

OPUS 2

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London Bridge Inquests

Day 27

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1 Monday, 17 June 2019
 2 (10.07 am)
 3 THE CHIEF CORONER: Good morning, Mr Hough.
 4 MR HOUGH: Good morning, sir. The first witness today is
 5 Paul Woodrow.
 6 MR PAUL WOODROW (sworn)
 7 THE CHIEF CORONER: Good morning, Mr Woodrow, please make
 8 yourself comfortable, please take a seat and if you can
 9 speak into the microphone, that will help us all.
 10 A. Yes.
 11 THE CHIEF CORONER: Thank you.
 12 Questions by MR HOUGH QC
 13 MR HOUGH: Would you please give your full name for the
 14 court.
 15 A. Paul Andrew Woodrow.
 16 Q. Mr Woodrow, you appreciate that I'm asking you questions
 17 first on behalf of the Coroner and you are likely then
 18 to have further questions from other lawyers?
 19 A. Yes, sir.
 20 Q. What's your current post, Mr Woodrow?
 21 A. My current post is director of operations for the London
 22 Ambulance Service NHS Trust.
 23 Q. Is this right: you are giving evidence today to provide
 24 an overview of the response by the London Ambulance
 25 Service to the London Bridge and Borough Market attack?

1

1 A. That's correct, sir.
 2 Q. You have made three witness statements, an operational
 3 statement and a learning statement, both
 4 of January 2019, and a supplemental statement very
 5 recently answering some questions from the families of
 6 the victims. You may refer to those as you wish.
 7 A. Yes, sir.
 8 Q. First of all, your own career. Is it right that you
 9 have worked for the London Ambulance Service for
 10 27 years?
 11 A. It's actually now 28, but I joined the London Ambulance
 12 Service in 1991.
 13 Q. Thank you. Have you been a senior operational manager
 14 for the last 15 or so years?
 15 A. That's correct.
 16 Q. Have you been director of operations since 2016?
 17 A. That's correct.
 18 Q. In a sentence or two, could you summarise what the job
 19 of director of operations is?
 20 A. So I'm responsible for the delivery of patient responses
 21 through 999 calls. I also have overall responsibility
 22 for the emergency operation centre, so the control
 23 rooms. In addition to that, I also have responsibility
 24 for non-emergency transport service and our emergency
 25 preparedness resilience and response functions.

2

1 Q. Thank you. Is it right that you personally didn't have
 2 an active role in the response to the London Bridge and
 3 Borough Market attack?
 4 A. That's correct, sir.
 5 Q. But is this also right: that you have considered the
 6 various logbooks, call records and so on, in order to
 7 provide an overview on behalf of the service?
 8 A. Yes, sir.
 9 Q. May I begin with the management of a major incident,
 10 which you deal with in your operational statement from
 11 page 5. Is it right to say that a number of policy
 12 documents govern the response of the emergency services
 13 to a major incident?
 14 A. That is correct, sir.
 15 Q. First of all, is there something called a London
 16 Emergency Services Liaison Panel Major Incident
 17 Procedure Manual?
 18 A. That's correct.
 19 Q. Does that deal with subjects such as the functions of
 20 the services, principles for co-working, scene
 21 management, command and control and so on?
 22 A. That's correct.
 23 Q. Are there also the Joint Emergency Services
 24 Interoperability Principles, documents focusing on
 25 cooperation and joint decision-making between the

3

1 emergency services?
 2 A. That is correct.
 3 Q. Does the London Ambulance Service itself have
 4 an Emergency Preparedness Resilience and Response
 5 Framework?
 6 A. It does.
 7 Q. And is that a document, in simple terms, concerning the
 8 structures in place to ensure compliance with various
 9 statutory duties?
 10 A. Indeed.
 11 Q. And that, I think, includes management roles and
 12 sections about planning and exercising and so on?
 13 A. Yes.
 14 Q. And finally in terms of policy documents, is there
 15 a substantial incident response procedure document of
 16 the London Ambulance Service?
 17 A. There is.
 18 Q. Does that amount to a detailed plan dealing with
 19 numerous aspects of the service's response to various
 20 types of major incident?
 21 A. That's correct.
 22 Q. Covering subjects like the declaration of a major
 23 incident, resources, command and communications, and so
 24 on?
 25 A. Correct.

4

1 Q. Looking at page 6 of your witness statement,
2 paragraph 3.2.1, can you tell us what the definition in
3 the NHS of a major incident is?
4 A. So a major incident within the NHS is any occurrence
5 that presents significant risk to health of the
6 community, or by the number or types of casualties would
7 need special arrangements to be implemented to manage.
8 Q. That, I think, is similar to other public authority
9 definitions of a major incident?
10 A. It is.
11 Q. Now, we've heard any one of the emergency services may
12 declare a major incident; is that right?
13 A. That is correct.
14 Q. And at that point, when a major incident is declared,
15 the other services will be informed and provide support?
16 A. Correct.
17 Q. There may or may not be declarations by multiple
18 services?
19 A. That's also correct.
20 Q. May we put on screen, please, {WS5040/216}. Now, this
21 is a page from the incident response procedure document,
22 and do we see included in it at paragraph 1.7 a series
23 of operational objectives for the London Ambulance
24 Service in a major incident?
25 A. That is correct.

5

1 Q. And as well as the overriding objective of saving life,
2 do we also see that they include providing treatment at
3 the scene?
4 A. Yes.
5 Q. Establishing triage arrangements?
6 A. Yes.
7 Q. Providing a focal point and communications for medical
8 staff?
9 A. Yes.
10 Q. Nominating and alerting hospitals and arranging
11 transport of casualties to hospitals?
12 A. Correct.
13 Q. We can take that off screen now and put on screen,
14 please, {WS5040/8}. If we focus on paragraph 3.5.2 of
15 your witness statement, do you set out here the
16 resources which should be sent to the scene by the
17 London Ambulance Service after any major incident has
18 been declared?
19 A. Yes, so what it actually sets out is the initial
20 predetermined attendance, so it's not a finite number of
21 resources but on declaration that minimum predetermined
22 attendance would be dispatched.
23 Q. And that minimum initial attendance do we see includes
24 20 double-crewed ambulances, eight officers, one
25 tactical advisor, command support and team, HART, and

6

1 TRU medics and so on?
2 A. That's correct.
3 Q. We can take that off screen now.
4 You have referred to control rooms when you talked
5 about your role. Does the London Ambulance Service have
6 a control room called the emergency operations centre?
7 A. Yes, sir, it actually has two emergency operations
8 centres. One of them is based in Waterloo, SE1, and
9 then we have one based in Bow, in east London.
10 Q. Now, there is also reference in the various documents to
11 a special operations centre. How and where and when
12 would that be set up?
13 A. So we have as a recommendation from the 2005 terror
14 attacks, there was a recommendation that we create
15 special operations centres, so in the declaration of
16 a major incident the control of that incident can be
17 moved into a separate control pod. So we have a room
18 with a number of pods. We have one of those located at
19 each of our control rooms and when we have major
20 incident declarations, part of the action is to take the
21 management of that major incident out of the main
22 control room, because you'll understand that despite the
23 major incident we're still getting high numbers of 999
24 calls for the rest of London. So that allows the main
25 control room to deal with business as usual, and then we

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1 move the major incident centre out into the special
2 operations centre.
3 Q. As to the responsibilities of the special operations
4 centre in a major incident, may we have on screen
5 {WS5040/31}. We're looking at paragraph 6.4.5 of your
6 statement. Do you set out a series of responsibilities
7 for the SOC in a major incident?
8 A. That's correct.
9 Q. Including coordinating the incident centrally, liaising
10 with the tactical commander, deploying resources to the
11 scene, nominating hospitals and so on?
12 A. Correct.
13 Q. We can take that off screen now.
14 Operation Plato next. You're aware and familiar
15 with procedures of Operation Plato for responding to
16 a marauding terrorist attack?
17 A. I am, sir.
18 Q. We've been through the procedural documents with
19 Superintendent McKibbin, so I can deal with these
20 matters relatively briefly with you. Would you agree
21 that the police are responsible for making a declaration
22 of Operation Plato?
23 A. Yes, sir.
24 Q. After such a declaration, will they notify the LAS
25 control room, the emergency operations centre?

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1 A. Yes, so they would initially use what we call ES5, which
 2 is an Airwave radio channel that is shared, it's an open
 3 channel, a command channel between the
 4 Metropolitan Police, the London Fire Brigade and the
 5 London Ambulance Service. So we would probably be
 6 initially told through that ES5 talk group and then
 7 a formal teleconference would be set up and the
 8 Metropolitan Police CCC, chief inspector, grip inspector
 9 is normally the person that would make that formal
 10 declaration of Plato.
 11 Q. We've heard that that's what happened in this case with
 12 Mr McKibbin making that declaration?
 13 A. Indeed.
 14 Q. In a marauding terror attack incident, is it right that
 15 the police, in consultation with the other services,
 16 will establish one or more rendez-vous points in safe
 17 locations?
 18 A. Yes, so very early on in terms of a declaration of Plato
 19 it would be the police that would nominate an RVP for us
 20 at a suitable safe distance away from the incident, and
 21 they would nominate those and we would send our
 22 resources to those RVPs.
 23 Q. So those would be places to which ambulances could be
 24 sent and from which they could be directed, as
 25 necessary, by the police and LAS staff?

9

1 A. Indeed.
 2 Q. And is it right that locations of RVPs may change during
 3 an incident?
 4 A. It is, and indeed they were on that night, sir.
 5 Q. We have heard that procedures for responding to such
 6 attacks involve the designation of hot zones and warm
 7 zones?
 8 A. That is correct.
 9 Q. What's your understanding of what a hot zone and a warm
 10 zone is?
 11 A. So a hot zone, we would not deploy into a hot zone
 12 because a hot zone is declared to be there's
 13 an immediate threat present through attackers. A warm
 14 zone is not necessarily a cleared zone as safe, but
 15 potentially more safe than the hot zone.
 16 There is something called limit of exploitation
 17 within those documents, and actually in terms of the hot
 18 zone it's only specialist firearms officers that will go
 19 into the hot zone with the idea of trying to neutralise
 20 the threat that indeed is making that area a hot zone.
 21 In terms of the warm zone, that is an area where the
 22 tri-service Plato commanders will make joint decisions
 23 around deploying assets into the warm zone, but they
 24 will also set up what we call limits of exploitation, so
 25 how far will they go into the warm zone, based on the

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1 latest intelligence that they received.
 2 Q. So drawing some themes out of that, the hot zone is
 3 where threat from attackers is presently judged to be?
 4 A. Yes.
 5 Q. A warm zone is a usually adjacent area --
 6 A. Yes.
 7 Q. -- where often an attack threat has recently been?
 8 A. Yes, and could return.
 9 Q. And could return. LAS staff may be sent into warm zones
 10 subject to direction from the commanders at the scene?
 11 A. Correct.
 12 Q. But only appropriate staff and appropriately equipped?
 13 A. Correct.
 14 Q. And LAS staff wouldn't normally be sent into hot zones
 15 at all?
 16 A. Absolutely not, no.
 17 Q. The staff which can be deployed into warm zones, is it
 18 right that they're referred to as ambulance intervention
 19 teams?
 20 A. Yes, so an ambulance intervention team actually is
 21 a tri-service, so we have -- the London Ambulance
 22 Service has deployed on the streets of London every day
 23 teams of people that would help to make up an ambulance
 24 intervention team but actually those ambulance
 25 intervention teams are also with specially trained

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1 firefighters from the London Fire Brigade and then
 2 officers from the Metropolitan Police Service.
 3 Q. We have heard that the London Ambulance Service has
 4 specialist medics called HART and TRU paramedics; is
 5 that right?
 6 A. Yes, so I can expand on that a little bit. So we do
 7 have hazardous area response teams and actually those
 8 staff routinely on a day-to-day basis would be deployed
 9 to provide support to emergency service colleagues at
 10 fire calls. Those staff have specialist training in
 11 working at height. They also have specialist training
 12 in terms of urban search and rescue and working on
 13 water. So that's part of their routine. In addition to
 14 that, those staff were also trained to provide ambulance
 15 intervention teams for a marauding terrorist attack.
 16 TRU, our tactical response units, are dedicated
 17 paramedics that only have the additional training to
 18 respond to a marauding terrorist attack, they don't have
 19 any of the other specialties that HART has.
 20 Q. When you have a marauding terrorist attack, are teams
 21 set up which include ambulance officers of these kinds,
 22 so HART and TRU staff?
 23 A. That is correct.
 24 Q. Alongside their fire brigade and police colleagues?
 25 A. Yes, specially trained firefighters and police

12

1 colleagues.
 2 Q. And is it teams set up in that way which can be sent
 3 into warm zones?
 4 A. That is correct.
 5 Q. Is it right that both HART and TRU medics have
 6 additional protective gear for going into warm zones as
 7 well as the additional training to which you've
 8 referred?
 9 A. They do.
 10 Q. Does their training to which you've referred include
 11 physical competency assessments as well as multi-agency
 12 live training?
 13 A. It does, sir.
 14 Q. As regards sending those teams into warm zones, will the
 15 deployment of those teams follow a joint risk assessment
 16 by the police, ambulance and fire brigade Plato
 17 commanders at the scene?
 18 A. That is correct.
 19 Q. When the teams do enter a warm zone, what is it the role
 20 of the LAS staff to do? What are they expected to do
 21 there?
 22 A. So when they're deployed into a warm zone and their
 23 limits of exploitation are set, their primary job is to
 24 search for casualties, to provide any life-saving
 25 interventions, and then they will make a decision based

13

1 on the intelligence and the briefing that they've
 2 received from the three Plato commanders to either treat
 3 and leave, or treat and evacuate those patients.
 4 Q. Now, you describe in your witness statement at 3.6.16
 5 that their work in a warm zone would be rapid triage and
 6 basic medical interventions?
 7 A. Indeed.
 8 Q. So not normally more extended and more complex medical
 9 interventions?
 10 A. No, there would be no complex clinical interventions
 11 carried out in a warm zone.
 12 Q. Next, command and control. We've heard about the
 13 standard incident command structure of the emergency
 14 services, so gold for strategic command, silver for
 15 tactical command, and bronze for operational command,
 16 usually on the ground?
 17 A. That's correct.
 18 Q. In responding to a major incident, will the London
 19 Ambulance Service have a number of gold commanders?
 20 A. So in terms of declaration we don't have strategic
 21 commanders on duty 24/7, but on declaration there would
 22 be a paging message and we have gold commanders on call
 23 24/7.
 24 Q. Would there also be one or more silver commanders
 25 appointed?

14

1 A. Yes, there would.
 2 Q. And a number of bronze commanders for different areas
 3 and for different roles?
 4 A. That is correct.
 5 Q. So for instance, is this right, that in this incident
 6 there was a bronze medic, Mr Passey, who allocated roles
 7 to others?
 8 A. That is correct.
 9 Q. A bronze Plato, Mr Marc Rainey of the LAS, responsible
 10 for Plato procedures?
 11 A. Yes, and that was because a major incident had been
 12 declared before Plato was formally declared and the
 13 Plato commander actually is another layer within that
 14 structure, but independent. The Plato commander only
 15 makes decisions in relation to the committal of
 16 ambulance intervention teams into the warm zone.
 17 Q. We've also heard that there were bronze commanders for
 18 particular sectors, including, I think, Mr Beasley, from
 19 whom we heard, who was bronze commander for the south
 20 sector?
 21 A. Yes, so it would be quite common practice based on
 22 geography and the size of the incident footprint to
 23 sectorise it if that assisted in the management of that
 24 incident.
 25 Q. I think we'll hear in this incident there was a sector

15

1 for the area to the south of London Bridge, which
 2 covered Borough Market, and then a sector which
 3 encompassed the north end of London Bridge where the
 4 casualty clearing station was?
 5 A. That's correct.
 6 Q. May I move on to training for major incidents, which you
 7 deal with from page 23 of your statement. I can deal
 8 with this relatively briefly, because we've heard about
 9 the experience and training particular staff had. Is it
 10 right to say that in general terms, frontline staff
 11 receive training on management and procedures in major
 12 incidents?
 13 A. It is, sir.
 14 Q. Is there also separate training for staff in the
 15 emergency operations centre?
 16 A. That is correct.
 17 Q. And additional major incident training for those who
 18 take on roles of dispatching LAS resources to the scene?
 19 A. That's also correct.
 20 Q. Are there also specific training courses for command
 21 roles at the three levels of gold, silver and bronze?
 22 A. That's correct, sir.
 23 Q. With, I think, periodic revalidation in each case?
 24 A. Indeed.
 25 Q. A few matters about communications next, please, which

16

1 you address from page 26 of your statement. Is it right
2 to say that the staff on the ground and the emergency
3 operations centre can communicate by various means with
4 each other and with others?

5 A. Indeed.

6 Q. First of all, do LAS staff have Airwave radios like the
7 police and fire service?

8 A. Yes, we all share a common radio system, the Airwave
9 radio system.

10 Q. On that system are there specific channels for LAS staff
11 to communicate with each other, to which others don't
12 normally have access?

13 A. Yes, that is correct, sir.

14 Q. Is it also the case that during a major incident,
15 additional channels can be established, allowing members
16 of the different emergency services to communicate about
17 that particular major incident?

18 A. So there is a channel which is known as ES5, Emergency
19 Service 5, which is an Airwave talk group. That channel
20 is open 24/7 and is monitored 24/7 in each other's
21 control rooms, and that is a common radio channel for
22 the services to communicate, but it would be commander
23 ops that would communicate; it wouldn't be routine
24 assets that are deployed out operationally.

25 Q. I see. So you have a standing channel --

17

1 A. Yes.

2 Q. -- for communication at command level between the
3 services, predominantly for major incidents?

4 A. Indeed. All critical information, if it comes to light
5 on an incident before a declaration, so it's there to
6 ensure critical information can be passed across the
7 services.

8 Q. But then is it in addition possible to set up further
9 channels for staff at ground level to communicate about
10 a particular major incident?

11 A. So we would initiate additional talk groups for London
12 Ambulance Service staff, but the Metropolitan Police
13 Service and the London Fire Brigade would not be able to
14 hear those transmissions; it's only ES5 from the command
15 channel.

16 Q. Now, in a major incident is a strategic coordination
17 group set up hosted by the Metropolitan Police?

18 A. Yes, it is.

19 Q. Is that hosted in their special operations room, about
20 which we heard?

21 A. Yes, in Lambeth.

22 Q. And who from the LAS, by role rather than individual,
23 attends that group?

24 A. So the lowest level of officer that would attend that
25 would be a silver level tactical commander, but more

18

1 often than not we would send a strategic commander
2 level.

3 Q. Would that person also be accompanied by a member of the
4 control room staff from the LAS to act as
5 a communication link to the special operations centre of
6 the LAS?

7 A. Yes. And contained -- that is correct, sir, and
8 contained within Lambeth SOR or, as we call it, GT. The
9 London Ambulance Service have a command point terminal
10 located in SOR. So our control representative will have
11 access to the running CAD and suchlike.

12 Q. As well as communication by radio between the services,
13 you've told us that in a marauding terrorist attack
14 incident, early on a tri-service conference call will be
15 set up?

16 A. That is correct.

17 Q. Until representatives of the ambulance service, the
18 police and the fire brigade are physically together?

19 A. Yes.

20 Q. Is it also right that staff -- command staff will also
21 be physically located with each other at the scene,
22 including bronze commanders at rendez-vous points?

23 A. Yes, or at casualty clearing stations, so the joint --
24 the JESIP principles are that the three services
25 congregate at a location where the three services can

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1 talk together through individual face-to-face means.

2 Q. In addition is it right that there are forward command
3 points at which Plato commanders can be together and
4 make those joint decisions you told us about as to
5 designation of warm and hot zones and deployment of
6 staff into them?

7 A. Yes, so for Plato declaration the forward command point
8 would be a separate entity purely dealing with the
9 committal of resources into the warm zone, but obviously
10 they would have the information before committal around
11 the location of the casualty clearing stations or the
12 casualty collection points if that was the structure
13 that was in place.

14 Q. Final point about communications: is it right that the
15 London Ambulance Service also uses pager messages to
16 alert key management staff to the declaration of a major
17 incident?

18 A. That is correct.

19 Q. Do those operate a traffic light system of a green
20 message for information only, an amber message to
21 request state of readiness and provide availability, and
22 red for immediate action required?

23 A. That's correct.

24 Q. Having dealt with those general matters of background,
25 can we now turn to the response to the London Bridge

20

1 attack which you address from page 16 of your
 2 operational statement.
 3 First of all, how many emergency calls relating to
 4 that attack did the London Ambulance Service receive
 5 that night?
 6 A. So between the first call being received and 23.00 hours
 7 we received 134 calls to multiple locations within the
 8 London Bridge area, giving multiple locations and
 9 multiple types of calls in terms of the information we
 10 received.
 11 Q. We'll begin with the first of those, {DC5184/1}.
 12 Mr Woodrow, I'm going to go through the chronology using
 13 the 24-hour clock because it is easiest when we have
 14 an event going overnight.
 15 Do we see here the first call, CAD 4497, a call made
 16 at 22.07.31 and answered 22.08.41?
 17 A. Correct.
 18 Q. And if we go over the page {DC5184/2}, we can see that
 19 it concerns a French lady who had been injured on the
 20 bridge. We think that refers to Christine Delcros. You
 21 tell us in your witness statement the priority level
 22 given to this CAD. What priority level was given?
 23 A. The priority was given as what we call a category 2. So
 24 the first questions that are asked are to ascertain
 25 whether the patient is breathing and whether the patient

21

1 is conscious. Depending on those two answers, that
 2 would eliminate -- if the patient was given as breathing
 3 and conscious, that would take away a category -- a red
 4 1 response. Red 2 was triaged, and that gives us a
 5 response time of 8 minutes.
 6 Q. We can take that off screen now. Is it right that there
 7 was then a further series of calls with the next several
 8 calls in the sequence all concerning injuries to people
 9 on the bridge?
 10 A. That's correct.
 11 Q. Then may we have {DC8209/27}, please. We can see,
 12 I think, from this combined log document that a number
 13 of emergency resources were dispatched to the scene at
 14 22.11.
 15 A. That's correct.
 16 Q. And we can see from that document that AP62,
 17 Mr Rutherford, an advanced paramedic practitioner, was
 18 dispatched at that time?
 19 A. Yes.
 20 Q. Mr Beasley, the incident response officer, with call
 21 sign IR51?
 22 A. Yes.
 23 Q. A double-crewed ambulance with, in fact, three staff,
 24 Ms Whale, Ms Mallett and Mr Browne, G330.
 25 A. Correct.

22

1 Q. Then over the page, please, to page 28 {DC8209/28}.
 2 N151, Mr Armstrong, a fast response unit medic, and
 3 NE02, Gary Green, another sole practitioner?
 4 A. Yes, he was on motorcycle.
 5 Q. So those were the initial resources dispatched to the
 6 scene at 22.11?
 7 A. Correct.
 8 Q. And then {DC5207/1}. We can see here a call made at
 9 22.10 answered at 22.11 which is I think the first call
 10 about a stab victim in the Mudlark, who we understand to
 11 be Helen Kennett.
 12 A. Correct.
 13 Q. Then {DC5197/1}, please. Also at 22.11, a call
 14 answered -- made by a person in a taxi who passed a stab
 15 victim who we think was Mr Livett?
 16 A. Correct.
 17 Q. So some early calls about stabbings at 22.11?
 18 A. Correct.
 19 Q. Your page 18 of your witness statement, you record that
 20 at 22.13, the Helicopter Emergency Medical Service was
 21 dispatched to the scene?
 22 A. Yes, although they were not actually in a helicopter;
 23 they were based in a car.
 24 Q. Yes, we've heard from Dr Lambert that they were
 25 activated at 22.14.

23

1 A. Correct.
 2 Q. Then {DC8209/28}, please. We can see the records for
 3 Mr Armstrong, N151, which show that he was at the scene
 4 at 22.13.
 5 A. Correct.
 6 Q. I think he was the first member of LAS staff on the
 7 scene.
 8 A. Correct.
 9 Q. Then is it right that from 22.15, calls started being
 10 received about stabbings in Boro Bistro and on Borough
 11 High Street?
 12 A. Correct.
 13 Q. We can give an example of those, {DC5221/1}. You will
 14 see a caller who is reporting in the middle of the page
 15 at 22.15, saying there are injured people in
 16 Boro Bistro, a market area downstairs from
 17 London Bridge?
 18 A. Correct.
 19 Q. And {DC8209/195}, please, also at -- a call detail
 20 record with reference 4570, call answered at 22.16, and
 21 a reference to the -- a female bleeding severely in
 22 Boro Bistro. I think that was passed on by the
 23 Metropolitan Police Service.
 24 A. Correct.
 25 Q. So those are the first communications about Boro Bistro

24

1 and injured people there, both from members of the
 2 public and the Metropolitan Police?
 3 A. Yes.
 4 Q. And {DC8209/27}, please. We can see by reference to the
 5 records for G330 that the first ambulance on the scene
 6 arrived at 22.16.
 7 A. Correct.
 8 Q. They went to the assistance of the casualties on the
 9 bridge.
 10 A. Correct.
 11 Q. And carrying on with the chronology, you, I think, are
 12 aware that the attackers were shot in Stoney Street just
 13 before 22.17?
 14 A. Correct.
 15 Q. Then may we go to {DC8209/36}.
 16 A. Yes.
 17 Q. And we can see an entry at 22.17, recording that the
 18 Metropolitan Police Service were treating the matter as
 19 a terrorist incident.
 20 Just above halfway up, ES5, that's the channel you
 21 were referring to before --
 22 A. Yes.
 23 Q. -- "Treating as terrorist incident".
 24 A. Yes.
 25 Q. Now, we've heard at 22.17 Mr Rutherford, the advanced

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1 paramedic practitioner, arrived at the scene and began
 2 moving north up Borough High Street triaging patients as
 3 he went.
 4 A. Correct.
 5 Q. For the lawyers, his arrival time is at {DC8209/27}.
 6 May we look at a map for his route, please,
 7 {MP0004/1}. This is a map of the scene. The crashed
 8 van and Boro Bistro courtyard, which I think you're
 9 aware, is at the north-east end of this plan; do you
 10 see?
 11 A. Yes.
 12 Q. And we have heard from Mr Rutherford that he proceeded
 13 up Borough High Street from the London Bridge station
 14 end towards where the van had crashed, triaging people
 15 as he went, including outside Lobos, which you see
 16 marked?
 17 A. Correct.
 18 Q. Then 22.18, if we go to {DC8209/36}, we can see that
 19 near the bottom communication that the
 20 Metropolitan Police had declared a major incident and
 21 were now making a conference call to the LAS.
 22 A. Correct.
 23 Q. If we go to the transcript of that call, {DC5234/1}.
 24 Now, this is a call from the Metropolitan Police to the
 25 LAS, and if we go to page 2 {DC5234/2}, we can see

26

1 towards the top of the page a running CAD, 8810,
 2 reference is provided; do you see that?
 3 A. Yes, I can.
 4 Q. The information passed on that this was a declared major
 5 incident?
 6 A. Yes.
 7 Q. And also the information passed on that it had been
 8 declared Operation Plato?
 9 A. That's correct.
 10 Q. We know that that declaration had been made at 22.16.
 11 A. Correct.
 12 Q. Then {DC8209/37}, please, we can see the second entry up
 13 from the bottom, 22.19, does Mr Rutherford, the APP,
 14 make a major incident declaration at the scene or,
 15 rather, pass that on to the control room?
 16 A. Indeed.
 17 Q. According to his evidence, he'd actually made the
 18 declaration a couple of minutes earlier.
 19 A. Correct.
 20 Q. Also at 22.19 was a tri-conference call established with
 21 the Metropolitan Police Service and the fire brigade, or
 22 efforts made to start one?
 23 A. Correct.
 24 Q. So, pausing there, it's now just before 10.20, and the
 25 ambulance service has received calls about both injuries

27

1 on the bridge and the stabbing injuries, including
 2 stabbing injuries in the Boro Bistro area?
 3 A. Correct.
 4 Q. The incident has been declared a major incident and
 5 a number of staff are already on the scene.
 6 A. Correct.
 7 Q. It's been declared Plato and the conference call is
 8 being set up.
 9 A. Correct.
 10 Q. Now, we've heard that the police tactical firearms
 11 commander, Inspector Spittlehouse of the
 12 British Transport Police, arrived at the scene at around
 13 22.20, and shortly afterwards set up a forward command
 14 post near the Bunch of Grapes pub; do you understand
 15 that to be right?
 16 A. That is correct.
 17 Q. Was he also joined in that area at, I think, 22.29, by
 18 a Metropolitan Police tactical firearms commander,
 19 Inspector Stumpo?
 20 A. That is my understanding.
 21 Q. And thereafter did Mr Spittlehouse take the role as
 22 commander for the warm zone and Mr Stumpo as commander
 23 for the hot zone?
 24 A. That is correct, from what I've read.
 25 Q. Looking at your timeline on page 19 of your statement,

28

1 was the tri-conference call formally established between
 2 the three services at 22.22 --
 3 A. That is correct.
 4 Q. After initial efforts? Then may we go to {DC8209/40},
 5 it's 22.23, and about a third of the way down can we see
 6 a report from AP62, Mr Rutherford:
 7 "... multiple patient stabbed and shots fired
 8 [query] by police."
 9 A. Correct.
 10 Q. And he makes a METHANE report, which we understand is a
 11 standard type of report made in a major incident?
 12 A. He attempts that, sir, yes, on the information he has.
 13 Q. Identifying a number of casualties and their locations,
 14 including outside Lobos?
 15 A. Correct.
 16 Q. By 22.23 we understand Mr Rutherford had reached
 17 Boro Bistro, the location we looked at on the map, and
 18 was then directed away from that area by armed police?
 19 A. So he was up on London Bridge and was in the area of the
 20 steps that went down into the courtyard where he was
 21 asked to evacuate off the bridge with colleagues.
 22 Q. We can bring up on screen a transcript from body-worn
 23 footage, {DC8318/1}. This is a transcript of body-worn
 24 footage of PC Norton. If we look at the entry from
 25 21.23 immediately after the officers have been working

29

1 on Sara Zelenak recognise that she was clearly dead,
 2 Mr Edwards, who was in the same area as Mr Rutherford,
 3 said:
 4 "There's not enough resources here, I'm going to
 5 have to tag her as dead."
 6 And then a couple of entries down, Mr Edwards speaks
 7 to a colleague, Mr Carlson, and these words are said:
 8 "I have PIs down there, we've got a dead here,
 9 there's another cardiac arrest down there."
 10 Then Mr Carlson says:
 11 "Can I suggest we need to RVP, OK. There are
 12 multiple deceased."
 13 Then they are interrupted by people shouting "Move"?
 14 A. Correct.
 15 Q. Then over the page, please, {DC8318/2}, Mr Rutherford
 16 then runs to the top of the stone steps above
 17 Boro Bistro and shouts down the steps:
 18 "Right, everybody, move! Come on, get out! Get
 19 out! Now, out now!"
 20 And so on at the people down below, and then
 21 officers shouting "Out now" and "Go" and so on.
 22 A. Correct.
 23 Q. So is this right from your understanding: that
 24 Mr Rutherford and his colleagues had reached the area
 25 immediately above Boro Bistro, there was some

30

1 information suggesting that there were casualties down
 2 below, but as that started to be discussed, these staff
 3 members were directed away from the scene by armed
 4 officers?
 5 A. Yes, and I believe that was shortly after AP62,
 6 Keir Rutherford, had reported hearing more gunfire.
 7 Q. We know that there was second rounds of gunfire from the
 8 police in Stoney Street at around that time.
 9 A. Correct.
 10 Q. Is this also right: that Mr Rutherford moved away, and
 11 when doing so, became aware of some further casualties
 12 in a very severe condition outside Tito's Restaurant on
 13 London Bridge Street?
 14 A. Correct.
 15 Q. As a result, did he shortly after arrange triage and
 16 evacuation of those individuals?
 17 A. Yes, he did.
 18 Q. And in fact was it as a result of that triage and
 19 evacuation that emergency care could be provided to some
 20 people in a very grave state?
 21 A. That is correct, sir.
 22 Q. May we return to the chronology on your page 19. We can
 23 take that document off the screen.
 24 22.24, was a red pager message sent to senior
 25 managers declaring a major incident at 22.24?

31

1 A. That is correct.
 2 Q. And that, for example, is recorded in the log of
 3 Dr Wrigley, the gold medic commander?
 4 A. Sir, Dr Wrigley was the gold medic on call that night,
 5 correct.
 6 Q. For the lawyers, her log entry is {DC5037/2}, but we
 7 don't need that on screen.
 8 Then may we go to {DC8209/41}, continuing with the
 9 chronology. 22.25, just above the middle of the page,
 10 can we see there a report was made at that time from
 11 Mr Rutherford, AP62, saying that the scene is not safe
 12 because multiple gunshots had been heard?
 13 A. That's correct.
 14 Q. And he was asked to get himself to safety.
 15 A. Correct.
 16 Q. Does that reflect what had just happened a minute or two
 17 previously as he had been directed away after those
 18 rounds of gunfire?
 19 A. That's correct.
 20 Q. Then 22.27, did Mr Beasley, the incident response
 21 officer, arrive on the scene near the Post Office to the
 22 south of the bridge?
 23 A. That is correct, sir.
 24 Q. For the lawyers, the record of his arrival time is
 25 {DC8209/27}, and in his log at {DC5029/3}, we've already

32

1 gone through those with him.
 2 At the same time, 22.27, was a rendez-vous point
 3 established by the police?
 4 A. There was an initial rendez-vous point at Elephant and
 5 Castle, that's correct, at that time, sir.
 6 Q. So that was a first rendez-vous point, which was
 7 a little distance away from the area of the attack?
 8 A. That is correct.
 9 Q. Around 22.29, were a number of injured casualties on
 10 Borough High Street, including PC Marques and
 11 PC Guenigault, evacuated out of the area by police
 12 officers?
 13 A. That is correct.
 14 Q. So at this time some of those who had been injured were
 15 starting to be evacuated away from the area by the
 16 police?
 17 A. Correct.
 18 Q. 22.30, was the specialist operations centre of the
 19 London Ambulance Service, that special adjunct to your
 20 main control room, set up?
 21 A. That's correct, it was opened and staff were removed
 22 from the main control room to take their positions
 23 within that special operations centre.
 24 Q. Obviously that's a process that takes a little time at
 25 the start of a major incident, but it is necessary to

33

1 have that dedicated control room?
 2 A. Yes, it is.
 3 Q. May we now have on screen {DC8317/1}. This is another
 4 body-worn video transcript of PS Wood, and do we see at
 5 21.30, which is a time, in fact, an hour out, real time
 6 22.30, that Inspector Jackson of the police is shouting
 7 that he doesn't want anyone going into Borough Market.
 8 A. That's correct.
 9 Q. And PS Wood making a communication asking for
 10 information about where there are casualties so that
 11 they can get LAS staff to those casualties; do you see
 12 that?
 13 A. Correct.
 14 Q. So that's what's going on at 22.30, the police are
 15 evacuating some people from the area, but telling others
 16 that nobody is to go into Borough Market?
 17 A. Yes, that -- it's a first indication that that area is
 18 deemed a hot zone by three of our staff being asked to
 19 evacuate off the bridge and then obviously
 20 Inspector Jackson saying that the Borough Market area
 21 itself is not safe.
 22 Q. Take that off the screen.
 23 22.32, was Adelaide House, an area at the north end
 24 of the bridge, nominated as the casualty clearing
 25 station?

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1 A. So it was nominated as one of the casualty clearing
 2 stations, that's correct, sir.
 3 Q. We've heard that over the time that followed, ambulances
 4 gathered there and triage arrangements were established?
 5 A. That's correct, sir, after multiple RVPs were set up,
 6 which included one at close proximity to Adelaide House,
 7 north side of the bridge.
 8 Q. Then if we can put on screen {DC8209/45}, five entries
 9 up from the bottom or so we can see an entry referring
 10 to the ES5 channel again, referring to a rendez-vous
 11 point at Park Street and Bridge Road.
 12 A. Yes, so that's an additional RVP nominated.
 13 Q. And that's a rendez-vous point which was rather closer
 14 to the scene than the Elephant and Castle one?
 15 A. Yes, this was by Southwark -- in proximity to Southwark
 16 Police Station.
 17 THE CHIEF CORONER: And that's 22.35.
 18 MR HOUGH: 22.35, sorry, yes.

19 Around the same time we understand that Mr Beasley,
 20 who was still in the area of the Post Office to the
 21 south of the bridge, was informed of an unattended
 22 victim under the bridge. If we can look at some
 23 body-worn transcript in relation to that, please,
 24 {DC8317/2}. Real time 22.34, can we see PS Wood
 25 approaching Mr Beasley, referring to "two victims just

35

1 down there who have been stabbed", Mr Beasley asks if
 2 it's safe to come up. Mr Wood says:
 3 "Yeah, as far as ... it's all in Borough Market. If
 4 they come straight up there. Stop at the 1st police
 5 car. There's two injured parties there. And you've got
 6 another one under the bridge."
 7 So he seems to be referring to some injured people
 8 on the road and then another one in an unspecified
 9 location under the bridge.
 10 A. It would appear so, sir.
 11 Q. And then a further communication from PS Wood over his
 12 radio referring to victims without London Ambulance
 13 Service under London Bridge by Borough Market and at the
 14 south side of London Bridge.
 15 A. Correct.
 16 Q. So Mr Beasley at that point is informed of an unattended
 17 victim under the bridge but without much detail about
 18 location?
 19 A. That's correct. I mean, there was -- Mr Beasley was
 20 getting multiple bits of information, obviously coming
 21 over the radio in relation to RVPs, in relation to
 22 information he was getting from members of the public
 23 and then obviously from colleagues from other emergency
 24 services.
 25 Q. We can move forward a few minutes to 22.41 and look at

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1 {DC8209/48}, an entry about a third of the way down from
 2 Mr Beasley, IR51:
 3 "Info from police incident commander -- containment
 4 established for Borough Market area -- patients believed
 5 there but not approved to move forward yet."
 6 A. That's correct.
 7 Q. Was that Mr Beasley reporting in that some police
 8 containment was being established for the area of
 9 Borough Market, but he wasn't able to move in?
 10 A. That's correct, it hadn't been deemed safe to move in.
 11 Q. And that there were some patients who were believed to
 12 be in that area?
 13 A. That is correct.
 14 Q. Meanwhile, we know over this period evacuations of the
 15 Borough Market area by police officers were continuing.
 16 We, for example, heard that Gavin Stacey was evacuated
 17 from the Market Porter at 22.38; were you aware of that?
 18 A. Sir, I was aware of the patients that were being
 19 evacuated by first response officers on the scene before
 20 the Plato declaration.
 21 Q. From 22.45 we've heard that police began bringing
 22 casualties up from the Boro Bistro courtyard with
 23 James McMullan evacuated at 22.46, Sébastien Bélanger at
 24 22.47, Marine Vincent and Marie Drago at 22.50.
 25 Were you aware, have you become aware, of those

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1 casualties being evacuated from the Boro Bistro
 2 courtyard at the bottom of those stone steps from around
 3 that time?
 4 A. I know that to be the case now, sir.
 5 Q. Continuing with the chronology, if we can go to page 51
 6 of this same document, {DC8209/51}, the entry just above
 7 the middle. We can see here an entry in the log
 8 referring to multiple patients being evacuated from
 9 London Bridge to a rendez-vous point outside
 10 Adelaide House. Does that reflect the standing
 11 instruction that patients were to be evacuated to
 12 Adelaide House at the north end of the bridge?
 13 A. At that time, yes, that's correct, sir.
 14 Q. That's 22.49. We've heard that a number of those who
 15 were evacuated from the area were sent to that point at
 16 the north end of the bridge?
 17 A. They were.
 18 Q. And was that because that point, at the north end of the
 19 bridge, had been designated as an appropriate, safe but
 20 reasonably close area from which to clear casualties?
 21 A. It was dedicated a cold zone and in proximity to the
 22 incident.
 23 Q. And the log reports that the LAS is intending to useless
 24 resources to evacuate those on the bridge to the
 25 rendez-vous point at the north end?

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1 A. Yes, and indeed in actual fact what happened, there were
 2 patients that were evacuated to the casualty clearing
 3 station north of the bridge, and as Mr Beasley received
 4 more officers, they set up a casualty clearing station
 5 at St Thomas Street south side of the bridge and
 6 patients were also evacuated and treated and removed
 7 from that casualty clearing station to hospital.
 8 Q. At 22.53 did Mr Rainey, the bronze commander, get to the
 9 scene?
 10 A. So he did. He was directed to the rendez-vous point
 11 north, which was King William Street near
 12 Adelaide House.
 13 Q. If we go to {WS1370/37}, please. Can we see that he
 14 records in his log being on the scene at 22.53, and
 15 liaising with a colleague about the location of the
 16 tactical firearms commander or commanders?
 17 A. Yes, so he was liaising with the bronze medic loggist
 18 who referred to the log to give the information to
 19 Marc Rainey on the location of the FCP.
 20 Q. Can we then see 10 minutes later he located to
 21 a rendez-vous point at St Thomas Street?
 22 A. That is correct.
 23 Q. That's the Bunch of Grapes pub, I think, that area?
 24 A. That area.
 25 Q. Continuing with the chronology and your timeline at

39

1 page 20, did the operational gold commander arrive at
 2 the London Ambulance Service headquarters at 22.55 to
 3 take up strategic command?
 4 A. That is correct.
 5 Q. And was a vehicle called the mass casualty equipment
 6 vehicle dispatched at 23.01?
 7 A. Correct.
 8 Q. What sort of equipment would that have had on it?
 9 A. Triage, heavy dressings, stretchers, carry sheets. So
 10 simple equipment, but equipment that would be required
 11 to move large numbers of casualties.
 12 Q. At 23.12 we have what I think is the first evidence of
 13 the hot zone area being designated. Could we put on
 14 screen {DC8319/1}, 23.12, a body-worn video transcript,
 15 refers to Inspector Stumpo making a transmission, or
 16 being heard over a transmission saying:
 17 "Can I just make it clear, our hot zone to be
 18 Stoney Street, up to Winchester Walk, round Montague
 19 Close [some inaudible words] and Borough High Street ..."
 20 So that is indicating, is it, that the covered area
 21 of Borough Market and a number of the surrounding
 22 streets including Borough High Street were to be treated
 23 as a hot zone?
 24 A. That is correct, despite the previous messages, yes.
 25 Q. Continuing with the chronology, 23.16, we understand

40

1 that explosives officers arrived in Stoney Street and
 2 checked the attackers, confirming at that stage that
 3 there were no viable explosive devices on them?
 4 A. On the attackers, yes, that's correct.
 5 Q. On the attackers themselves. We'll later hear about the
 6 van being considered a possible explosive threat?
 7 A. Yes.
 8 Q. Then 23.25, if we look at Mr Rainey's log again,
 9 {WS1370/37}, if we look at the entry at 23.25 does
 10 Mr Rainey record that he is now with the tactical
 11 firearms commander, that he has had a briefing, that
 12 Borough Market is a hot zone, the south side of
 13 London Bridge and Borough High Street a warm zone,
 14 Stoney Street, Winchester Walk, Cathedral Street, hot
 15 zones.
 16 A. That's correct.
 17 Q. He is reflecting there that the Borough Market area is
 18 being treated as a hot zone, including the streets
 19 immediately around it, but Borough High Street and the
 20 south side of London Bridge is a warm zone?
 21 A. That's correct.
 22 Q. Now, also at 23.25, returning to your timeline, at that
 23 time were pager messages sent to a number of dedicated
 24 hospitals which would be receiving patients?
 25 A. That's correct.

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1 Q. So while we have Mr Rainey at the Bunch of Grapes pub
 2 liaising about what are the hot and warm zones for staff
 3 to be sent into or avoid, at the same time, work is
 4 going on to clear casualties from the north end of the
 5 bridge to the various hospitals?
 6 A. Yes, and officers were dispatched to act as liaison
 7 officers at each of those hospitals, sir.
 8 Q. And centrally, messages are being sent out to the
 9 hospitals to assist in that clearing process?
 10 A. Yes, sir, the major incident declaration would have been
 11 given to the hospitals as soon as the major incident was
 12 declared. This pager message was to dispatch more
 13 officers to act as liaison officers at each of those
 14 hospitals that were receiving patients from this
 15 incident.
 16 Q. Returning to Mr Rainey's log, can we see that at 23.31
 17 he confirms Plato resources were available on the scene.
 18 What's the meaning of that reference?
 19 A. So that's the dedicated TRU staff and the HART teams
 20 ready to form up to make the ambulance intervention
 21 teams.
 22 Q. So 23.31 he has those teams, or at least some of those
 23 teams, available to him?
 24 A. He does.
 25 Q. Then at 23.37, do we see that he records a discussion

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1 with the tactical firearms commander about options,
 2 including consideration for a warm zone recce, and then
 3 he refers to the presence of some fatal casualties in
 4 Borough High Street.
 5 A. Yes, so that was Mr Rainey discussing deployment of
 6 ambulance intervention teams to do a reconnaissance
 7 mission for patients within the warm zone.
 8 Q. That's what's being discussed at that stage, potentially
 9 sending some teams forward in that way?
 10 A. That's correct.
 11 Q. And then {DC8209/61}. I'm sorry to keep skipping around
 12 but this is, I am afraid, the only way to go through the
 13 chronology properly.
 14 A. Okay.
 15 Q. Two-thirds of the way down the page, we can see
 16 a reference to Borough Market still being considered
 17 a hot zone and Borough High Street being a warm zone?
 18 A. That's correct.
 19 Q. So that that information which Mr Rainey had recorded
 20 about the designated hot zone and warm zone comes
 21 through to the control room at 23.37?
 22 A. That's correct.
 23 Q. If you go back to his log now, {WS1370/37}, at 23.46, do
 24 we see that he records a TRU, tactical response unit,
 25 staff arriving from the north rendez-vous point, teams

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1 being made up and told to stand by?
 2 A. Correct.
 3 Q. Does that suggest plans being made to divide teams
 4 before sending them into warm zones?
 5 A. Correct.
 6 Q. That was 23.46.
 7 A. Correct.
 8 Q. Then is this right: at 23.50, shortly after that, there
 9 was a report of a potential IED in the van?
 10 A. So there was at that time, although there was previous
 11 information that -- in evidence Keir Rutherford
 12 mentioned around the possibility of an explosive device
 13 in the van, but at that time, sir, it was discussed and,
 14 I believe explosive officers were asked to attend the
 15 van at that time.
 16 Q. You can see Mr Rainey records that in his log at 23.50,
 17 the consideration that fuel cans in the van might be
 18 a threat.
 19 A. Yes, sir.
 20 Q. Then 23.54, do we see he records that the van has been
 21 made safe?
 22 A. Correct.
 23 Q. Then over the page to page 38 of the same log
 24 {WS1370/38}, do we see at 23.56 Mr Rainey recording
 25 a discussion about getting clinical staff into the

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1 market area because there's some concern that patients
2 may be inside?
3 A. Sir, that was a discussion exactly in that regard, sir.
4 There was concern that Mr Rainey wanted to commit teams
5 in for live patients and it was still a hot zone, but
6 concerns were raised around the amount of time taken to
7 commit.
8 Q. Just to be clear, Mr Rainey, according to this log,
9 isn't sitting back because an area is designated a hot
10 zone: he is expressing his desire to get staff in as
11 soon as he can?
12 A. Yes, correct.
13 Q. And just to be clear also, that at this stage it wasn't
14 known, was it, whether all casualties had been
15 extricated from the area of Borough Market itself,
16 obviously a much larger area than the Boro Bistro
17 courtyard?
18 A. Yes, so it was all -- it was all connected as one large
19 area with multiple establishments in that area, so the
20 concerns were that there was a possibility that there
21 were patients that still needed to be treated within
22 that area that weren't deceased.
23 Q. If we go to {WS0923/4}, please. Now, these are notes by
24 Inspector Stumpo, one of the police tactical firearms
25 commanders. Can we see he makes a record at 23.58:

45

1 "140 MOP [members of the public] evacuated out of
2 the west side of Borough Market."
3 A. Yes, sir.
4 Q. So at this time active evacuation of substantial numbers
5 of people from Borough Market was going on?
6 A. Yes, sir.
7 Q. And back to Mr Rainey's log, please, {WS1370/38}, at
8 00.01, so just after midnight, into 4 June, can we see
9 that ambulance intervention teams had been designated,
10 including those of the names in the teams?
11 A. That is correct.
12 Q. A total of seven teams, the fourth of which includes
13 Gail Collison from whom we heard?
14 A. Correct.
15 Q. And then can we see at 00.03, Mr Rainey records the
16 first team, team 1, being sent into Borough Market from
17 Borough High Street?
18 A. Yes, so if -- within that log you can actually see the
19 joint decision model which describes the scenarios that
20 they were talking about and the decisions to be made,
21 and Mr Rainey, despite Borough Market being a hot zone,
22 still declared as a hot zone, he discussed with the
23 ambulance intervention teams that despite being a hot
24 zone based off intelligence would they be prepared to
25 enter in as part of these AITs, and it was that

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1 discussion then that commenced committal of teams into
2 the hot zone.
3 Q. I'll ask you about that a little more later.
4 00.20, team 2 is put on standby?
5 A. Correct.
6 Q. While team 1, as we can see from the preceding entries,
7 was clearing a number of other areas and checking that
8 they didn't have casualties?
9 A. Correct.
10 Q. Then 00.25, there's a reference to team 2 not being
11 committed because of a blue-on-blue risk. What do you
12 understand that decision to reflect?
13 A. So there were multiple reports around that time of still
14 outstanding assailants, one armed with an assault rifle
15 and blue-on-blue was the danger that ambulance
16 intervention teams could be caught in crossfire between
17 the assailants and officers that were in there to try to
18 neutralise that threat.
19 Q. And if we look at page 39 of the same log, please, and
20 rotate it so it's the right way up, {WS1370/39}, can we
21 see that over the period that follows between 12.30 and
22 going towards 1.00, a series of further teams were
23 deployed?
24 A. They were.
25 Q. 00.40, can we see that team 1 reports that two x-rays,

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1 or attackers, were deceased --
2 A. Correct.
3 Q. -- outside the Wheatsheaf public house? And then 00.52,
4 on the right-hand side of the page, can we see Mr Rainey
5 reports that team 4 was on standby?
6 A. Correct.
7 Q. Then page 40, please, the next page of the log
8 {WS1370/40}, at 01.05, do we see that that team,
9 Ms Collison's team, was tasked to crashed van and the
10 surrounding area?
11 A. Correct.
12 Q. So while other teams had been tasked to specific areas,
13 this team was being tasked to the crashed van and the
14 area immediately surrounding it.
15 A. Correct.
16 Q. Then 01.12 you see a report from team 4 of an adult
17 female deceased outside the Mudlark public house.
18 A. Correct.
19 Q. We understand that to be Kirsty Boden?
20 A. We do.
21 Q. Then 01.13, this entry, refers to discussion with the
22 tactical firearms commander about Southwark Cathedral
23 and a lead assault team being sent to use explosives as
24 a method of entry to search the cathedral, which was
25 still a hot zone?

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1 A. Yes, it was part of Borough Market, which was still
 2 deemed a hot zone, but yes, there was an intervention
 3 team sent into Southwark Cathedral.
 4 Q. Is it your understanding that the area of Boro Bistro,
 5 which of course was right next to the cathedral, was
 6 also a hot zone at this point?
 7 A. That's correct.
 8 Q. So it was at this point in time that team 4 was going
 9 through that area of Boro Bistro, still a hot zone,
 10 looking to identify any casualties?
 11 A. That's correct.
 12 Q. We can take that off screen now.
 13 Meanwhile, had a further casualty clearing station
 14 been established at Liverpool Street?
 15 A. It had.
 16 Q. And a survivor reception centre at the Andaz hotel?
 17 A. That is correct, for P3 patients.
 18 Q. Were casualty figures reported, then, over the time that
 19 followed from the various casualty clearing stations?
 20 A. That is correct.
 21 Q. Going back to your timeline on page 22, at 01.46 was the
 22 gold medic, Dr Wrigley, told that both casualty clearing
 23 stations were now clear of patients?
 24 A. That is correct.
 25 Q. And was it from 02.10 that teams at the scene began to

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1 be stood down?
 2 A. That is correct.
 3 Q. Was the incident reduced formally from a major incident
 4 to a significant one at 02.50?
 5 A. That is correct.
 6 Q. And then finally stood down as a significant incident at
 7 04.51?
 8 A. Correct.
 9 Q. May we look, please, at {WS5040/33}. You told us before
 10 that the number of ambulances and other staff deployed
 11 to the scene in a major incident was an initial minimum.
 12 Do we see here a summary of the resources which were in
 13 fact deployed to the attack area?
 14 A. That is correct.
 15 Q. Including 20 double-crewed ambulances, 22 solo
 16 responders, 7 operational commanders and various other
 17 specialist staff?
 18 A. Correct.
 19 Q. And {WS5040/38}, do we see here a summary of the various
 20 999 calls that were made, reflecting a diversity of
 21 reference to road traffic collision, stabbing injuries
 22 and other medical incidents?
 23 A. Correct.
 24 MR HOUGH: Thank you very much. I've now dealt with the
 25 chronology. Would that be a convenient time before

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1 moving on?
 2 THE CHIEF CORONER: We'll break there, Mr Hough, and we will
 3 sit again in 15 minutes' time.
 4 (11.29 am)
 5 (A short break)
 6 (11.48 am)
 7 MR HOUGH: Mr Woodrow, now that we have dealt with the
 8 chronology in detail what I propose to do is to go
 9 through a number of issues and ask for your assistance
 10 with them, broadly following the order in which they are
 11 addressed in your third witness statement which you
 12 prepared in response to questions from the
 13 representatives of the families.
 14 So the first issue concerns calls coming in and when
 15 it was appreciated that there were casualties in
 16 Boro Bistro courtyard. First of all, before the
 17 London Bridge attack began, what was the level of
 18 emergency call traffic that day?
 19 A. So it was a Saturday and it was a busy Saturday for us.
 20 Up until the point of this incident starting to unfold,
 21 the control room had taken 4,400 emergency calls that
 22 day, which is significantly up on what we would expect
 23 for that time of day.
 24 Q. We've seen that from 22.07 multiple calls were coming
 25 in, the first referring to a road traffic collision, but

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1 shortly afterwards some referring to stabbings, yes?
 2 A. Yes, there were numerous calls with numerous
 3 descriptions of events.
 4 Q. Now, where, as in a case like this, you have multiple
 5 calls coming in about the same incident, is there
 6 a standard practice to link in subsequent calls and
 7 create a common or running CAD log?
 8 A. Yes, that's a common practice across all of the
 9 emergency services where we're getting large numbers of
 10 calls, essentially in the same geographical area. We
 11 try to link those calls to ensure that we're not sending
 12 multiple resources uncontrolled into different calls.
 13 We try to link the information to ensure that we've got
 14 a working CAD which is describing events.
 15 So, for an example, in routine business where you
 16 might see a simple two-car road traffic collision,
 17 because of mobile phone technology now you might get 20
 18 calls to that road traffic collision and obviously what
 19 we try to do is to link as much of that information to
 20 say that it's a duplicate incident and send resource to
 21 that one particular incident if it can be identified
 22 that they're linked.
 23 Q. Thank you.
 24 Would the location of casualties be entered on to
 25 that running log as a result of the emergency calls

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1 made?
 2 A. So where we could link locations they would be. It's
 3 not automatically the case that the exact location of
 4 those incidents would be transferred across to the
 5 running log. That's a process of having to analyse
 6 information and trying to link those calls into the --
 7 what we would describe as the running CAD.
 8 Q. Now, we've seen that the LAS were informed of potential
 9 casualties in Boro Bistro at 22.16.
 10 A. Yes.
 11 Q. As we've heard, Mr Rutherford, Mr Edwards and Mr Carlson
 12 arrived on the scene in the following minutes, moving
 13 north up Borough High Street, reaching the area above
 14 Boro Bistro at 22.23. As we've heard, Mr Carlson saw
 15 a casualty receiving care in Boro Bistro at about 22.23,
 16 and we've heard from his evidence that he told the
 17 officer in the courtyard that medical assistance would
 18 be with him soon.
 19 A. That's what I've read, yes.
 20 Q. Could we look, please, at {DC8209/40}. We can see here
 21 on the running log HT59, which is Mr Carlson's call
 22 sign, reporting three patients in cardiac arrest.
 23 That's at 22.24.
 24 A. Correct.
 25 Q. Is it your understanding that those would have been

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1 patients in the Boro Bistro area?
 2 A. I think there were a number of patients, not all in the
 3 Boro Bistro area, but a number of patients that
 4 Mr Carlson had come across.
 5 Q. You have told us that it was at that point that they
 6 were directed away from the scene.
 7 A. By armed police, yes, that's correct.
 8 Q. Yes. And that they then continued the work of triage
 9 and evacuation elsewhere?
 10 A. Correct.
 11 Q. Meanwhile, as you've told us, further resources were
 12 being sent to rendez-vous points at first of all
 13 Elephant and Castle, and then the second nominated
 14 rendez-vous point of Park Street and Bridge Road?
 15 A. Correct.
 16 Q. And we know that Mr Beasley was closer to the scene at
 17 the Post Office from 22.27?
 18 A. Correct.
 19 Q. So that's the context.
 20 Given that we have reports of casualties in the
 21 Boro Bistro courtyard, and Mr Carlson aware that some of
 22 them were actually being worked on by police officers,
 23 could any more have been done to ensure that those
 24 officers, those people in the courtyard, were told that
 25 London Ambulance Service staff couldn't get to them?

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1 A. So there are a number of ways that that information
 2 could have got them. There was information that
 3 rendez-vous points, once Plato had been declared, the
 4 rendez-vous points were not set by the London Ambulance
 5 Service, they were provided to us for the RVPs by the
 6 Metropolitan Police Service.
 7 There clearly was interactions with emergency
 8 service colleagues on the ground both north side and
 9 south side, and also we have talked about ES5 being
 10 a command channel which is open to all three services.
 11 So there are a number of options where questions can
 12 be asked, but clearly there was communication issues in
 13 relation to information from people that were actually
 14 below street level in terms of understanding where
 15 resource is. I accept that.
 16 Q. So specifically at 22.23 some staff, three members of
 17 staff, were in an area and at least one or two of them
 18 became aware that there were casualties in the
 19 Boro Bistro area actively being worked on, requiring LAS
 20 support if possible?
 21 A. Clearly.
 22 Q. Yet even as late as 22.45, 22.46, 22.47, nobody had got
 23 the message to those people in the courtyard that
 24 ambulance staff couldn't get to them for any reason?
 25 A. Yes, and I think this needs -- it needs to -- it's

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1 important that we put some context around this because
 2 there were multiple locations within the general area of
 3 SE1. So, as I've described earlier in my evidence, we
 4 received 134 calls between 22.07, and there were
 5 numerous interactions between police services and the
 6 LAS on CAD. So we had to take it into the context of
 7 what we actually had. We had large numbers of calls not
 8 just to that particular area of Borough Market but there
 9 were multiple locations within that overall facility
 10 that were describing very similar things. We had
 11 patients that were severely injured in lots of locations
 12 in that area.
 13 So I'm trying to say in the context of what was
 14 a very chaotic scene, where there was a lot of
 15 conflicting information, there were clearly issues in
 16 terms of the environment that people were working in.
 17 It has created some confusion as to where resources
 18 were, where exactly patients were and how we could get
 19 to them.
 20 Q. From 22.27 onwards, we've heard from Mr Beasley that
 21 ambulances started gathering to the south; that there
 22 were ambulance staff 100 yards or less from the location
 23 of Boro Bistro. Or it may be a bit more than 100 yards,
 24 but a very short distance to the south.
 25 A. So Mr Beasley in his role as bronze sector was aware

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1 that there were patients presenting in multiple areas
2 south of the bridge and he makes a request to our
3 emergency operations centre that ambulances need to come
4 forward to him at his location where he is, St Thomas
5 Street; that he is requesting additional equipment, such
6 as orthopaedic stretchers and carry sheets, so that
7 people could be evacuated. So it was Mr Beasley that
8 was calling those ambulances forward for patients that
9 were presenting to him and colleagues in that area south
10 of the bridge.

11 Q. I think we can see Mr Beasley's report, if we put on
12 screen {DC8321/1}. Is this a transcript recently made
13 of Airwave communication with the emergency operations
14 centre?

15 A. That's correct.

16 Q. And if we look at the third entry in the transcript, can
17 we see Mr Beasley reporting to the emergency operations
18 centre that he had been approached by a firearms team
19 and adding:

20 "... we need LAS down the staircase I believe, just
21 on the south side, I believe it's still unsafe though,
22 active shooters."

23 Yes?

24 A. That's correct.

25 Q. And then do we see the emergency operations centre

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1 reports:
2 "Yeah roger that so the current situation we have
3 been told is that it's being evacuated south side and
4 borough road... and everyone to be moving north, so if
5 it's not safe ... I probably won't send anyone into you
6 yet, but get them to [the] RVP ..."

7 Do you see that?

8 A. Yes.

9 Q. And then Mr Beasley reporting his location at St Thomas
10 Street being covered by a firearms team, as he described
11 to us.

12 A. Yes.

13 Q. So that communication, I think, was made at or shortly
14 after 22.30; is that right?

15 A. Correct.

16 Q. And that tallies with a body-worn video transcript from
17 Mr Woods at 22.34 which I think we looked at?

18 A. Correct.

19 Q. Now that suggests that Mr Beasley was aware of some
20 casualties in an area we know to be the courtyard area
21 of Boro Bistro; is that right?

22 A. So I think he was aware of casualties in that general
23 area, not that specific area, but Mr Beasley was subject
24 to lots of information being passed to him, given the
25 nature of the incident and what was presented to

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1 Mr Beasley when he arrived south side of the bridge.

2 Q. Given that he had casualties in a place which wasn't
3 safe, as he understood it, as far as you know, was there
4 anything more that he or the emergency operations centre
5 could do to get messages to people in that area via, for
6 example, police officers to say: ambulance staff are
7 nearby, they can't get to you, can you get out to them?
8 A. So I believe in the context of the night and what was
9 happening at that particular time, there was real issues
10 in terms of bandwidth with the amount of information
11 that was coming in. There were multiple communications
12 going on between EOC, the tri-service conference call
13 was live and actually ran for the duration of this
14 incident, so there were multiple discussions coming
15 across, but clearly there was this issue around a very
16 wide area, lots of information, and actually we were
17 trying to rationalise that information.

18 Borough Market and Borough High Street was one
19 generic area. You have to take into the context that
20 some of the responders that went there would not have
21 had an intimate knowledge of that area, they wouldn't
22 know individual locations within that general area, and
23 obviously the FCP had been established at 22.20 and
24 there were conversations. So contextually, you know --
25 and I've reflected on this, how can we -- this is

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1 an area about how can we, despite all the communications
2 channels that we've had that we didn't have previously,
3 the use of ES5, the tri-service call, how do we better
4 manage as partner organisations, I think, you know,
5 we've heard in evidence that the Metropolitan Police
6 Service had 400 CADs to this with lots of different
7 information. It's how can we link that information up
8 in a more timely way to be able to get better
9 situational awareness of the scene that we're dealing
10 with.

11 Q. As we've heard, two groups of people in the LAS were
12 aware of casualties potentially requiring urgent
13 treatment in the general area of the Boro Bistro
14 courtyard, even if they didn't understand the precise
15 topography. That was Mr Rutherford, Mr Edwards and
16 Mr Carlson, and then it was Mr Beasley and anyone with
17 him.

18 Neither of those groups got the message to the
19 people in the courtyard that ambulance staff couldn't
20 get to them. Now, as far as you can see, looking at
21 what happened, was that a failure of the systems for
22 communication, was it a failure of the judgments of
23 individuals, admittedly under great pressure, or was it
24 just one of those things that could happen again
25 tomorrow?

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1 A. So I wouldn't describe it as a failure per se. I think
2 what we had is we had a scene that was incredibly
3 chaotic, there were people that were fearing for their
4 own safety, members of the public, and despite the
5 patients that we had within the Boro Bistro area, we had
6 a number of patients that were severely injured in lots
7 of other areas.

8 So despite what was happening in that general area,
9 there was, you know, people doing really good work,
10 trying to treat critically ill patients in other parts
11 of that vicinity. It was a very dynamic situation. The
12 information that we were receiving around firearms being
13 discharged, IEDs, improvised explosive devices, all of
14 that information was coming in, and that created in that
15 first early development of that incident, it hindered
16 our ability jointly to get full situational awareness on
17 that situation.

18 Q. Is there anything that can be done to stop that
19 happening again?

20 A. So obviously I have personally reflected long and hard
21 over this issue. It is of regret that there is any loss
22 of life when we're exposed to such incidents.

23 It is a very difficult issue, because I think we
24 have -- we have a certain level of resource within our
25 control rooms that's put there to manage routine

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1 business, and we don't have an army of additional
2 resource that we can call on in the first 20 minutes of
3 a major incident being declared: we have to try to
4 manage in those early stages of the incident with the
5 staff that we have on duty and then we put into place,
6 as you can clearly see, through paging and through
7 a number of other systems, to recall people back to
8 duty.

9 But in the very early stages of these incidents, and
10 I was an ambulance incident commander at 7/7, they
11 really are chaotic and it's just the fact that we do not
12 have an army of people there to be able to filter all of
13 that information, and that's where I think we as
14 an organisation, and I think with partner agencies, need
15 to understand how we can actually get that information,
16 get a common understanding and get some coordination
17 earlier on in an incident and obviously we as
18 an organisation, along with partner agencies, as
19 a result of this process and other debriefs, will
20 clearly take that on board and seek to see how we can
21 improve that, but it's not an easy position and in terms
22 of the response on the night, by the time all this
23 happened, we had relatively few resources that had
24 actually managed to arrive on the scene because of
25 a Plato declaration because they were all being pushed

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1 into RVPs as part of that national guidance for the
2 management of an MTFA.

3 Q. But the problem here wasn't a lack of manpower on the
4 scene: your staff on the scene knew, in varying degrees
5 of specificity, where the injured people were, but for
6 reasons you've explained, they understood that to be
7 a hot zone where they couldn't go and were being
8 directed away by firearms officers.

9 A. Yes.

10 Q. The problem surely wasn't one of lack of people, but not
11 getting the information through the police to those in
12 the courtyard.

13 Now, is there a way that -- is there any way that
14 that kind of problem can be avoided in future, of people
15 in inaccessible locations being told quickly of the
16 limited access to them so that if they can be moved,
17 they are moved to critical care?

18 A. So I think, you know, we will have to look at whether
19 we, despite all of the additional things that we've put
20 into place to try to improve communications across
21 emergency services, quite clearly there were issues
22 around communicating pieces of information on that
23 night.

24 Whether we need to consider -- the principles of
25 JESIP are that there is coordination there from an early

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1 stage. I've described that the way major incidents are
2 managed, it takes time to get those mechanisms in place,
3 it takes time to get personnel from all over London in
4 to focus on an incident.

5 So whether it is that we have to describe a way of
6 physically having assets 24/7 located together where
7 actually within one space there is visibility of
8 everyone's resources, the different communication
9 channels that are coming through from our individual
10 CADs, whether we need to seriously think about whether
11 we need to locate those people not on an on-call to duty
12 and let's bring people in, but to have them there 24/7
13 would be something that we need to consider.

14 Q. So there might, for example, be a value in having LAS
15 operators permanently stationed in the
16 Metropolitan Police's special operations room?

17 A. Correct, with London Fire Brigade colleagues, would be
18 worth considering.

19 Q. So, for example, in a situation like this, after
20 a communication is made by someone like Mr Beasley,
21 saying that there are casualties he can't get to, that
22 person in the control room can say to police colleagues
23 right next to them "We've got casualties we can't reach,
24 can word be got to them so that they can be moved if
25 necessary".

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1 A. So I think there is that physical communication that can
 2 happen, but I also think in terms of identifying
 3 physical assets and the whereabouts of those assets, you
 4 know, that could be explored where you've got the
 5 visibility of all the assets on the scene in one place
 6 as opposed to across the three separate organisations.
 7 Q. Could that include more use of technology to give
 8 precise locations of each service's assets so that they
 9 can be seen in a single place and a single operations
 10 room?
 11 A. Yes, so certainly we've been talking about the use of
 12 drone technology to provide better situational awareness
 13 of where casualties are and coordination of that, those
 14 scenes.
 15 Q. And what about the use of -- potentially of GPS
 16 technology to identify the location of different
 17 ambulances and paramedics so that the police know where
 18 they all are at any one time?
 19 A. So there is an ability to do that in a small scale with
 20 the current Airwave radio programme with the new
 21 emergency services network radio programme, then clearly
 22 that is a feature that we would be able to use, and that
 23 is in -- the process of bringing in that system is
 24 underway.
 25 THE CHIEF CORONER: Can I -- obviously one can understand

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1 how GPS might work, that would give you the location of
 2 a device. So, for example, if someone has a radio, you
 3 would know where that device was.
 4 A. Yes, sir.
 5 THE CHIEF CORONER: But in terms of, supposing you've got
 6 somebody who doesn't have a radio, it's become detached
 7 whilst they are attending to someone. You may not know
 8 where they are if it's reliant upon the technology.
 9 A. Yes, so I think radio technology is not the answer in
 10 isolation, but clearly where you can use GPS positioning
 11 through radios, that would be an added resilience to the
 12 identifying of resources.
 13 MR HOUGH: Next, Mr Rainey, please, and the steps he took.
 14 We've seen that he arrived at the scene at 23.25, and he
 15 became aware very shortly afterwards that there may be
 16 people who had died in the Boro Bistro area; is that
 17 right?
 18 A. So he recalls being told there were deceased people in
 19 that general area, yes.
 20 Q. From 23.37 there were discussions about committing teams
 21 into the area where the attack had taken place because
 22 Borough High Street itself was by that stage a warm
 23 zone?
 24 A. So I believe -- well, officially it was declared a warm
 25 zone, the reality is Borough High Street was a warm zone

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1 for the duration of that incident until the incident was
 2 stood down, because of the patients that were presenting
 3 in that area and its proximity to the hot zone, which
 4 was the Borough Market area. So, yes.
 5 Q. The AIT teams were committed over a period, as we've
 6 seen, between just after midnight and about 1.00 am.
 7 A. Yes, so the decision to commit teams is not made by the
 8 LAS in isolation: it's the three commanders are making
 9 those decisions (a) the declaration of hot zones and
 10 warm zones is led by the police service in those
 11 circumstances, so it's not set by either the fire
 12 brigade or the London Ambulance Service. The decision
 13 to commit is based on a joint assessment and a joint
 14 risk analysis based on the latest intelligence
 15 available, and a decision is reached using the joint
 16 decision model, as Marc Rainey evidenced in his log, the
 17 outcomes of those discussions and the outcome in
 18 relation to the decision that's taken.
 19 Q. Now, the teams were sent in to a number of areas from
 20 about midnight which were hot zones, or part hot zones?
 21 A. They were hot zones.
 22 Q. How did it happen that against the protocols, against
 23 the textbooks, AITs were sent in to hot zones?
 24 A. So the decision was initiated by -- or the discussion
 25 was initiated by Marc Rainey. You can see in

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1 Marc Rainey's log that just before midnight, Marc Rainey
 2 is raising concerns about the length of time to commit
 3 teams into areas where he believed there might be live
 4 casualties.
 5 There was a discussion that took place and
 6 Marc Rainey discussed with the individual AITs whether
 7 they would be willing to volunteer to commit to the hot
 8 zone under the protection of armed police, so they were
 9 informed volunteers to deploy into the hot zone, which
 10 as we know under the joint operating procedures is not
 11 normal standard practice.
 12 Q. So before they started going in, just after midnight,
 13 Mr Rainey had to speak to all those teams, explain the
 14 situation to them, and ask whether they were prepared to
 15 volunteer to go into the hot zones?
 16 A. Yes.
 17 Q. Did they all agree to?
 18 A. They did.
 19 Q. So all those LAS staff which we saw -- who we saw listed
 20 in the log, they all agreed, and reasonably quickly, to
 21 go into danger zones?
 22 A. Well, they were asked before they were deployed, because
 23 in evidence there were a number of teams that were
 24 created and then there were decisions about where those
 25 teams would be deployed, so it wasn't a case of just

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1 having a mass group there and asking whether they would
 2 volunteer. They were asked around what they were going
 3 to be deployed into, what the risk assessment was, and
 4 they were each individually as teams asked whether they
 5 would be willing to volunteer into -- commit the hot
 6 zone?
 7 Q. They all agreed?
 8 A. They did.
 9 Q. And then over the period, as I've said, from midnight
 10 until 1.00 am, the teams were sent in to various places
 11 in stages; is that right?
 12 A. They were, and the reason that was happening is that was
 13 still a very dynamic situation because there were
 14 a number of reports that were coming in while teams were
 15 committed. So one of them was around an active shooter
 16 still being in the area. There were reports of shots
 17 being fired in a different part of Southwark. There was
 18 the Southwark Cathedral issue that was being discussed
 19 and we've heard from evidence previously this morning
 20 that military teams were deployed in to do a sweep of
 21 that area.
 22 So whilst the teams were being committed into the
 23 hot zone, there was lots of discussions round, that was
 24 still very dynamic and that was why the zone was hot.
 25 It was deemed to be unsafe.

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1 Q. So part of the decision about the timing of sending
 2 teams into individual areas was how dangerous or
 3 potentially dangerous they were considered to be?
 4 A. Yes, and that was very dynamic in terms of information
 5 that was coming through.
 6 Q. Was that decision also informed by a view of whether
 7 there might be living casualties in the various areas?
 8 A. Yes, so that's what we prioritised, where we thought the
 9 areas where living casualties would be, and the
 10 information that Marc Rainey had is that the area you've
 11 described, the courtyard area, had deceased patients in
 12 and it was obviously proximal to Southwark Cathedral.
 13 Q. Now, we know that the area of Borough Market itself is
 14 large --
 15 A. Yes.
 16 Q. -- and was still being evacuated very late in the day,
 17 as we saw from that note of Mr Stumpo's?
 18 A. Correct.
 19 Q. We know that the Boro Bistro courtyard had been very
 20 substantially evacuated before 11.00 pm.
 21 A. Correct.
 22 Q. And that by this point there weren't any living
 23 casualties there.
 24 A. That was the understanding of Mr Rainey.
 25 Q. And that understanding is right, as far as you're

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1 concerned, isn't it?
 2 A. Yes.
 3 Q. So is the priority decisions, the set of priority
 4 decisions, which involved sending staff into
 5 Borough Market first, and to Borough Market rather
 6 later, a set of decisions that you, looking back on it,
 7 would agree with and say were justified?
 8 A. I would.
 9 Q. So is the time taken to reach casualties in a hot zone
 10 in this situation a function of first of all
 11 an assessment of how dangerous the different areas were
 12 and, secondly, a function of an assessment of how much
 13 good could be done to help living casualties?
 14 A. Well, given the fact that actually the joint operating
 15 principles say that you do not deploy into the hot zone
 16 at all with ambulance intervention teams, it was
 17 a decision that was there to try to preserve life as
 18 much as possible.
 19 Q. May I move on, now, to debriefs and lessons to be
 20 learned, and you deal with these in your learning
 21 statement. After the attack, was material gathered from
 22 various sources to inform London Ambulance Service and
 23 enable lessons to be learned?
 24 A. Yes, it was.
 25 Q. Were commanders' logbooks reviewed?

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1 A. They were.
 2 Q. Were hot debriefs carried out immediately after the
 3 incident in which staff were asked for their instant
 4 reflections?
 5 A. Yes, so the hot debrief happens immediately after the
 6 incident is stood down, so on that evening personnel
 7 that were involved in that incident were directed to our
 8 station in Deptford, New Cross Road, and that's where
 9 the hot debriefs were undertaken on that night.
 10 Q. Can we look at {DC5058/1}, and we see these were
 11 recorded in a log of notes.
 12 A. That's correct.
 13 Q. Page 2, please {DC5058/2}. Can we see, for example,
 14 that staff with various call signs gave records of what
 15 they had done and their immediate reflections?
 16 A. Yes.
 17 Q. So, for example, G330, the first ambulance on scene, the
 18 staff from that ambulance gave their reflections of what
 19 they had seen and those were all noted down?
 20 A. Correct.
 21 Q. We can take that off the screen. Then in the early part
 22 of July 2017 were structured or cold debriefs carried
 23 out for various staff?
 24 A. They were.
 25 Q. I think they were separate debriefs for, first of all,

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1 control room staff, frontline staff, specialist staff
 2 and so on?
 3 A. Correct.
 4 Q. We can look at an example of one of those, {DC5054/1}.
 5 Can we see notes of the cold debrief of operations staff
 6 with the comments of the various individuals deployed to
 7 the scene? Do you see that?
 8 A. Yes.
 9 Q. And then {DC5054/5}, do we see that a whole series of
 10 points emerging from that debrief are recorded,
 11 including issues about training, issues about adequacy
 12 of equipment, positive and negative points?
 13 A. Correct.
 14 Q. Then can we have {DC5049/1} on screen, please. Was
 15 a debrief report produced as a result of this debrief
 16 process?
 17 A. Correct.
 18 Q. And at {DC5049/5}, please, do we see there that it
 19 summarised the response, including the resources
 20 deployed to the scene, which you have summarised
 21 already?
 22 A. Correct.
 23 Q. Then page 6, please {DC5049/6}, a list of the numbers of
 24 casualties, a total of 45 casualties of varying
 25 priorities conveyed to treatment centres?

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1 A. Correct.
 2 Q. And the treatment centres set out there.
 3 Then the recommendations begin at {DC5049/8}. Is it
 4 right that they include a wide range of topics,
 5 including, as we see here, the first recommendation
 6 concerning training for call taking and automatic
 7 dispatch of assets?
 8 A. Correct.
 9 Q. May I look at a number of these recommendations which
 10 are, perhaps, particularly pertinent. Page 10, please
 11 {DC5049/10}, recommendation 10, do we see here that
 12 there's a recommendation for reiterating reporting lines
 13 during major incidents?
 14 A. Correct.
 15 Q. And does that refer to, in the text underneath, concerns
 16 having been expressed on various matters including a
 17 lack of clarity on hot, warm and cold zones in the early
 18 stages of an incident?
 19 A. Correct.
 20 Q. Was it the assessment of the debrief process that there
 21 was a lack of clarity about where the various zones
 22 were, at least in the early stages?
 23 A. There was, and staff, as you will have heard in
 24 evidence, would have dictated, as would be normal
 25 practice in the very early instance of an incident, on

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1 where those zones were before they were formalised.
 2 But as you can see through the debrief process,
 3 there was a fair amount of confusion around the safety
 4 of the overall scene in the early stages of the
 5 incident.
 6 Q. Then {DC5049/11}, please, recommendation 13. Do we see
 7 there a recommendation for a technical upgrade to allow
 8 radio handsets to be tracked?
 9 A. That's correct.
 10 Q. Did that reflect any concern about locating staff at the
 11 scene with precision so that those staff could be
 12 directed and others be told where they were?
 13 A. So there were two areas for consideration there,
 14 certainly that was one of them, but also the ability for
 15 us to, within what was a very hostile environment, was
 16 to be able to track members of staff and where they were
 17 within the incident ground.
 18 Q. And page 13, please {DC5049/13}, recommendation 20,
 19 there's a recommendation about the use of immediate
 20 casualty evacuation methods to remove patients and the
 21 public from immediate danger, and the text refers to
 22 concerns about confusion over rendez-vous points and
 23 conflicting instructions at the scene; do you see that?
 24 A. Yes, I can.
 25 Q. And the text also refers to staff having been told to

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1 avoid hot zones but there being a lack of clarity about
 2 the routes to be used?
 3 A. Yes, because the declaration of those zones was very
 4 dynamic and then obviously staff have concerns that they
 5 were, from rendez-vous points, being pulled forward into
 6 potential hot zones, and they were some of the issues
 7 the crews on the night raised.
 8 Q. So does this recommendation reflect concerns in the
 9 debrief process about the challenges of removing both
 10 patients and members of the public from areas of danger?
 11 A. Correct.
 12 Q. {DC5049/14}, please, recommendations 22 and 23 involve
 13 action cards and live exercises being suggested because
 14 of confusion caused due to the scene being run as two
 15 separate sectors; do you see that?
 16 A. Yes, I can.
 17 Q. And it refers to a degree of sector isolation between
 18 the two sectors by which the scene was being managed?
 19 A. Yes.
 20 Q. Was that another difficulty raised by the debrief
 21 process which you were trying to address by those
 22 changes that are identified there?
 23 A. That's correct.
 24 Q. Then {DC5049/17}, please, recommendations 33 and 34
 25 concern specialist staff, including HART and TRU staff,

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1 and do we see that the concerns refer to confusion in
 2 directing those staff to rendez-vous points and to
 3 difficulties in identifying the forward control point?
 4 A. Correct.
 5 Q. Were those other problems raised in the course of the
 6 debrief process?
 7 A. They were.
 8 Q. Is a degree of confusion in the finding of rendez-vous
 9 points and the forward control point a common feature of
 10 incidents of this kind?
 11 A. So I think it needs to be put into the context that
 12 whilst we're talking about the declaration of
 13 an Operation Plato incident, that's the first time Plato
 14 has been declared for what was a marauding terrorist
 15 attack in London, and as I've said in the very early
 16 stages, there was literally hundreds of messages coming
 17 in describing different things.
 18 So RVPs were being changed as a matter of course,
 19 and that's for good reason, but also the identification
 20 of hot and warm zones which, you know, it's very
 21 difficult when you're trying to allocate resource early
 22 into the scene and try to get -- I keep referring to
 23 situational awareness and situational awareness is
 24 difficult within a routine major incident that's got one
 25 static site. Where we had this, which had multiple

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1 locations with multiple areas of danger, to get that
 2 overall situational awareness when so many things were
 3 changing dynamically, both through information from the
 4 control room but through personnel on the ground, that
 5 inevitably led to confusion and it wasn't until those
 6 command structures and the FCP became fully populated
 7 that you start to see some discipline and you start to
 8 see what the job states should happen start to take
 9 shape.
 10 Q. So, in reality, is all the effort that goes into the
 11 debrief and learning process in part an effort to find
 12 procedures which will minimise the chaos that is present
 13 to a certain degree of necessity?
 14 A. Yes, I think -- yes, the whole idea of those debriefs is
 15 to understand the difficulties that personnel had on the
 16 ground, it is to identify lessons, it is to see how can
 17 we better improve not just the LAS as an organisation,
 18 but we work very closely with emergency service
 19 partners, so, you know, this was all fed into
 20 multi-agency debriefs and, indeed, to -- as far as the
 21 ambulance service was concerned, was fed into a national
 22 debrief.
 23 Q. There are perhaps two headline issues that have been
 24 raised in the course of these Inquests concerning the
 25 LAS. I think you're aware of them and I've asked you

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1 about them. First of all is locating and assisting
 2 casualties in areas which are either inaccessible or
 3 dangerous, and, secondly, there is the problem of
 4 identifying danger areas and potentially getting
 5 assistance into them.
 6 Now, looking at those separately, you have accepted
 7 that to address the first problem, identifying people in
 8 those areas, there would be a value in having some LAS
 9 staff permanently located with the Metropolitan Police
 10 special operations room; yes?
 11 A. I think that's definitely worth exploring, yes.
 12 Q. And you've also indicated that there may be a value in
 13 exploring technical improvements either that are going
 14 through at the moment or could be considered in future
 15 to allow the location of LAS assets to be more precisely
 16 identified and passed on to others?
 17 A. So I think the identification of assets but also to use
 18 technology to be able to identify patients in the exact
 19 locations within a general area of danger and have early
 20 visibility of that would help, because I think one of
 21 the issues, Borough Market is a big area, and obviously
 22 there were multiple establishments in there. There was
 23 information coming, but some of that information was
 24 conflicted. The area wasn't deemed to be safe and
 25 that's right from the beginning of the incident there

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1 are multiple messages before you start getting official
 2 declarations, and we've heard from previous evidence
 3 around people being told to stay out of Borough Market.
 4 So we do need something additionally that can help
 5 us to identify where people are in exact locations when
 6 they are at different levels, you know, might be with
 7 constricted views. How can we get a helicopter view of
 8 that location so that when we're deploying ambulance
 9 incident teams in as per the jobs, we have more
 10 intelligence about where people are and actually
 11 analysing the risk to whether we deploy assets in to
 12 provide support or indeed we just need to, if there are
 13 assets there, just extricate them out to resources that
 14 are in a safe area away from that particular zone.
 15 THE CHIEF CORONER: And this is where you mentioned the
 16 potential use for a drone going in and looking around
 17 the area --
 18 A. Yes, sir.
 19 THE CHIEF CORONER: So it could go in, have a look, feed
 20 back the information straightaway.
 21 A. Start transmitting from cameras around where we've got
 22 them.
 23 THE CHIEF CORONER: Yes, and you've got those images. So
 24 I think Mr Hough asked you about the other, which was
 25 first of all locating assets, which is one point, but

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1 then you are saying also deploying other technology to
 2 help you actually search for where people are?
 3 A. Yes.
 4 MR HOUGH: Is there also scope for improving communications
 5 about the extent of warm and hot zones in a more formal
 6 way in those early stages?
 7 A. So my personal reflections are the FCP, which was the
 8 forward command point, it took some considerable time
 9 for three services to be able to engage in those
 10 discussions, and clearly we are looking as
 11 an organisation about how we can improve that so that
 12 those risk assessments and analysis can be done in
 13 a more timely manner. And, indeed, you have seen
 14 throughout the incident debrief that we did that that
 15 issue was raised around the identification of FCPs and
 16 specialist assets being mustered to those FCPs.
 17 What we did with that information is obviously the
 18 Plato SOPs are a national document, it's adopted
 19 nationally, we fed those issues in, and my understanding
 20 is that there has been a refresh of those joint
 21 operating principles in relation to MTA incidents and
 22 certainly one of the things that we are implementing
 23 within the London Ambulance Service to speed up the
 24 deployment of AITs is to remove the reliance for
 25 a recall to duty Plato commander to be paged and

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1 recalled to duty from home, and actually train the HART
 2 duty managers and the tactical response unit duty
 3 supervisors to undertake that role to commit and deploy
 4 AITs in the first instance, so removing the need for
 5 a recognised bronze Plato commander to be recalled to
 6 duty to take those decisions.
 7 Q. So potentially get somebody to the scene in that role
 8 before the time Mr Rainey was able to get to the scene
 9 on this occasion?
 10 A. Yes, clearly. My reflections are it took too long to
 11 make decisions to commit and that's one of the ways that
 12 I think we, as an organisation, will improve that by
 13 giving that authority to duty managers and not a bronze
 14 Plato.
 15 So we would still recall bronze Plato commanders to
 16 duty to go in and overtake that duty on their arrival,
 17 but not to delay a commitment to deploy AITs because we
 18 are waiting for someone to be recalled to duty.
 19 Q. Any other way that those decisions to get the AITs into
 20 zones of potential danger can be speeded up?
 21 A. So I think it is an area, it's a fundamental area that
 22 I think, you know, us as an organisation and our
 23 emergency services colleagues need to, as a result of
 24 this process and, indeed, our own debriefing processes,
 25 to see whether there is anything more that we can do to

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1 speed up the deployment of AITs because they are the
 2 critical resource once the hot zones and the warm zones
 3 are deployed.
 4 The management of those zones aren't for
 5 non-specialist operational staff, they are for the
 6 specialist assets and therefore we've got to find ways
 7 of deploying those staff with the specialist skills in
 8 a more timely manner if it is at all possible.
 9 Q. Finally this: your staff, on those individual teams,
 10 with considerable courage all agreed to go into danger
 11 zones?
 12 A. Yes, so my reflections of the events of two years ago
 13 span many dimensions. For me, as someone that works for
 14 the ambulance service and has been a paramedic and
 15 delivered clinical care, to see people lose their life
 16 in such circumstances is clearly distressing. I am the
 17 accountable director for the London Ambulance Service
 18 and it is incumbent on me to ensure that we do as much
 19 as we can to learn so that we do learn from these.
 20 This is not around individual blame. These were
 21 a set of very difficult circumstances and I know the
 22 purpose of today is to try to provide answers to family.
 23 I think it does have to be put into the context that we
 24 had not only staff that were actually prepared to go and
 25 commit themselves into a hot zone when quite clearly at

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1 that time there were military personnel landing on
 2 London Bridge and sweeping through, so the area was by
 3 no means safe, and, actually, in the early stages of the
 4 incident we had a small number of staff that just
 5 actually were arriving to go to a road traffic collision
 6 and actually just got caught in the terrible events that
 7 unfolded in those early stages. You know, they worked
 8 in really difficult circumstances and actually there
 9 were a lot of patients that were severely injured that
 10 night that actually did make it to hospital and did
 11 survive.
 12 And I think there is a caution about with hindsight,
 13 you know, criticising individuals. You know, the staff
 14 did a great job, a fantastic job in very difficult
 15 circumstances and of course there will always be
 16 learning, and actually these Inquests are part of that
 17 process. So I'm proud of my staff who put themselves in
 18 harm's way on occasion to deliver patient care to people
 19 that were severely injured.
 20 Q. My question is directed slightly elsewhere. Despite
 21 that courage, it happened on that night that police
 22 medics got to people first.
 23 A. Yes.
 24 Q. And I think you're aware that it often happens that
 25 police medics are those who get to people first.

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1 A. Yes.
 2 Q. But police medics aren't trained to do some of the more
 3 complicated procedures which can potentially save life
 4 in stabbing, and indeed ballistic injury situations;
 5 correct?
 6 A. Yes, although I would put a note of caution that under
 7 the JOPs, when you're committing -- so I think the
 8 police medics and the emergency services as a whole did
 9 a fantastic job in difficult circumstances, but there
 10 would be minimal intervention when we were committing
 11 teams into a warm zone, and there would not be complex
 12 interventions be incoming. There is a thing of treat
 13 and leave, which is, you know, you try to address
 14 haemorrhage and address an airway or you do minimal
 15 interventions and extricate the patients out.
 16 Q. I appreciate that's the theory, but on the night, police
 17 officers and police medics stayed with people in
 18 Boro Bistro, working on them for 10, 15, 20, 25 minutes,
 19 they didn't just treat and leave, and that was because
 20 of the circumstances. But that may often be the case or
 21 may sometimes be the case.
 22 Would there not be some value in having some police
 23 medics trained to a higher level capable of delivering
 24 more complex treatment, not LAS staff but police
 25 officers, for exactly that sort of situation, not

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1 limited to terrorism but to other situations where the
 2 police inevitably get to the situation first?
 3 A. So I think I wouldn't discount that, but certainly we --
 4 that would need to be a discussion between organisations
 5 around what the benefits would be of uplifting the level
 6 of training that police medics get, so if there's
 7 learning to be had in terms of upskilling anyone in
 8 terms of getting treatment to the patient, just in terms
 9 of the circumstances that people find themselves in,
 10 then clearly we need to explore whether there is
 11 anything further that needs to be done in that regard.
 12 MR HOUGH: Thank you very much. Those are all my questions.
 13 THE CHIEF CORONER: Mr Patterson.
 14 Questions by MR PATTERSON QC
 15 MR PATTERSON: Mr Woodrow, I ask questions on behalf of
 16 families of six of those who were killed on the night,
 17 of which five of those were killed in and around the
 18 courtyard of the Boro Bistro.
 19 Can I begin, please, with that topic of the three
 20 hours that transpired between the attacks in that area
 21 and the entry into that area of those LAS paramedics,
 22 because it's plain, isn't it, from all the evidence that
 23 in the early stages, LAS paramedics wouldn't go in, so
 24 Mr Edwards, Mr Carlson, even though they were both
 25 TRU-trained specialist paramedics; yes?

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1 A. So they were TRU paramedics, yes.
 2 Q. And you agree that they were aware of the casualties but
 3 wouldn't go into that area?
 4 A. So they deemed the area to be unsafe so did not enter
 5 that area, no, they suggested to RVP.
 6 Q. And the advanced paramedic Mr Rutherford didn't go into
 7 the area; yes?
 8 A. That's correct.
 9 Q. And we'll come to Mr Beasley in a moment, who was the
 10 senior bronze figure at the scene, and that recording
 11 that shows that he was aware of casualties in that
 12 general area, you told us, that 10.30 radio call, yes?
 13 A. So I think he was aware of casualties, yes. I'm not
 14 sure he was specifically aware of --
 15 Q. Precisely, yes.
 16 A. -- precisely where they were, but I think he was aware
 17 that there were casualties --
 18 Q. Downstairs?
 19 A. -- down a set of stairs south side of the bridge.
 20 Q. After 10 minutes the three [attackers] had been killed
 21 at 10.16, yes, on Stoney Street?
 22 A. Yes.
 23 Q. But not a single paramedic stepped foot in that area for
 24 something like three hours from the time of the attack
 25 until after 1 o'clock in the morning; is that the

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1 picture?
 2 A. No, that's not the accurate picture. There were --
 3 Q. Were there any LAS figures in that area prior to that
 4 time?
 5 A. Well, so there were resources that were allocated but
 6 the area that you described was an unsafe area. It
 7 wasn't that resources weren't going in there; the area
 8 was unsafe.
 9 Q. Yes, but can you name a single person who stepped foot
 10 in that area prior to the HART team at something like
 11 1 o'clock in the morning?
 12 A. So it was the ambulance intervention team, so at 12.05
 13 when ambulance intervention teams were committed into
 14 that area and then, as you say, the last team to be
 15 committed was just around 1 o'clock.
 16 Q. Yes, so can you name a single LAS individual who was in
 17 that courtyard prior to 1 o'clock in the morning?
 18 A. Well, there wasn't.
 19 Q. There wasn't, right.
 20 So the Plato procedures kicked in, yes?
 21 A. So the declaration of Operation Plato was made, yes.
 22 Q. And there were these highly trained paramedics that were
 23 available. How many in total were present at the scene
 24 ultimately that night?
 25 A. Well, when we committed the seven teams, we had 21

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1 trained TRU personnel.

2 Q. 21. One of them gave evidence that she had managed to
3 get from Isleworth to the scene by potentially something
4 like 11.20?

5 A. Correct.

6 Q. And then obviously we can do the maths, there's quite
7 a period of time, isn't there, between 11.20 and
8 something like an hour and a half, or an hour and
9 three-quarters later when they stepped into the
10 courtyard, yes?

11 A. So I wouldn't altogether agree with that, because --

12 THE CHIEF CORONER: I think, to some extent, Mr Patterson,
13 you're setting out the timetable, or the timing gap.

14 MR PATTERSON: Exactly.

15 THE CHIEF CORONER: And I'm conscious that it may well be
16 the witness is trying to answer a slightly different
17 question to the one that you are posing because
18 certainly with your initial question you said was there
19 a three-hour gap between the shooting and people going
20 in?

21 MR PATTERSON: Yes, that's right.

22 THE CHIEF CORONER: And we got there eventually that in fact
23 there were resources deployed, but I think he accepts
24 that actually no one did go in until just after
25 1 o'clock, and it's really -- I am looking at you but my

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1 comments are really directed at the witness to actually
2 answer the question, but it may well be that other
3 things flow from it.

4 Q. Yes, and we will be coming to reasons and danger and
5 confusion and all of in due course, I'm just trying to
6 get the headline times.

7 It looks, does it not, as though certainly some of
8 those HART teams were there in the area from about
9 11.20. That was the evidence we had from the HART
10 paramedic who gave evidence to the court; does that
11 sound about right?

12 A. It does, and we also had the Operation Plato commander
13 from the LAS on scene at the FCP, at the Bunch of Grapes
14 public house from around 23.25.

15 Q. And the van, you told us, was declared clear before
16 midnight at 23.54, was the time you gave.

17 A. That's the information contained in Marc Rainey's log.

18 Q. And although there might be considerations as to whether
19 you suspected that the courtyard is clear, you can't be
20 certain that the courtyard is clear of casualties until
21 you go in, can you?

22 A. No, sir, clearly the decisions to deploy the teams were
23 made at the tri-service FCP and they were made on the
24 latest intelligence and information that was available
25 not just to Marc Rainey but his counterparts in the

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1 police service and the fire service.

2 Q. But these highly trained paramedics -- we will not be
3 making the most of their usefulness, will we, if we
4 delay their employment?

5 A. So, sir, I think I reflected on the arrival of Mr Rainey
6 after he had had the initial discussion. It was
7 Mr Rainey that was raising concerns around the length of
8 time it was taking to deploy those specialist assets
9 into the defined warm zone and actually there was
10 a discussion around the need to deploy assets, if
11 possible, into the hot zone because of concerns.

12 Q. Mm, but with all their training, with all their
13 expertise, with all their kit and bearing in mind that
14 many other paramedics don't have those features, we
15 don't want to hold them back such that they're only
16 really going in for a sort of formal declaration of life
17 extinct, do we? We want to be really making the most of
18 these features, of their resources; would you agree?

19 A. Sir, I have reflected that whilst it took time to deploy
20 those assets in, the process under the joint operating
21 procedures to deploy those was followed, so the zones
22 were not set by London Ambulance Service commanders,
23 they were set at the FCP by police service commanders in
24 terms of the zones, and there was discussions around the
25 delay to deploy those resources into those zones which

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1 subsequently led to personnel willingly volunteering
2 themselves to go into the hot zone to look for
3 casualties to be treated.

4 Q. I mean, was it a hot zone or was it a warm zone? We
5 don't have any clear entry that we can find in any of
6 the records as to whether that courtyard is categorised
7 as a warm zone or as a hot zone?

8 A. Well, I agree, because I have searched evidence to
9 say -- the specificity around the Boro Bistro is not
10 there, but when you talk of Borough Market, you talk
11 about Montague Close, you talk about Southwark Cathedral
12 was all deemed to be a hot zone, in actual fact, past
13 midnight, the boundaries of the hot zone actually get
14 increased and actually Borough High Street and
15 London Bridge turns into a hot zone because there was
16 reports of active shooting. So the zones were changing.

17 Q. Would you agree that these decisions are very important,
18 because there's a degree of prioritisation as to which
19 areas they then go into, because we have team 1 going in
20 at something like, I think you told us midnight, around
21 about 12.00?

22 A. 00.03 there was a decision to deploy.

23 Q. But then about an hour before they go into the
24 courtyard, even though the van had been cleared back at
25 11.54, over an hour earlier.

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1 A. But I must stress, sir, it's not an independent decision
 2 for the LAS to deploy. It is based on latest
 3 information that's coming into the Tactical Firearms
 4 Commander that is at the FCP, the London Fire Brigade
 5 representative who is at the FCP, and the ambulance
 6 Plato commander: the three of them are digesting the
 7 latest analysis and intelligence and jointly agreeing in
 8 which way to deploy those assets and what there is
 9 they're going to deploy them in. It's not an individual
 10 decision for the London Ambulance Service under the
 11 doctrine contained that we were working to.
 12 Q. So was there any delay in waiting for a firearms officer
 13 to accompany any of these paramedics? Or was that
 14 resource available at an early stage?
 15 A. So, there were firearms officers available.
 16 Q. So that wasn't a problem. And, typically, is it
 17 one-on-one needed before you can go in? Can you have
 18 one paramedic with one firearms officer, or are there
 19 any rules as to numbers?
 20 A. Well, so the ambulance intervention teams are three LAS,
 21 specially trained LAS personnel. They would be
 22 accompanied by London Fire Brigade personnel to assist
 23 them with specialist training, and then they would take
 24 cover from armed police.
 25 But that is not -- in the warm zone that is not

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1 a reason not to deploy because there aren't armed
 2 officers. So if you've got your fire and rescue
 3 colleagues and the London ambulance, not having armed
 4 police to go and do recovery within a warm zone is not
 5 a determinant. But what we were talking about at 00.03
 6 was deploying assets into what had been classified by
 7 the police service as a hot zone.
 8 Q. We understood that hot zones were a complete no-no?
 9 A. So --
 10 Q. Paramedics can never go into the hot zone?
 11 A. No, they can't.
 12 Q. So the rules weren't being followed in that respect?
 13 A. So there were discussions had about the length of time
 14 so, indeed, the rules were broken.
 15 THE CHIEF CORONER: I think that's why you told us there
 16 would have been these discussions between the --
 17 A. Yes.
 18 THE CHIEF CORONER: -- before each team deployed --
 19 A. They were asked, yes.
 20 THE CHIEF CORONER: -- they were asked whether they were
 21 happy to volunteer?
 22 A. Yes, whether they would commit into a hot zone, so they
 23 were informed volunteers.
 24 THE CHIEF CORONER: Yes.
 25 MR PATTERSON: If they declined to give consent, would that

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1 be the end of that deployment?
 2 A. Well, we would clearly look -- we were deploying teams,
 3 as I've said, the personnel that the LAS contribute to
 4 each team is three people. If team 1 had a discussion
 5 with Marc Rainey and one person in team 1 said: I'm not
 6 prepared to be deployed in a hot zone, we would then
 7 seek from the remaining tactical and HART staff whether
 8 we would have another willing volunteer to deploy
 9 themselves into the hot zone.
 10 Q. So on a given day, a typical Saturday night, how many of
 11 these specialist paramedics do you have available in
 12 London?
 13 A. So we are bound by national specification for our HART
 14 teams, so 24/7 we have to have two teams of six, that's
 15 for HART provision --
 16 Q. So a total of six.
 17 A. Sorry, two teams of six.
 18 Q. A total of 12?
 19 A. Pan-London 12, and we have a minimum of 10 tactical
 20 response unit staff.
 21 Q. And there's no distinction between the two types: both
 22 of these types of specialist paramedics can do the tasks
 23 that we are focusing on?
 24 A. Yes, so those two groups of staff have that particular
 25 skill, yes.

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1 Q. So a total of 22 who are available typically on a given
 2 day?
 3 A. Yes.
 4 Q. And when a major incident is declared, we saw that
 5 automatically a given number of resources is allocated
 6 to the scene, 20 ambulances, you told us.
 7 A. Yes, so that's known as -- on declaration as
 8 a predetermined attendance.
 9 Q. And that includes a HART team or teams?
 10 A. Yes.
 11 Q. So automatically they will be, what, called to the
 12 scene, or ...?
 13 A. Well, depending, because if they're deployed, because
 14 obviously they are deployed to other types of incident
 15 so as part of that predetermined attendance, the
 16 emergency operations centre will look for available
 17 vehicles and HART, if they're deployed onto another
 18 particular call, there would be a conversation about how
 19 quickly they could be released but they would be
 20 dispatched as quickly as possible as part of that
 21 predetermined attendance, yes.
 22 Q. So it's an automatic dispatch rather than any judgment
 23 or discretion?
 24 A. No, they are part of the predetermined attendance.
 25 THE CHIEF CORONER: Mr Patterson, I note the time. Would

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1 that be a convenient point for us to break?
 2 MR PATTERSON: Yes, certainly.
 3 THE CHIEF CORONER: We will sit again at 2.05 pm.
 4 (1.01 pm)
 5 (The Luncheon Adjournment)
 6 (2.05 pm)
 7 THE CHIEF CORONER: Yes.
 8 MR PATTERSON: May it please your Lordship.
 9 Mr Woodrow, do I understand accurately from your
 10 evidence earlier today that in fact when one of these
 11 specialist paramedics deploys into one of these
 12 dangerous zones they don't, in fact, have to be
 13 accompanied by an armed police officer at all?
 14 A. So the evidence that I gave you earlier in terms of the
 15 MTFA JOPs say that when a decision to deploy into warm
 16 zones and within those warm zones when an agreed limit
 17 of exploitation is agreed between tri-service commanders
 18 that the presence, the mandatory presence of armed
 19 support officers to provide cover should not be a reason
 20 not to deploy into a warm zone.
 21 Q. So that these specialist paramedics can go in just,
 22 I think you said, accompanied by an escort from the
 23 London Fire Brigade; is that right?
 24 A. So the London Fire Brigade provide specialist staff for
 25 working in those areas and they make up the team with

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1 the London ambulance personnel, and the JOPs state that
 2 when decisions are made to deploy into warm zones only
 3 that the lack of firearms-trained officers to provide
 4 support should not be a reason not to deploy those AITs
 5 into a warm zone.
 6 Q. So it may be that the situation is such that the risks
 7 aren't so great and that a paramedic can safely go into
 8 a warm zone without an armed officer escorting them?
 9 A. So the JOPs state that that should be a consideration
 10 when the three service commanders are analysing all of
 11 the intelligence and are analysing risk, and based on
 12 those assessments when deploying into a warm zone, not
 13 a hot zone, when deploying into a warm zone, the
 14 availability of armed police officers, specialist
 15 firearms trained police officers to provide cover to
 16 those teams, if that's not available, that should not be
 17 the only reason for them not to deploy: it should be
 18 a consideration, but based on the risk assessment it
 19 should not be a reason not to deploy.
 20 Q. Unless we have missed them, we are aware of no documents
 21 or records that were made analysing all of these issues
 22 and making these decisions about different locations and
 23 different priorities as to which area should be the
 24 subject of the first team going in and which area should
 25 be the subject of a later team and the reasons for all

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1 of those decisions; is that right? Is there -- are
 2 there detailed notes explaining all of this
 3 decision-making?
 4 A. So there will be management logs for each of those Plato
 5 commanders. Marc Rainey's log, I believe, has been
 6 presented, and the joint decision model tool that is
 7 part of the joint emergency services interoperability
 8 principles, that model of decision-making is included in
 9 that log and I believe Marc Rainey logs a number of
 10 those decisions highlighting what the issue is, what the
 11 intelligence is, what the discussions are and what's the
 12 final decision, I believe that's been submitted as
 13 evidence.
 14 Q. We looked at that log by Mr Rainey this morning.
 15 A. Yes.
 16 Q. There isn't a great deal of detail as to the
 17 decision-making though, is there?
 18 A. Well, he's one commander of the three. I haven't seen
 19 the joint decision model logs of the other Plato
 20 commanders at the forward command point, so I would be
 21 unable to comment on what's contained within those. The
 22 evidence I've looked at is what's contained in
 23 Mr Rainey's log.
 24 Q. You appreciate that the families are very keen to find
 25 out, if they can, what the reasons were for the passage

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1 of time and what might, to them, appear to be delays?
 2 A. I clearly understand that, sir.
 3 Q. And one of the paramedics from the HART team came and
 4 gave evidence and was unable to assist us with any
 5 details as to the reasons for the timing. Was there any
 6 delay or disagreement as to timing between the
 7 individuals involved, between, for example, those making
 8 the decisions and those members of the paramedic teams?
 9 A. So the teams would have just been asked to form up in
 10 their protective equipment. They would not have been
 11 involved in the discussions that took place between
 12 a number of bronze Plato commanders at the forward
 13 control point.
 14 So my understanding is Marc Rainey was one of those,
 15 there was a representative Plato commander from the
 16 London Fire Brigade and there were also representatives
 17 from British Transport Police and the Metropolitan
 18 Police Service.
 19 Q. Do none of these experienced paramedics have helpful
 20 inputs that they could make to the decision-making?
 21 A. Well, sir, the decision-making is made in terms of the
 22 JOP is the Plato commanders. They are the ones having
 23 those discussions. So that is the command structure
 24 that is in there. The specialist teams are the assets
 25 that are used to deploy, so the discussions they're

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1 having are about the use of those specialist assets,
 2 it's not a situation where you've got 21 specialist
 3 paramedics having discussions.
 4 Marc Rainey is the person that was responsible for
 5 those discussions with his colleagues and counterparts
 6 from other services at the forward control point.
 7 Q. {DC5052/1}, please. There was a debriefing, wasn't
 8 there, in relation to what was described as specialist
 9 assets?
 10 A. Yes.
 11 Q. And did that include these specialist paramedics?
 12 A. So those that would have attended that, yes.
 13 Q. At paragraph 5, we can see that in this debrief, which
 14 was just a few days after the incident on 6 July, the
 15 supervisor, the HART supervisor indicated that they
 16 received a courtesy call from EOC -- that's, what, the
 17 emergency operations centre?
 18 A. Yes.
 19 Q. Advising that it was a Plato incident, they had the
 20 expectation that they would be dispatched but not called
 21 and "left to sit".
 22 Can you help us: what was the observation or
 23 possible criticism that was being voiced there?
 24 A. Well, so I think that's probably one individual's
 25 perspective in terms of the supervisor. The emergency

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1 operations centre in terms of when declaration of
 2 a major incident and, indeed, Plato is made, will have
 3 the holistic view of where the resources are and the
 4 attendance that's required, so it could have been that
 5 based on that initial decision, that individual was
 6 asked to stand by.
 7 Q. So it appears to be suggested here that they were
 8 criticising the failure to dispatch them and get them to
 9 the scene swiftly in the first place; is that right?
 10 A. Well, I think the individual is saying that there was
 11 a courtesy call updating them there was a Plato incident
 12 but didn't deploy that particular individual at that
 13 particular time.
 14 But that could have been for a multitude of reasons,
 15 based on the number of assets that had already been
 16 dispatched, and obviously further information coming
 17 through. We had two HART teams and 10 TRU personnel on
 18 duty.
 19 Q. Over on to {DC5052/2}, please, at paragraph 31,
 20 returning to this topic, the HART team that:
 21 "... received the courtesy call advising them of the
 22 Plato incident dressed into their specialist PPE ..."
 23 Is that the protective kit?
 24 A. Yes.
 25 Q. "... and then encouraged EOC to dispatch them to the

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1 scene. After multiple requests and calls ... they were
 2 dispatched."
 3 Again, this rather suggests that there was a sense
 4 of frustration that they weren't being summonsed and
 5 brought to the scene when they expected or wanted to
 6 make their contribution; do you agree?
 7 A. Well, I would agree that that would be a concern raised.
 8 I think what's important to note is that when Plato is
 9 declared, we won't just dispatch resources to the scene,
 10 we will wait for information on RVPs. There were
 11 multiple RVPs, and we do know that the emergency
 12 operation centre when RVPs were set were dispatching
 13 resources to those locations.
 14 Q. But was one of the points being made at this debriefing
 15 that the HART team themselves, these specialist
 16 paramedics, would have liked to have been deployed and
 17 made use of at an earlier stage?
 18 A. Well, so teams that self-deploy, that want to
 19 self-deploy themselves will come through to EOC and say:
 20 we've heard there is something, there's an incident
 21 that's in progress, just send us. But it needs to be
 22 done in a controlled way because a Plato incident has
 23 been declared and therefore there needs to be some
 24 control and grip on who is allocating the resources and
 25 where they're being allocated to. That's part of the

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1 overall management of a major incident that we don't
 2 have resources just self-deploying.
 3 Q. But in these early minutes, timing is critical, isn't
 4 it?
 5 A. So, sir, in any incident timing is critical, but these
 6 resources were not going to be deployed directly into
 7 the scene. There needed to be the structure set up in
 8 terms of the forward command point with the relevant
 9 Plato commanders to do that job, which was to deploy,
 10 assess and deploy those specialist teams.
 11 Q. At {DC5052/6}, please. Towards the end of this
 12 debriefing it was recorded at paragraph 94:
 13 "HART would like to be deployed earlier."
 14 That was the message that was coming across in this
 15 debriefing, wasn't it?
 16 A. So that was a view given in the debrief, yes, sir.
 17 Q. And, indeed, at paragraph 79, on {DC5052/5}, please, one
 18 of the other specialist teams, the TRU -- that's the
 19 tactical response unit; is that correct?
 20 A. Tactical response unit, yes, sir.
 21 Q. At paragraph 79, in the debriefing it was being said:
 22 "It was challenging for TRU remaining on
 23 location/RVP ..."
 24 Is that the rendez-vous point?
 25 A. Yes.

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1 Q. "... people wearing less armour than them are screaming
2 at them to take action."

3 So was there criticism or urgings at the scene from
4 others to get a move on and to deploy these specialists?

5 A. Well, there were two individuals that were working on
6 tactical response units and they were sent as part of
7 the response to the first road traffic collision. So
8 they were not dispatched because they were
9 Plato-trained; it's just because they were the nearest
10 resources being sent to the road traffic collision.

11 Obviously on their arrival the dynamics of the scene
12 have changed, but the fact remains that assets, its
13 EOCs -- when Plato is declared EOC have a set of action
14 cards, our emergency operation centre have a set of
15 action cards, have a systematic way to deploy those
16 assets, to deploy them to the right place and to ensure
17 that we've got the command structure as well covered.

18 So Mr Rainey was paged and was mobile at 22.27. So
19 EOC were already thinking around the deployment of
20 tactical response units and HART assets in terms of
21 getting Marc Rainey as the Plato commander recalled to
22 duty and to make his way to the rendez-vous point.

23 Q. Although you admitted to Mr Hough earlier that one of
24 the things you need to look at is getting a Plato
25 commander on the ground, getting a grip, making

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1 decisions at an early stage?

2 A. So I entirely agree, Mr Patterson, we recalled -- at the
3 time we were recalling Plato commanders to duty that
4 clearly had an effect on how quickly we could get the
5 Plato commanders into a position where those decisions
6 were being made and we've identified that learning and
7 are taking steps to address that.

8 Q. {DC5049/17}, please. One of the other debriefing
9 documents, and we looked at this earlier, about a third
10 of the way down in the debriefing, this document records
11 that:

12 "Both the HART and the TRU were expecting more
13 direction and to be dispatched to a dedicated forward
14 RVP for specialist assets, but instead they were sent to
15 a range of [rendez-vous points] alongside the
16 non-protected responders."

17 So the message that emerged from that debriefing, it
18 seems, was that these specialists were voicing
19 frustrations and criticisms with the management on the
20 night; would you agree?

21 A. No, I don't agree with that statement. I think what
22 they're frustrated about is around the chaotic scene and
23 the multitude of RVPs and information that was coming
24 out which meant there was no single point where those
25 resources were being mustered to because we have HART

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1 resources at both sides of the river, so some were being
2 deployed to the north RVP, which had been established,
3 and some were being directed to multiple RVPs south of
4 the river. That's the situation that we had. We had
5 a very dynamic situation where RVPs were constantly
6 changing and I think that's a reflection on how
7 difficult they found it.

8 Once Marc Rainey had arrived on scene and actually
9 had got to the forward control point, it was very clear
10 around Marc Rainey taking those actions and mustering
11 those TRU teams very quickly. There was a cohort of
12 them already at the RVP north of the bridge, there were
13 others at the RVP south, and Marc Rainey's first action
14 is to get them into a state of readiness and get them to
15 the forward control point.

16 Q. But still we had this period of three hours when nobody
17 went into the courtyard?

18 A. Absolutely. I've agreed that, sir.

19 Q. And for the future, the public who find themselves in
20 a terrorist situation and police constables who find
21 themselves in a terrorist situation will need to
22 recognise that delays of this sort might recur?

23 A. So I think it's important to add that we also had
24 resources there that were non-specialist, that were
25 caught up in that situation. We had a number of

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1 resources originally going to a road traffic collision
2 and ended up putting themselves into a position where
3 they were in a hostile area. I think I've acknowledged
4 in previous evidence that the two areas that are the
5 priority for us as an organisation is how can we more
6 effectively and more swiftly get to the point where we
7 can make decisions around allocation of ambulance
8 intervention teams in a more timely manner.

9 Q. Now, you told us that you have been for some 28 years
10 with the London Ambulance Service; is that correct?

11 A. That is correct.

12 Q. And for 15 years at a very senior level, a senior
13 operations manager; have I got that right?

14 A. So at different levels, yes, sir.

15 Q. Can we see, please, {DC8332/1}. The Times newspaper has
16 reported that around about the time leading up to the
17 2012 Olympics, the Prime Minister himself had concerns
18 about the likely conduct of the service in the event of
19 a terrorist attack. Are you aware of this report,
20 Mr Woodrow?

21 A. No, I'm not, sir.

22 Q. And it has been reported that:

23 "[Mr] Cameron had told the ambulance service that it
24 was unprepared to deal with a potential terrorist
25 incident years before the London Bridge attacks ..."

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1 If we just look down the page, about halfway down:
 2 "The former prime minister accused the service of
 3 being unprepared to take risks after a cabinet security
 4 committee ran a trial before the 2012 Olympics of
 5 a marauding terrorist attack of the type later seen at
 6 London Bridge.

7 "Ambulance officers told the cabinet committee that
 8 they had enlarged the 'hot zone' -- the area around any
 9 such incident that they were not prepared to let their
 10 staff enter to ensure their safety -- as a result of
 11 'lessons learnt' from the [7/7] bombings, according to
 12 a source present at the ... exercise."

13 "During [this] planning 'the prime minister pointed
 14 out that there were likely to be people who survived
 15 such an attack and would need rescuing' ... and [he] was
 16 said to have been 'very angry' at the increase in the
 17 size of the hot zone."

18 And this person, who it seems was present, reported
 19 as follows:

20 "'I will not forget the look on Cameron's face. It
 21 was one of the most dramatic meetings I have ever been
 22 in '... 'The London Ambulance Service had a "we know
 23 better than you" approach which did not go down well.
 24 He asked them to reconsider."

25 Then over, please, onto the next page {DC8332/2}:

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1 "[The Prime Minister's] view was that paramedics
 2 should understand that they might be more at risk than
 3 a member of the public, and that they should be trained
 4 to deal with these kind of attacks.

5 "He considered the idea that the back-up might be
 6 miles away [he was] shocked to find they had had years
 7 to prepare for such an attack and had not done more."

8 Then there were issues about whether there were
 9 enough anti-ballistic vests. Then apparently the Prime
 10 Minister referred to a particular incident in his
 11 constituency in which the emergency services had stood
 12 off for hours during an incident when he believed they
 13 should have gone in, and then other reporting in
 14 relation to what happened at London Bridge.

15 So, first of all, no doubt you were aware from your
 16 experience and your senior position about this exercise
 17 that took place prior to the London Olympics?

18 A. No, I'm not, sir.

19 Q. Can you help us with that report and that suggestion
 20 from someone who was present that there were these
 21 issues raised about the approach that was being adopted
 22 to going into dangerous or potentially dangerous zones?

23 A. So I'm not in a position to be able to reflect on that
 24 particular report. I had no involvement with
 25 an exercise. At the time when we were responding to the

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1 incident at London Bridge in 2017, the LAS had adopted
 2 the incident response procedures, the LESLP guidance,
 3 which all emergency services in London adopt, the JESIP,
 4 joint emergency services interoperability principles and
 5 the JOPs for MTFA. They're all national guidance.
 6 They're all documents that we are held to account for
 7 and regulated by the NHS.

8 So whilst this refers to something historically
 9 before the Olympics, at the time we were responding to
 10 this incident in 2017, they were the documents and
 11 procedures that we were working to.

12 Q. But can you help us with this, at least, Mr Woodrow: can
 13 you see if any records exist of this meeting, and no
 14 doubt you would be happy to disclose them and assist us
 15 with anything of relevance along the lines of what that
 16 reports suggests?

17 A. I certainly will undertake to do that for you, sir.

18 Q. I'm very grateful.

19 So in your statement, the most recent statement that
 20 you have done analysing these issues, you make it plain
 21 that in this sort of situation, no emergency resources
 22 are to be sent into the area, and that there has to be
 23 liaison and there has to be planning and then, if
 24 appropriate, deployment. Is that really what it boils
 25 down to?

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1 A. No, sir, I think that's not a fair reflection on what
 2 I was trying to put across in the statement, sir.

3 What I was saying is that once Operation Plato has
 4 been declared, there are procedures and those procedures
 5 are contained with action cards for both operational
 6 frontline members of staff, specialist and
 7 non-specialist, managers that respond to a declaration
 8 of a major incident or Plato incident, and the staff in
 9 EOC. What I was trying to say is that those procedures
 10 are followed once a Plato incident is concerned, and the
 11 way we deploy assets, once Operation Plato has been
 12 declared, is different from a major incident declaration
 13 that does not have Operation Plato associated to that
 14 incident.

15 Q. But in relation to all this decision-making about
 16 whether you do go in or whether you don't and whether
 17 you go into area A first or area B later, all of this
 18 can make a very significant difference, can't it, to
 19 casualties who are potentially still in these different
 20 locations?

21 A. Absolutely it can, and that's why those decisions are
 22 not taken independently by any one service. That is why
 23 joint emergency interoperability is to get coordinated
 24 decision-making and discussions based on all the
 25 intelligence that the three services have available to

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1 them at the time when the decisions are being made.
 2 Q. Are there any written criteria that help the
 3 decision-makers to make the right decision?
 4 A. Well, I think it's the -- it's depending on the
 5 information that is available, it's also around the
 6 appetite of risk, and the size of that risk, and then
 7 there is a collective discussion and a decision made on
 8 deployment decisions. That's not made arbitrarily by
 9 one commander: it is a collective decision-making
 10 process.
 11 Q. Despite our researches we can find no written criteria
 12 that govern this decision-making. Are we wrong about
 13 that? Are there written criteria or guidance to help
 14 them get to the right decision?
 15 A. No, the joint decision model tool that is contained
 16 within the joint emergency service interoperability
 17 principles is the recognised process on which these
 18 joint decisions are made, and that is documented in the
 19 infographic and in the decision log itself, and that is
 20 completed by all three members -- four in this
 21 particular scenario because there were two tactical
 22 firearms commanders present at the FCP.
 23 Q. But as I think you've agreed already, there were no
 24 detailed notes made of the reasons why they do go into
 25 one area earlier and they do go into another area later.

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1 A. So, yes, all I've been able to provide you evidence on
 2 is the log that I was able to see, which was
 3 Marc Rainey's.
 4 Q. Mr Rainey's?
 5 A. I have no view of any logs from the London Fire Brigade,
 6 the BTP, or the Metropolitan Police Service in terms of
 7 their joint decision model and then logged decisions for
 8 that process.
 9 Q. In your most report, and perhaps if we can look at this
 10 on the screen, it's at {WS5067/1}. If we go, please, to
 11 page 8, {WS5067/8} you dealt with Mr Carlson, the
 12 suggestion at 2.24, that Mr Carlson, one of those TRU
 13 paramedics, made reference to three patients in cardiac
 14 arrest, and you tried to work out who that might have
 15 been?
 16 A. Yes.
 17 Q. And then you say this:
 18 "The log does not record a location being given to
 19 EOC, however, as stated above, had the location of
 20 Boro Bistro been given, the EOC would not have
 21 dispatched any resources to this specific location due
 22 to the declaration of Operation Plato."
 23 Is that correct?
 24 A. So when it refers to "the log does not record", that is
 25 the information that Jacob Carlson transmitted across

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1 the radio into EOC, and what that's referring to is when
 2 that transmission is made, the report of three patients
 3 are in cardiac arrest is in the EOC log, but the exact
 4 location of those patients is not included in the log.
 5 The point I was trying to make subsequently is that even
 6 if that exact location had been recorded in the log,
 7 resources would not have been sent directly to that
 8 exact location, because Operation Plato had been
 9 declared and the procedures once Plato had been declared
 10 is to dispatch those resources to the nominated RVPs
 11 that are provided to us from the Metropolitan Police
 12 Service.
 13 Q. You appreciate, Mr Carlson's evidence was that he was
 14 shouting down at one of the police officers that we
 15 believe was with James McMullan in that dark corner of
 16 the courtyard, below the van; yes? You're familiar with
 17 his statement?
 18 A. I am.
 19 Q. And that there was a cry for help, a request for help
 20 from Police Constable Miah, I think it was, either him
 21 or Police Constable Attwood, who were trying to give
 22 treatment to James McMullan, and the paramedic told him
 23 that help would be coming, and no doubt in reliance on
 24 that they remained for all those minutes that followed
 25 at that location, so not bringing the casualty up to the

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1 ambulances for the assistance that was available, and,
 2 secondly, no doubt putting themselves, those two
 3 officers, at continued risk in that location.
 4 Is it your understanding that this location wasn't
 5 reported by Mr Carlson to the LAS, to the EOC?
 6 A. I can't find any specific information where he makes
 7 that transmission of an exact location of those
 8 patients. I think it's at the time when he is with
 9 Keir Rutherford and Gary Edwards and they're asked to
 10 move off the bridge by armed police, in that segment of
 11 the incident is when that occurs, but clearly
 12 Jacob Carlson, for whatever reason, did not report that
 13 exact location.
 14 Q. So he promised help, but it doesn't look as though he
 15 did anything to provide the help that he had promised?
 16 A. Well, I'm unable to answer why he promised help. All
 17 I'm saying, the facts of the matter is that they were
 18 told to move off the bridge, they complied with the
 19 request, and actually Jacob Carlson went north of the
 20 bridge and then continued to triage and treat other
 21 patients.
 22 Q. But is it your evidence that even this if paramedic had
 23 tried to get help down to the casualty and those police
 24 officers, that it wouldn't have been provided?
 25 A. Well, they were asked to remove themselves from the

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1 bridge by armed police because they deemed it to be
 2 unsafe and there had been a second exchange of gunfire,
 3 which was audible to those personnel.
 4 Q. Well, many, many people remained in that courtyard and
 5 not a single one of them gave evidence about having
 6 heard that or knowing that they had been instructed to
 7 leave.
 8 A. Well, the evidence that I've reviewed does include
 9 evidence including Keir Rutherford shouting down the
 10 stairs telling everyone to get out.
 11 Q. Yes.
 12 A. So they were instructed to move off the bridge by armed
 13 police because the area was deemed to be unsafe.
 14 Q. But you can see no doubt, Mr Woodrow, why the public
 15 might find all of this worrying?
 16 A. Well, I can understand why the questions are being
 17 asked, sir, yes.
 18 Q. And [DC5156/1], please. Some months after the attack in
 19 this PowerPoint document provided by the London
 20 Ambulance Service, if we go, please, to {DC5156/10}, if
 21 we can just expand the right-hand side of the page,
 22 please, one of the points that was being made was that:
 23 "Run/hide/tell [which was] (the national police
 24 guidance) made the tracking of some casualties complex."
 25 What did that mean?

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1 A. So later on into the incident, there were numerous
 2 reports coming in from various locations within the hot
 3 zone of patients not presenting necessarily with stab
 4 wounds but other conditions and we were unable to reach
 5 those patients and it was -- in some of the debrief
 6 there was concern raised by some of the operational
 7 crews that treated those patients that run, hide and
 8 tell, the nature of that meant that the location of some
 9 of those patients was made more difficult by the fact
 10 that people were holed up in various premises and we
 11 weren't aware of it.
 12 Q. And so if a casualty does run to find cover, and finds
 13 a hidden location out of sight, perhaps, in reliance on
 14 what we're all being told, and if they do tell, in other
 15 words, they manage to make a phone call radioing for
 16 an ambulance, and if they're then waiting in the
 17 expectation that the London Ambulance Service will reach
 18 them, they may be in for a long wait, mightn't they?
 19 A. Well, clearly what I've described is a set of
 20 circumstances where the decision to move forward into
 21 hot zone and warm zone areas by the AITs took
 22 a considerable period of time from the initial call, and
 23 I've acknowledged that that's an area that we need to
 24 focus on. This is in relation to comments that were
 25 made around run, hide and tell potentially making the

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1 issue to identify patients that might not have been in
 2 that zone, because we had patients that were living in
 3 residential addresses as well close to that location,
 4 where we were struggling to meet their routine needs as
 5 well, so that's not in specific relation to any specific
 6 patients, but just that run, hide and tell made it more
 7 complex.

8 This is a view, it's not -- it's a view of staff
 9 that came out of the debrief.
 10 Q. But evidence that this court has heard was that one of
 11 the injured casualties with a very serious stabbing to
 12 the neck was Paul Saint-Pasteur, who was attacked in the
 13 courtyard and it was 10.56 before he left the area, and
 14 a second very serious casualty, Helen Kennett, it was
 15 11.01 before she left the area, and in both cases having
 16 remained in that general area near the Boro Bistro and
 17 the Mudlark pub, eventually, having not received any
 18 help from paramedics, they both left, and if they hadn't
 19 left and moved out by themselves, helped by some police
 20 constables, they would have had even greater delays,
 21 wouldn't they, before they ultimately received very
 22 urgently needed treatment?
 23 A. Well, those particular patients that were in that
 24 particular area, there was a considerable time before
 25 AIT teams were deployed. There were other parts of the

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1 incident ground such as the Globe Tavern where
 2 paramedics did go in with armed police and located
 3 patients and actually removed those and took them to the
 4 casualty clearing station and removed them to hospital.
 5 That took a period of time, and this is, as I say, it's
 6 a comment around the tracking of some of those patients
 7 could have been impacted by run, hide and tell. That's
 8 not an organisational view, it's an observation.
 9 Q. Mr McKibbin, the superintendent who made the
 10 declaration, the Operation Plato declaration, was asked
 11 about this issue, about how long all of this
 12 realistically is going to be taking if this is the
 13 approach, and he candidly stated that we have to
 14 recognise that these things do take time; do you agree
 15 with that observation?
 16 A. So I think from my experience, and I've not experienced
 17 an incident of this magnitude and the dynamic nature of
 18 this incident, but my experience from the management of
 19 major incidents is it does take time for command
 20 structures to be put in place. I think what we need to
 21 recognise is ways that we can reduce those delays so
 22 that we can deploy those specialist assets in the
 23 quickest way possible in order to do the most for
 24 patients. I have alluded several times, not just in my
 25 statement but in evidence today, that we are committed

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1 as an organisation to learn with partners how we achieve
2 that.
3 Q. Would you agree with this, Mr Woodrow: that at the
4 minute, the reality of the practice is inconsistent with
5 the golden hour and the imperative of getting treatment
6 to people at a very early stage?
7 A. So I think we are, without sounding disrespectful,
8 trying to conflate two things. I think the golden hour
9 is very important once contact has been made and the
10 initial medical interventions that you make with that
11 patient, but that is taking an assumption that you can
12 access that patient in a safe way and without hindrance
13 to do that, and clearly, when we had the type of
14 incident that we had, there was -- and rightly so --
15 concerns around the safety of the area where some of
16 those patients were contained, and that therefore
17 required structures to be put in place to deploy
18 specialist teams and try to treat patients. That did
19 take time and will always take time. I think my
20 colleague from the Metropolitan Police Service gave
21 an equal commitment that we should work together to see
22 how much we can improve that and I would fully support
23 that.
24 Q. You will be aware of the details of one of the
25 casualties, Sébastien Bélanger, who was down under that

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1 archway in the courtyard; yes?
2 A. I am aware, sir.
3 Q. Are you familiar with the timings and the details of the
4 treatment that he was receiving?
5 A. I'm not familiar with the treatment that he was
6 receiving, sir.
7 Q. But he was there for quite some time with a number of
8 members of the public who were trying to assist him,
9 with a number of police officers who were trying to
10 assist him, and eventually, at something like 10.45 or
11 10.46 they brought him up to the street, and even at
12 that stage they didn't know as they brought him up to
13 the street where an ambulance might be.
14 Now, I want to ask you about HEMS, because we had
15 evidence that a HEMS doctor, Dr Christopher Lambert, had
16 arrived on Tooley Street nearby by 10.25, and Dr Lambert
17 gave evidence that he was there waiting for instructions
18 for a period of time and that he didn't see any single
19 patient at all until 10.53, and essentially he took the
20 initiative himself and went north, drove eventually
21 round over Tower Bridge to the north bank of the river
22 and offered his services on the north end of the bridge.
23 Can you help with why the opportunity to make use of
24 that HEMS doctor was not taken for those casualties in
25 the courtyard?

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1 A. Well, for the same reason that the resources -- that
2 area was declared as being unsafe, that's why our
3 personnel moved away from that area. I do know that
4 Dr Lambert was involved, and Dr Lambert would have had
5 one of the LAS paramedics with him as part of that duty
6 that night in the car, and I know there were a number of
7 interactions, but, you're right, they were sent to
8 an RVP to wait further instructions; they were not
9 committed to the scene like we were not committing any
10 of our own specialist resources or non-specialist
11 resources directly to locations within the incident
12 ground.
13 Q. So for Sébastien Bélanger, for example, there wasn't
14 just a missed opportunity to get up early onto the High
15 Street and take advantage of paramedic resources, there
16 was also a missed opportunity to have the very
17 specialist intervention, perhaps, of a HEMS doctor.
18 A. Well, that is conjecture, sir. At the time we were
19 deploying resources to the RVP and that would have
20 included HEMS. They don't have authorisation to just
21 self-deploy into those, they are under control of the
22 emergency operation centres when they're deployed.
23 Q. Now, you looked with Mr Hough at some of the early
24 reports mentioning the Boro Bistro, one at 10.11, making
25 reference to a stabbing, and one at 10.16, making

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1 reference to a female who was bleeding in the
2 Boro Bistro. Another example, please, {DC5224/1}, again
3 at an early stage this is a CAD message that was
4 answered at 22.15, again making reference to the
5 Boro Bistro; do you see that?
6 A. Yes.
7 Q. Again making reference to a suspected terrorist attack,
8 and making reference to somebody having had their throat
9 cut, if you look down towards the bottom of the page.
10 A. I do.
11 Q. And on to page 3, please, of this document {DC5224/3},
12 it was made plain what the location was, down towards
13 the bottom of the page, that it was next to the
14 Borough Market, so the name of the location, again, was
15 given, Boro Bistro, and assistance in locating it next
16 to Borough Market; do you see that?
17 A. I do.
18 Q. And so there were also requests, weren't there, for the
19 London Ambulance Service to come to the Mudlark, to the
20 pub that was just next to the Boro Bistro restaurant.
21 A. Yes, sir.
22 Q. And Mr Beasley, who was the IRO, the incident response
23 officer?
24 A. Correct.
25 Q. Who was there some time between 10.20 and 10.27, he gave

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1 evidence to the court that none of this information
 2 about those various radio requests, none of that
 3 information reached him. Can you help us with why that
 4 was?
 5 A. So --
 6 Q. Repeated references to that particular location.
 7 A. So I'm not aware of what radio transmissions. I think
 8 Mr Beasley was aware of patients in that location,
 9 although not necessarily from radio transmissions. As
 10 I've described this morning, we were seeing a huge
 11 number of calls, 134 in the first 45 minutes, that were
 12 giving us various locations. At the time Mr Beasley
 13 arrived, I would not be surprised that actually he was
 14 not getting exact locations of those patients from our
 15 EOC. I described this morning the difficulty that we
 16 have when we're receiving such large numbers of 999
 17 calls and physically trying to tie all that information
 18 up and then get that information given to people on the
 19 scene in addition to Plato being declared in that time
 20 between 22.11 and 22.27 when I think Andy Beasley
 21 arrives on the scene.
 22 Q. But especially given the declaration of Plato and the
 23 importance that that means, surely it would have been
 24 possible for him to have been told over his radio: there
 25 are reports coming in of stabbings in and around the

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1 Boro Bistro. Why couldn't something as simple as that
 2 have been communicated to him, the man in charge on the
 3 scene on the south bank of the river?
 4 A. Well, there were lots of radio communications being
 5 sent. What exactly went to Andy Beasley I cannot be
 6 sure, but there were lots of radio transmissions being
 7 sent at that time and there was lots of information
 8 around the location of patients.
 9 So we didn't have just one focused area around the
 10 Boro Bistro. I was trying to explain this morning that
 11 we were having multiple calls in multiple locations in
 12 the London Bridge/Borough High Street area, and that was
 13 the difficulty we had in trying to rapidly analyse that
 14 information, put it all together, try to link it to
 15 a running CAD and then get that information out to
 16 people on the ground.
 17 In addition, when Plato was declared, the people in
 18 the control room, their focus was then to implement the
 19 actions required within the control room and
 20 operationally in terms of the set process and steps that
 21 we need to take once a declaration has taken place.
 22 Q. {DC5066/1}, please. He told the court that these
 23 procedures governed his work; you would agree?
 24 A. They provide guidance to his work, yes.
 25 Q. Page 61, please {DC5066/61}. He accepted that he was

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1 the extraction officer, so the officer who had
 2 responsibility for the removal of patients in
 3 an appropriate way, for logging the number and location
 4 of casualties, as we can see in that first bullet point,
 5 that require recovery, to request teams to deal with
 6 issues such as, for example, entrapment, and to deal
 7 with carrying of patients.

8 As this summary of his duties sets out, if we look
 9 at the end of that section for extraction officers, it
 10 makes plain that:

11 "A dynamic assessment should be made by the
 12 [extraction] officer on what those teams need to look
 13 like."

14 So these are multi-agency teams to carry out this
 15 work; yes?

16 A. Yes, I think what we need to be clear here is that these
 17 are the procedures that would be used when Plato was not
 18 declared. The fact that Operation Plato was declared
 19 adds another layer to complexity over this because in
 20 actual fact, what Andy Beasley was doing at the time
 21 actually was trying to locate patients: they were
 22 treating patients, Andy Beasley did set up a casualty
 23 clearing station, he did radio for orthopaedic
 24 stretchers and carry sheets to identify patients and get
 25 them to the casualty clearing station.

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1 The difficulty once Operation Plato was declared is
 2 that that changes the dimension of the incident and
 3 those assessments around how far and what -- how far you
 4 go in based on your risk assessment of safety, and there
 5 is evidence to say that Andy Beasley on several
 6 occasions quoted that there was gunfire and that there
 7 were active shooters within the area that you describe.

8 So that's why Plato, the first actions in Plato are
 9 to page the necessary commander and get that commander
 10 going to the scene, because that's now how we will deal
 11 with patients in those areas that are deemed to be high
 12 risk, is the committal of those specialist teams.

13 Q. Mr Woodrow, you say all that about the efforts he was
 14 making to locate casualties, but he was asked in his
 15 evidence:

16 "Question: Did you apply your mind, never mind
 17 note-taking, did you apply your mind to locating the
 18 people ...?"

19 And his answer was "No".

20 A. I can't comment. What I know in evidence is there was
 21 a significant number of patients treated at the casualty
 22 clearing station at St Thomas Street. Those patients
 23 were triaged, treated. Some of those were severely
 24 injured and they were removed to hospital. So to say
 25 that they were not actively extracting patients -- now,

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1 they might not have done the physical extraction because
 2 we do know that some of those patients were extracted by
 3 members of the public and they were extracted by police
 4 service colleagues that were on the scene, but the
 5 process for triaging, treating those patients and
 6 getting them to hospital was carried out in the way that
 7 is described within the incident response procedures.

8 The issue around those patients in areas, not just
 9 the Boro Bistro but other areas within Borough Market,
 10 that was an issue that Operation Plato and the zoning of
 11 those issues, whether they were deemed to be safe or
 12 unsafe, and we have had evidence from some of those
 13 colleagues when they were at that particular area by the
 14 van that they were asked to evacuate that area and
 15 that's why the Plato commander was dispatched to
 16 coordinate the response into those zones using
 17 specialist committal teams.

18 But it's not Mr Beasley as the bronze sector or
 19 bronze extraction, according to the IRP procedures, to
 20 make deployment decisions to go into unsafe areas,
 21 that's what Plato command joint tri-service officers at
 22 the forward command point do.

23 Q. He accepted, eventually, that he was responsible for
 24 logging, as this document records, that he was as the
 25 extraction officer responsible for logging the number

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1 and location of casualties that require recovery. Now,
 2 you would agree that that is a very important and
 3 desirable thing in a marauding terrorist attack like
 4 this?

5 A. Well, so I would say his actual role in terms of bronze
 6 extraction within these procedures are that actually, as
 7 bronze sector, he takes on a number of roles, so he's
 8 trying to discharge three roles until he gets further
 9 officer support allocated to those roles.

10 Q. Yes. The importance of finding the casualties barely
 11 needs to be set out in writing. It's blindingly obvious
 12 that it's vital to find out where the people are who
 13 need urgent help, isn't it?

14 A. So, I'm not being difficult and I'm not trying to
 15 disagree with you, the complexity of this incident was
 16 that Operation Plato had been declared above, we had the
 17 resources that had been told to evacuate the area. That
 18 changed the way -- that information was very dynamic in
 19 terms of the reports were coming through the MPS control
 20 room, the reports that were coming in through BTP, it
 21 was a very dynamic situation and the way to deal with
 22 that was not through Andy Beasley, it was to mobilise
 23 the Plato commander, put the joint operating procedures
 24 that are in for an MTA once it was been declared, and
 25 that would be the way to extract those patients.

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1 So I think it would be very difficult for
 2 Andy Beasley, given what he was confronted with when he
 3 arrived, to be able to undertake all of that information
 4 when we've heard that the Met Police had 400 CADs in
 5 relation to this incident, we had 134. He just
 6 physically wouldn't have the capacity to be able to note
 7 everything, and there were patients being presented to
 8 him and information coming from people on the ground as
 9 well.

10 Q. So if not Mr Beasley who was in charge, who should have
 11 had responsibility for locating casualties?

12 A. So Mr Beasley was, as bronze sector, locating casualties
 13 and treating casualties. So whilst we're focused, and
 14 I fully understand why we are focused on that particular
 15 area, there were a large number of patients that were
 16 involved in that incident with severe injuries that were
 17 treated at casualty clearing stations that were set up
 18 by Mr Beasley, Mr Lesslar and other colleagues and there
 19 were equally patients treated at the casualty clearing
 20 station north of the bridge.

21 The responsibility for locating patients within the
 22 areas of high risk, warm and hot zones, was for the
 23 joint Plato commanders to make at the forward control
 24 point and using the committal of specialist teams to do
 25 that.

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1 Q. You've told us that they don't arrive and get started
 2 until some time after 11 o'clock?

3 A. Yes.

4 Q. When we are well beyond golden hour?

5 A. Yes, and I think we've acknowledged the difficulty with
 6 the golden hour in terms of a patient that is accessible
 7 and needs rapid treatment and indeed we saw patients
 8 that had the minimal of treatment delivered to them when
 9 they were presented to LAS personnel and they were
 10 removed to hospital and the right hospital as quickly as
 11 possible, but that is on the assumption that you can
 12 make safe access to those patients and it was deemed in
 13 that particular area not to be safe to commit
 14 non-protected staff into that area to deliver that care.

15 Q. {DC7820/1}, please. We have been told that this is
 16 an Operation Plato, something called a call taker
 17 aide-memoire; is that correct?

18 A. Yes.

19 Q. And is this an aide-memoire so that when a person who is
 20 operating -- who is receiving incoming calls, has
 21 a report of a marauding terrorist attack, they will have
 22 these reminders in front of them so that they can elicit
 23 as much relevant information as possible from the
 24 caller?

25 A. Yes, that is the idea. Once Plato has been declared and

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1 those cards are distributed, it is designed to help
 2 call-takers, because I think what's important to realise
 3 is that although the management of the incident is taken
 4 out of the main control room and put into our specialist
 5 operation centre, any subsequent 999 calls in relation
 6 to this incident will just be targeted to the first
 7 available call handler that is available in the
 8 emergency operations centres, and that could be a call
 9 handler sitting in our control room at Bow. So it's not
 10 necessarily going to be apparent to those particular
 11 people that locations are important, which is why these
 12 action cards are, or aide-memoires are distributed once
 13 Plato has been declared.

14 Q. And in that middle section under the heading
 15 "Documentation. Listen, ask, record & communicate", the
 16 very second bullet point that they are reminds to deal
 17 with is how many casualties and the exact locations, for
 18 example room numbers or where in the building if it is
 19 that sort of marauding terrorist attack. So identifying
 20 where the casualty is crucial, is it not, in the
 21 early minutes of any of these sorts of attack?
 22 A. It is, but in the very early minutes of this attack,
 23 Plato had not been declared and these aide-memoires
 24 would not have been distributed to staff. So in the
 25 very early stages of this incident, call handlers were

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1 just taking routine 999 calls and trying to get as much
 2 information down as they could.

3 Q. You told us about the various CAD messages and the
 4 influx of information, and you were asked about linking
 5 the information as to locations and, as I understand it,
 6 what you were saying was that with every subsequent
 7 incoming 999 call where further locations are being
 8 reported by members of the public, that that isn't being
 9 recorded and added to the main CAD to expand upon the
 10 knowledge of where these casualties are positioned.

11 A. Well, that's what I was saying is the process is that
 12 once we've got ourselves a running CAD, the actual
 13 dispatch or the computer system will recognise that it's
 14 in the broad location of the running CAD. What we have
 15 to physically do manually, though, is to try to analyse
 16 that information and understand whether that is directly
 17 linked to the running CAD, or if it's a completely
 18 unrelated incident, and what I was trying to explain
 19 this morning was given the volume of 999 calls in a very
 20 short space of time, that process to duplicate those
 21 calls and get the information associated with the
 22 running CAD took a period of time.

23 Q. If all of this were to happen tomorrow, hopefully the
 24 CAD would be updated with the additional details as they
 25 came in of further locations and geographical places; is

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1 that right? Have the changes now been made so that this
 2 problem doesn't recur?

3 A. So we have highlighted to EOC staff the importance of
 4 locations. We haven't -- this is a problem that, you
 5 know, we as a service are struggling with, because when
 6 you get high volumes of CADs with lots of information
 7 which is conflicting, so there were some people, just
 8 like we had responders that weren't familiar with the
 9 area, we also had a lot of information that was not
 10 consistent. I'm accepting that there were a number of
 11 CADs that mentioned Boro Bistro and said it was in
 12 Borough High Street near Borough Market, but we also had
 13 lots of information that was inconsistent, people not
 14 knowing where they were.

15 We just physically do not have the resources
 16 currently to have a large cadre of people waiting for
 17 an incident like this to happen to enable us to process
 18 that information, because the separate 999 calls will be
 19 going in to just the first operator that's made
 20 available, and they're generating information which then
 21 goes into a dispatch group, and that information has to
 22 be examined by the allocator, try to work out whether it
 23 is a linked incident or whether it's an unrelated
 24 incident, and that takes time, and that's one of the
 25 issues, apart from the deployment of ambulance

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1 intervention teams, that needs more work for us.

2 Q. Superintendent McKibbin gave evidence that these issues
 3 about geography and locations and visibility and
 4 topography, as he described it --

5 A. Indeed.

6 Q. -- were not new and that particularly in the 2008 Mumbai
 7 attacks the lessons to be learned from that incident had
 8 fed into his training, which had involved exercises,
 9 more than one, between the Metropolitan Police and your
 10 organisation, all before the night in question.

11 A. So it is a difficult problem and this has brought it
 12 into stark view again, but it is not a problem that is
 13 easily resolved.

14 I think also you have to take it into the context
 15 that when we were receiving these calls, 999 calls from
 16 the rest of London didn't stop, so although I keep
 17 talking about 134 calls in that particular hour from
 18 22.00 to 23.00 we took well over 400 calls that were all
 19 requiring emergency responses. So it has to be taken in
 20 the context of the operating environment and the
 21 resource levels that we have on a day-to-day basis,
 22 which requires us to take time when you get these
 23 extraordinary events to try to pin all that information
 24 together and make sense of that and get some situational
 25 awareness, which I was describing this morning.

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1 Q. Superintendent McKibbin gave evidence that those
2 training exercises that had taken place with the London
3 Ambulance Service had addressed issues as to extraction,
4 so that this whole business about locating the
5 casualties and extracting them, all of that would have
6 been gone through in the training with the London
7 Ambulance Service before the London Bridge attacks. So
8 it was nothing new.

9 A. Well, except that training exercises are one thing where
10 you practice principles. What you can't do is ever set
11 the procedure that will actually address all the issues
12 you face on the night or on the day when you are faced
13 with dealing with that incident. I've also heard
14 Superintendent McKibbin telling -- giving evidence and
15 explaining the chaotic scenes there were and the
16 conflict of information that was happening and, indeed,
17 the size of the incident ground and the multiple
18 locations contained within that, and actually the
19 requirement for time to build up a picture that gives
20 you the situational awareness in terms of getting
21 a command and grip of it, as he described, and then
22 actually committing teams within those areas.

23 I think, you know, we have to look at it in the
24 reality of what occurred that night. It was very
25 dynamic and whilst hindsight is a wonderful thing and

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1 there are lessons that we can learn, undoubtedly -- and
2 I've been very open and honest about where those lessons
3 need to be focused on -- we do have to take it in the
4 operating context on the night where I believe my staff
5 did a really good job and as a result of what they did
6 we had over 40 patients, 19 of which were critically
7 ill, were removed from that scene and taken to hospital
8 and survived.

9 So whilst the loss of life is regrettable, and there
10 are lessons to learn, I think we have to understand
11 there was an awful lot done that night for patients in
12 really difficult circumstances, but nevertheless,
13 learning needs to take place.

14 Q. But Mr Woodrow, your senior LAS management figure on the
15 south side of the bridge in those crucial early minutes,
16 Mr Beasley, hadn't even been trained in Operation
17 Plato --

18 A. No, so ...

19 Q. -- he told the court?

20 A. Sorry?

21 Q. He told the court?

22 A. Yes, so he was an incident response officer and he was
23 not, at the time of that incident, was not the cadre of
24 officers that were trained to be Operation Plato
25 commanders, and I've described the process of recall to

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1 duty for those commanders to oversee Operation Plato
2 deployments. Mr Beasley wasn't one of those officers.

3 Q. He said in his evidence that it would have been helpful
4 if he had been aware of Plato guidelines for dealing
5 with marauding terrorist attacks, and he said that would
6 have been helpful but he is not trained in Plato so he
7 couldn't respond to it. Those were his answers when he
8 gave evidence to the court?

9 A. So in relation to your first point, the incident
10 response procedures that we publish for managers and
11 staff in our organisation does describe Plato and active
12 shooters, it does describe what will happen when
13 an Operation Plato is declared. I accept that
14 Andy Beasley was not trained. I think what Andy Beasley
15 was relating to that if he was a Plato commander then
16 perhaps something more could have been done in terms of
17 deploying ambulance incident teams in a more timely
18 manner. I think that's a point that we as
19 an organisation have acknowledged and we're putting
20 steps in train now to ensure that those HART supervisors
21 and HART managers do have that training to deploy those
22 people.

23 Q. Superintendent McKibbin, who has drafted a lot of the
24 documentation about guidance for Plato incidents, stated
25 that the first LAS person at the scene needs to be able

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1 to deal with these situations if they arise. You would
2 no doubt agree with that evidence?

3 A. Well, what I agree is that we have a first predetermined
4 attendance which includes people that are able to make
5 the decision at the forward command point that can
6 deploy ambulance intervention teams more timely.

7 Q. Would you agree that the first LAS person on the scene
8 needs to be able to deal with these situations if they
9 arise?

10 A. No, I don't agree with that, sir, because it could be,
11 actually, just an ambulance crew or a member of staff in
12 a single response, such as a motorcycle.

13 So it would be impossible for us to train 3,500
14 people to become Plato commanders with the level of
15 training they need, the level of exercising, the
16 revalidation they need, that would just not be
17 practical. So what we have done is look at ways that as
18 part of the predetermined attendance to a major
19 incident, which is assets that are already on duty,
20 whether we can use those assets and train those people
21 to be able to deploy in a more timely manner.

22 Q. So if there was an attack tomorrow the first person on
23 the scene who might for the first hour have bronze
24 extraction responsibilities might yet again, like
25 Mr Beasley, be somebody who is untrained in Operation

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1 Plato, in marauding terrorist attack procedures?
 2 A. No, that's not what I'm saying, sir, what I'm saying is
 3 our tactical response unit supervisors and our HART
 4 teams, which are on duty 24/7, we have a national
 5 specification and we're held accountable to ensure that
 6 we provide that level of provision seven days a week,
 7 365 days a year, we're talking about those people being
 8 trained to give the authorisation to deploy and commit
 9 ambulance incident teams. So whilst it might not be the
 10 first person on scene, HART and TRU are part of a
 11 predetermined attendance to a Plato attack and a major
 12 incident and therefore we've decided to train those
 13 people to take the deployment decisions before the
 14 arrival of the bronze Plato commander.
 15 Q. Mr McKibbin's understanding had been that all responding
 16 agencies at all grades were aware of what a marauding
 17 terrorist attack was and what it meant to be involved in
 18 a response to it.
 19 From what you've said it sounds as though your
 20 agency at all grades was not aware of what a marauding
 21 terrorist attack was and what the response should be.
 22 A. Well, the fact that Mr Beasley relates to Operation
 23 Plato would mean that he does have some awareness about
 24 what a marauding terrorist attack was, and, as I have
 25 said, every member of staff is issued with guidance and

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1 action cards which are very clearly defined around
 2 actions in a normal major incident and then additional
 3 actions to be taken or the additional things to be aware
 4 of once Operation Plato has been declared.
 5 Those guidance cards are distributed to each member
 6 of staff and each manager and signed for to say that
 7 they've been received.
 8 Q. Mr Beasley told the court that he wasn't aware of the
 9 casualties in the courtyard and that to this day he was
 10 unaware of the courtyard where all this activity took
 11 place. Does the London Ambulance Service take seriously
 12 the importance of learning lessons from attacks like
 13 this?
 14 A. So, sir, as the director of operations, I do take this
 15 incredibly seriously and this process has been very
 16 helpful in terms of highlighting issues, deep-rooted
 17 issues that I had to dig further and further in to find
 18 evidence on to highlight these issues. So the ambulance
 19 service as part of the London emergency services takes
 20 this very seriously and we are committed and I've
 21 produced evidence in terms of learning that we've
 22 undertaken since those incidents, that learning is
 23 ongoing and, as you know, there was a subsequent number
 24 of attacks that year, so the process of learning doesn't
 25 stop. We seek to continually improve, and this process

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1 will be another process that helps us to achieve that in
 2 conjunction with our emergency service partners.
 3 Q. If all that's correct, Mr Woodrow, why is it that your
 4 senior figure on the scene, on the south bank for about
 5 the first hour, was unaware to the day that he gave
 6 evidence about the courtyard where five of the eight
 7 people who died were killed?
 8 A. Well, I can't answer why Mr Beasley does not know about
 9 that at this time because it's been subject to a great
 10 deal of investigation in the organisation, and I think
 11 I've evidenced the amount of debriefing and multi-agency
 12 debriefing we've done that have looked at the range of
 13 issues that we're discussing here today.
 14 Q. We had evidence that police officers were calling up
 15 from the courtyard about help, that didn't reach him.
 16 We've had evidence of those CAD messages asking for help
 17 to the Boro Bistro, that didn't reach him, he told us.
 18 We've heard evidence about the tri-service telephone
 19 call at 10.22 that remained open for quite some time,
 20 you told us, that didn't cause the officers in the
 21 courtyard to be notified of the presence of the
 22 resources.
 23 We've heard about the ES5 channel, that command
 24 channel that was open to the LAS and the police, and
 25 again, despite that, still the message didn't reach the

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1 police officers in the courtyard about the presence up
 2 on the High Street of these ambulances. There was
 3 a failure, wasn't there, in any procedure or system to
 4 give early notification to those police officers about
 5 where the ambulance resources were; would you agree?
 6 A. Well, what I would say is that actually where the
 7 resources were was where we were being directed to place
 8 those resources. So the RVPs were set as part of the
 9 declaration, so it wasn't that we were withholding
 10 information: we were complying with requests to send
 11 resources to the RVP. I acknowledged this morning in
 12 evidence that there were indeed issues around people in
 13 that particular area of Borough Market that were trying
 14 to tend to victims to understand where those resources
 15 were, but actually we were sending those resources to
 16 the RVPs we'd been directed to send them to.
 17 Q. Yes, but you can't shift responsibility onto members of
 18 the public or police constables down on that courtyard
 19 to know: well, there must be an RVP, therefore I can
 20 safely bring my casualty up onto the street confident
 21 that there will be an RVP?
 22 A. Sir, I wasn't shifting responsibility: there was clearly
 23 a breakdown of communications in that stage around where
 24 the resources were, but what I'm saying is that there
 25 were a number of channels that were open for agencies to

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1 exchange information, because the first information that
2 we got around a potential terrorist incident came across
3 on the ES5 Airwave channel. I can't find any evidence
4 of any request on ES5 asking our special operations
5 centre what the location of the ambulances were. I've
6 looked for those transmissions and I cannot find them.

7 So there were channels open for those questions to
8 be answered and I can't answer why all of those channels
9 weren't used and I accept -- and I accepted this
10 morning -- that's another key area that we need to learn
11 and perhaps it is something that we need to permanently
12 co-locate in a special operations room to ensure that we
13 do coordinate all that information and we do have
14 visibility of each other's assets. I've acknowledged
15 that this morning and I would be happy to explore that
16 with emergency service partners, as I've said this
17 morning.

18 Q. Mr Woodrow, Mr Hough took you to a document,
19 a debriefing document, that made it plain that your own
20 people didn't even have a clear understanding of where
21 these RVPs were.

22 A. Well, no, I think that's actually not quite what that
23 document said. I think there was confusion around RVPs
24 because there were multiple RVPs, multiple RVPs given
25 for our resources to muster at because of the dynamic

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1 situation that we were facing, and there was information
2 coming in of various threats such as IEDs, active
3 shooters, even descriptions of outstanding active
4 shooters armed with assault rifles, and therefore, RVPs
5 were very much being moved around and there was a lot of
6 communication around trying to confirm where those RVPs
7 are. I think it's just the nature of the chaotic scene
8 that we were trying to deal with, that as the threats
9 seemed to move, RVPs were being moved to try to keep
10 responders, and that's not just LAS responders but
11 responders in general, safe from immediate risk.

12 Q. Mr Woodrow, all marauding terrorist attacks will involve
13 chaotic scenes, won't they?

14 A. Yes.

15 Q. It's something that's to be expected?

16 A. Well, I think it is, but I think it's essential to
17 understand that you cannot make sense of that chaos in
18 very quick time. We need to get resources there, we
19 need to get information, we need to get situational
20 awareness. It's not something that can be achieved when
21 we have got resources already deployed across London on
22 a very busy Saturday night, it's just not realistic to
23 expect that we can get 100, 150 people into an area in
24 the first 10 minutes of an incident, all of that takes
25 time, and I think Superintendent McKibbin also

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1 acknowledged that in terms of the deployment of police
2 service assets as well.

3 Q. The knowledge that these things are chaotic is why we
4 need procedures for these things, and the reason why
5 nobody down in that courtyard was notified of the
6 location of the resources is because you had no specific
7 procedure for giving early notification of the location
8 of your resources. There was an absence of a system or
9 a procedure --

10 A. No, sir --

11 Q. -- to give notification?

12 A. Sir, I disagree with that, because outside of this major
13 incident we deal with 1.2 million incidents a year where
14 we get our resources to multiple patients, to multiple
15 incidents, so it wasn't a failing of having procedures,
16 because those procedures serve us well. The issue that
17 we had on that night is that we were overflowing with
18 information which was conflicting.

19 We also had information in relation to the safety of
20 scenes, and that's what made it difficult, and I've
21 acknowledged that actually to try to get through that
22 information in a timely manner when you're getting such
23 a large volume of calls is difficult and indeed it does
24 take time.

25 I know that's not necessarily the answer that you

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1 would like, but that is the reality when you're dealing
2 with a major incident, and what I have acknowledged is
3 that we need to do more work, using some of the means
4 that I've described this morning, to see if we can make
5 that process a more timely process so that we can
6 identify patients in a quicker way, that we can commit
7 specialist resources to provide treatment to those
8 patients and that's the two key areas that I keep
9 referring to that we as the London Ambulance Service and
10 an emergency service partner will look to improve as
11 a result of this process.

12 MR PATTERSON: My Lord, I don't know what time you are
13 thinking of for the mid-afternoon break, but I do have
14 a little more still to cover and it may be that a break
15 at this stage would allow me to --

16 THE CHIEF CORONER: Yes, we've got two more witnesses to get
17 through, so I know we are going to have a late session
18 anyway, but we will take a break there, but I am going
19 to suggest we just have a 10-minute break,

20 Mr Patterson --

21 MR PATTERSON: Yes.

22 THE CHIEF CORONER: -- so that we have time to, as I say,
23 address the other witnesses that I know are waiting.

24 MR PATTERSON: Yes, of course.

25 (3.21 pm)

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1 (A short break)
 2 (3.34 pm)
 3 MR PATTERSON: Mr Woodrow, you appreciate that until a few
 4 days ago the families that I represent were unaware that
 5 Mr Beasley had any knowledge of the casualties in the
 6 courtyard. That was the effect of the evidence that he
 7 gave to this court. Are you aware of his evidence?
 8 Have you read the transcript?
 9 A. Yes, I have.
 10 Q. However, a few days ago we received disclosure of
 11 a recording of a radio message that features Mr Beasley
 12 and you touched upon this earlier. It's {DC8321/1},
 13 please, if we could see it once again on the screen.
 14 Your assessment is that this was made at about 10.30 in
 15 the evening; is that correct?
 16 A. Yes, it will be on the CAD log, radio transmission on
 17 the log, and the transmission obviously was transcribed.
 18 Q. And in this we can see about six or seven lines down,
 19 "AB", so Andy Beasley, saying that he had been
 20 approached by firearms teams:
 21 "... we need LAS down the staircase I believe ... on
 22 the south side."
 23 And so your evidence is that it's understood that
 24 that's a reference to that area down the stairs which
 25 lead down towards the Boro Bistro?

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1 A. So whilst we can't be conclusive on that, it would be --
 2 it would be my assumption that that was indicating that
 3 general area.
 4 Q. So if that's right, there can be no suggestion that this
 5 was somebody who was overwhelmed with the chaos or
 6 unaware of the presence of the casualties for whatever
 7 reason. If that's right, this is somebody who was made
 8 aware specifically of the casualties in that general
 9 area, down below street level; yes?
 10 A. Well, so what Andy Beasley was told by firearms teams is
 11 that they believed there was casualties down a staircase
 12 on London Bridge.
 13 Q. So if that's right, given that knowledge, given that
 14 awareness of the casualties down off street level, the
 15 next question then is what steps did he take to try to
 16 secure their extraction?
 17 And we have seen no evidence of any actual steps by
 18 that bronze extraction officer to have them extracted;
 19 can you identify or pinpoint any such evidence?
 20 A. So what I will say is that he has been given that
 21 information by a firearms team, he then quantifies that
 22 he believes that that area is still unsafe, "active
 23 shooters", that is there, he's reporting that
 24 information to EOC and he's asking for carry sheets,
 25 orthopaedic stretchers, and he's asking for ambulances

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1 to be brought forward from the RVP.
 2 So whilst I don't believe Andy Beasley was
 3 conscious, fully conscious that these were patients that
 4 were located in the area of Boro Bistro, it was clear
 5 that firearms teams had come to him and said that there
 6 was patients at, or there was a patient down a staircase
 7 south side of the bridge.

8 What Andrew Beasley goes on to do then is to
 9 acknowledge that. He does make a request to EOC to
 10 bring ambulances forward from an RVP and he also makes
 11 requests for further carry sheets and orthopaedic
 12 stretchers, talking about extracting patients and
 13 getting them to the north side.

14 But I must stress that when he talks about that
 15 particular area down the staircase, he quantifies that
 16 with he doesn't believe it's safe, "active shooters",
 17 and EOC as a result of that turn around and say: we're
 18 not going to deploy directly to that location, we'll get
 19 vehicles down to the RVP, and it is at that point that
 20 there is an interjection from a clinical team leader
 21 John Rice, who is at Bridge Street, Southwark,
 22 interjects, hearing that radio transmission and asks for
 23 permission for EOC to go forward because he had five
 24 ambulances with him. That permission was granted by EOC
 25 to move forward and there was a conversation between

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1 Andy Beasley and the clinical team, John Rice, as to
 2 where the appropriate place would be and would their
 3 route that they were taking from Bridge Street,
 4 Southwark, be safe?
 5 Q. How on earth could Mr Beasley have been unaware of all
 6 of this detail and have told the court on the contrary
 7 that he was unaware of these casualties in that general
 8 area; can you help us?
 9 A. So I'm not saying that Andy Beasley was consciously
 10 aware of patients in that area; I was saying that Andy
 11 Beasley was getting information from lots of sources,
 12 including some information around [assistance] being
 13 required at the bottom of the staircase.
 14 What he does with that information is that he gets
 15 on to EOC and reports that to EOC and he requests
 16 a number of resources, physical assets in terms of
 17 ambulances. So from that, Andy Beasley is trying his
 18 best in a difficult situation to try to extract patients
 19 that he can, and he requests the equipment and he also
 20 informs EOC that they're going to start to evacuate
 21 patients to the casualty clearing station on the north
 22 side of the bridge.
 23 So to say Andy Beasley was not actively trying to
 24 manage casualties, was not actively trying to locate
 25 patients, I don't think is truly accurate. I don't

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1 believe he knew that those patients were in the
 2 Boro Bistro area, but he was getting information about
 3 a number of patients and clearly that information also
 4 gave him some information around the safety of that site
 5 because he immediately in that transmission talks about
 6 "I don't believe it's safe, active shooters".
 7 Q. In the next paragraph we have following that EOC
 8 speak: "Yer, Roger", and speak about the current
 9 situation; do you see that paragraph?
 10 A. Yes.
 11 Q. And in that response to him revealing about the need for
 12 the LAS to go down the staircase, what he's being told,
 13 if you read to the end of that response, is that they:
 14 "... won't send anyone into you yet, but get them to
 15 RVP ..."
 16 In other words, he is being advised or instructed to
 17 do what he should obviously do is get them out,
 18 extricate them and get them to where the ambulances are,
 19 but he still doesn't do that, does he?
 20 A. No, that isn't actually what is being described there,
 21 sir, it's actually EOC saying they will not deploy
 22 resources into that area because of Andy Beasley saying
 23 there are active shooters. What EOC do turn round and
 24 say is that they will send further resource into the
 25 RVP. That's not the same as extracting the patients and

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1 taking them to the RVP. Andy Beasley set up a casualty
 2 clearing station at St Thomas Street junction of Borough
 3 High Street. The RVP that was serving that casualty
 4 clearing station, well there were a number, were
 5 Elephant and Castle, Bridge Street in Southwark, and
 6 then we had King William Street north of London Bridge,
 7 which was servicing ambulance assets for patients that
 8 were being evacuated to the casualty clearing station
 9 north of the bridge.
 10 Q. But in the minutes that followed this at 10.30, so at
 11 10.35, 10.40 and 10.45, still the police officers down
 12 in that courtyard weren't told by anyone from the LAS of
 13 the arrival of the ambulances up on the High Street,
 14 were they?
 15 A. No, but you would read from the evidence that the
 16 firearms team that informed Andy Beasley there was
 17 a patient down on a staircase south of the bridge would
 18 be aware of where ambulances were because they were with
 19 Andy Beasley at the casualty clearing station when that
 20 conversation took place.
 21 Q. And Mr Beasley himself didn't cause any message to be
 22 passed to those officers in the courtyard, did he?
 23 A. No, he called EOC and asked for further resources to
 24 come forward and also for extrication equipment, such as
 25 orthopaedic stretchers and carry sheets.

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1 Q. And your EOC didn't pass the message to the courtyard in
 2 the minutes that followed either, did they?
 3 A. So the EOC staff would not have been in a position to
 4 pass any messages direct to anyone in the courtyard
 5 because we didn't have actually LAS personnel in the
 6 courtyard at that time, sir.
 7 Q. So again it brings me back to absence of training of
 8 Mr Beasley as to how to bring about locating and
 9 extricating, and it brings me back to the absence of a
 10 procedure for notifying those of the arrival and the
 11 location of the resources. Those two things have fed
 12 into or caused those people to remain there in the
 13 minutes that followed; would you agree?
 14 A. No, I don't agree with that, sir. I believe
 15 Andy Beasley was discharging his duties as a member of
 16 the command structure for a major incident. That major
 17 incident was more complex because Plato had been
 18 declared as part of that major incident, and the command
 19 for Plato does not fall to Mr Beasley, and the actions
 20 that EOC took was to recall the on-call Plato commander
 21 and mobilise that Plato commander to the scene so that
 22 they could manage the Plato dimension of this major
 23 incident.
 24 Q. Isn't it possible, Mr Woodrow, that if the person in
 25 charge of extraction for that first hour had been

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1 properly trained in Plato, or if there had been a proper
 2 procedure for notifying the arrival of the resources, if
 3 either of those things had occurred, it's possible,
 4 isn't it, that those people would have come out of the
 5 courtyard at a much earlier time than they did?
 6 A. Sir, the guidance that we were working to, which is the
 7 marauding terrorist attack JOPs, that is a national
 8 document that was embedded into our incident response
 9 procedures, it's embedded into the joint emergency
 10 service interoperability principles, and it's embedded
 11 into every document that London emergency services use.
 12 The process to manage a Plato incident and to recover
 13 patients from the warm zone was through an FCP and the
 14 requirement to send multi-agency partners to that FCP,
 15 to have those discussions, share intelligence and make
 16 those deployment decisions. That was the procedure, and
 17 on the night that procedure was followed.
 18 Now, I have on several occasions today said that
 19 that took time, and I think colleagues that have given
 20 evidence have also said that that took time, and I have
 21 committed to work with partners to see whether we can
 22 improve that and indeed, I've spelt out some of the
 23 actions that the LAS as an organisation will do to
 24 ensure that to commit AIT teams we do that in the
 25 shortest possible position. I will reiterate, we will

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1 do that through the use of HART team managers, on duty
2 team managers, and tactical response unit supervisors
3 who will actually give the authorisation for the
4 multi-partner commanders at the FCP to deploy those
5 assets.

6 Q. Mr Woodrow, my suggestion is this: on the night there
7 was insufficient urgency and the procedures were
8 deficient for urgently getting people out of that
9 courtyard.

10 A. So that is not my reflection and that is not what the
11 evidence would reflect, because there were significant
12 numbers of patients that were moved rapidly from that
13 scene. 19 of those patients were triaged as P1, so
14 critically life threatened, and those patients were
15 triaged, treated, extricated and removed to hospital.
16 And no patient that we took to hospital on that night
17 lost their life, sir.

18 Q. {DC5052/3}, please. This is one of the debriefing
19 documents we looked at earlier and at paragraph 37 in
20 the feedback meeting a few days after the attack it was
21 stated that:

22 "There were complications with commanders arriving
23 on scene and being unable to notify anyone via radio
24 that they had arrived (the radios were not working)."
25 What was the difficulty?

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1 A. So the radios were working. The issue that was
2 highlighted in the debrief was an issue that when
3 resources were initially being sent, bearing in mind the
4 resources were initially being sent on their own home
5 dispatch groups, so their own talk groups, and then
6 obviously the information changed in relation to what
7 was happening on the scene, and so there was issues in
8 the first instance with people managing to get their
9 transmissions -- you can only have one resource transmit
10 through the Airwave talk channel at a time. That issue
11 was looked into as a part of this debrief process and
12 actually that issue was resolved when, in accordance to
13 procedures, the major incident talk groups for command
14 channels and resource channels were implemented.

15 Q. Police Constable Attwood who was dealing with
16 James McMullan down in the courtyard stated that he had
17 no direct link on his radio with the ambulance service
18 and although he spoke about the possibility of having
19 talk groups, that it would take some time before they
20 are set up and, as you have told us today, in any event,
21 talk groups would only be for staff on the ground within
22 the LAS, so that there would be no procedure for those
23 sorts of radio communications between the LAS on the
24 ground and police officers on the ground; is that
25 correct?

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1 A. So that is correct currently. There is a command
2 channel that is shared that is always open, that is the
3 ES5. So if there are communications going back into the
4 MPS control room, those messages can be shared across
5 into the control rooms with the London Fire Brigade and
6 the London Ambulance Service through Emergency Service 5
7 channel, which is an Airwave talk group.

8 Q. So when we think about the questions that Mr Hough was
9 asking you about potential procedural improvements for
10 the future and communications, does it remain the case
11 to this day that a police officer on the scene who wants
12 to speak directly with the LAS on the scene cannot have
13 direct radio contact?

14 A. So there are ways where an officer's Airwave radio could
15 be programmed by the individual to be used as a mobile
16 phone, using an ISI number, and then us to contact the
17 individual through an Airwave terminal in the ambulance
18 service headquarters.

19 But I think what we're talking about here is
20 a fundamental review around shared command and
21 operational resource groups within a major incident,
22 which would need to be explored further.

23 Q. So the constables on the ground are reliant upon those
24 above them for passing to them the information they need
25 to receive.

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1 A. Well, for each associate organisation they would be
2 passing information or asking questions of their control
3 room or their special operations centre and then the
4 coordination across the three services would either
5 happen on the tri-service conference call or ES5, which
6 is the open channel where each control room can talk to
7 each other, which is operational 24/7.

8 MR PATTERSON: Thank you, Mr Woodrow. Those are all my
9 questions.

10 MR HOUGH: Those are all the questions we have for you.
11 Thank you very much for giving evidence.

12 A. Thank you.

13 MR HOUGH: Sir, the next witness is Dr Wrigley.

14 DR FENELLA WRIGLEY (sworn)

15 THE CHIEF CORONER: Good afternoon. Please do make yourself
16 comfortable, if you want to take a seat that's
17 absolutely fine.

18 Questions by MR HOUGH QC

19 MR HOUGH: Would you please give your full name for the
20 court?

21 A. My name is Dr Fenella Kate Wrigley.

22 Q. Dr Wrigley, I ask you questions first on behalf of the
23 Coroner, and then you may receive questions from other
24 lawyers.

25 What is your current position in the London

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1 Ambulance Service?
 2 A. My role at the London Ambulance Service is medical
 3 director. I've been medical director since March 2016.
 4 I also retain a practising role at the
 5 Royal London Hospital where I am an emergency medicine
 6 physician.
 7 Q. I think within the London Ambulance Service you've
 8 worked for ten years; is that right?
 9 A. That's correct, I joined the ambulance service in 2008
 10 as an assistant medical director for control services
 11 and then was appointed deputy medical director in 2010
 12 before being appointed to medical director in 2016.
 13 Q. In a sentence or two, what is the role of the medical
 14 director?
 15 A. The medical director is responsible for the clinical
 16 strategy across the trust, which includes clinical
 17 safety, looking after the clinical education and
 18 standards, the clinical audit and the advanced paramedic
 19 and clinical practice guidelines.
 20 In addition to that, I'm the trust responsible
 21 officer for doctors, I'm the controlled drugs
 22 accountable officer, the Caldicott Guardian and the
 23 director of infection prevention control.
 24 Q. And as you have also told us, you're a practising
 25 consultant in emergency medicine?

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1 A. I am.
 2 Q. You appreciate you're here to give evidence on clinical
 3 aspects of the London Ambulance Service emergency
 4 response to the attack.
 5 A. Yes.
 6 Q. You made a number of witness statements, two of them
 7 concerning the victims of the attack, and it's those
 8 about which I will be asking you. You may refer to them
 9 as you wish.
 10 A. Thank you.
 11 Q. During the attack itself, is it right that you were gold
 12 medic, or gold doctor, the strategic medical director
 13 for the incident?
 14 A. That's correct.
 15 Q. Again, briefly, what were the responsibilities in that
 16 role within the attack itself, or the response to it?
 17 A. The strategic medical advisor is an advisory role to
 18 support the gold commander with clinical aspects of
 19 an incident as it unfolds, and to act as a point of
 20 liaison to the wider NHS to be able to support the
 21 hospitals that have been prepared to receive patients,
 22 and also to ensure that the right clinical resources are
 23 available to be deployed at the right time.
 24 Q. In preparing your statements and preparing your evidence
 25 relating to the clinical aspects of the response, have

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1 you had access to a wide range of material?
 2 A. I have, and I would also like to bring to your attention
 3 that I have subsequently to submitting my statement,
 4 I have seen the video footage from the police officers
 5 for the patients that are in my statement.
 6 Q. So just to understand what you've had: you've had the
 7 patient report forms of the LAS crews?
 8 A. I have.
 9 Q. Witness statements made by crew members, both internally
 10 and to the police?
 11 A. Yes.
 12 Q. The reports of the police investigation team about each
 13 of the victims?
 14 A. Yes.
 15 Q. Post mortem examination reports?
 16 A. Yes.
 17 Q. And you tell us you have also seen police body-worn
 18 video showing the efforts at resuscitation?
 19 A. I have.
 20 Q. May I then ask you some questions first of all in
 21 relation to your overview witness statement, first of
 22 all about the clinical skill sets and scope of practice
 23 of different staff members. Now, is it right to say
 24 that the LAS workforce encompasses staff with a number
 25 of different skill sets and qualifications?

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1 A. That's correct. We have emergency ambulance crew who
 2 are non-registered clinicians who have undertaken
 3 a training course to enable them to make clinical
 4 assessments, to be able to administer drugs under
 5 schedule 19 and to be able to understand the operational
 6 aspects of working on an ambulance, including major
 7 incidents.
 8 We also have paramedics, who have either undertaken
 9 a three-year degree course or been through the London
 10 Ambulance Service academy, and they, after doing
 11 an 18-month apprenticeship, after they've completed
 12 their degree, are able to work as fully autonomous
 13 paramedics.
 14 Q. So first of all, the emergency ambulance crew. I think
 15 the service has more than 800 such people?
 16 A. That's correct.
 17 Q. Do their skills enable them to perform life support as
 18 well as providing some medication of the types you have
 19 alluded to?
 20 A. That's correct, they can undertake basic life support
 21 and defibrillation and they can administer drugs that
 22 are under schedule 19 which means drugs for emergency
 23 situations.
 24 Q. But they're not permitted, is this right, to perform
 25 invasive procedures, such as cannulation or needle chest

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1 decompression?
 2 A. That's correct.
 3 Q. As to the paramedics, is it right, according to your
 4 statement, that the service has a little under 1,700
 5 fully qualified paramedics?
 6 A. That's correct.
 7 Q. And just over 180 newly qualified ones?
 8 A. Yes.
 9 Q. And as we've heard, there are further practitioners
 10 known as advanced paramedic practitioners who have
 11 undergone additional training on top of their paramedic
 12 basic training?
 13 A. They have. These are paramedics who have a vast range
 14 of experience and have undertaken additional training up
 15 to masters level, and are able to administer a wide
 16 range of drugs and undertake a wide range of procedures,
 17 emergency procedures.
 18 Q. And then above that level still further, is this right,
 19 are the skills of a HEMS doctor, who brings with him or
 20 her all the surgical skills of a hospital doctor?
 21 A. So the -- we work in collaboration with the London's Air
 22 Ambulance and the HEMS doctors. The HEMS doctors are
 23 under the governance and employed by Barts Health. The
 24 paramedics are employed by London Ambulance Service, but
 25 between the London's Air Ambulance doctors and the

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1 doctors that work within my team, there are a range of
 2 doctors who can take additional skills to the scene.
 3 Q. I would just like to ask a few questions in relation to
 4 Christine Archibald, having regard to your evidence
 5 about different levels of staff having different
 6 qualifications and skills.
 7 Now, we know from the evidence of the pathologist
 8 that Christine suffered injuries which were immediately
 9 fatal and not survivable. From all your assessment as
 10 an emergency doctor looking at the records that you have
 11 referred to, do you agree with that conclusion?
 12 A. I do, sadly. The injuries were unsurvivable.
 13 Q. We've also heard that Mr Armstrong, a member of
 14 emergency ambulance crew staff, carried out a needle
 15 chest decompression at one stage in the treatment of
 16 Christine in order to relieve a risk or perceived
 17 pneumothorax. I think you're aware of that?
 18 A. I am. So Mr Armstrong, based on the mechanism of the
 19 injury that Christine had received, and the fact that
 20 she was in cardiac arrest, felt that there was
 21 a possibility that she had a tension pneumothorax.
 22 A tension pneumothorax is where air gathers in the side
 23 of the chest and compresses the lung so it makes
 24 ventilation, breathing, even with assisted ventilation
 25 very difficult and this can be relieved by inserting

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1 a cannula, which is a needle with a plastic tube over
 2 the top of it, into the pleural space, which is the area
 3 around the lung, to try to relieve it. It is a skill
 4 which requires clinical diagnosis, so you need to be
 5 trained to understand what you are looking for and what
 6 the indications are, and it is not without risk: there
 7 are a significant number of cases of a pneumothorax
 8 being caused if it is done incorrectly.

9 The situation Mr Armstrong found himself in without
 10 support immediately available from a paramedic, he had
 11 seen and witnessed the procedure being done previously
 12 and he made a decision to undertake it.

13 Q. Now, he accepted that he wasn't qualified to administer
 14 the process, but he said that he did it because
 15 Christine was in an asystolic condition and he
 16 considered that it might help him restarting her heart.
 17 He also described using a 18G cannula in the process.

18 First of all, what's your view of his decision to
 19 carry out that procedure at all?

20 A. Whilst I can understand the decision that Mr Armstrong
 21 made given the situation that he found himself in on
 22 that night, all of our clinicians work to very clear
 23 guidelines around the level of practice that they may
 24 undertake and therefore it is not a procedure that
 25 I would support being undertaken by a non-registered

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1 clinician who has not received the right training. That
 2 being said, sadly in the case of Christine Archibald,
 3 she was already deceased when that procedure was
 4 undertaken and, therefore, it would have caused no harm
 5 to her.

6 Q. Based on your understanding of the evidence, had
 7 Mr Armstrong carried out a proper assessment for tension
 8 pneumothorax before administering the procedure?

9 A. I think that within the scope of what he had been
 10 taught, he assessed the patient as well as he could.
 11 That being said, the patient had significant injuries
 12 and therefore the anatomy that he was examining would
 13 have been very distorted.

14 Q. What is your view of his method, using specifically
 15 an 18G cannula?

16 A. It's -- we would normally use a larger cannula because
 17 a 18 gauge cannula has a very fine bore and is therefore
 18 at risk of blood, which is very often in the chest as
 19 well, clotting the end of it. It's also quite a short
 20 cannula, it's only 32 mm long and in the majority of the
 21 population that is not long enough to actually get
 22 through into the pleura. My reading of the post mortem
 23 report it suggests that it did not go through into the
 24 pleura.

25 Q. Moving on now to triage and the triage sieve, could we

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1 have on screen, please {WS5037/12}. We've heard through
 2 other witnesses how triaging operates according to
 3 an algorithm which we can see on this page; is that your
 4 understanding too?

5 A. That's correct. In a major incident there are two
 6 stages: a triage sieve and then a triage sort. What is
 7 there in colour is a triage sieve.

8 Q. That's a triage sieve which identifies patients
 9 according to a P1, P2 and P3 and deceased triage
 10 categories?

11 A. That's correct.

12 Q. What is the triage sort that is then carried out?

13 A. So when patients arrive at the casualty clearing station
 14 where there will be additional clinicians and advanced
 15 clinicians available, the triage sort is used to look at
 16 their conscious level, their respiratory rate and their
 17 systolic blood pressure and from that to recategorise
 18 them.

19 An example to give to you would be that somebody at
 20 the scene may be categorised as a P2 because they're
 21 unable to walk because they've got a lower limb injury,
 22 whereas when they get to the casualty clearing station,
 23 actually if they are conscious and they are breathing
 24 and their blood pressure are all all right, then they
 25 may well then be categorised as a P3. So it's a way of

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1 ensuring that the sickest and the ones that need help
 2 are moved from the scene to the casualty clearing
 3 station, but then prioritising those that need to get to
 4 hospital quickest using physiology to be able to make
 5 that decision.

6 Q. During the initial triage sieve when staff in a major
 7 incident are going through the scene and looking at
 8 a number of injured people, what types of medical care
 9 are they expected to provide, as I say, while they're
 10 doing the triage process?

11 A. So immediately looking for signs of life, so talking to
 12 anybody who has been injured and seeing if they're
 13 responding to immediately provide bandage and pressure
 14 to bleeding, to stop catastrophic bleeding, and anybody
 15 who is unconscious, so not responding when spoken to, to
 16 open their airway, and to see when they have an opened
 17 airway which can be done with an adjunct, which is
 18 an oropharyngeal plastic tube to put in their mouth to
 19 see whether they maintain regular spontaneous
 20 respiration so if they can breathe for themselves
 21 without requiring somebody to stay and assist them with
 22 their breathing. If they are unable to do that, then
 23 sadly they are declared dead in a major incident.

24 Q. So during the triage process, the initial triage sieve,
 25 would LAS staff be expected to provide care such as CPR?

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1 A. They would not provide CPR and they would not advise to
 2 carry on CPR on a patient that is not spontaneously
 3 breathing.

4 Q. Can I move on to your assessment of each of those who
 5 died, which you set out in detail in your clinical
 6 statement. You address each of the victims other than
 7 Xavier Thomas; is it right that he wasn't addressed
 8 because he didn't come under the care of LAS and was --
 9 his body was recovered some time later?

10 A. That's correct, although I did attend and listen to the
 11 post mortem outcome for Xavier.

12 Q. Can we address the other victims of the attack one by
 13 one then, please.

14 First of all, Christine Archibald, you've already
 15 told us that you concur with the view that her injuries
 16 were immediately fatal and non-survivable. We know that
 17 she was attended to by an ambulance crew member, Keeley
 18 Whale, a student ambulance paramedic, Mr Browne, who
 19 were also assisted by nurses from Guy's Hospital. She
 20 was asystolic throughout and showed no sign of life. It
 21 may be an obvious question, but if the triage sieve had
 22 been applied to her, what view would have been taken?

23 A. So had the triage sieve been applied to her, then she
 24 would have been categorised as dead and cardiopulmonary
 25 resuscitation wouldn't have started.

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1 In the case of Christine Archibald, she was the
 2 first patient that the calls came in about and it was
 3 reported that she was a lady who had been hit by the van
 4 and was already receiving chest compressions from
 5 members of the public, and a lifeguard, I recall, who
 6 came to her assistance.

7 When the crew arrived they were aware of other
 8 people who had been injured by the van, it was their
 9 belief. They were not aware of the events unfolding on
 10 the south end and therefore they continued to treat
 11 Christine as the victim of a road traffic collision.

12 Q. In that context, not seeing her as one victim of a very
 13 major incident, was it in your view reasonable for them
 14 not to take a triage approach, but simply to treat the
 15 very badly injured person in front of them?

16 A. It was reasonable.

17 Q. And as to the quality of their clinical treatment, based
 18 on all your reading of the evidence, what was your view
 19 of that?

20 A. That the quality of care that she was provided by both
 21 the ambulance service and all of the personnel who
 22 assisted the ambulance service was very high.
 23 Unfortunately her injuries were unsurvivable: she had
 24 a transection of the aorta, which is the largest blood
 25 vessel taking blood around the body, and therefore she

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1 would have immediately lost her blood into her body.
 2 Q. May we now move on to Sébastien Bélanger, who you
 3 address from page 9 of your clinical statement. We know
 4 that resuscitation efforts started on him at an early
 5 stage involving initially members of the public and then
 6 police officers soon becoming involved. We know that he
 7 suffered a range of injuries, 12 incised wounds,
 8 a severe chest wall injury with an injury to the lung,
 9 a collapsed lung, also injuries to his neck and facial
 10 area, his arm and that he suffered very serious blood
 11 loss.

12 We know that he was brought up from the Boro Bistro
 13 courtyard while CPR was still being performed at around
 14 22.46, at which point it was reported that he was in
 15 cardiac arrest.

16 First of all, have you considered the evidence in
 17 relation to his injuries and their effects?

18 A. I have, yes.

19 Q. What views have you formed?

20 A. So Sébastien suffered a significant number of incised
 21 wounds which are wounds caused by a stabbing or knife
 22 device, the most significant of these wounds were to his
 23 arm, which bled profusely, and also one to the side of
 24 his face and to his neck as well, which is reported to
 25 have caught a small branch of the carotid artery, which

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1 is the large artery taking the blood up to the head.
 2 The reports that I have seen indicate that prior to the
 3 police arriving a member of the public had found
 4 Sébastien and that he was not breathing. At the point
 5 that the police arrived, the combination of the blood
 6 loss externally from his arm wounds and from his neck
 7 and internally from the injuries that you have
 8 described, which were the two significant chest injuries
 9 to his lung and one lower in his right lung and through
 10 into his liver, which would have been bleeding both
 11 internally and externally, meant that he was in
 12 a hypovolemic and hypoxic cardiac arrest, so
 13 a combination of having lost a huge amount of blood and
 14 having not enough blood pumping round the body to be
 15 able to take oxygen round, and the injury to his lung.

16 He received extremely good care from the people that
 17 were at the scene who did everything they could, but at
 18 the point that he went into cardiac arrest, which from
 19 the timeline that I have put together is around 22.16,
 20 the blood loss had resulted in him having
 21 an unsalvageable situation. The reason that I've drawn
 22 that conclusion is that I have watched the body-worn
 23 footage from the police who were there and the extent of
 24 the blood that was seen around Sébastien suggests that
 25 he had had a massive blood loss, and I subsequently

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1 reviewed that position after having heard Dr Swift's
 2 evidence as well.

3 Q. Dr Swift, you appreciate, gave the opinion that it is
 4 possible that more could have been done for Sébastien,
 5 and ventured to suggest that it might have been possible
 6 to save him, although the pathologist qualified that by
 7 commenting that it wasn't his particular area of
 8 expertise, and he was careful about that qualification.

9 Emergency medicine, of course, is your area of
 10 expertise. What would be your comment on the evidence
 11 from Dr Swift in that regard?

12 A. So I fully respect that Dr Swift has a vast range of
 13 experience of doing post mortems on these type of
 14 patient. When patients reach a situation where the
 15 body's response to losing blood has been overwhelmed, so
 16 the increase in your heart rate, the tightening up of
 17 all of your peripheral blood vessels to try and pump
 18 back the blood to your heart and to your brain, and the
 19 clotting cascade, which is there to be able to help the
 20 blood loss reduce by forming clots, has been
 21 overwhelmed, that is when a patient becomes
 22 unsalvageable.

23 From the point of view of are all of these patients
 24 unsalvageable, I think we need to recognise that in this
 25 situation Sébastien was in a situation where there was

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1 live fire being heard, there were shouts at both 22.24
 2 and again at 22.26 advising people to get out. The
 3 police and two members of the public remained with
 4 Sébastien, but at that point, there was no chance of
 5 reversing the situation that he was in.

6 Q. Let's for the moment ignore the surrounding
 7 circumstances and focus on the clinical picture, which
 8 is your particular area of expertise. You've indicated
 9 to us that Sébastien was not salvageable by 22.16; is
 10 that right?

11 A. So at 22.16 he was in cardiac arrest and had suffered
 12 significant blood loss that he was not salvageable at
 13 that point.

14 Q. Was there any medical intervention at all from that
 15 point, 22.16, which could have saved his life?

16 A. Not in my opinion, no.

17 Q. Before that, between the time that he was attacked at
 18 around 7 or 8 minutes past, and 16 minutes past, is
 19 there anything that could have been done for him over
 20 that period, first of all, in any context, even in
 21 an emergency room, that could have saved him?

22 A. So if Sébastien had been in an emergency room or been
 23 an isolated patient in an isolated incident, then trying
 24 to stop the bleeding by putting a tourniquet on his arm,
 25 packing his bleeding wound from his neck, establishing

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1 a definitive airway, so passing a tube down his trachea,
2 into his lungs to take over his breathing to be able to
3 provide oxygen for him and giving fluid could have been
4 done.

5 If London's Air Ambulance team had been able to get
6 to him as an isolated patient, there are then additional
7 things that they bring because they carry blood and they
8 are able to do more advanced procedures such as opening
9 the chest in order to be able to try to get control of
10 the bleeding by then pressing the aorta, the big vessel.

11 The survivors that they have reported from
12 haemorrhagic cardiac arrests remain very low, but it is
13 certainly an area that they continue to work really hard
14 with and we're all supporting to push those boundaries
15 to make sure these people can survive in the future.

16 Q. Is this right: that if Sébastien had received dedicated
17 treatment at some point between 22.07 and 22.16, it is
18 possible that he might have survived but the chances of
19 surviving such injuries are nevertheless not very
20 optimistic?

21 A. That's correct, on the balance of probabilities the
22 extent of his injuries and the extent and speed of his
23 blood loss would have almost certainly meant that he
24 sadly would not have survived, but more would have been
25 able to have been done.

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1 Q. After 22.16, though, it's your view that with any
2 practical treatment he could not have been salvaged?

3 A. That is correct.

4 Q. We know that when he was taken to the ambulance at
5 shortly after 10.45, he was initially regarded as
6 appropriate for transfer to hospital, but at that point
7 a P1 patient with a severe neck laceration, Marine
8 Vincent, was brought to the staff at the ambulance.
9 We've heard from Mr Lesslar that he and Mr Rutherford
10 decided that she should be treated as a priority because
11 she was alive but her bleeding was difficult to control.
12 At that point Sébastien was assessed again and
13 a conclusion reached that he was not survivable and he
14 was treated as deceased. What's your view of that
15 process and that decision?

16 A. The decision-making was very difficult for the crews on
17 the scene, it was the correct decision to make. That
18 being said, it is really important to recognise that
19 this is not a decision that any of the crews or any of
20 the clinicians on the scene would have made lightly,
21 because to have an ambulance and then to give the
22 ambulance to somebody else is a really, really hard
23 decision, and I would like to say how sorry I am to the
24 family because I'm sure that's something that's really
25 hard for them to understand, that decision-making

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1 process.

2 Q. Is this right: that by that stage, 10.45, when Sébastien
3 was in cardiac arrest and had been for some time, and
4 based on everything you had seen, is there any realistic
5 chance that he could have been saved if taken into
6 an ambulance?

7 A. Sadly not, no.

8 Q. Can we move to Kirsty Boden, whom you address at
9 pages 12 and 13. We have received evidence from the
10 pathologist that Kirsty received injuries which were
11 quickly fatal and not survivable. Have you taken a view
12 of her injuries and their effects?

13 A. Yes. Kirsty had multiple stab wounds including one to
14 the left side of her chest, her left upper arm and
15 behind her left ear. The most serious was the left side
16 of her chest which damaged her ribs and perforated her
17 left lung and the left ventricle resulting in an injury
18 to the main pumping chamber of the heart and blood going
19 into the sack surrounding the heart.

20 Q. Do you therefore concur with the pathologist as to the
21 speed of those injuries causing her to be beyond saving?

22 A. I do.

23 Q. She was attended to by an off-duty doctor and that
24 doctor's friends, and we've heard that they made
25 considerable efforts and recognised that very sadly that

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1 she had died at an early stage, and they had to leave
2 her because of danger at the scene. Have you considered
3 the treatment they gave?

4 A. I have reviewed their statements and it would appear
5 that the basic life support that they provided was of
6 a high standard, but sadly the injury that Kirsty had
7 sustained was unsurvivable.

8 Q. We've heard that a HART paramedic formally recognised
9 her as deceased after 1.00 am, and presumably you would
10 agree with that assessment?

11 A. I would.

12 Q. May I move on to Alexandre Pigeard. We have heard that
13 Alexandre suffered very severe stab injuries, including
14 a very severe injury to the neck, and the pathologist
15 gave evidence that they also could not be survived and
16 led to swift collapse and death. Have you considered
17 the injuries and formed a view yourself?

18 A. I have. The injuries that Alexandre sustained were
19 multiple incised wounds again, but the most significant
20 one was to the right side of the lower neck where both
21 a significant artery and vein were damaged, resulting in
22 profuse and rapid bleeding from those wounds. These
23 wounds are particularly difficult to get compression on
24 to try to stop the bleeding. They're known as
25 junctional wounds and they're where vessels separate out

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1 and so to actually try to get control of the bleeding
2 just with direct pressure is much more difficult.

3 So my view is that he suffered a fatal neck stabbing
4 with catastrophic blood loss as the cause of his cardiac
5 arrest and death.

6 Q. PC Attwood rendered resuscitative care to him and
7 applied a bandage to his neck wound but recognised that
8 there was massive blood loss and received no response to
9 all his efforts. Have you considered the particular
10 efforts that PC Attwood made?

11 A. PC Attwood did everything that was possible by trying to
12 compress the bleeding wound. As I've described, these
13 junctional wounds are very difficult to compress, but he
14 did his best but recognised very quickly that the blood
15 loss was catastrophic.

16 Q. Once again, do you support the decision of the HART team
17 after 1.00 am to recognise Alexandre as deceased?

18 A. I do.

19 Q. James McMullan suffered severe stab injuries including
20 a severe wound to the chest. He received care from
21 PC Miah and others. The pathologist's view of his
22 condition was that his injuries, like those of some of
23 the others, resulted in early collapse and were not
24 practically survivable. What is your view of those
25 injuries and their effects?

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1 A. For James, the most significant injury he had was a stab
2 wound to the left front of the chest which went through
3 his rib into the chest, into the right side of the
4 heart, and then transected, so cut across the aorta,
5 just as the aorta was coming out of the heart, and then
6 into the left side of the chest. Cutting the aorta at
7 that point would result in immediate catastrophic blood
8 loss because no blood can go anywhere round the body
9 because the aorta is the main pipe to take blood round
10 the body.

11 Q. He was brought up to an ambulance shortly after 22.45
12 that evening and his condition was at that stage
13 reported to be one of cardiac arrest. Is it your view,
14 like that of the pathologist, that his injuries could
15 not have been successfully treated by any practical
16 means at the scene?

17 A. Sadly it is, yes.

18 Q. James was triaged as deceased when found to be in
19 cardiac arrest near the ambulance. Was that
20 an appropriate decision, based on your understanding of
21 all the events?

22 A. It is, yes.

23 Q. May I ask you about Sara Zelenak. Sara also suffered
24 severe stab injuries. We have heard from the
25 pathologist that they were quickly fatal and not capable

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1 of being survived. She was provided with CPR but
2 without giving any response at all for between 10 and 15
3 minutes before she was seen by paramedics and triaged as
4 deceased. From all your view of the evidence, what is
5 your view of Sara's injuries and whether they could have
6 been treated?

7 A. Sara sadly received a wound through the top part of her
8 neck, just below her skull, which resulted in
9 a transection of her spinal cord at a very high level.
10 The result of transecting the spinal cord at that level
11 is that the patient is unable to move and that area of
12 the cord is also responsible for autoregulation of
13 both -- of the blood pressure and the heart rate, but
14 also the nerve supplies the diaphragm, which is
15 important in breathing, so by transecting the cord at
16 that level there would have been immediate loss of the
17 ability to breathe, to move, and she would have suffered
18 a catastrophic drop in her heart rate and her blood
19 pressure. She almost certainly would have gone into
20 a respiratory arrest and stopped breathing initially,
21 and at that point the lack of circulation of oxygenated
22 blood would have led her to go into cardiac arrest. And
23 it was unsurvivable, unfortunately.

24 Q. Do you consider that the triage decision made after that
25 period of CPR without response was a correct one?

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1 A. I do.

2 Q. Finally, Ignacio Echeverria, we have heard that Ignacio
3 suffered stab wounds, including to his back, from which
4 he bled profusely, and after which he moved for only
5 a minute or so. We have heard that he received
6 resuscitative care from a police officer and after a few
7 minutes from an off-duty doctor who gave evidence that
8 Ignacio was unresponsive to CPR throughout the period
9 that followed. Thereafter he received further care from
10 an LAS crew.

11 Now, what view have you formed of his injuries and
12 whether they could have been treated?

13 A. So Ignacio's injuries included a stab wound to the
14 mid-part of his back towards the left side, which
15 transected or cut across two branches of his pulmonary
16 artery. The pulmonary artery is the large vessel which
17 carries deoxygenated blood, so blood that is going back
18 into the lungs to get oxygen reattached to it from the
19 right ventricle and they bleed very, very profusely and
20 rapidly if they are cut. It would have been a very
21 catastrophic bleed with rapid death.

22 Q. We've heard that he was initially triaged by Mr Edwards,
23 the paramedic, as a P1 patient in the very early period.
24 He was then moved across London Bridge to a casualty
25 clearing station because of a perceived danger at the

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1 scene after gunfire had been heard. Was that decision
 2 to move him a reasonable one in your view?
 3 A. Based on the situation that we've heard during the
 4 course of this Inquest, the decision to move was
 5 reasonable. They were also trying to move him to where
 6 there was additional help, should that have been
 7 required, but sadly the injury was fatal and moving him
 8 would not have either altered his outcome or improved
 9 his chances of survival.
 10 Q. He was assessed at the casualty clearing station by
 11 Dr Lambert and determined to be deceased just before
 12 11.00 pm.
 13 A. That's correct.
 14 Q. You were aware of that?
 15 A. Yes.
 16 Q. Is that an assessment decision with which you concur?
 17 A. I do.
 18 MR HOUGH: Thank you very much, those are all my questions.
 19 Questions by MS AILES
 20 MS AILES: Doctor, my name is Victoria Ailes. I'm asking
 21 questions on behalf of the families of a number of those
 22 who died, in particular for these purposes I am asking
 23 questions on behalf of the family of Sébastien Bélanger.
 24 You've provided today your opinion that the injuries
 25 that Sébastien sustained had become non-survivable by

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1 10.16; is that right?
 2 A. That's correct.
 3 Q. That's not a conclusion, I think, that we find in any of
 4 your statements?
 5 A. So the conclusion that I've come to is having viewed the
 6 body-worn footage where the degree of blood loss was
 7 apparent. That was not something that I had seen prior
 8 to the start of the Inquest.
 9 Q. You also, I take it, reviewed the evidence that Dr Swift
 10 gave --
 11 A. Yes.
 12 Q. -- and his opinion? Have you had any discussion with
 13 Dr Swift about this?
 14 A. No.
 15 Q. You are commenting on Dr Swift's opinion but you have
 16 not provided any disclosure that would give him
 17 an opportunity to comment on yours?
 18 A. No.
 19 Q. So we're not in a position to know whether he would
 20 agree with you about the conclusion that you have drawn
 21 in light of the particular information that you have
 22 seen?
 23 A. No, the opinion that I'm giving is based on being -- is
 24 a clinical opinion. I would not be able to comment on
 25 his pathology opinion at all.

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1 Q. I think on the fundamental point, in fact, it may be
 2 that you agree with Dr Swift about this: you both agree
 3 that the original injuries may possibly have been
 4 survivable at the point that they were sustained?
 5 A. I think we need to recognise that Sébastien had
 6 a significant number of profusely bleeding injuries.
 7 However, if he had been an isolated patient in
 8 an isolated case, then by trying stem the flow of that
 9 bleeding there may have been a window of opportunity
 10 where additional help could have been got to him.
 11 However, by the time he collapsed and was found
 12 unfortunately the blood loss was too significant.
 13 THE CHIEF CORONER: And by isolated...?
 14 A. So, sir, if he hadn't been caught up in the situation,
 15 so if he had sustained this injury just as an individual
 16 patient in London.
 17 THE CHIEF CORONER: As a one-off?
 18 A. Yes. Yes. So we would have immediate access to him.
 19 MS AILES: So, similarly, if it had been an isolated
 20 incident with prompt attendance by the HEMS team these
 21 injuries would remain possibly survivable?
 22 A. So just from the timing of being able to get the HEMS
 23 team there, if we look at the time of night, they would
 24 be travelling in a car at that time of night. We
 25 understand that Sébastien received his injuries at

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1 around 22.08 and collapsed at 22.16. Unless the
 2 London's Air Ambulance car was in the vicinity to be
 3 able to mobilise at night by car or in the day by [air],
 4 they would be arriving at the point that he was going
 5 into cardiac arrest.
 6 Q. And appreciating that these are questions about what
 7 might have happened, not what did happen, your evidence
 8 is essentially that death resulted from the loss of
 9 blood?
 10 A. That's correct.
 11 Q. That was the thing that made these injuries
 12 non-survivable. So had there been some sort of medical
 13 intervention that led to better control of bleeding,
 14 then it's possible that that might have extended the
 15 time of 10.16 that you have identified?
 16 A. So I think medical intervention or general first aid
 17 intervention.
 18 Q. Yes.
 19 A. So being able to apply a tourniquet, and since this
 20 event we've been working closely with the
 21 Metropolitan Police to get tourniquets rolled out, but
 22 also rolling them out wider across London, so transport
 23 hubs have them as well because they are life-saving
 24 devices.
 25 Q. Exactly. we've heard evidence that a tourniquet was

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1 applied to Sébastien much later, at 22.45, you have seen
 2 that in the footage, but that's equipment that if it had
 3 been available earlier in the time period might have
 4 been of some assistance to him?
 5 A. It might.
 6 Q. And in particular, it might have extended the time that
 7 a team such as the HEMS team would have had to have got
 8 to him --
 9 A. Yes.
 10 Q. -- in an isolated incident or otherwise.
 11 A. Yes.
 12 Q. We've heard some evidence that at 10.34 those providing
 13 treatment appear to have believed that they could detect
 14 a faint pulse. Is that, first of all, something that
 15 you have seen on the body-worn footage?
 16 A. I have watched it several times, I see them looking and
 17 feeling for a pulse both in his wrist and in his leg, in
 18 his groin earlier on, but not at that particular point.
 19 I think it's important to recognise that feeling for
 20 a pulse is something that the 2005 UK resuscitation
 21 guidelines removed because it was recognised that it is
 22 not uncommon for a responder to be feeling for a pulse
 23 and actually feel their own. The environment that
 24 they're working in, taking out the major incident, just
 25 doing a resuscitation means people are working very

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1 heart, their heart rates have gone up, they are
 2 understandably very anxious, and it's really, really
 3 common to think that you can feel a pulse, but it's
 4 actually your own that you can feel.
 5 Q. Nevertheless, the practice did continue, for example,
 6 Dr Lambert, the HEMS doctor, told us that it was his
 7 practice to feel for a pulse?
 8 A. So it remains practice for trained healthcare
 9 professionals to feel for a pulse, not for lay people.
 10 Q. I see, and would that under the triage sieve indicate
 11 that that further treatment should be carried out?
 12 A. Not under the triage sieve, no.
 13 Q. If it were right that there was a faint pulse at 10.34
 14 or at any other point around that time after 10.16,
 15 would that be incompatible with the conclusion that you
 16 have reached?
 17 A. I think the amount of blood loss that Sébastien had
 18 sadly suffered meant that when chest compressions which
 19 were being given to a very high quality were being given
 20 his heart actually had very little blood in it, and
 21 therefore the report that they could feel a pulse is
 22 mistaken.
 23 Q. In other words, if your evidence is right, then they're
 24 wrong; equally, if their evidence that they could feel
 25 a pulse was right, then your conclusion would be wrong?

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1 A. So I ...
 2 Q. I appreciate you prefer your conclusion.
 3 A. It's not a conclusion. To have a pulse palpable in your
 4 wrist or in your groin means you've got to have blood in
 5 your heart to be able pump it round. The amount of
 6 blood loss that Sébastien had experienced both
 7 externally, which is visible on the footage, and
 8 internally, and on his jumper and on his T-shirt meant
 9 that the heart was empty and there was no blood to pump
 10 round so it was not going to be pulse that could be
 11 palpable.
 12 Q. At 10.46 Sébastien was moved up to Borough High Street
 13 and in the context of a major incident in which more
 14 casualties must have been expected, the decision was
 15 taken to move him into an ambulance, as you've already
 16 said, and the evidence that we have from Mr Lesslar was
 17 that he was considered to be the person with the best
 18 chance of survival. Now, as you've said, he was then
 19 taken out of the ambulance because another casualty
 20 presented who was a P1 and who was then taken to
 21 hospital.
 22 But, given that conclusion, that he was the person
 23 with the best chance of survival, it would be right,
 24 wouldn't it, that there must have been some purpose to
 25 the treatment that paramedics were providing up until

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1 that point?
 2 A. So up until that point he had been treated by the
 3 Metropolitan Police officers and two members of the
 4 public. When he arrived at the edge of the ambulance
 5 there was ongoing active resuscitation and Mr Lesslar
 6 asked for him to be loaded onto the ambulance whilst he
 7 got a history. He then put him through the triage sieve
 8 and identified the amount of time that resuscitation had
 9 been going on and confirmed sadly that he was dead and
 10 at about the same time, I think in all of these
 11 situations it is dynamic, things are happening
 12 simultaneously, the other patient who was breathing
 13 arrived and a very difficult and sad decision was made
 14 to take him off the ambulance and to use the ambulance
 15 for that patient.
 16 Q. We can all understand the difficult situation that
 17 arises when two patients present and only one can be
 18 taken to hospital there and then, but what I want to
 19 suggest is that these are fast-moving videos, there's
 20 a great deal going on, the video cameras are not always
 21 pointed in the direction of the patient. Is it right
 22 that you can draw the conclusion that you have drawn in
 23 preference to the decision that Mr Lesslar, who was
 24 actually present at the scene, made to load Sébastien
 25 onto the ambulance?

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1 A. So Mr Lesslar would not have had sight of the amount of
2 blood loss at the scene. By the time he met Mr Lesslar,
3 he had been moved up the stairs and to the ambulance and
4 I am drawing my clinical opinion on the ability to
5 review all of the information, not the information just
6 presented at the time.
7 But in a major incident if you have a patient who is
8 not breathing spontaneously, then they are sadly dead.
9 MS AILES: Thank you.
10 MR HOUGH: Thank you very much, Dr Wrigley. Those are all
11 the questions we have for you.
12 THE CHIEF CORONER: Thank you very much indeed.
13 MR HOUGH: Sir, we had very much hoped to start DAC D'Orsi's
14 evidence this afternoon.
15 THE CHIEF CORONER: Yes.
16 MR HOUGH: I apologise to her that we haven't been able to
17 but she will be our first witness tomorrow.
18 THE CHIEF CORONER: I think in fact, Mr Hough, this might be
19 the very first time we've managed not to start a witness
20 that we had planned to start. I know that Detective
21 Superintendent Riggs we were going to take at one stage,
22 but she has been less inconvenienced because she has
23 been here every day, but my apologies to the witness
24 that we had not been able to get to them but we will
25 start first thing tomorrow, and I hope that gives us

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1 good time to get through her evidence and, indeed we
2 have a second witness tomorrow.
3 MR HOUGH: We do. The second witness is expecting that she
4 will likely go into Wednesday.
5 THE CHIEF CORONER: Mr Hough, I think you know on Wednesday
6 I was going to start a little bit later but in fact we
7 are going to start at the same time because my other
8 commitment is no longer happening, so that at least
9 gives us a full day on Wednesday.
10 10 o'clock.

11 (4.48 pm)
12 (The court adjourned until 10.00 am on
13 Tuesday, 18 June 2019)
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