THE SOUTHPORT INQUIRY

CLOSING STATEMENT ON BEHALF OF

NORTH WEST AMBULANCE SERVICE NHS TRUST

INTRODUCTORY REMARKS

1. Throughout the nine weeks of this phase of the Inquiry, the North West Ambulance Service NHS Trust ("**NWAS**") has followed closely the evidence given and the documentary evidence submitted. NWAS wishes to acknowledge at the outset the courage, dignity and fortitude shown throughout this phase of the Inquiry by the families of Elsie, Alice and Bebe and all those who were so grievously harmed, physically and psychologically, by the murderous attack of the 29 July 2024.

2. NWAS is mindful of the Chair's remarks on the approach to be taken by Core Participants to Closing Statements (6 November 2025, page 181, lines 21 - 25):

   "I would be most assisted by focused submissions that reference the evidence that has been given and, in particular, to be provided with observations on substantive recommendations that it is considered that I should make."

3. Consequently, these submissions are succinct and focus upon three key areas:
   - What went well;
   - What could have been improved; and
   - Learning and recommendations.

WHAT WENT WELL

4. It is important to keep in mind the horror and unprecedented nature of the incident to which NWAS responded when considering what went well. Professor Lyon commented (23 September 2025, page 51, lines 20 - 25) that, *"It should be remembered that an incident involving multiple children with severe penetrating injuries is a very rare occurrence, likely to be a once-in-a-career event for many of the clinicians involved. The emotional burden of such an event is also extreme."*

5. In summarising the response of the emergency services, Counsel to the Inquiry (CTI), Mr Boyle, adopted the words of NWAS Senior Paramedic Team Leader, Paul Smith, the first NWAS resource on scene: (29 September 2025, pages 101 - 102, lines 18 to page 102, line 6):

   "The position in relation to all emergency responders may well have been aptly described by Mr Smith in his statement to the Inquiry, NWAS000990, at paragraphs 43 to 44: "I would like the Inquiry to understand that as emergency responders we build some resilience to dealing with patients who have suffered severe injuries or illness. However, we are all human beings and have all been greatly affected, some more than others, by the horrific events that occurred that day." He goes on to say that "so many people have been so severely affected by the events that occurred" and that his thoughts will forever remain with them, giving his condolences."

6. The response of NWAS in doing the very best they could in the face of such appalling and murderous acts was captured by the words of DCI Pye – again, summarised by CTI: (29 September 2025, page 103, line 29), *"DCI Pye described the public response to this tragedy as a case of "bad meeting good".* CTI stated that the description was *"an entirely apt one".*

Speed of response and quantity of resources deployed

7. The first call to NWAS was received at 11.47.56 (24 September 2025, page 110, line 15) and within 9.5 minutes the first resource, Paul Smith, arrived on scene at 11.57.25 (24 September 2025, page 127, line 23).

8. A clear example of the speed of NWAS' response was summarised by Professor Lyon thus (23 September 2025, page 44, lines 12 - 23):

   "The CCTV shows Alice running out of the Hart Space at 11.46.28…the first North West Ambulance Service (NWAS) crew were next to Alice at 11.59.02."

9. Referenced again by Professor Lyon (23 September 2025, page 47, line 20):

   "Alice received rapid care, with both Merseyside Police and NWAS being on scene within a small number of minutes. Given the complexity of this incident, consideration being needed for responder and scene safety and the multiple patients involved, this response timeframe was commendable."

10. Dan Ainsworth, Director of Operations for NWAS, confirmed in evidence that, "*within the first 15 minutes, the pre-determined attendance for a major incident standby had been deployed with the additions actually of additional specialist clinical resource*" (24 September 2025, page 146, lines 16 – 21) and that the full pre-determined attendance (PDA) for an NWAS 'Major Incident Declared' was achieved 28 minutes after the first 999 call was received by NWAS (24 September 2025, page 147, line 18).

Clinical supervision on scene

11. Whilst acknowledging that there were some areas for improvement in terms of his response, as detailed elsewhere within this statement, Paul Smith should also be recognised; in particular for the bravery with which he acted, having adjudged the situation to be 'safe enough', coupled with his initial actions at scene. CTI summarised his response thus: (29 September 2025, page 98, line 12 to page 99, line 4):

"Turning to the initial ambulance response, as I mentioned Sergeant Gillespie had spoken to senior paramedic team leader Paul Smith, MERP000723 and NWAS000990, on his way to Hart Street. Despite being told to stand off by ambulance control twice and, at around the same time, being told that there were reports of armed men, Mr Smith decided that with police on scene he would be "safe enough" and made his way directly to the scene. On arrival he began to triage casualties, dealing first with Alice, with C1, with Ms Lucas and with another injured child…The best thing he could do for them was to ensure that additional resources arrived at the scene as quickly as possible and he swiftly conveyed the need for those resources back to the emergency operations centre. As the first ambulances began to arrive he directed the paramedics to start treating casualties, including Bebe, who Mr Verite had brought out to him. He also carried out triage of Elsie and Jonathan Hayes. As further senior NWAS staff, such as Gary Fitzpatrick, MERP000286 and NWAS001078, began to attend, Mr Smith conducted a handover to them."

12. When asked to comment upon the actions of Mr Smith during his evidence, Mr Ainsworth said, *"I think Mr Smith, Paul, made a brave decision based upon what he observed when he attended at scene but I think his decision to go forward was commendable and brave" (24 September 2025, page 128, lines 9 - 12).*

13. NWAS also wish to recognise Gary Fitzpatrick and the integral part he played with respect to scene management, triaging casualties and setting up the required structure to thereafter treat and convey patients swiftly from scene. He took over command upon his arrival and directed the NWAS response admirably.

14. Additionally, Paul Brennan was fundamental in the treatment of Alice. Professor Lyon comments upon the significant role he played in this, describing how he, "*led Alice's resuscitation calmly, methodically and professionally*" (PFL000001, page 27).

Clinical care and treatment afforded to those injured

15. The summary of Professor Lyon's evidence, read to the Inquiry by CTI, (23 September 2025, page 42, line 12 onwards, concluding page 54, line 2), as taken from his full report (PFL000001), highlights several aspects of the NWAS response. The Chair is respectfully invited to consider the agreed summary of Professor Lyon's evidence in full when reflecting on the response of NWAS, and in particular the clinical care and treatment afforded to the injured.

16. The following excerpt from Professor Lyon's summary (23 September 2025, page 47, line 25 to page 48, line 22) encapsulates just some of the aspects of the response of NWAS which, in his considered view, merit recognition:

> *"The delay in attending other patients was minimal, a paramedic attending to Alice would not have been able to prevent her deteriorating into traumatic cardiac arrest if she was not already in cardiac arrest. (i) While the overall ambulance dispatch and management processes of NWAS would be a matter for an expert in ambulance operational command and management, Professor Lyon considers the NWAS system to have been entirely appropriate. (j) Given the nature of this incident, NWAS paramedics should be commended for performing a dynamic risk assessment and attending the scene without any significant delay or holding at a rendezvous point. Professor Lyon considers that Alice received rapid medical care from NWAS and that there was minimal, if any, delay in Alice receiving emergency medical care in the context of this type of incident. (k) The bystanders correctly attempted to control Alice's external bleeding. The paramedics who attended to Alice correctly followed the standard European Resuscitation Council guidance and provided rapid, high-quality care."*

17. With specific reference to the treatment given to Alice, Professor Lyon summarised it thus: (23 September 2025, page 49, line 19 - 22), *"the timeline and sequence of paramedic treatment given to Alice at the scene was entirely appropriate. The pre-hospital care that Alice received was of high quality and was entirely adequate and appropriate."*

18. Within his statement at MERP001097, page 13, Consultant Forensic Pathologist Paul Cieka states that: "*I cannot give an opinion on the appropriateness of any clinical treatment provided to each victim in this case, although I note that at least six of the victims would have died without the urgent medical intervention they received*".

19. NWAS would respectfully suggest that the Chair endorse these comments.

WHAT COULD HAVE BEEN IMPROVED

Ambulance A664

20. NWAS acknowledge, as accepted in the evidence of Mr Ainsworth (24 September 2025, page 124, line 3) that A664 did not travel to scene using blue lights and sirens as one would expect. Although, as was accepted by Mr Ainsworth as endorsed by CTI, this was unlikely to have made a difference to either the speed of the response by the crew aboard A664 or NWAS more generally, this was not the expectation; blue lights and sirens should have been deployed.

Declaration of Major Incident and sharing with other agencies

21. There was some confusion and delay within NWAS as to the declaration of a Major Incident. Once declared within NWAS, the Major Incident declaration was not shared with other blue light agencies as it should have been by the Emergency Operations Centre (EOC). This was accepted by Mr Ainsworth in his evidence (24 September 2025, page 142, line 22 to page 143, line 16).

METHANE

22. Again, it is accepted by NWAS that there was confusion and arguably some delay with the passing of a METHANE from scene. Additionally, a METHANE was not shared with other blue light agencies as it should have been by EOC (24 September 2025, page143, lines 8 - 16).

EOC

23. Mr Ainsworth accepted in evidence that the EOC passed information to the first resources allocated that was inaccurate regarding the police presence on scene and

there being 'armed men' present, (24 September 2025, page 125, line 23 to page 127, line 20). This may have led to the sense, as conceded by Mr Ainsworth in his evidence, that the EOC management were overwhelmed, which, in turn, fed into inaccuracies in their communications (24 September 2025, page148, line 16 to page149, line 11).

Absence of all functional roles

24. Mr Ainsworth also accepted in evidence that not all functional roles had been allocated (24 September 2025, page 160, line 17 to page 162, line 1). He noted in particular that an Equipment Officer would have assisted with the issue that arose regarding the ambulance which conveyed Leanne Lucas to hospital having been stripped of all its equipment.

Use of paediatric analgesia

25. NWAS' own internal clinical reviews accept that paediatric analgesia was not used as it should have been in all cases. Mr Ainsworth discussed this within his evidence (24 September 2025, page 162, lines 18 - 21): *"the clinical view and our view was there was an opportunity in a number of the cases to administer a stronger pain relief."*

Debrief

26. NWAS accept that there was a delay in completion of their internal debrief. Again, Mr Ainsworth acknowledged this in his evidence and the same is addressed when considering learning below.

LEARNING AND RECOMMENDATIONS

NWAS Organisational Learning

Enhanced 'Stand Off' Policy

27. Mr Ainsworth made reference to this in evidence, via questions from Mr Boyle (CTI), as follows (24 September 2025, page 124, line 22 to page 125, line 2):

"On review, we have enhanced the policy, so we have added greater guidance for staff. Having said that, standing off is something that a crew would be asked to do relatively routinely and is understood".

Duty Officer

28. Mr Ainsworth told the Inquiry that since this incident, albeit not solely as a consequence of it, NWAS have introduced Duty Officers, who will as part of their overall responsibilities be able to assist within the EOC during a major incident (24 September 2025, page 144, lines 10 - 18) *"...within our organisation, we have recently sought to introduce duty officers to operational commanders into the control room to be able to support staff in terms of the formation."*

Paediatric analgesia

29. Accepting (as set out above) that paediatric analgesia was not used as it should have been at scene, NWAS are raising awareness internally, as to which Mr Ainsworth made reference in his evidence as follows: (24 September 2025, page 163 line 24 to page 164, line 4): *"So as an organisation working through the medical teams and clinical teams, we have enhanced our briefings and awareness in guidance for our staff to give them greater confidence in the utilisation where appropriate of pain relief and analgesia."*

EOC Training

30. NWAS has introduced a number of measures since this incident to increase the preparedness of the EOC to handle major incidents. There is no national mandate to do this, but NWAS recognised that those at the EOC had, at times, felt overwhelmed by the information they were handling. An increase in roles and training will safeguard against this (24 September 2025 page 149, lines 14 - 25; page 150, line 13 to page 151, line 1; page 144, lines 10 - 13.)

Debrief Process

31. Mr Ainsworth acknowledged in his evidence (24 September 2025, page 152, lines 18 - 25) that the internal debrief took too long. An initial review of the debrief led to the conclusion that it did not meet the required needs and, consequently, further

work upon it was needed. NWAS recognise the importance of accurate and timely reflection upon incidents. Since this incident, NWAS has taken steps to ensure that there is greater senior oversight of any post incident debriefs, so to minimise any unnecessary delay in completion of that process and any subsequent learning.

Learning arising from the Debrief

32. NWAS continues to progress with the learning outcomes identified within its internal debrief. The working group established to oversee the implementation of the twelve high level lessons, continues to meet and progress the actions and recommendations. The NWAS Incident Response Plan and Action Cards that were updated in July 2025 formed part of NWAS' Annual Command Training (completed in September) and will be included in Mandatory Training for operational staff.

Recommendations

Bleed control kits

33. The evidence of Professor Lyon, as summarised by CTI, raises important questions for the Inquiry and the suggestion pertaining to bleed control kits.

> *"He* [Professor Lyon] *has highlighted a few more general areas in terms of preventing future fatalities in similar incidents: First, gaining situational awareness of a complex scene when multiple 999 calls are received from the public. Next, use of chest seals and blood control kits by lay responders. The use of lay person bleed control kits could be more widely adopted. The use of chest seals in these kits could also be considered in future. There will always be a challenge in the location of these kits and making enough immediately accessible." (*23 September 2025, page 52, lines 14 - 25).

34. Mr Ainsworth acknowledged the value in principle of this recommendation within his evidence and made some comments concerning the coordination and the governance of administering it, for example, who controls and replenishes the kits and gives the ambulance service the codes for locked cabinets. In this regard Mr Ainsworth said this: (24 September 2025, page 169, lines 1 - 5): *"So, what I would ask is that, if the recommendation was for wide-scale introduction of bleed kits or*

chest seals, that considerations around the practicalities of how they would be utilised and administered would be worked in."

35. If the Chair is minded to pursue a recommendation in this regard, NWAS is able to assist in signposting him to publications and organisations able to support him with how such recommendation might be best achieved.

Major Incident Exercising/Training

36. NWAS would fully support this recommendation. It was, as the Inquiry is aware, Monitored Recommendation 20 (see also recommendations 105,106 and 107) following the Manchester Arena Inquiry. No NHS England funding has yet been provided for NWAS to facilitate this. Mr Ainsworth confirmed this within his evidence when asked, quite properly and in some detail by CTI, about that funding (24 September 2025, page 156, line 23 to page 158, line 24).

CONCLUDING REMARKS

37. NWAS remains fully committed to supporting this Inquiry in its difficult and important work and will continue to respond promptly and efficiently to all requests for information and assistance, should such be needed, as the Inquiry moves into its next phase.

38. As ever, the thoughts of all at NWAS, and in particular those who responded to this atrocity, remain steadfastly with the bereaved families and all those so profoundly affected by what occurred on 29 July 2024; to all of whom NWAS extends its most sincere condolences.

Lisa Roberts KC
Lincoln House Chambers
For and on behalf of NWAS
24 November 2025