
 17 that's the slight difference but, yes, absolutely, in
 18 either circumstance, it meets the nine out of ten, 90
 19 percentile target for Category One.
 20 **Q.** So the response time target for the Category Two call
 21 would have been longer?
 22 **A.** Yes, it would have been 18 minutes on average and 40
 23 minutes nine out of ten times.
 24 **Q.** But actually, because Mr Smith deployed under blue
 25 lights and sirens and, bar talking to PS Gillespie, that

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1 **A.** Yes.
 2 **Q.** Just considering the hypothetical situation, if they had
 3 deployed under blue lights and sirens from the start,
 4 they clearly would have arrived at scene slightly
 5 earlier, but, if they had stood off, they wouldn't have
 6 proceeded forward to the scene in any event, correct?
 7 **A.** That's correct.
 8 **Q.** So, they either could have stayed stood off and followed
 9 in Mr Smith, in which case they would have arrived 35
 10 seconds earlier. In that scenario, did that time
 11 difference, based on your preparation and understanding,
 12 have a substantive impact on the NWAS response?
 13 **A.** It didn't have a substantive impact on the response, no.
 14 **Q.** Thank you. They would have been entitled under the
 15 policy, if their risk assessment was such not to follow
 16 Mr Smith into the scene, given the stand-off
 17 instruction; is that correct?
 18 **A.** Yes, I guess it is speculative in terms of the decision,
 19 if they were first, but I think Paul's bravery certainly
 20 aided the decision that they took.
 21 **Q.** Thank you very much. I'm just going to finish off the
 22 time that it took Mr Smith to arrive, sir, and then that
 23 might be a good moment in a few minutes to take a break.
 24 The first call we have seen into NWAS was received
 25 at 11.47.56 minutes; is that right?

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1 actually didn't impact the time it took to reach the
 2 scene, notwithstanding the fact the category was changed
 3 when he was en route.
 4 **A.** No, for any Category One or two, crews would proceed on
 5 blue lights. So the category of response would make no
 6 difference to their arrival time.
 7 **Q.** The time, that 9.5 minutes, was slower than the
 8 seven-minute average time for Category One, with the
 9 caveat you have given about the recategorisation. Does
 10 that give you any cause for concern?
 11 **A.** It doesn't. We recognise that, as an organisation we
 12 have a good response to Category One calls. We respond
 13 currently in just around the seven minutes on average.
 14 Availability of resource, where those resources are and
 15 geography can make achieving the seven-minute target, in
 16 all circumstances, difficult.
 17 **Q.** So we know that Mr Smith drove straight from the
 18 Southport Ambulance Station to Hart Street, bar a short
 19 time for a discussion with PS Gillespie. Any delay on
 20 his part, was that attributable to the time it took to
 21 dispatch him and also the geography in terms of his
 22 distance from Hart Street?
 23 **A.** Yes, I mean, in terms of the dispatch on the Category
 24 One element, that was immediate. It is geography and
 25 I think the delay to discuss with the police was

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1 probably building up his situational awareness.

2 **MR BOYLE:** Thank you.

3 Sir, I move on to more general questions about the

4 response, I wonder if that is a good time to break?

5 **SIR ADRIAN FULFORD:** It certainly it. Just before we do.

6 I just want to be clear in my own mind in relation to

7 stand off. So stand off for NWS will always have

8 within it the notion that there will be a dynamic risk

9 assessment. So whatever else you do, you are going to

10 be thinking about whether it looks as though it is

11 appropriate to carry on going forwards to the

12 destination. The bit I want to be clear about is: is

13 there also then, because it is a standoff, that you are

14 thinking about parking up somewhere that is removed from

15 where you understand the scene of the incident to be?

16 **A.** It would be as close as practically possible.

17 **SIR ADRIAN FULFORD:** It wouldn't have had to have been

18 defined as being a school or somewhere else, it would

19 just be, in your assessment, a sensible location for you

20 to go to.

21 **A.** That's correct.

22 **SIR ADRIAN FULFORD:** Good. Thank you. I was no doubt being

23 slow but I wasn't sure about the second part.

24 We will sit again at 3.05 pm.

25 **(2.45 pm)**

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1 I believe post transportation of all critically injured

2 patients there was a utilisation of a rendezvous point

3 later on but more of a survivor welfare centre, than in

4 relation to the specifics related to the incident

5 itself.

6 **Q.** Understood. We heard in evidence this morning relating

7 to Chief Inspector Hughes, that, following a call with

8 Merseyside Police at 11.55 a warning alert was given by

9 a call handler to a dispatcher -- sorry, to alert

10 a dispatcher, based on that information. You addressed

11 this at paragraph 68 of your statement on page 21.

12 Can you just explain what is meant by a warning

13 that's given by the call handler to the dispatcher?

14 **A.** The warnings were put onto an alert a dispatcher, so

15 an example would be if there is information that relates

16 to -- sorry, a follow-up call which relates to

17 an ongoing incident and the alert will advise the

18 dispatcher to review the record.

19 **Q.** Thank you. You have said that at 12.03 the dispatcher

20 turned off the warning because Mr Smith was already on

21 scene with a clear police presence on scene. So is it

22 right that the warning didn't actually impact the

23 response -- the way the response was handled centrally

24 at NWS?

25 **A.** No, it had no bearing.

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1 **(A short break)**

2 **(3.05 pm)**

3 **SIR ADRIAN FULFORD:** Yes, Mr Boyle.

4 **MR BOYLE:** Mr Ainsworth, we dealt, I think, with the first

5 responders and their specific routes to the scene.

6 I just want to deal with the dispatching of further

7 resources but I'm not going to go through the full

8 chronology, you will be pleased to hear, which is set

9 out in your witness statement and also addressed in the

10 chronology. But is it right that it accounts for 37

11 resources being deployed by the scene in total by NWS.

12 **A.** Yes.

13 **Q.** Going just to the conclusion of your statement, which is

14 at paragraph 111 -- we don't need it on the screen --

15 but you say that you were satisfied that all available

16 resources were allocated in line with guidance and that

17 it was the nearest available resources that were

18 dispatched?

19 **A.** Yes.

20 **Q.** I just want to ask about the overall position with

21 stand-off and rendezvous points. Is it right to say

22 that, in the way that we have defined rendezvous point

23 earlier, that no NWS resources were deployed to that

24 sort of rendezvous point?

25 **A.** No, resources were deployed in the initial response.

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1 **Q.** Thank you. We have addressed the first two responders

2 that received, I think, direct messages from the

3 dispatchers to stand off; is that right?

4 **A.** Yes.

5 **Q.** There was no other instruction or generalised

6 instruction to stand off; is that correct?

7 **A.** That's correct.

8 **Q.** Thank you. Was that because, by the time Mr Smith and

9 Ms March-Jackson were on scene, they radioed their

10 presence with the police and so there was no need to

11 relay a wider standing-off message?

12 **A.** That is correct.

13 **Q.** Thank you.

14 NWS had some resources that were diverted to pick

15 up HEMS crews and others that were moved into the area

16 to cover for those resources that were attending the

17 scene; is that correct?

18 **A.** Yes.

19 **Q.** Some of those resources might have deployed without

20 sirens because they were looking to fill an area that

21 had been vacated; do I summarise that correctly?

22 **A.** You do.

23 **Q.** Thank you. Those resources aside, for the resources

24 that were mobilised directly to the scene, so far as you

25 can tell, did they all mobilise directly and under blue

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1 lights and sirens?

2 **A.** Yes.

3 **Q.** Thank you. So when we look at the timings of their

4 arrival and to the extent that they are staggered, is

5 that explained by, firstly, the timing of their dispatch

6 and, secondly, the travel time that it took them to get

7 to the scene?

8 **A.** Yes, and an RRV would proceed slightly quicker than

9 an ambulance.

10 **Q.** It is not explained by any delay in them getting to the

11 scene due to standing off/RVP or any other issue?

12 **A.** No, all -- both of those two resources all proceeded on

13 blue lights directly to scene.

14 **Q.** I just want to very briefly address the timeline of

15 treatment to Alice, but we have had it summarised by

16 Professor Lyon, so I just want to do the timeline from

17 the perspective of NNAS.

18 Is it right that the first contact Alice had, or

19 direct contact or treatment Alice had, with a NNAS

20 paramedic was with -- and you will have to forgive my

21 pronunciation -- Richard Krcmer?

22 **A.** It is, yes.

23 **Q.** Thank you. That was at 11.59?

24 **A.** Yes.

25 **Q.** The fact that he was the first resource on the scene, is

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1 just looking at the last three sentences:

2 "... I have not been able to confirm the timing of

3 the major incident declaration, I can confirm that at

4 that time, the resources allocated to the incident met

5 these criteria with further doctors en route to scene

6 instead of a third advanced paramedic."

7 I just want to take you, please, to some of the

8 further records, so forgive jumping around to a few

9 documents, but I want to take you to some different

10 times to see if we can unpick this at all.

11 Can we please first have NNAS000738. This is the

12 action card of the primary Emergency Operations Centre

13 duty manager, is that Mr Ashley Charnock?

14 **A.** It is, yes.

15 **Q.** Do these action cards give a set of tasks for someone in

16 a particular role when responding to a major incident?

17 **A.** They do.

18 **Q.** We can see at section 1, the first action is based on

19 the information received:

20 "Is this a major incident, standby or declared?"

21 We can see that Mr Charnock has circled "standby" at

22 12.02 and given his initials there?

23 **A.** Yes.

24 **Q.** Could we look please now at Paul Smith's witness

25 statement that we have had up before. It is MERP000723

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1 that expected because early resources are expected to

2 triage, rather than treat?

3 **A.** Initially, we would require the first on scene to triage

4 and then, where they are able to, then make a decision

5 of the most critically in need of treatment and begin

6 treatment there first.

7 **Q.** Alice was the first page to leave the scene?

8 **A.** She was.

9 **Q.** She left before the arrival of the HEMS doctor who would

10 have been able to administer blood products?

11 **A.** Yes.

12 **Q.** In fact, she had been transported to Southport Hospital

13 only a minute after that HEMS doctor arrived at Hart

14 Street; is that correct?

15 **A.** Yes.

16 **Q.** Thank you. We will come onto the issues identified in

17 the debriefs but Professor Lyon's conclusion was that

18 none of those negatively impacted on the care and

19 treatment Alice received. In your preparation for

20 giving evidence, have you seen anything to call that

21 into question?

22 **A.** I have not, no.

23 **Q.** I want to move on, please, to the timing of the major

24 incident declaration and I think you have said in your

25 statement at paragraph 103, which is page 27, and I'm

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1 and we want page 10, please, and the top of the page.

2 Do we see there that Mr Smith's account was that at

3 12.05 he declared a major incident and was given details

4 of the predetermined attendance for a major incident

5 that we covered before?

6 **A.** Yes.

7 **Q.** Thank you. Can we now move please to the chronology,

8 which is NNAS001090. Can we look please at page 15 of

9 that chronology, and I'm looking, please, at the bottom

10 entry which reads:

11 "Major incident declared. Notification passed by

12 the AP on the Complex Incident Hub to the MERIT doctor."

13 Can you just explain who has declared major incident

14 in that entry? I don't need a name just the role.

15 **A.** It's the advanced paramedic.

16 **Q.** The advanced paramedic on the Complex Incident Hub?

17 **A.** Yes, sorry.

18 **Q.** Is that a reference to Mr Smith or someone who is within

19 the Hub?

20 **A.** Apologies. So, no, within the Complex Incident Hub they

21 are staffed by advanced paramedics, so this is the

22 declaration by the advanced paramedic working remotely

23 within the Complex Incident Hub.

24 **Q.** Thank you. I'm deliberately taking this out of order

25 with the 12.05 declaration by Mr Smith, just so we stay

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1 on the chronology, but does that Hub suggest major
 2 incident being declared separately by two people at
 3 around the same time?
 4 **A.** It does.
 5 **Q.** Thank you. Can we now move please to page 17 of the
 6 chronology and the top entry at 12.08.01. We see there
 7 "EOC on call advising MI standby". Is it right to say
 8 that you wouldn't call major incident on standby after
 9 a major incident has been declared?
 10 **A.** You would not, no.
 11 **Q.** Thank you. Just, finally, could we have NWS000176. So
 12 this is a logbook, which I think is filled out by a NWS
 13 practitioner as they go through their response to the
 14 incident; is that right?
 15 **A.** Yes, for any major incident.
 16 **Q.** Thank you. Could we turn to page 3 of that document.
 17 So we see that this is the logbook of Jayne Copeland,
 18 who is a performance manager. Where would she be based?
 19 **A.** She would be based at Estuary Point. Apologies, that is
 20 the Merseyside Emergency Operations Centre.
 21 **Q.** Can we move to page 12 of that document and look at the
 22 middle of that page. At 12.25 we have a radio message
 23 from QX617. Is it right that QX617 was Advanced
 24 Paramedic Gary Fitzpatrick --
 25 **A.** That is correct.

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1 **Q.** Would you agree that although we see more consistent
 2 recording around 12.25, there's no consistent time
 3 that's seen throughout all of the documentation?
 4 **A.** That is correct.
 5 **Q.** Just starting first with the declaration that Paul Smith
 6 says that he made at 12.05. Was that declaration lost,
 7 if I can put it in colloquial terms?
 8 **A.** So I think the clarity that Paul was making
 9 a declaration of major incident was lost by virtue of
 10 the evidence of no onward communication. Paul certainly
 11 provided the significant majority of the information
 12 that we would normally want to see through a M/ETHANE
 13 message, so location, scene safety, patient numbers,
 14 access, required resources. But I think, in my review,
 15 with what he faced, it was not clear that he was
 16 declaring major incident.
 17 **Q.** We have seen earlier this morning the requirements of
 18 a M/ETHANE message, so I'm not going to put it back up
 19 again but clearly the "M" is whether there is a major
 20 incident or not.
 21 **A.** It is.
 22 **Q.** I'm certainly not going to understate the impact of the
 23 scene that Mr Smith faced. In more general terms, are
 24 there any steps do you think that can be taken to help
 25 clinicians when they face these kind of scenes to make

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1 **Q.** -- who took over the on-scene operational commander role
 2 from Mr Smith?
 3 **A.** He did until the operational commander arrived.
 4 **Q.** We see there that at 12.25 it says that he is saying
 5 "major incident", which I think was consistent with the
 6 time that you had seen was suggested in the hot debrief.
 7 Can I take it quickly this way, are there a number of
 8 other documents suggesting that this major incident
 9 declaration was made at 12.25?
 10 **A.** In my appraisal investigation, going through logbooks
 11 and all available information in making this statement,
 12 it was difficult to ascertain declaration but I believe
 13 12.25 was -- the evidence dictated it was 12.25 made by
 14 Gary Fitzpatrick.
 15 **Q.** Thank you. One of the pieces of evidence in support of
 16 that, which I don't say needs to be brought up but is
 17 the transcript of body worn footage of Mr Charnock, the
 18 duty manager, which I think starts at 12.22.38 and
 19 includes reference to a major incident being called soon
 20 after; is that correct?
 21 **A.** It is.
 22 **Q.** Thank you. Would it be fair to say that there is
 23 a level of confusion about whether a major incident has
 24 been declared in the documentation?
 25 **A.** Yes.

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1 a M/ETHANE declaration?
 2 **A.** So I think there are two elements to this, really.
 3 I think the first is that, for a paramedic, they may
 4 never attend a major incident in the course of their
 5 career and, if they do, it may be -- it will certainly
 6 be highly infrequent. So one thing is the support we
 7 can provide remotely to those individuals, to ensure
 8 that the communication and the information they want to
 9 provide us from scene is translated correctly.
 10 So an example being, within our organisation, we
 11 have recently sought to introduce duty officers to
 12 operational commanders into the control room to be able
 13 to support staff in terms of the formation. Paul is
 14 a very good example: Paul had the information that he
 15 knew what he wanted to relay but I think sometimes the
 16 mnemonics and even some of the action cards can make it
 17 more complex in the operational environment, given the
 18 frequency of potential utilisation for frontline staff.
 19 **Q.** And the pressures that might be on clinicians when
 20 they're actually on the scene?
 21 **A.** Exactly.
 22 **Q.** You've referred there to a duty officer in the EOC, what
 23 role can the EOC play in ensuring that practitioners or
 24 clinicians on the scene are able to provide the right
 25 information?

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1 A. So I think it is good practice to support the
2 operational crews through dispatch, so within the
3 context of the discussion that Paul -- that it would be
4 reasonable to seek clarification, given the information
5 Paul provided as to whether he was making a declaration
6 of major incident.

7 Q. How would the duty officer assist with that?

8 A. Either through their dispatch and leadership team or,
9 given what was presented, they can contact the crew, the
10 individual and seek clarity.

11 Q. So they can pull the information in as well as it being
12 pushed?

13 A. Absolutely, yes.

14 Q. Are you satisfied that, having the duty officer in
15 place, is a sufficient safeguard to avoid these issues
16 happening in the future?

17 A. I think it is a very clear step to improving or reducing
18 the potential for confusion. I think it would be
19 difficult for me to assure you today that that would
20 eradicate any potential, given the dynamic fast-moving
21 nature of majority incidents. I think -- I couldn't
22 take that step but it certainly is one of the areas we
23 have identified through learning that would improve the
24 communication process.

25 Q. Are there any other alternative measures that you have

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1 had been or because they recognised this was a very
2 serious incident, however it was to be termed?

3 A. Yes, the declaration of major incident, in my view,
4 simplistically looks to deliver two primary objectives:
5 one is the deployment of the predetermined attendance;
6 and one is to initiate increased communication both
7 internally and with wider organisations. In terms of
8 the requirements of the predetermined attendants, I am
9 absolutely assured that, in the timescales with the
10 resources and with the level of specialist clinical
11 resource that was deployed, the EOC team absolutely met
12 the objectives of predetermined attendance for both
13 major incident and major incident standby.

14 Q. You have addressed in your statement there the time that
15 the major incident on standby predetermined attendance
16 had been dispatched. Are you able to help with the
17 predetermined attendance for a major incident?

18 A. That was achieved within 28 minutes of first call.

19 Q. Thank you.

20 Just putting to one side the M/ETHANE message.
21 Would you agree that NWAS, addressing the organisation
22 as a whole, had the information it needed to make
23 a major incident declaration earlier than 12.25?

24 A. Yes, I would.

25 Q. So, when we talked about the M/ETHANE message, we were

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1 considered that might assist with this?

2 A. I think there is an element of staff exposure and
3 experience within the major incident type scenarios and
4 their kind of lack of experience, training, exposure is
5 always going to be problematic in these types of
6 instances.

7 Q. Thank you. So we come back to the exercising point
8 again, do we?

9 A. Yes.

10 Q. Moving on to the impact that this had on the response.
11 You say at paragraph 87 of your statement, which is at
12 page 24, that -- I think I might have got a bad
13 reference in your statement -- but I think you say that
14 resources had been dispatched for a major incident on
15 standby at 12.04; is that right?

16 A. Yes. I have conducted analysis that, if we take the
17 point of first call at 11.47, within the first 15
18 minutes, the predetermined attendance for a major
19 incident standby had been deployed with the additions,
20 actually, of additional specialist clinical resource,
21 such as helicopters.

22 Q. We see that actually in the final paragraph of 87. Does
23 that mean that, regardless of whether dispatchers knew
24 that major incident or major incident on standby had
25 been declared, they were dispatching resources as if it

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1 perhaps focusing on the position at the scene but,
2 obviously, there was also information coming in to the
3 Emergency Operations Centre. Could staff at the
4 Emergency Operations Centre have declared a major
5 incident, in your view?

6 A. I think with the number of calls, with the information
7 provided, there was sufficient information for
8 a declaration to be made sooner.

9 Q. So, we have seen examples of conflicting information
10 being seen, which no doubt would have made for
11 a confusing picture in the early stages of the response
12 but, having seen the Incident Response Protocol, that
13 says, if in doubt, declare a major incident; is that
14 right?

15 A. That's correct.

16 Q. Thank you. In terms of the lack of a major incident
17 declaration at the EOC level, again, have you been able
18 to deduce the reasons for that?

19 A. Certainly when we look at the debrief, I think it is
20 reasonable to conclude that the dispatch leadership team
21 felt overwhelmed with the level of information and
22 actions that are required. There is a lot on the
23 performance, the critical incident manager and the duty
24 manager, and I think they have indicated that they felt
25 overwhelmed with the level of information and I think,

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1 in my review -- and this is not definitive, it is
 2 partially speculative -- I think the actions that they
 3 deployed indicated there were working at major incident
 4 but the formality of the declaration of the M/ETHANE and
 5 the sharing of that information didn't occur.

6 The duty manager does take part in our twice yearly
 7 annual command training. My view is that both
 8 internally and externally, there is a greater focus in
 9 that training on the operational response and that that
 10 does present sometimes challenges for that initial
 11 response within the control environment.

12 **Q.** Can I just understand the duty manager and the duty
 13 officer. Are they working together or separately?

14 **A.** Apologies. So the duty manager is the lead responsible
 15 for the Emergency Operations Centres. The duty officers
 16 are a role that have been introduced post-the Southport
 17 incident. They are operational, they work on a rapid
 18 response car, and they are operational commanders, who
 19 we have six 24/7, they work operationally out in
 20 operational environment. We have increased their
 21 numbers recently and we will be deploying those to work
 22 to support the duty manager, to help with that
 23 information, reduce that information overload, and
 24 improve the bandwidth within the team to be able to
 25 support.

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1 of a single individual.

2 **Q.** Was, so far as you can tell, NWS's major incident
 3 declaration ever passed onto MerPol?

4 **A.** Not that I'm -- I could not definitively state that, no.

5 **Q.** Would you agree that that should be clearly set out
 6 somewhere?

7 **A.** I think, just for clarity, if I -- apologies -- my
 8 understanding, based on all the information, is that
 9 through the JESIP huddles that happened on scene, there
 10 was clarified around declaration post-12.25. That
 11 clarity was not the same based on the use of the
 12 Emergency Service Control Room network. I can't find
 13 evidence there was clear communication of a M/ETHANE.

14 **Q.** So, that message should have been broadcast over the
 15 Airwave channel, the Emergency Services Interoperability
 16 Airwave channel --

17 **A.** It should, yes. I think the material impact of that on
 18 the response, given the declaration was 12.25, was
 19 negligible, if at all, given the presence on scene. If
 20 there had been an earlier declaration made, then that
 21 communication to Mersey Police, through exactly as you
 22 have described, would have greater importance. It
 23 should be done either way.

24 **Q.** I am going to move now on to debriefs. So, you have
 25 just referred to the NWS hot debrief that was done on

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1 **Q.** Thank you. Do you consider that the information risk of
 2 overwhelm is too much for one duty manager to be able to
 3 deal with?

4 **A.** So within our action cards, we do have a duty manager
 5 within the other two respective Emergency Operations
 6 Centres, who do have a role to provide support. Often
 7 the running -- the leading of the incident within the
 8 command and control principles, someone does need to be
 9 in charge, but the support in terms of, ultimately, in
 10 any major incident we are responding to hundreds of
 11 other patients at the same time, such that the support
 12 and business as usual is brought in to do that.

13 **Q.** In terms of the measures that have been brought in after
 14 the attack, are you satisfied in your role that there
 15 are now sufficient safeguards to avoid the overwhelm of
 16 a duty manager?

17 **A.** I think we have taken reasonable steps to improve the
 18 situation and reduce the demands. So that's both within
 19 revisions to the incident response plan, which remove
 20 a number of the actions associated with the primary duty
 21 manager -- ie focusing on what are absolutely the
 22 critical actions that they take -- the additional
 23 support that we have brought in there and the increase
 24 in terms of those numbers of duty officers, certainly
 25 are significant steps to reduce the information overload

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1 the day of the attack. I am just going to give the
 2 references without asking anything to be turned up at
 3 this stage. That's NWS000588. In addition, NWS did
 4 what's called a structured or cold debrief, is that
 5 right, which is NWS000379. I am going to come to
 6 particular examples from these debriefs but can
 7 I summarise the structure of the debrief this way: it
 8 identified 12 high-level lessons and recommendations and
 9 working groups being formed, which is meeting to distil
 10 the recommendations into actions, correct?

11 **A.** That is correct and post-publication of the debrief
 12 those -- they are being distilled with some actions
 13 already in place and some being worked through still.

14 **Q.** Without wanting to get into the nuts and bolts of this,
 15 did it take a bit of time to complete the debrief
 16 because there was a change in the approach that was
 17 taken to it?

18 **A.** So, the debrief took longer than I would expect and that
 19 we would anticipate. That was initially due to a change
 20 of approach, which on review of the draft of the
 21 debrief, when I received that, I identified that it
 22 hadn't met our needs, and so there was a request by
 23 myself that that was taken back and further work was
 24 completed and that led to a delay and, certainly, it
 25 would be reasonable to say the debrief took longer than

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1 it should.

2 **Q.** We are still then at an early stage, but are you

3 satisfied that progress is being made against those

4 recommendations?

5 **A.** In the majority. The majority sit within NWAS and they

6 are within our ability to deliver. So our areas of

7 focus are very much upon enhancing communication

8 mechanisms, so the automation and cascade of

9 information. We have already made a decision

10 organisationally to personally issue body worn video

11 cameras to all of the command cars to reduce some of the

12 issues that were identified within the debrief. There

13 is a broader challenge, which came across both from the

14 EOC and the operational staff, which was that they did

15 not feel adequately prepared for this type of incident.

16 That is a broader consideration, as we touched on

17 already --

18 **Q.** I'm going to stop you there, actually, because I'm going

19 to pick up on that as a discrete topic shortly. Just

20 before we get to that can I just cover the two other

21 reviews that have been done after the attack.

22 First of all, NHS England did a review of the

23 clinical response. Sir, just for your note the

24 reference for that is NWAS000360. I think there was

25 also a review by the North West Children's Major Trauma

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1 what people felt happened and so, in this example, what

2 this will be reflecting is that staff both within the

3 EOC and operationally did not feel that message had been

4 conveyed, as opposed to Mersey Police had not conveyed

5 the message.

6 **Q.** Does that show an issue with the kind of cascade of that

7 information at the emergency operation sector level?

8 **A.** It does.

9 **Q.** Do you know why that was?

10 **A.** So, it is certainly clear that there is a process

11 utilising the Emergency Service Control Network that you

12 must acknowledge messages that are passed and there is

13 a process that we test that on a frequent basis, sharing

14 responsibility to lead the testing. So it is

15 a reasonable expectation that the duty manager or

16 somebody on their behalf would acknowledge that message

17 and communicate it across. I think looking at the time

18 of that message, which I believe was around -- certainly

19 between 12.00 and 12.15, those messages, that may go

20 back to speak to the discussion we have had already

21 around them feeling overwhelmed.

22 **Q.** Thank you. In practice, on the scene, we know that

23 Mr Smith deployed more or less immediately after

24 Sergeant Gillespie and was able to pass back the message

25 that he was present with the police. So, that important

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1 Network, which, sir, you can find at AHCH000244.

2 **SIR ADRIAN FULFORD:** Yes.

3 **MR BOYLE:** Picking up on certain issues from those debriefs,

4 the structured debrief report addresses some element of

5 contact with the police, which I think we have picked up

6 on as we have gone through the chronology.

7 Could we have NWAS000379, which is that structured

8 debrief, and then once we have seen the first page,

9 could we move on to page 16. Thank you.

10 So, looking at communication areas for improvement,

11 the first was:

12 "Police had not made any type of declaration

13 (according to a point in time referenced in the debrief)

14 and NWAS did not receive a M/ETHANE report on ESICTRL."

15 Which is the Emergency Services Interoperability

16 Quality Control Channel.

17 We heard evidence this morning that a M/ETHANE

18 message was passed by MerPol to NWAS. Are you aware of

19 that?

20 **A.** Yes, I believe there was an ETHANE originally passed

21 that was updated to M/ETHANE.

22 **Q.** Thank you. Is that then an error in this debrief or am

23 I misunderstanding the section within brackets?

24 **A.** No. So the debrief isn't there as a factual assessment

25 of what happened. So the debrief will pull together

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1 information was passed but it was passed by Mr Smith and

2 again, to use sort of colloquial language, lost when it

3 was passed between the control rooms of NWAS and MerPol;

4 is that right?

5 **A.** That's correct.

6 **Q.** Can we move on to training, which I think we have

7 already traversed in many ways. You were starting to

8 talk when I cut you off about the ability of NWAS staff

9 to train and exercise for a major incident. Is it right

10 that there are difficulties with that, in terms of

11 having the resources to allow staff to take the time out

12 of their daily roles to do the exercise?

13 **A.** So, for clarity, anybody who performs a command role or

14 a role associated with command of a major incident,

15 inclusive of the duty manager, will undergo training

16 twice yearly and will have the opportunity and will be

17 required to exercise. In terms of the wider workforce,

18 so both the staff within the dispatch teams, within

19 emergency operations, paramedics and Emergency Medical

20 Technicians, we do not have the capacity or the funding

21 to enable us to ensure everybody is able to participate

22 in an exercise, as an example.

23 **Q.** Thank you. You refer in your statement to paragraph 196

24 to the recommendation from the Manchester Arena Inquiry,

25 which was Monitored Recommendation 20, that North West

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1 Ambulance Service should ensure non-specialist ambulance
 2 personnel are involved in multi-agency exercising. Do
 3 I take from your answer that that hasn't been possible
 4 because NWAS hasn't been given the resources to do so?
 5 **A.** That hasn't been possible. As an organisation and as
 6 a sector, we are still in discussions with NHS England.
 7 **Q.** Thank you. That recommendation was specifically aimed
 8 at North West Ambulance Service but is it right that it
 9 is a recommendation aimed at ambulance services as
 10 a whole?
 11 **A.** Yes.
 12 **Q.** You are seeking from NHS England greater resources to be
 13 able to carry out this exercising; is that right?
 14 **A.** It is, yes.
 15 **Q.** Can you just explain the process that has happened so
 16 far and where you have reached with that?
 17 **A.** Certainly for the North West, we initially wrote to our
 18 Commissioners, to the ambulance commissioning team, to
 19 advise of the recommendation and request additional
 20 funding. That has subsequently been managed through
 21 national communications directly with NHS England,
 22 Urgent Emergency Care team. We haven't reached
 23 a conclusion as to whether that funding will be made
 24 available or not.
 25 **Q.** At this gap of time from the recommendations of the
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1 right that we see, by way of example in the structured
 2 debrief report, issues with ambulances running out of
 3 supplies at the scene?
 4 **A.** I think -- for clarity, I think there was equipment at
 5 scene but, by the nature of how that scene emerged, the
 6 equipment hadn't -- had moved around, simply put.
 7 I think it is reasonable that, in an ideal world, you
 8 would have an officer who would fulfil the role as the
 9 equipment coordinator. I think with the scene that the
 10 crews faced, they made the dynamic and correct decision,
 11 in my view, to initiate treatment and what that did lead
 12 to is some confusion around where equipment -- where it
 13 may lay.
 14 **Q.** Thank you. My question was perhaps a bit too broad.
 15 There was sufficient equipment at the scene but it was
 16 perhaps not always in the place where clinicians needed
 17 it though, at the exact moment that they were seeking to
 18 treat someone?
 19 **A.** I think I have seen no evidence to suggest there wasn't
 20 sufficient equipment at scene and available to
 21 clinicians, with the exception of a lack of equipment on
 22 one of the conveying ambulances.
 23 **Q.** Was that the ambulance of Ms March-Jackson which
 24 conveyed Ms Lucas from the scene?
 25 **A.** It was.

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1 Manchester Arena Inquiry, does it concern you that NHS
 2 England hasn't yet resolved this issue?
 3 **A.** So I think there are probably three points I'd want to
 4 draw out on this aspect. I think the first is that we
 5 recognise, as an ambulance sector, we have received
 6 investment towards our frontline resources over the last
 7 few years but that's been very clearly allocated that we
 8 increase the number of our ambulances available, not to
 9 provide, effectively, backfill for another activity. So
 10 I think that is the first area.
 11 It is still, therefore, a gap in terms of our
 12 ability to exercise our entire workforce. I think there
 13 is a contextual element here of it is difficult, even in
 14 that context, to be assured that the training would
 15 fully prepare somebody to respond to some of the complex
 16 and horrific scenes but, certainly, it would give people
 17 greater familiarity with some of the core processes and
 18 communication.
 19 **Q.** Thank you. Is that a process that input from this
 20 Inquiry might assist with in terms of the case you are
 21 presenting to NHS England?
 22 **A.** I think it would be helpful to reach a definitive
 23 position, to allow an organisations to take the
 24 appropriate steps in response to that decision.
 25 **Q.** Thank you. Moving on now to equipment, please. Is it
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1 **Q.** Is it right that Ms March-Jackson says in her statement
 2 that there was no available kit in the surrounding area
 3 which was being used for children at the scene?
 4 **A.** It was and I think they made -- given the speed of
 5 transportation to hospital, I think they made the
 6 decision based on the presenting need to convey the
 7 patient at speed, instead of seeking out that equipment.
 8 **Q.** Thank you.
 9 Sir, it doesn't need to be put on the screen, but
 10 the witness statement of Ms March-Jackson, just for your
 11 note, is MERP000128 and page 6 and the clinical report
 12 of Ms Lucas referring to this is NWAS000376.
 13 **SIR ADRIAN FULFORD:** Thank you.
 14 **MR BOYLE:** You referred to the fact that an equipment
 15 officer would have been able to assist and I think,
 16 looking at your paragraph 167, and speaking more
 17 generally, you accept that there were other roles
 18 envisaged by the incident response plan that weren't
 19 present at the scene but would have allowed for a better
 20 coordination of resources; is that right?
 21 **A.** That is correct. I think my view is that there will
 22 always need to be a decision around the allocation of
 23 functional roles versus the allocation of clinicians to
 24 provide treatment to patients and there will always be
 25 a balance and, within that balance, there may be
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1 a detriment in one of those two things. So I think,
 2 whilst it would have been desirable that those roles
 3 were allocated, I think the decisions that were taken to
 4 initiate care and treatment were the right ones on the
 5 day.

6 **Q.** So, there is an understandable need, when you are one of
 7 the early resources on the scene, firstly, to triage
 8 quite a substantial number of patients, which is
 9 obviously time-consuming and perhaps takes you away from
 10 setting up the command structure; is that correct?

11 **A.** That is correct, yes.

12 **Q.** Then, also, perhaps for someone in a paramedic role, it
 13 is a natural desire to want to treat casualties as you
 14 arrive on the scene?

15 **A.** It is and I think different incidents will require
 16 different considerations. I think when we look at the
 17 number of potential functional roles, if all of those
 18 roles have been allocated, in this case prior to
 19 initiating treatment, I think that would have been the
 20 wrong decision given the criticality of patients. There
 21 will be other protracted incidents where the allocation
 22 of functional roles will either be more practical or it
 23 will not be possible to provide the care and treatment.

24 I think, in this context, there was some lack of
 25 coordination but I think the decisions that were taken

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1 **A.** That is correct.

2 **Q.** The Major Trauma Network Review that I cited before,
 3 could we have that up on the screen, please. It is
 4 AHCH000244. Thank you. Could we please just see the
 5 first page overleaf -- sorry, the second page, which is
 6 the first page of the report. Could we now go, please,
 7 to page 13.

8 So, we see at the bottom at 4.7, if we could just
 9 enlarge the bottom third of the page, that section
 10 please.

11 "It was reported that in some cases analgesia was
 12 considered but not administered as the patient reported
 13 no pain."

14 I recognise this is, to some extent, a clinical
 15 issue but, from your discussion with clinicians at NWAS,
 16 have you considered whether asking the child patient is
 17 the right criteria to use when deciding whether to
 18 administer it?

19 **A.** It may be one of the criteria but, for our clinicians,
 20 there are a broader range of considerations. I think
 21 internally what we have noted is that there is
 22 sometimes -- and this may be because of expertise or
 23 exposure -- there is sometimes greater hesitancy to
 24 provide stronger pain relief to young children. So as
 25 an organisation working through the medical teams and

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1 were the right ones in terms of that balance.

2 **Q.** Can I move on please to paediatric analgesia. Looking
 3 at your paragraph 171, you note that the NHSE Clinical
 4 Debrief -- I'm starting at the top of paragraph 171, at
 5 the bottom of page 41.

6 "... noted that the pain relief administered to
 7 paediatric patients was oral paracetamol. Patients with
 8 [intravenous] access could have received parenteral
 9 paracetamol or morphine but NWAS had also introduced
 10 oro-dispersible morphine in November 2023 (with
 11 a reminder issued by way of Clinical Bulletin dated
 12 2 July 2024) ..."

13 So only shortly before the attack.

14 Is it right that those medicines could have been
 15 administered to child patients?

16 **A.** In some of them. It would be difficult to generalise on
 17 all because there will be elements of contraindication
 18 dependent on the children but, certainly, the clinical
 19 view and our view was there was an opportunity in
 20 a number of the cases to administer a stronger pain
 21 relief.

22 **Q.** Thank you. I think that Clinical Debrief notes the
 23 contrasting position with the analgesia afforded to
 24 adult patients and those afforded to child patients; is
 25 that right?

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1 clinical teams, we have enhanced our briefings and
 2 awareness in guidance for our staff to give them greater
 3 confidence in the utilisation where appropriate of pain
 4 relief and analgesia.

5 **Q.** Thank you. Can we have page 15 please. Just looking
 6 again at 4.7 there, I think there is a suggestion of
 7 review and learning of that administration. Is that
 8 what you have just been referring to when you say this
 9 has been looked at?

10 **A.** That's what we have done, yes, internally.

11 **Q.** Are you aware of what the findings have been and the
 12 changes that are to be effected by that review?

13 **A.** I couldn't categorically say. As in, have I seen any
 14 instances where there has not been adherence?
 15 I couldn't say.

16 **Q.** Is there any cause for concern that the clinical
 17 bulletin was issued on 2 July 2024 -- the attack
 18 happened four weeks later -- that the bulletin may not
 19 have been appreciated by clinicians at the scene in that
 20 short time period?

21 **A.** We recognise through a number of reviews that we need to
 22 consider our mechanisms of communication. So one of the
 23 steps we have taken is a change to our frontline
 24 leadership roles. So our senior paramedic team leaders
 25 now spend 70 per cent of their time working on

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1 an ambulance with their team. That gives them
 2 opportunities to have those clinician-to-clinician
 3 conversations. We are also, at the moment, revising our
 4 communication channels in terms of improving the ease at
 5 which staff can access the things that are most
 6 appropriate and most necessary for them to read. We
 7 think we recognise that issuing a bulletin in isolation
 8 and in itself isn't sufficient to be assured that we
 9 have communicated with the entirety of the workforce.
 10 **Q.** There's also a mention of Pentrox in the documentation.
 11 It might be a clinical question but are you able to
 12 assist with Pentrox at all and when it might be used or
 13 if it is something that could be useful?
 14 **A.** I think I had a discussion with clinical colleagues to
 15 try and provide some insight. Certainly Pentrox is
 16 contraindicated in children. That doesn't necessarily
 17 mean it wouldn't be used or, certainly with discussions
 18 I have had, it would be utilised in a consultant-led
 19 hospital environment out of licence. It is certainly
 20 not something that we as an organisation feel is
 21 a consideration we require. We had a range of
 22 alternative pain relief medication that was not
 23 utilised. So our focus, actually, is on ensuring that
 24 our crews are confident in utilisation of the medication
 25 and the drugs we have now.

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1 ability to identify those patients who would benefit
 2 from, and that is obviously what we do by allocation of
 3 helicopters.

4 The second broader consideration is the scarcity and
 5 the complexity of the mechanisms of delivery of blood to
 6 resources, the utilisation of, the following of the
 7 guidelines, the following of the governance and the
 8 commitment that organisations -- you must make use of
 9 blood.

10 We don't believe that: (a) it is practical in terms
 11 of the scarcity provision; and (b) in terms of the scale
 12 of the need or the use case, that we feel it is
 13 appropriate to take further steps and we wouldn't
 14 recommend. However, we do just contextualise that with
 15 the move for critical care paramedics to be able to use
 16 large blood products.

17 So our focus, working with the Complex Incident Hub
 18 is to ensure that, as quickly as we can, we identify
 19 patients who may benefit from blood products and
 20 allocate our helicopter resources to those patients.

21 **Q.** Understood. Moving on to chest seals and bleed control
 22 kits by zero responders. I understand that zero
 23 responders does not refer to NWAS clinicians; is that
 24 right?

25 **A.** That is correct.

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1 **Q.** Moving on to blood products, please. You describe in
 2 your statement that, at the time of the attack, North
 3 West Ambulance Service Critical Care Paramedics were not
 4 able to provide pre-hospital blood transfusions and we
 5 have already discussed that in evidence. Is it right
 6 that that has since changed and they now are able to do
 7 so?

8 **A.** That's correct. So, effectively, at times, we could
 9 have one resource within the North West, it gives them
 10 a minimum of four now. So that's correct.

11 **Q.** So the first helicopter crew that arrived at the scene
 12 was HO8 and it was crewed by a critical care paramedic
 13 and so was not able to deliver blood products; is that
 14 right?

15 **A.** Yes, any double-crewed critical care paramedic
 16 helicopter would not have had the ability to do that at
 17 the time and they do now.

18 **Q.** Has NWAS put any consideration into the administration
 19 of blood products by advanced paramedics?

20 **A.** We have considered and I will just kind of talk through
 21 the -- there are probably two or three considerations or
 22 factors. So, the first is that the use of blood
 23 products is clearly incredibly beneficial but to a very,
 24 very specific presentation in clinical need. So the
 25 first challenge we always have organisationally is our

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1 **Q.** But it was a matter that was considered within the NHSE
 2 Clinical Review and also referred to by Professor Lyon.
 3 Are you able to give any comment from NWAS's perspective
 4 on whether that would be useful?

5 **A.** So, there are probably a couple of areas here I would
 6 like to pick up, if possible.

7 Again, I think, in specific patients, conditions,
 8 presenting need, chest seals are very good and
 9 an effective mechanism of early intervention. Both in
 10 terms of bleed kits or chest seal type kits, if they
 11 were to become more widely available, then I do have
 12 a really clear steer I would like to provide to the
 13 Inquiry.

14 They need to be available in a mechanism that is
 15 accessible to the public and how I describe the
 16 challenge that we currently see as a sector is with
 17 defibrillators, they are registered through a network
 18 and they are all visible within our computer systems,
 19 within our 999 environment. So if anybody calls, we are
 20 able to say where they are and what the code is to
 21 unlock those because they are managed through a circuit,
 22 as it is described.

23 We have seen with some emergence of bleed kits that
 24 there is no coordination of those and, therefore, some
 25 of those are locked and we don't have the ability or we

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1 don't have the codes for those. So, what I would ask is
 2 that, if the recommendation was for wide-scale
 3 introduction of bleed kits or chest seals, that
 4 considerations around the practicalities of how they
 5 would be utilised and administered would be worked in.
 6 But, principally, we recognise there is a value.

7 **Q.** Just from NWS's perspective, you are talking about the
 8 location of these kits. Might an NWS call handler,
 9 while they are on the telephone to someone dialling 999,
 10 advise them where the nearest kit was, if they knew
 11 where it was and how to access it?

12 **A.** There are two aspects to that again. If we do and we
 13 knew, then it does give us that ability. As I said,
 14 within the country, we know where every registered AED
 15 is and we know the codes for those and that's been
 16 a significant step forward.

17 It is also beneficial because whomever -- whoever is
 18 the keeper of the defibrillator also becomes notified if
 19 it is utilised, so they can then go and ensure that it
 20 is restocked and replenished to work again. In that
 21 aspect, yes.

22 The second consideration though would be around NHS
 23 Pathways. So, NHS Pathways, as we have discussed
 24 earlier on, is the triage system that we utilise.
 25 Currently within that triage system, there isn't an end

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1 **Q.** An issue raised by Professor Lyon and the NWS
 2 structured debrief and the NHSE Clinical Review is the
 3 challenge of prioritising multiple Priority 1 patients.
 4 So where you have multiple patients that meet that
 5 definition, how you then prioritise, presumably, their
 6 evacuation from the scene primarily.

7 Are you familiar with this issue?

8 **A.** Yes, and certainly upon review and consultation with
 9 colleagues, I think we have a fairly clear
 10 organisational view. Without doubt, the scene faced and
 11 the age and nature of injuries and casualties created --
 12 generated a large number of Priority 1 patients. Our
 13 view is that the role of the senior clinician on scene
 14 to make those dynamic clinical assessments around the
 15 secondary priority of P1 patients, in terms of treatment
 16 and transport, is the most effective mechanism.

17 We believe it would be very difficult and not
 18 necessarily practical to build another framework,
 19 another guidance, another action card. 10-second triage
 20 is designed to make an initial assessment and
 21 prioritisation. The deployment, utilisation of those
 22 advance clinicians and medics to then make those complex
 23 and dynamic decisions we believe certainly is most
 24 effective and appropriate.

25 **Q.** Thank you.

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1 point or a recommendation that the call handler should
 2 consider a tourniquet, for example, or a bleed kit. So
 3 what we would need to see is the development of that
 4 circuit, that network, alongside work from -- with NHS
 5 Pathways to ensure that there is a pathway of care and
 6 a recommendation that coincides.

7 **Q.** It sounds like both of those things are issues that you
 8 think should be taken forwards; is that right?

9 **A.** I certainly think they are issues that should be
 10 considered. I certainly think in the right -- it is
 11 really clear that, in the right environment,
 12 a defibrillator, a chest seal, a tourniquet for the
 13 right patients delivered quickly clearly has benefit.

14 **Q.** Is it NHS England who NWS raises that issue with?

15 **A.** So, any changes to NHS Pathways, which is effectively
 16 NHS England, we would need to -- we have a mechanism to
 17 request change. My suggestion would be, if the Inquiry
 18 does see that these things would be beneficial, it would
 19 certainly be helpful in the context of this Inquiry to
 20 raise those with NHS Pathways as well.

21 **Q.** Thank you. My final issue is triage and prioritisation,
 22 where there are multiple Priority 1 patients.

23 Is a Priority 1 patient a patient with any severe
 24 bleeding, penetrating injury or haemorrhaging?

25 **A.** It is.

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1 **SIR ADRIAN FULFORD:** Sorry, can I just understand that. You
 2 are saying that the current guidance is effective and
 3 sufficient or it needs to be improved?

4 **A.** So, we feel the current guidance delivers what it is
 5 designed to do, which is to make a rapid assessment of
 6 prioritisation. As an organisation, how we manage that
 7 is that we will have senior clinicians on scene who will
 8 then make dynamic decisions as to who is receiving
 9 treatment first. Given the complexity of patients and
 10 presentation, we don't believe you could design
 11 a framework that captures that. Apologies.

12 **MR BOYLE:** Mr Ainsworth, thank you. Those are my questions,
 13 bar one: is there anything that I haven't asked you that
 14 you would like to say?

15 **A.** Not in terms of our response but I think it is
 16 absolutely appropriate just to -- from myself and from
 17 our organisation's perspective, to just pass on our
 18 condolences to the families of Elsie, Alice, Bebe, but
 19 also to recognise the impact the events of the day have
 20 had on the survivors, the wider families, the community
 21 and the responders, and I just wanted to take time to
 22 acknowledge that.

23 **MR BOYLE:** Thank you. I will just look around the room and
 24 see if there are any further questions. No.

25 Thank you.

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1 **SIR ADRIAN FULFORD:** Mr Ainsworth, thank you very much
 2 indeed. You have had to cover a lot of ground and I'm
 3 very grateful to you.
 4 **THE WITNESS:** Thank you.
 5 **SIR ADRIAN FULFORD:** That I think brings us to the end of
 6 the evidence for today, Mr Boyle.
 7 **MR BOYLE:** It does, sir. Tomorrow, we have Mr Poland who
 8 will be giving evidence remotely, Mr Rice and Mr Toohey
 9 and, sir, I'm in your hands but I would suggest
 10 a 10.00 am start.
 11 **SIR ADRIAN FULFORD:** Yes, 10.00 am. Thank you all very much
 12 indeed. 10.00, tomorrow morning.
 13 **(4.10 pm)**
 14 **(The Inquiry adjourned until 10.00 am the following day)**
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