

Coroner's Inquests into the London Bombings of 7 July 2005

Hearing transcripts - 28 February 2011 - Morning session

1 Monday, 28 February 2011

2 (11.00 am)

3 LADY JUSTICE HALLETT: Mr Hay, I need to announce, for the  
4 sake of the press and others, that the temporary ban on  
5 electronic communications is now lifted.

6 MR HAY: I'm grateful, my Lady. My Lady, may I invite you  
7 to call Dr Gareth Davies, please?

8 LADY JUSTICE HALLETT: Thank you.

9 DR GARETH EDWARD DAVIES (affirmed)

10 Questions by MR HAY

11 MR HAY: Good morning.

12 A. Good morning.

13 Q. Dr Davies, can I ask you to give your full name to the  
14 court, please?

15 A. Yes, my name is Dr Gareth Edward Davies.

16 Q. Dr Davies, you are the medical director of the  
17 Helicopter Emergency Medical Service but also known as  
18 London's air ambulance?

19 A. That's correct, sir.

20 Q. Can I start first by just acknowledging through you the  
21 integral role played by HEMS on 7 July 2005?

22 As the medical director, what are your  
23 responsibilities?

24 A. My main responsibility is to oversee the training and  
25 education of staff that are seconded to the air

1 ambulance, but also ensure that the clinical governance  
2 programme that surrounds the care that we deliver is as  
3 good as it could possibly be.

4 Q. Dr Davies, may I ask you to do your best to keep your  
5 voice up?

6 A. Yes.

7 Q. It's quite a large courtroom and everyone needs to hear  
8 what you have to say.

9 A. Okay.

10 Q. As well as being the medical director, I think you wear  
11 other medical hats as well. Is it right that you are  
12 a consultant in accident and emergency pre-hospital care  
13 at the Royal London Hospital?

14 A. Yes, that is correct.

15 Q. Are you also qualified to act as a Medical Incident  
16 Officer?

17 A. Yes, that is correct, it's a role I've taken several  
18 times.

19 Q. Just to clarify, that role is the Silver doctor role --

20 A. Yes.

21 Q. -- and should be distinguished from the ambulance  
22 incident officer, which is the Silver medic?

23 A. Yes, they are two quite distinct roles at the scene of  
24 a major incident.

25 Q. Turning back to HEMS -- I hope you will excuse me if

1 I call it that, we've been calling it HEMS throughout  
2 the whole proceedings.

3 A. Yes, I understand.

4 Q. Can I start with an obvious question? What is its  
5 primary purpose?

6 A. HEMS' primary purpose is essentially to support the  
7 statutory emergency services around patients who have  
8 severe injury. So, on a day-to-day basis, we provide  
9 a very senior doctor and paramedic who have special  
10 training in trauma, injury that is, and we are tasked to  
11 incidents, the few incidents, that occur in London that  
12 require the specialist skills of that particular team.

13 Q. I believe you attend on average about 7 to 8 calls per  
14 day?

15 A. Yes, in the region of 7 to 8.

16 Q. HEMS has been in existence since 1988?

17 A. Yes, that's correct.

18 Q. You mentioned the makeup of the HEMS team --

19 A. Yes.

20 Q. -- an experienced clinician and experienced paramedic?

21 A. Yes.

22 Q. On any given day, how many teams are on duty?

23 A. Essentially, we aim to provide one team, so one doctor  
24 and one paramedic per 24-hour shift. Occasionally,  
25 there are times when we have spare doctors and

1 paramedics and we can muster a second team, but that  
2 situation is relatively rare, it only happens literally  
3 in a handful of the cases in the year, really.

4 Q. We'll come to 7 July itself, but that was one of those  
5 exceptional days?

6 A. Yes, very definitely.

7 Q. The service has one helicopter, is that right?

8 A. Yes, sadly, yes.

9 Q. And five fast response cars?

10 A. Yes.

11 Q. The five fast response cars, those have blue light  
12 status, don't they?

13 A. Yes, they have blue light status and are driven by the  
14 paramedics that are seconded to the unit from London  
15 Ambulance Service.

16 Q. I'm not sure if you will be aware of this, but it was on  
17 your website that training for the blue light status  
18 takes five days. Is that right?

19 A. Yes, in the region of that.

20 Q. How many paramedics have that qualification for the blue  
21 light status driving?

22 A. All of our paramedics have that status and they have  
23 additional training, we have a specific driver training  
24 manager who takes them through another layer of training  
25 to respond to these types of incidents.

1 Q. HEMS itself is a registered charity?

2 A. That's correct.

3 Q. How is it funded?

4 A. It has several funding streams. It operates as  
5 a charity, which means that we have income from  
6 corporate donors, but also just charitable donations,  
7 but we are also supported through the NHS; for example,  
8 our paramedics that are seconded to the unit come from  
9 London Ambulance Service and the doctors come from Barts  
10 and the London NHS Trust. So it's very much  
11 a collaborative project.

12 Q. Your website tells us that in addition to the NHS  
13 funding, and also the corporate funding, there is still  
14 a deficit of about a million pounds or so that needs to  
15 be raised from other sources?

16 A. Yes, it's constantly an uphill struggle to try to  
17 acquire the funding necessary to deliver the sort of  
18 service we aspire to.

19 Q. The service itself has attended a number of major  
20 incidents over the years prior to 7 July.

21 A. Yes.

22 Q. Including the Southall, Paddington and Potters Bar rail  
23 crash --

24 A. Yes.

25 Q. -- and the Bishopsgate and Aldwych bus bombs?

1 A. Yes, that's correct.

2 LADY JUSTICE HALLETT: Did I read recently that you had  
3 secured some funding for a year or two to come, or was  
4 that wishful thinking?

5 A. That was probably wishful thinking. The actual position  
6 is that the group concerned have helped finance the  
7 aircraft for another seven years, they're not  
8 a corporate sponsor as such. So they've just helped  
9 with us the purchase lease on the aircraft. So it's not  
10 a new sponsor like -- replacing Virgin.

11 MR HAY: Just to give my Lady some idea of the amount of  
12 missions attended -- again, something I've taken from  
13 your website, but hopefully you can confirm this is  
14 correct -- in 2009, HEMS attended 672 road traffic  
15 accidents, 377 falls from height, 349 stabbings and 69  
16 shootings.

17 A. Yes, it would be in the region of that. I couldn't say  
18 the exact numbers for that, yes.

19 Q. HEMS obviously works very closely with the London  
20 Ambulance Service.

21 A. Yes, very much.

22 Q. Can you just explain to us the process by which HEMS are  
23 called to attend any scene which they are required to?

24 A. Yes, the paramedics that are seconded to the charity  
25 have two roles. Firstly, they operate the dispatch desk

1 for the helicopter in the Ambulance Control room, and  
2 when they're not on the dispatch desk, they are either  
3 in the helicopter or as part of the team in the cars.  
4 Their role in the control room is essential, and  
5 a very difficult one. They have to sort out the seven  
6 or eight cases that exist, literally, in thousands of  
7 999 calls that come in to that room on a daily basis,  
8 those small number of cases that would really benefit  
9 from the skills of the doctor and paramedic team, and it  
10 is a very onerous task because information is often  
11 scant to begin with, and they have developed good skills  
12 in identifying the cause as early as possible so that we  
13 can task the helicopter as quickly as possible.  
14 But it simply isn't a case that the helicopter  
15 attends every motorcycle versus pedestrian or motorcycle  
16 versus car, because there are literally dozens of those  
17 occurring on a daily basis in a city the size of London.  
18 So we have to tailor it to make sure we get to the right  
19 patient and that's their job.  
20 Q. That sifting process, is that done entirely by the  
21 paramedic based at Ambulance Control --  
22 A. Yes.  
23 Q. -- or do the other call handlers working for London  
24 Ambulance Service feed in particular areas which they  
25 think may be of interest to HEMS?

1 A. That's absolutely right. I mean, again, it's  
2 a collaborative approach. The people who take the calls  
3 may identify something very early on that looks  
4 suspicious or would warrant the team and they may flag  
5 it to the HEMS paramedic to identify the call early.  
6 There are, indeed, some incidences where we just  
7 automatically send the helicopter, where we've looked at  
8 data and realised that actually statistically you're  
9 going to be very ill in those circumstances; so,  
10 patients that have been hit by trains, patients that  
11 have fallen certain heights. There are certain  
12 categories where, as soon as that information is  
13 identified, we don't ask about the patient, we just  
14 launch on the mission.

15 Q. In the event of the London Ambulance Service declaring  
16 a major incident, would that also normally be something  
17 which automatically triggers a response by HEMS?

18 A. Yes, by the very nature of our day-to-day work, that  
19 flight paramedic is always looking for patients that are  
20 severely injured. So it's a simultaneous process in the  
21 context of a major incident.

22 Q. Can I turn now to deal briefly with the events of  
23 7 July 2005?

24 A. Yes.

25 Q. We've heard from a number of your colleagues. On that

1 day, we know that there were more medical teams  
2 available than usual because there was a clinical  
3 governance day being run by HEMS.

4 A. Yes.

5 Q. That allowed you to employ -- sorry, to deploy 27  
6 doctors and paramedics to the various scenes.

7 A. That's correct.

8 Q. Perhaps if we could just bring up [INQ8391-11], this is  
9 a page which comes from your report written after  
10 7 July 2005.

11 A. Yes.

12 Q. I think that lists all the doctors and all the  
13 paramedics who attended the various scenes.

14 A. Yes.

15 Q. We can see there that, in Aldgate, yourself attended by  
16 road. At King's Cross, the attendance was by air.  
17 Edgware Road, also by air. Tavistock Square, by road,  
18 and Russell Square, by road?

19 A. That's correct.

20 Q. I've referred to the report and perhaps if we could just  
21 go to the first page of that report [INQ8391-1] just to confirm this  
22 is a report which you wrote after the events.

23 A. Yes, that is.

24 Q. Do you recall when you wrote it, approximately?

25 A. I think -- I cannot remember specifically, but it would

1 be a matter of weeks.

2 Q. We can see there under the heading "Source of  
3 Information" there's reference to the events of  
4 21 July 2005. So presumably at some point shortly  
5 thereafter?

6 A. Yes, that's right, there was another incident.

7 Q. You tell us in your report that initially you were  
8 notified at about 9.10 of incidents involving power  
9 surges on the Underground?

10 A. Yes.

11 Q. That had come via the chief pilot who himself had been  
12 informed through the London Ambulance Service, but  
13 again, that call had come from London Fire Brigade?

14 A. Yes, that I think had come from the flight paramedic on  
15 the HEMS desk at the time, who I think had recognised  
16 something unusual was happening.

17 Q. You were told that there were multiple incidents at  
18 Aldgate and Liverpool Street?

19 A. Yes.

20 Q. King's Cross and Russell Square, Edgware Road, but you  
21 were also told there were incidents at Paddington and  
22 Leicester Square.

23 A. Yes.

24 Q. Can I ask, over the course of the morning, did you  
25 receive better information about exactly where all of

1 the incidents were occurring? Were Paddington and  
2 Leicester Square ever excluded, to your knowledge?  
3 A. Not whilst we were operating at Aldgate. When we had  
4 finished dealing with the situation at Aldgate, we did  
5 receive information that King's Cross was still in need  
6 of support. So we mobilised there. But we weren't  
7 given a formal brief on the general situation and how  
8 the other sites were coping or, indeed, how many there  
9 were.

10 Q. You mention that you went to Aldgate and we've heard  
11 from Dr Lockey.

12 A. Yes.

13 Q. In respect of Aldgate, what I wanted to ask you about  
14 was, on your arrival -- and we know from the document  
15 we've just looked at that you arrived at just about  
16 9.30 --

17 A. Yes.

18 Q. -- to what extent was there a Command and Control  
19 structure already in place from the other emergency  
20 services?

21 A. I think it's fair to say that the infrastructure to the  
22 incident was quite primitive at that point. There were  
23 a few cordons set up, but it was very much work in  
24 progress, trying to set up the necessary infrastructure  
25 to deal with that, and by the word "infrastructure" what

1 I mean is parking points, loading points, triage points,  
2 casualty clearing points, all of these crucial places  
3 and roles that help treat a main incident.

4 Q. As the person who is going to fill the role of Silver  
5 doctor --

6 A. Yes.

7 Q. -- how easy was it for you to find your opposite numbers  
8 in the Ambulance Service, in the Fire Brigade, in the  
9 police, and gather the requisite information you needed?

10 A. I think we were very lucky that that occurred very  
11 quickly, literally within a few minutes I established  
12 contact with the ambulance incident officer, and then we  
13 made contact with the other Silver Commanders. The  
14 scene wasn't widespread so people were localised around  
15 the entrance and foyer to Aldgate. So it happened  
16 reasonably quickly.

17 Q. From discussions with your colleagues who attended other  
18 scenes, was that something which they also experienced,  
19 or did they have greater levels of difficulty?

20 A. Well, I think you've heard from many of the doctors  
21 previously at the inquest that some of them did  
22 experience some problems in getting the Silver Command  
23 group together in as timely a way as might have wished.

24 Q. How quickly were you aware that the incident wasn't  
25 caused by a power surge but was caused by an explosion,

1 possibly a bomb?

2 A. I think we were of that impression on the way to the  
3 incident, that whilst it was passed over as power surges  
4 on the phones, that certainly paramedic Matt Fisher was  
5 giving the impression that this looked like it was  
6 something else, that it was either crashes or an  
7 explosion.

8 Q. I want to move on to a separate topic of communications.  
9 You've mentioned the phones there. We've heard much  
10 evidence about the communication difficulties which were  
11 experienced on the day.

12 A. Yes.

13 Q. It appears that HEMS was no different from the other  
14 services. Can we have your report back up, [INQ8391-9]?  
15 Just focusing on the bottom, we can see there in your  
16 report that you identified that one of the problems is  
17 communications.

18 A. Yes.

19 Q. "Staff at all the incidents reported tremendous problems  
20 with both radio and mobile telephone communications.

21 "Contact with Gold or CAC [Central Ambulance  
22 Control] was at best sporadic and for most of the teams  
23 nonfunctional.

24 "When mobiles did work, nobody answered the number  
25 identified in the initial text from Central Ambulance

1 Control and staff simply queued.

2 "There were insufficient UHF radios available at the  
3 majority of the scenes."

4 In your statements you've provided you've gone  
5 a little bit further and you tell us at paragraph 58  
6 that the radio system would simply not carry the  
7 messages or only a very small proportion would get,  
8 through, approximately less than 10 per cent.

9 A. Mm-hmm.

10 Q. That reads as if you experienced considerable  
11 communication difficulties on the day. Would that be  
12 fair?

13 A. Yes, I think that is a fair comment. The plan obviously  
14 identifies that we should try and communicate with the  
15 whole chain of command and it was something that was  
16 difficult to do and, when the plan asks you to do that,  
17 it does cause apprehension if you can't do it.

18 Q. What, particularly, did you want to communicate to  
19 Central Ambulance Control which you weren't able to?

20 A. I think that's essentially about keeping the control  
21 room informed. I think from our point of view on the  
22 ground, there was no material issue that affected what  
23 we did or how we treated patients. Part of it is just  
24 a natural communication to let the control room know  
25 what is happening to us and what we're dealing with: it

1 wasn't specifically an issue that we couldn't -- we  
2 needed more resource or anything like that. It was just  
3 a natural communication back to them to let them know  
4 what was happening.

5 Q. Presumably, one of the things you would like to know is  
6 whether or not more ambulances were on the way to the  
7 scenes?

8 A. I can only speak for Aldgate and we weren't deplete in  
9 that way. There was never a point where we didn't have  
10 a vehicle to put a patient into or a means of transport  
11 to take the patient to hospital. So it didn't  
12 materially affect us like that. We never got to the  
13 point where we needed more resource.

14 Q. Although not at Aldgate, that would be the sort of  
15 information, though, you would usually like to know;  
16 would that be fair?

17 A. Yes, I mean, one key element of communication for the  
18 health system is to identify where and how many  
19 resources you need or ambulances that you need.

20 Q. Presumably, the other information you would like to know  
21 is which hospitals are ready to admit patients?

22 A. I think the answer to that question is "Yes" and "No".  
23 In a major incident, once a hospital, particularly  
24 a teaching hospital the size of Barts and the  
25 London Trust, you know, once their plan has been

1 activated, exactly what its capacity is, what its surge  
2 capacity is, and just a working knowledge of those  
3 hospitals will give you an appreciation of what they can  
4 take, how many patients per hour and of what severity.  
5 So it is not as essential as you might think that,  
6 once they've triggered a switch and activated the plan,  
7 you have an idea of exactly how many patients you can  
8 send.

9 Q. But where there are a number of multiple incidents  
10 across London, presumably that information becomes more  
11 critical because you have a number of different sites  
12 sending patients to a number of different hospitals all  
13 over London and, therefore, knowing which is the right  
14 hospital to send your patients to becomes even more  
15 essential than at a single incident?

16 A. I would still say that if you are the Medical  
17 Incident Commander at a scene and you know we were aware  
18 that the nearest teaching hospital had declared its  
19 plan, it really doesn't affect what you do or how you  
20 manage the patients, knowing about the other incidents.  
21 I think you could make a case, if the hospital had  
22 been involved in some form of terrorist attack, then  
23 that information is patently important to know.

24 Q. We've heard a lot about the introduction of Airwave  
25 digital radios, and HEMS now has the benefit of that,

1 doesn't it?

2 A. Yes, that's correct.

3 Q. In addition, you've also purchased your own analogue

4 radios --

5 A. Yes.

6 Q. -- for line of sight communications at the scene?

7 A. Exactly.

8 Q. One thing I wanted to ask you about in respect of the

9 Airwave digital radio system is something you say at

10 paragraph 71 of your statement. You said:

11 "In theory, these radios allowed communications

12 between the emergency services."

13 It was the words "in theory" I wanted to ask you

14 about. From your experience, in practice, are the

15 talkgroups widely used at all?

16 A. We have -- certainly not on an operational, day-to-day

17 situation, it is not something that happens. The reason

18 I put in the words "in theory" there is that there is

19 a line of thought that that might not necessarily be

20 good.

21 Q. What's that line of thought?

22 A. Well, quite simply, that you break down the Command and

23 Control structure so that, if you have a member of the

24 Ambulance Service or HEMS liaising with the police

25 service or Fire Service at a local level, and other

1 people in the chain of command aren't aware of that  
2 conversation or decisions, then you do end up  
3 potentially with a breakdown in the Command and Control  
4 structure.

5 Historically, if you are going to pass information,  
6 it goes up the chain and down the chain, thereby  
7 everyone in the chain knowing what's going on. So  
8 that's why I added the words "in theory". It is not  
9 necessarily something that we would look to do or  
10 encourage, but that's not to say there may be a specific  
11 time where it may be helpful.

12 Q. As a Silver doctor at a scene, by and large you wouldn't  
13 want to use the talkgroups?

14 A. No.

15 Q. But if it was required, if you were separated from your  
16 other corresponding Silvers, then that of itself would  
17 be useful?

18 A. Yes, yes, I think the key point, as a Medical  
19 Incident Commander, is that you stand by the ambulance  
20 incident officer and your clinical decision-making  
21 should be together and most of the communications should  
22 be done through the ambulance incident officer.

23 Q. I want to move on to a separate topic. It's not one  
24 dealt with in your statement. I want to explore briefly  
25 with you triage.

1 A. Yes.

2 Q. We've heard evidence from Dr Mackenzie in respect of  
3 King's Cross that there was, in some respects,  
4 a duplication of triage, that the paramedics triaged and  
5 then the HEMS team also triaged.

6 A. Yes.

7 Q. Similarly, at Tavistock Square, Dr Teasdale was asked to  
8 retriage. So that had already been done by the  
9 paramedics. I think it's fair to say that triage is  
10 a dynamic process.

11 A. Yes.

12 Q. The concern obviously about duplication of triage, is  
13 that that can lead to delay in treatment. But are there  
14 actually benefits of the HEMS team retriaging?

15 A. Yes, I think it's a very important part of the response,  
16 the role of triage, and I think, over the years, we have  
17 underestimated the importance of it in producing a plan  
18 that produces the greatest survivability and,  
19 historically, the person that did the triage may not be  
20 that senior or experienced. I think what medicine now  
21 understands is that triage should be undertaken by the  
22 more senior people in an organisation.

23 So the fact that patients underwent retriage is  
24 a good thing, because it is a dynamic process and  
25 patients can improve and patients can deteriorate.

1 Just referring to your point about delay, there are  
2 two ways of undertaking triage. For inexperienced  
3 personnel, it's quite a didactic process where you  
4 measure the heart rate, measure the respiratory rate,  
5 et cetera, and you come up with, essentially, a score  
6 that gives the patient a category.  
7 More senior people literally eyeball a patient and  
8 can tell who is the sickest, literally in a few seconds.  
9 So the sort of triage that takes place by senior HEMS  
10 doctors and perhaps paramedics is slightly different to  
11 more inexperienced personnel who haven't seen this sort  
12 of thing on a regular basis. It's done very quickly.  
13 I think it's probably also worth pointing out that  
14 the patients that were being triaged by ambulance  
15 personnel on the ground, those patients are very rare.  
16 An individual paramedic or ambulance person would see  
17 a patient with those sorts of injuries once every two  
18 years or something of that nature. To have someone  
19 triage them who deals with it on a daily basis and sees  
20 several patients of that gravity every day, they are  
21 obviously in a place to make a much more clear and quick  
22 decision of that patient.  
23 Q. Where someone with less experience compared to  
24 a clinician, such as a paramedic, conducts a triage with  
25 someone with significant trauma, is it right there can

1 be a danger of what is called over-triage, so assigning  
2 too high a priority to the particular patient?

3 A. Yes.

4 Q. Or undertriage, assigning too low a priority?

5 A. Yes.

6 Q. That of itself could have knock-on consequences for --

7 A. Triage can be a dangerous process unless it's done  
8 accurately. You may feel that simply labelling everyone  
9 as "very severe" is in the interests of every patient,  
10 and they'd all get to hospital as quickly as possible.  
11 But quite frankly, what that does is move the incident  
12 from the scene to the hospital. There has to be some  
13 sort of process of prioritising the patients.

14 Q. On 7 July, where HEMS took on a more active role in  
15 triaging at certain scenes, did that improve the overall  
16 response in terms of moving patients to hospitals in the  
17 right order, as it were, so limiting over-triage or  
18 undertriage?

19 A. Yes, it does affect your survivability and the mortality  
20 from the incident.

21 If you over-triage and you just move everyone to the  
22 hospital in a high priority category, then the hospital  
23 becomes swamped. There will be too many patients to go  
24 into the resuscitation room.

25 So the problem is just moved. It hasn't been

1 sorted.

2 So it is really important that senior people do that  
3 processing and, actually, that processing takes place on  
4 arrival at hospital, and then, when the patient is being  
5 resuscitated in the emergency room, that process then  
6 takes place again by a senior surgeon, and they decide  
7 the priority on which patient should go to the -- which  
8 patient should go to theatre first.

9 So over-triage is important to get right, just as  
10 much as undertriage. If you label a patient as not  
11 being severely injured, but it turns out that they were,  
12 of course they potentially come to harm by being not  
13 left at scene but delayed in the prioritisation.

14 Q. I'm not going to go to it in detail, but I think you  
15 contributed to an article in the Lancet about the events  
16 of 7 July 2005 in triaging.

17 A. Yes.

18 Q. The research from that article showed that, where HEMS  
19 did the retriage process, or the initial triage, there  
20 was a lower rate of over-triage than at other scenes  
21 where the role had been predominantly done by the  
22 paramedics?

23 A. Yes, and I think that's correct and simply represents  
24 the degree of experience.

25 Q. One of the things you mentioned was that obviously

1 paramedics don't experience these nature of injuries  
2 very often, maybe once every two years.

3 In your view, is there any benefit in trying to  
4 improve the triage training which paramedics have to  
5 improve their response to more traumatic injuries?

6 A. I think any training you can provide is always a good  
7 thing for patients. I think the most important thing is  
8 that the people undertaking it are the most experienced  
9 because a lot of the response or performance at triage  
10 is based on experience and the most important thing is  
11 to not put junior and inexperienced people into that  
12 role, make sure that they are experienced, and I'm sure  
13 there are many experienced paramedics throughout the  
14 Ambulance Service who would perform at a very high level  
15 when it comes to triage, the same as many doctors.

16 Q. Then presumably, similarly, the earlier the deployment  
17 of clinicians such as HEMS doctors, the better?

18 A. Yes.

19 Q. Can I move on to pre-hospital care?

20 A. Yes.

21 Q. It appears from your statement, your evidence, that  
22 pre-hospital care is not as well established in the UK  
23 as it is in other countries. Western Europe,  
24 Scandinavia, Australia.

25 A. That's correct.

1 Q. I suppose the first question is: why is that?

2 A. I don't think I can really answer that. I think it's  
3 simply a historical position.

4 What we do know is that pre-hospital medicine as  
5 a sub-specialty of medicine exists in the United States  
6 and in other countries. It just doesn't currently exist  
7 at the moment in this country.

8 LADY JUSTICE HALLETT: In whose hands lies that decision,  
9 Dr Davies?

10 A. In whose hands? That is in the hands of the General  
11 Medical Council who essentially accredit specialties and  
12 sub-specialties, and there's a legal process for  
13 defining a sub-specialty such as paediatrics,  
14 obstetrics, everyone recognises those sub-specialties.  
15 Not many people have heard of pre-hospital medicine as  
16 yet.

17 MR HAY: We've heard evidence that there is the possibility  
18 that pre-hospital medicine will become a sub-specialty.

19 A. Yes.

20 Q. I think the last point we heard was that it was at  
21 phase 2 of the application before the GMC.

22 A. Yes.

23 Q. I know nothing about the phases. What are the next  
24 steps which need to happen?

25 A. Well, unfortunately, it went into phase 2 but got

1 knocked back recently, which is a big blow to all of us  
2 who have desperately been working towards this for most  
3 of our careers. So we do have another opportunity to  
4 re-submit to stage 2 to try to get it through, and then  
5 move on to the third stage.

6 LADY JUSTICE HALLETT: The basis of the knock-back?

7 A. I think several issues. One of the most important is  
8 the recognition of need, because to many people their  
9 response to the issue of pre-hospital medicine is "Well,  
10 we have an Ambulance Service, why do we need  
11 pre-hospital medicine as a sub-specialty?". That's  
12 a difficult issue to get across to many people.

13 Then I think there were issues regarding the  
14 assessment of the training programme and things,  
15 technical issues.

16 LADY JUSTICE HALLETT: What happens if you get recognition  
17 as a sub-specialty? What is the practical effect?

18 A. Well, I think for -- the practical effect is that people  
19 who are training to become consultants in emergency  
20 medicine or anaesthesia will have a recognised  
21 qualification in pre-hospital care and that in per se  
22 you may not think is very much, but actually, around the  
23 country, the amount and number of doctors involved in  
24 pre-hospital care is still relatively small, whether  
25 it's doctors that do jobs like mine or they are doctors

1 that are medical directors of ambulance services, they  
2 are all small in number at the present time.

3 What it will allow is for people to go into those  
4 posts, or posts be developed for them to go into. So  
5 there are air ambulances up and down the country that  
6 currently don't have any doctors on them or they have  
7 doctors on them but they're unrecognised positions.

8 MR HAY: Presumably, it would improve the training of junior  
9 doctors. Those who wanted to embark upon the  
10 sub-specialty would have to have specific training in  
11 pre-hospital care?

12 A. Yes, so it would cascade down, like every specialty in  
13 medicine. You're taught about paediatrics and  
14 obstetrics as a student. You would then be taught about  
15 pre-hospital medicine as a student, which is something  
16 that we do now at Barts and the London Trust, but is not  
17 very common throughout the rest of the country.

18 I think the most important practical element of it  
19 is getting medicine in its wider sense to understand the  
20 needs of patients when they're not in hospitals. So the  
21 medical needs of patients that are at mass gatherings or  
22 football stadiums, the medical needs of patients in  
23 major incidents, the medical needs of patients that are  
24 treated by ambulance services. Not many doctors have an  
25 understanding of it in this country.

1 Q. Would that come down to decision-making? "Is this  
2 someone I can treat now on the scene, or is this someone  
3 I should be getting to a hospital as quickly as  
4 I possibly can?", and having to make that decision very,  
5 very quickly?

6 A. Some of it is about the medicine that's delivered,  
7 you're absolutely right, or deciding where patients  
8 should be treated. But some of it is also about  
9 planning, and organising, and predicting.

10 So if you take mass casualty medicine and stadium  
11 medicine, it's working out what sort of health load  
12 exists in an event like that. Medicine doesn't have  
13 a great handle on those issues at the present time.

14 A specialty of -- the sub-specialty of pre-hospital  
15 medicine will bring that into medicine and allow regions  
16 to cater for it, plan for it and, if you plan for  
17 something, you stand a better chance of treating it and  
18 getting a good outcome.

19 LADY JUSTICE HALLETT: Usually, if something sounds like  
20 a good idea and it doesn't go through, the nasty  
21 question of money raises its ugly head.

22 You haven't said anything about money so far --

23 A. No.

24 LADY JUSTICE HALLETT: -- apart from obviously funding the  
25 HEMS service, but you haven't said anything about money

1 when it comes to recognising it as sub-specialty. Does  
2 money play any part?

3 A. Yes, money will eventually play a part because the GMC  
4 may grant a sub-specialty recognition, but a budget  
5 doesn't come with it. So, for example, if a region such  
6 as Yorkshire wanted to create something like we have in  
7 London here, someone would have to fund the salaries of  
8 those doctors involved, so, yes, fundamentally there  
9 will be.

10 LADY JUSTICE HALLETT: You mentioned how one of the  
11 important aspects is planning. Have you been involved  
12 in the planning -- looking at your report, it doesn't  
13 suggest to me that you have been either involved  
14 sufficiently or involved at all -- in planning for, for  
15 example, things like the Olympics next year?

16 A. Yes, we have had some involvement in the issues around  
17 the Olympics and we've had regular meetings with the  
18 medical director involved with that.  
19 We specifically are obviously only involved in a few  
20 events, most events in the Olympics are not  
21 life-threatening or present a major threat to patients,  
22 so there are a few that we will be engaging with as  
23 a charity to support them.

24 LADY JUSTICE HALLETT: I was thinking more if anything  
25 terrible, God forbid, happened.

1 A. From a major incident point of view, no, we haven't been  
2 engaged in planning from that point of view.

3 LADY JUSTICE HALLETT: You say in your report -- I'm sorry,  
4 I'm probably pre-empting Mr Hay's questions -- but you  
5 say that you haven't been consulted formally with regard  
6 to the Civil Contingencies Act, you've not been asked to  
7 contribute to the latest edition of the document, and it  
8 seems as if the London Emergency Services Liaison Panel  
9 seems to be carrying on without you.

10 Is that a bad reading of what you're saying?

11 A. I think we do get a little mention in the plan, but  
12 I think it would be very helpful, and I think we could  
13 contribute to the overall plan for London in any future  
14 editions of the document.

15 The document doesn't come out particularly  
16 frequently. It may well account for some of the reasons  
17 why we aren't. But I think we do have experience as an  
18 organisation, a charity, of major incidents over the  
19 years and we could potentially contribute to the plan.

20 LADY JUSTICE HALLETT: So you weren't asked to contribute.  
21 When was the latest edition of the plan? The London  
22 Emergency Services Liaison Panel plan.

23 MR HAY: There is one due to be published this year,  
24 my Lady. I think the eighth edition from recollection.

25 I can't remember the precise date of the seventh

1 edition. It may have been about 2007, but I could be  
2 wrong about that.

3 MR SAUNDERS: 2007.

4 MR HAY: 2007.

5 LADY JUSTICE HALLETT: You say in your report you would  
6 welcome the opportunity to consult on the plans and  
7 their execution, but you seem to find out about it by  
8 means of the press.

9 You don't want to say because you're trying to be  
10 diplomatic, Dr Davies; I'm not.

11 A. We would welcome the opportunity to contribute to it,  
12 and we have had experience that I think could help.

13 I think one of the -- if we look at the LESLP  
14 document, it could be considered quite a theoretical  
15 document because, for example, where the charity  
16 supports the emergency services is very much at the back  
17 end of the document. It's just a helicopter, you may  
18 want to use it for moving patients or for other reasons.  
19 The document doesn't really acknowledge that our  
20 raison d'etre in supporting the Ambulance Service is  
21 about injury and we are usually aware of it reasonably  
22 soon after it happens. So we're more at the front end  
23 of the response than the back end.

24 LADY JUSTICE HALLETT: What did you mean when you said in  
25 the report, "Approaches were made to emergency planners,

1 Strategic Health Authority, both regionally and  
2 nationally. Little funding or support came forth", when  
3 you tried to submit, with, I think, the London Ambulance  
4 Service, proposals to deliver an enhanced service for  
5 major incidents? So you prepared a report as to how  
6 you'd responded to 7/7?

7 A. No, this was in response to 7/7, both myself and  
8 Dr Fiona Moore, other representatives of London  
9 Ambulance Service and, indeed, representatives from  
10 Barts and the London, we were making an effort to  
11 produce a resilient plan that would cater for a similar  
12 event in the future. We all recognised that how the  
13 charity contributed was very much by fortune, that it  
14 was a governance day, and we could respond with more  
15 doctors and teams. We wanted to work with the Ambulance  
16 Service to produce that in a more robust way in the  
17 future. So both ourselves and LAS and the hospital made  
18 representations to the Strategic Health Authority, to  
19 London Trauma Office, to try and deliver plans that  
20 wouldn't be based on a voluntary response or a look,  
21 essentially.

22 MR HAY: It wasn't just those two organisations. It was  
23 also the London Emergency Planning Office and the London  
24 Specialist Commissions which you submitted the plans to.

25 A. Yes.

1 Q. Has there been any response at all from any of those  
2 organisations?

3 A. In terms of getting funding, very, very little. I think  
4 we've moved a little bit lately in the last couple of  
5 months, that there is a plan in place that has some  
6 financial support to deliver a robust response, but it's  
7 actually -- it's not, in my view, sufficient to deliver  
8 the sort of response that we delivered on 7 July.

9 Q. Is the position today, God forbid an incident happened  
10 tomorrow, but there would be effectively one team,  
11 clinician and a paramedic, on duty?

12 If you then needed to muster more clinicians and  
13 more paramedics, how would you go about doing that in  
14 a very short space of time?

15 A. Well, I think we have, with everyone's efforts, nudged  
16 it to two teams that we could respond to two incidents  
17 with a Medical Incident Officer and a MERIT team or  
18 doctors working at the coalface.

19 Q. You've used the term "MERIT team", can you explain what  
20 that is?

21 A. Sorry, a MERIT team, the words stands for "Medical  
22 Emergency Response Incident Team", which is a bit of  
23 a mouthful and doesn't really make things very clear.  
24 But essentially, they are a mobile medical team that  
25 used to come out of hospitals, but I think the

1 Government recognised that taking doctors out of  
2 a hospital that was being besieged by a major incident  
3 was not a good thing, and that there had to be  
4 a capability of producing a mobile medical team to  
5 incidents such as 7/7 or Paddington and they renamed  
6 that team a MERIT team, and that could be -- it could  
7 come from hospitals or such as places like London where  
8 the charity exists, they could help support that MERIT  
9 function.

10 Q. So going back to my question, effectively you would have  
11 two teams who could be deployed by HEMS, a MERIT team  
12 who could be deployed --

13 A. Yes, I mean, these MERIT teams are deployed under the  
14 London Ambulance Service. One of them would be the HEMS  
15 team, and there is a second team on call to provide that  
16 Medical Incident Officer post and a MERIT team.

17 But it's still very much contextualised in  
18 a voluntary capacity, and I think our passion was that  
19 we would try and produce something that was robust and  
20 part of the medical infrastructure and not based on  
21 people volunteering. Because we might volunteer, but  
22 there may be a generation that comes behind us that  
23 doesn't volunteer, and then we'd be vulnerable, I think.  
24 Fiona Moore and myself were desperate to get  
25 something in place that was robust and structured and

1 part of the health economy, so to speak, where people  
2 would be on call, paid to do it and responsible to do  
3 it, and we quite haven't realised our dream yet because  
4 I think we set out to deliver something that would at  
5 least respond to an incident like 7/7 where there were  
6 four incidents, so we haven't quite got to that point.

7 Q. That capacity really is nowhere near the 27 doctors or  
8 paramedics which were actually deployed on the day?

9 A. I think you have to be proportionate in what you ask  
10 for. Yes, it isn't, but you couldn't go to  
11 Commissioners and say, "We want 27 doctors on call for  
12 a major incident in London all the time". That would be  
13 unreasonable. But what we could do is produce something  
14 that would respond to something like 7/7. There will  
15 always be a voluntary response underneath that that  
16 would add in the extra doctors so that you could  
17 eventually produce something like we did on the 7th.

18 Q. That voluntary response, would that depend on paging  
19 those physicians who are not on call on HEMS that day --

20 A. Yes.

21 Q. -- and the like, and paramedics similar?

22 A. Yes, and a group of doctors and paramedics who have to  
23 have agreement from their Trusts that, in the case of an  
24 event, like 7/7, they can be deployed by the Ambulance  
25 Service.

1 Q. We moved on to resources --

2 LADY JUSTICE HALLETT: Just before you do, to put in place  
3 what you described as something robust and structured,  
4 are we talking many millions of pounds? Are we  
5 talking --

6 A. No.

7 LADY JUSTICE HALLETT: What sort of sums are we talking  
8 about, ever so roughly?

9 A. I think just under one, wasn't it? Just under one.

10 LADY JUSTICE HALLETT: Just under one million?

11 A. Yes, not a -- and --

12 MR HAY: Is that £1 million per annum, is that a rolling  
13 cost?

14 A. Yes, but actually, there were huge economies of scale in  
15 there, because those doctors don't necessarily have to  
16 sit at home doing nothing. They can contribute to the  
17 trauma system and we designed it such that those doctors  
18 would do trauma retrievals between hospitals in the  
19 trauma networks of London. So they wouldn't be sat  
20 idle, they would be contributing to the health economy  
21 all the time.

22 And, as I think I pointed out to you, in my report,  
23 this specialty or the issue of emergency preparedness is  
24 not a part of medicine that receives a lot of money for  
25 research and, like every specialty, you need to research

1 it for it to get better and to understand it.

2 So there is -- there's a huge vacuum there that,  
3 again, could be mopped up by those individuals looking  
4 at research into major incidents and how best to deal  
5 with them and make sure that medicine and everyone  
6 understands them better in the future.

7 Q. Going back to the plans which were submitted to the GMC,  
8 which were rejected, are there plans to submit again in  
9 the near future?

10 A. Yes. When I say it's been knocked back, we do have  
11 a second chance.

12 Q. Is there only a second chance, or is there a chance to  
13 keep on going?

14 A. I couldn't answer that specifically, but I ...

15 Q. Do you know when that application is going to be made  
16 again?

17 A. I haven't got the dates at hand, but it's literally  
18 measured in weeks and months, not -- it's not something,  
19 you know, six or seven months down the line.

20 Q. Two final topics, both fairly short. Can we just have  
21 up on the screen, please, [BARTS49-9]? I just want to ask  
22 you about paragraph 94 of your statement.

23 Towards the bottom, you say:

24 "Plans are not delivered by remote centres of

25 Command and Control but by robust infrastructures at the

1 scene. Centres of Command and Control do need to ensure  
2 the resources are sent to the right place and in the  
3 right amount, but an overemphasis on the role of remote  
4 Command and Control will defocus on the issues that  
5 produce survivability."

6 As we understand it, the current position is that  
7 there is a Silver doctor and a Silver medic at each  
8 scene.

9 A. Yes.

10 Q. I think we're going to hear evidence that the London  
11 Ambulance Service are planning to have the Silver  
12 tactical role, a different role I think referred to as  
13 Silver Tango, in the incident control room.

14 A. Yes.

15 Q. Is that something which you would support or something  
16 which would cause you concern?

17 A. I would support. I think the most important thing is  
18 that, in major incidents, it's very easy to look at  
19 communication as being an issue why things may or may  
20 not have gone well and, actually, the focus should not  
21 necessarily all be on the Command and Control and  
22 communication and deciding which patient should go  
23 where.

24 We should be in a position where, once an incident  
25 has gone off and the Ambulance Service -- the number of

1 ambulances have been defined and the hospital that is  
2 the receiving hospital been defined, that actually  
3 relatively little information needs to flow, that  
4 actually those on the ground can get on with the work in  
5 hand in putting the infrastructure down, and one thing  
6 that you see is weak in lots of debriefs and plans  
7 around the country is this issue of infrastructure, how  
8 long did it take you to put the infrastructure in place.  
9 In many ways, we could have that as an audit  
10 standard, like we have audit standards in various other  
11 areas of medicine. It's not conceptually there yet for  
12 major incidents, and that's because there's very little  
13 research or medical time put into the phenomenon.

14 Q. Provided at the scene you have the Silver medic --  
15 sorry, the Silver doctor and the Silver -- the ambulance  
16 incident officer, provided you have those two people at  
17 the scene, you're confident that the scene is  
18 sufficiently managed?

19 A. I think you would need all the roles, you would need  
20 a Silver in the Ambulance Control, but you also need an  
21 equivalent of the old AIO, if that's the best term to  
22 use, plus the MIO at the scene to run the incident,  
23 because it's on the ground, making sure that everyone is  
24 doing the jobs that they're supposed to do, encouraging  
25 them in the most onerous and difficult of circumstances

1 to get things right.

2 If that isn't there, and that isn't done well, then  
3 the chances of survivability are reduced because you  
4 won't have the right treatment, you won't -- you'll have  
5 delays from leaving the scene, et cetera.

6 Q. Dr Davies, a final, very discrete topic from me. You  
7 mention in your statement that, as far as you're aware,  
8 HEMS don't have a system for establishing the  
9 identification and location of trains on the  
10 Underground.

11 I think we're going to hear evidence that the London  
12 Ambulance Service in conjunction with London Underground  
13 now have a unique reference number for Underground  
14 stations which are provided. Presumably, if the London  
15 Ambulance Service have that, that's something which  
16 would then be passed to the HEMS paramedics sitting in  
17 the control room in any event?

18 A. Yes, I would hope so, yes. I'm not aware of it, but ...

19 MR HAY: Dr Davies, thank you very much. Those are all the  
20 questions that I have, but there may be some more for  
21 you.

22 LADY JUSTICE HALLETT: Before you are asked questions,  
23 Dr Davies, can we go back to liaison at the scene  
24 between the various people and getting the  
25 infrastructure in place?

1 When you arrived at Aldgate, where did you go to  
2 make sure you got the group of Silver together?

3 A. It's a very simple process of marching round, asking  
4 where the person in senior is or the Silver Commander  
5 for the police, and literally treading the boards to  
6 find those individuals and literally corralling them  
7 into a group and, at that point, most times we would  
8 move to a specific vehicle for a meeting, a command  
9 vehicle.

10 LADY JUSTICE HALLETT: I think I was told at some stage that  
11 there were meant to be specific rendezvous points in  
12 Underground stations. Was that system working, as far  
13 as you are aware, on 7 July?

14 A. Rendezvous points, no, I wasn't specifically aware of  
15 a rendezvous point other than the entrance to a ...

16 LADY JUSTICE HALLETT: So you would just go up to somebody  
17 in a Fire Brigade uniform or an ambulance uniform and  
18 say, "Where's your chap in charge?"

19 A. Yes, because there is a -- the reality of the situation  
20 is that the police, fire and ambulance all have their  
21 own roles and the individual commanders need to be  
22 making sure that their specific jobs are being done.  
23 It is at times quite difficult to get that Silver  
24 group together, because it may feel quite -- the need  
25 for it at times might not be obvious to the various

1 members of the group, but, for example, if you want to  
2 park the ambulances at point X, you need the police to  
3 help you move vehicles and allow that to happen.  
4 We have had incidents in the past where -- over the  
5 years, where that hasn't happened because the Silver  
6 group hasn't got together or has been delayed and, human  
7 factors being human factors, each individual is often  
8 looking at their own particular issues and sometimes  
9 bringing them together is a difficult issue.  
10 But, again, that I think could be reflected in the  
11 LESLP document, the importance of that meeting. I can  
12 cite a major -- a declared major incident last year  
13 where it didn't happen. Mercifully, there were no  
14 patients involved. But the Silver Command meeting never  
15 took place.  
16 So it is a difficult issue, it's still a difficult  
17 issue the more we understand about major incidents, but  
18 it's very person dependent and you literally have to  
19 pull people physically together at times to make it  
20 happen.  
21 LADY JUSTICE HALLETT: So when you arrived, there's no  
22 question of finding a group of Silver there ready,  
23 waiting for you; you had to go round and find them?  
24 A. It's not happened yet.  
25 LADY JUSTICE HALLETT: So it's still not happening? If you

1 arrive at the scene of an extremely unpleasant, nasty  
2 incident, you're still not finding Silver Commanders  
3 there?

4 A. No, you will find them at various locations. You have  
5 to bring them together. I don't think it's in anyone's  
6 minds that the Silver Commanders should meet at point X.  
7 They have to bring themselves together.

8 LADY JUSTICE HALLETT: It seems so simple, Dr Davies.

9 A. Yes, it --

10 LADY JUSTICE HALLETT: Am I being overly simple?

11 A. No, I mean, you're right. It is simple. But actually,  
12 in the emotion and chaos in the first few minutes of  
13 a major incident, where these individuals are all being  
14 approached by multiple people from their own  
15 professional groups, asking them questions, it is very  
16 hard to gather them together into this group. But it  
17 has to be a focus, and should be -- it's things like  
18 this that research can help propagate and disseminate  
19 that as an issue. It's -- things like the LESLP  
20 document can be more robust on issues like that.

21 LADY JUSTICE HALLETT: I appreciate that you weren't at the  
22 other sites, but you've obviously considered what went  
23 on that day throughout the whole of the dreadful day.  
24 As far as liaison at other sites was concerned, there  
25 were plainly difficulties in getting the groups

1 together.

2 Do I take it that, from your understanding of what  
3 happened at the other sites, your colleagues had even  
4 more trouble getting the various Silver Commanders  
5 together?

6 A. From what I heard from my colleagues, yes, some of them  
7 did experience problems getting the group together.

8 MR HAY: At your site, because Aldgate was a contained site,  
9 it was less of an issue, whereas at King's Cross, which  
10 was a much larger site, with different levels inside the  
11 Underground, outside the Underground station, it was  
12 much more of an issue?

13 A. Yes, I think that is partly it. But again, experience  
14 and authority helps. Getting more senior people into  
15 those roles, and being more motivated, making it happen,  
16 obviously helps the situation. So probably a mixture of  
17 both in reality.

18 LADY JUSTICE HALLETT: It's obviously something that  
19 training plays an important part in, and the evidence  
20 seems to suggest that an awful lot of people in senior  
21 management roles are going to a lot of meetings about  
22 emergency planning, but what I haven't been clear about  
23 as yet is the extent to which the training in how you  
24 should respond to a major incident, the training, and  
25 how important it is getting the structure in place about

1 which you've just spoken, has been sent down the line to  
2 the people who are actually going to arrive at the  
3 scene, who are going to be confronted with the chaos,  
4 the carnage, the desperation.

5 Do you think there's room for this training to be  
6 far greater, all the way down the line, with the various  
7 emergency services?

8 A. Yes, I mean I think that's fair comment, and it  
9 certainly wouldn't do harm. Particularly not just  
10 within our service, but interservice training, which is  
11 very hard to coordinate and make happen. But I think  
12 all of us would acknowledge the major incidents that  
13 have really gone well are when people know each other  
14 and they've trained together. There can't be too much  
15 of an emphasis on that.

16 MR HAY: Going back to HEMS' integration with the other  
17 emergency services in respect of emergency planning, do  
18 HEMS doctors and paramedics, specifically in their HEMS  
19 hat, as it were, attend inter-agency training?

20 A. Relatively infrequently. Not as frequently as we would  
21 like it.

22 Q. How frequent is it at the moment, Dr Davies?

23 A. I mean probably once every few years. So it's more of  
24 an organisational involvement because not every doctor  
25 will.

1 MR HAY: No more questions from me, my Lady.

2 LADY JUSTICE HALLETT: Right. Mr Saunders?

3 Questions by MR SAUNDERS

4 MR SAUNDERS: As your Ladyship knows, Ms Thomson and I have  
5 been looking at triage and all of this as well as  
6 representing the families we do, and we've touched on  
7 a number of matters already between your Ladyship and  
8 Mr Hay.

9 Can I ask you this, Dr Davies, to start with: you  
10 went, first of all, to Aldgate?

11 A. Correct.

12 Q. At Aldgate, there had been no formal clearance of CBRN,  
13 chemical, biological, radiological, nuclear?

14 A. Yes.

15 Q. But that didn't prevent you and your team going straight  
16 to work, as it were?

17 A. Yes.

18 Q. We know for some of the organisations there were some  
19 difficulties if things had not already been cleared.  
20 But is the position this, that you, the HEMS team, took  
21 the view, because you saw police officers, firemen, and  
22 other clinicians already below ground, you decided that  
23 the problems were not so serious that it would prevent  
24 from you going down?

25 A. I mean, I think this makes a very good point about the

1 Silver level meeting and also makes the case for having  
2 MIOs and doctors involved, because --  
3 Q. We're trying not to use acronyms. We're getting better,  
4 but after five months, we should be. But we are really  
5 trying, especially if I may say so --  
6 A. Sorry.  
7 Q. -- one of the issues -- I'm not in any way going to  
8 detract from what Mr Hay has said, and I have  
9 personally, on behalf of some of the families  
10 I represent, thanked those HEMS technicians, in  
11 particular Mr Nation and Dr Bland who dealt with  
12 Lee Harris, as you know.  
13 A. Yes.  
14 Q. But what we're trying to look at is, if her Ladyship  
15 felt she was in a position to make some recommendations,  
16 what issues maybe that you can assist us with. So we're  
17 trying to make sure we don't use --  
18 A. So if I can perhaps answer that with what we did at  
19 Aldgate, which is we didn't have CBRN clearance and we  
20 didn't have secondary device clearance. If we move the  
21 secondary device issue aside for a moment, when it comes  
22 to CBRN clearance, there are certain toxidromes, what  
23 patients look like, in chemical attacks, and quite  
24 simply for myself and Dr David Lockey we were able to  
25 discuss with each other, discuss with the other

1 Silver Commanders, that actually this incident does not  
2 look like or have any of the features of a chemical  
3 incident, and we are both well-read on the attacks on  
4 the Tokyo subway of Sarin and what have you.

5 So we were able to make a measured judgment about  
6 whether we should continue working in the tunnels and  
7 allow other personnel down there or not and, of course,  
8 it is -- it's always a judgment of risk.

9 The problem is that, again, this is about learning,  
10 training and education. You're trained that a Sarin  
11 attack is a chemical attack, is a gas that is odourless  
12 and tasteless and colourless. Well, actually, if you  
13 look at all the incidents that have involved Sarin, it's  
14 a very putrid smell, the terrorists can't make it very  
15 purely. People know that they are in the middle of  
16 a chemical attack.

17 Q. Can I stop you just for a moment? It's all right,  
18 Dr Davies, one of the themes I suggest -- and I'll ask  
19 you in terms of something later -- is that, if you have  
20 a mandatory or prescriptive decision that some  
21 organisations have to follow and feel they're obliged to  
22 follow, is that part of the difficulty, whereas with  
23 HEMS, because you are much more senior, some of you, you  
24 are able to make decisions on the spot of what you say?

25 A. I think that is absolutely the point. The plan is but

1 a framework on which to deal with these incidents. In  
2 every incident the Command team will face decisions that  
3 they have not come across before. They have to make  
4 judgments.

5 Obviously, the more medicine that is in that  
6 decision-making, the more robust it will be, and we were  
7 in a position to reassure the fire crews, reassure the  
8 police, that actually we could continue as we were and,  
9 yes, the chemical agent monitors eventually declared it  
10 as safe, which was just rubber-stamping, really.

11 Q. Can I ask you about one other matter? You felt, when  
12 you arrived, that it would be helpful to have had  
13 a hospital liaison officer.

14 A. Right.

15 Q. I think that's what you were saying, that you were  
16 minded to go back to the Control, have a hospital  
17 liaison officer deployed I think to the Royal London?

18 A. Sorry, did I say that or did I write that?

19 Q. You wrote that at paragraph (h) of your initial  
20 statement.

21 "We indicated to Control ..."

22 A. Oh, yes, yes.

23 Q. If you'd like to see it, it's INQ8391-3.

24 A. I do remember.

25 Q. First of all, I wanted to ask you, what is a hospital

1 liaison officer?

2 A. Well, it is, I think, very much a historical position  
3 within a major incident plan that a member of the  
4 Ambulance Service will go to the receiving hospital.

5 There is usually a radio point at that hospital where  
6 they can put in a radio and communicate perhaps back to  
7 the scene, or perhaps back to the Gold control.

8 It is part of the plan. As I think I've intimated  
9 several times today, how useful that role now is, in  
10 hindsight, is debatable. Obviously, when a hospital is  
11 reaching its surge capacity that information would be  
12 useful. But my point is that you should know what the  
13 surge capacity of a hospital is, so in many ways it's  
14 a role that is becoming increasingly defunct. There may  
15 be other issues that may help the Ambulance Service per  
16 se.

17 Q. But for a situation like this -- as Mr Hay says, we all  
18 pray that it never happens again -- but in a situation  
19 like that, is it a role that would have assisted or  
20 would assist in the future, having somebody who is  
21 a hospital liaison, to ensure that the surge -- when you  
22 refer to "surge", it's the number of patients --

23 A. Yes.

24 Q. -- or casualties who are suddenly taken to a particular  
25 hospital? The idea is to spread it to different

1 hospitals and, depending on whether you have  
2 a specialist burns trauma -- Burns Unit or neurological,  
3 that the right patient goes to the right hospital?  
4 A. I think in theory it may help, but I say that hesitantly  
5 because, whenever you put a role in like that, you have  
6 to make sure that the communication that comes back to  
7 the scene, that that individual truly understands the  
8 capacity and the capability of the hospital, and it  
9 should be the senior clinician, people like  
10 Alistair Wilson at the London, who feed that information  
11 into the liaison person.  
12 There is a danger that that person will be junior,  
13 not experienced, he will see a resuscitation room full  
14 and say, "Please don't send any more", whereas, if  
15 you're the doctor in that resuscitation room, you might  
16 know that three of those patients are about to go,  
17 they're going to theatre, and actually you do have the  
18 capacity. So that's why I hesitate.  
19 Q. So any recommendation should be on the basis that it's  
20 sufficient seniority?  
21 A. Yes, yes.  
22 Q. Can I then move on, please, because you were at Aldgate  
23 first and I think you then went across to King's Cross.  
24 A. Yes.  
25 Q. I think the point that her Ladyship was asking you

1 about, a rendezvous point, and we've heard various  
2 mentions of this. Again, in your principal report there  
3 were the communication problems Mr Hay has already asked  
4 you about, but also, at the time you arrived, you didn't  
5 know that there was a rendezvous point, notwithstanding  
6 it was King's Cross, which is obviously one of the  
7 principal stations in London.

8 A. Mm-hmm.

9 Q. Now again, certain things have been mentioned, but  
10 presumably it would assist if, in fact, the station  
11 supervisor was tasked with having somebody at the front  
12 door or at the rendezvous point, you arriving, as you  
13 did, I think, about 10.50, so some time after, would  
14 have been assisted knowing where the Silver meeting was  
15 taking place next?

16 A. Yes, but I think you also have to acknowledge that those  
17 Silver Commanders, yes, they can have a meeting, explore  
18 the issues that face each service, but they do have to  
19 break away and run the rest of the incident.

20 So it would not be a functional position to say you  
21 have a Silver Command point and you stay there and you  
22 don't do anything.

23 Q. Forgive me, my suggestion, or one of the thoughts, was  
24 that, if there was a rendezvous point, so that every  
25 team that turns up knows "That's where I must start" --

1 A. Yes, yes.

2 Q. -- there are, for good reasons often, a movement of  
3 Silver Command away from the scene in case of  
4 a secondary device?

5 A. Yes, yes.

6 Q. But the problem is, of course, if, like you, you've been  
7 to scene number 1, and are then going on, Silver Command  
8 has already moved on --

9 A. It has, yes.

10 Q. -- and you don't know where to go.

11 A. Yes.

12 Q. So you're wasting time --

13 A. Yes.

14 Q. -- unless you can be directed as to where Silver group  
15 are either themselves or the next group meeting taking  
16 place?

17 A. Are going to meet, yes.

18 Q. Thank you. In terms of the number of casualties, as  
19 we've heard, with King's Cross there was the need to, as  
20 it were, commandeer a bus because of the number of P3  
21 casualties?

22 A. Mm-hmm.

23 Q. I think one of the things that was done -- I don't know  
24 whether it was by you, under your direction -- was that  
25 various doctors went on the buses.

1 A. Yes.

2 Q. That's part of the plan, I think, isn't it?

3 A. Yes.

4 Q. That even if you have P3s, they should be escorted by

5 medically qualified -- and in that case I think it was

6 Dr Weaver --

7 A. It was Anne, yes, yes.

8 Q. -- who was the senior doctor.

9 You've mentioned already part of LESLP, the London

10 Emergency Liaison Panel. Our understanding is that the

11 current update is waiting for this inquest to complete.

12 A. That's my understanding.

13 Q. So should her Ladyship have any recommendations or

14 thoughts, it is actually in the process of waiting at

15 the moment for this matter to conclude. It's quite

16 clear that, having gone through, not only your

17 statements, but the other material, that HEMS -- your

18 body for which you're the clinical director -- are not

19 consulted or are part of what they call the core group

20 that contribute to that panel.

21 A. Yes.

22 Q. You've touched on it already, but is there, as far as

23 you can see, any reason why you shouldn't be a main

24 contributor?

25 A. No, perhaps just in the title, because the title is the

1 "emergency services", and we're not an emergency  
2 service. We support the emergency services, so perhaps  
3 in a titular way. But there is no other reason why we  
4 shouldn't.

5 Q. I mean, can you see any disadvantage to you not being  
6 a primary contributor?

7 A. No, no.

8 Q. It seems to me, as her Ladyship I think has already  
9 said, it's quite simple, isn't it, that you are  
10 attending as some of the most senior clinicians at major  
11 incidents?

12 A. Yes.

13 Q. Another topic, if I may, please. In the course of the  
14 evidence her Ladyship has heard, we have understood how  
15 the system works, with the priority 1s, 2s and 3s, but  
16 there is also -- and we've heard it twice so far --  
17 another category called "expectants", and those,  
18 Dr Davies, are those unfortunate casualties whom it is  
19 believed are not going to survive, that no matter what  
20 intervention there is, they will not survive.

21 This expectant category -- and we heard how one has  
22 to fold back the triage card with a special flash in the  
23 corner. My question to you is this: if one looks at the  
24 plan, the LESLP plan transferred into the major incident  
25 plan for London Ambulance, it appears that somebody can

1 only be designated into the expectant category if  
2 there's the authority of a Gold medic.  
3 Now, we know, because of what we've heard over the  
4 last few months, that there were problems with the  
5 communications here, there was no Gold medic at the  
6 scene. So how would it work in a situation like this?  
7 How does that sort of communication take place if  
8 somebody is triaging and they don't believe the person  
9 will survive, no matter what happens? Do they classify  
10 them as a priority 1 or are they entitled to use their  
11 discretion and to say that this is an expectant in those  
12 rare occasions?

13 A. I mean, that's probably an issue probably best dealt  
14 with by London Ambulance Service because it is not  
15 something -- it's not the authority that we give to  
16 people. I would only say that it's a monumental  
17 decision to make and it should be taken by the most  
18 senior person at scene, and the reality is that it is  
19 something that needs -- a judgment that needs to be made  
20 really in a matter of seconds.

21 It's not -- this isn't someone who's sat up and  
22 talking. This is someone whose life is ebbing away and  
23 unconscious and you can see that the totality of their  
24 injuries are not consistent with survival, and it's only  
25 a decision, I think, that can be made there. It's not

1 something that can afford to be made through a chain of  
2 command. It has to be devolved to people who are at the  
3 scene.

4 Q. Thank you. Moving on to the different types of triage.  
5 You've already again touched on the more senior person  
6 being able to triage hopefully more effectively to avoid  
7 the elements of both under and over-triaging.

8 A. Yes.

9 Q. Her Ladyship has heard evidence that, especially at  
10 Edgware Road, there was, as it were, a number of  
11 paramedics who were dealing with the triage concept,  
12 some of whom left or never took down their equipment,  
13 and the rationale behind it was: if we take equipment  
14 down, we're likely to get brought into treating, and,  
15 therefore -- Aldgate, forgive me -- and, therefore, if  
16 you don't take it, you can't therefore be brought in.  
17 But in terms of HEMS, your teams do take their  
18 equipment down, don't they?

19 A. Yes, it's a bit of a golden rule, you never get  
20 separated from your kit or equipment.

21 Q. Because?

22 A. Well, you never fundamentally know what role you'll end  
23 up taking, and you don't want to be left. You can, in  
24 that process, very quickly decant out elements of the  
25 equipment to perhaps other patients, to other bystanders

1 to help with issues. In that sort of scenario you are  
2 just simply doing your best.  
3 You do have to -- I would hate it -- the court to go  
4 away with the impression that, when you go to these  
5 scenes, you walk round and you don't interact with any  
6 of the patients when you try to establish the triage  
7 category or the number of patients or their severity.  
8 It is a process where you do engage with patients and  
9 you get people to do bits that they can possibly do, and  
10 that's why you should have equipment with you. You  
11 don't know that someone in that carriage may be a member  
12 of St John ambulance or have some first aid training, so  
13 it's prudent to have your equipment with you at all  
14 times.

15 Q. In fact, we saw at King's Cross, where Dr Bland and  
16 Mr Nation went down and Ketamine was then available to  
17 be administered to Lee Harris.

18 A. Yes.

19 Q. But what happens here if, in fact, there is no team  
20 coming immediately behind? It's a question we've asked  
21 a number of the emergency services.

22 The principle of triage we understand, that one goes  
23 through and prioritises, but once you've committed that,  
24 that role, what happens if there's no team immediately  
25 behind to treat?

1 A. It depends on the resources you have. If there is no  
2 other teams, medical teams, or -- I presume you're  
3 referring to medical teams, not ambulance teams in that  
4 scenario?

5 Q. Either.

6 LADY JUSTICE HALLETT: Treating teams.

7 MR SAUNDERS: Treating clinicians is I think the general way  
8 we have described it.

9 A. The most important thing is the person who does the  
10 triage at -- say, in the carriage, identifies which  
11 patients should leave first and which patients can have  
12 certain treatments. That individual will probably stay  
13 there administering aid to those in that arena until  
14 resources do come to help.

15 There are many things that you can do to expedite  
16 the patient's removal from the scene.

17 So they may engage in some of those processes and  
18 also engage with members of the public to help them.  
19 Unfortunately, it's a matter of thinking on your feet  
20 and making sure you do your best by your patients.

21 Q. Again, in terms of triaging and the labelling, the major  
22 incident plan is mandatory; every patient that's triaged  
23 must have a label attached?

24 A. Yes.

25 Q. Now, we know that at Edgware Road that didn't happen,

1 because there was a team looking at the patients and  
2 they were all in such close proximity they were able to  
3 explain to each other. But as far as you are concerned,  
4 if there is no labelling taking place and you're coming  
5 after the initial triage, does it not, in fact, delay  
6 everything that happens with you, if you're the first  
7 doctor downstairs, as it were?

8 A. Would the label -- I mean, in effect, I wouldn't look at  
9 the label. If I was coming down to triage the patient,  
10 I would simply look at the patient, and people who  
11 theorise about these triage systems and the labelling do  
12 talk that the labels can potentially do as much harm as  
13 good, that once someone is a 3, they stay a 3. Human  
14 nature makes it very difficult to upgrade it to a 2 or  
15 a 1 and patients that you might have thought were quite  
16 bad, but actually have come round from the shock of the  
17 event, so what I --

18 Q. You can only go one way, can't you, with these labels,  
19 because they tear off, if somebody is a 1, they can  
20 never go down to a 2 unless you relabel --

21 A. Yes, yes.

22 Q. -- because you've already torn off 3s and 2s?

23 A. And that's --

24 Q. So you wouldn't be in favour of the mandatory labelling  
25 for all patients?

1 A. Well, personally not, and we have never done that. We  
2 tend -- because triage is a dynamic process, you should  
3 be looking at the patient at that point in time, not  
4 what their label is.

5 So as long as -- if people are there to help remove  
6 the patient from that area, you can still look round and  
7 see what that patient is like, whether they've  
8 deteriorated or not, and I can only see a benefit, if  
9 there are literally hundreds upon hundreds upon hundreds  
10 of patients, where there will be whole segments of  
11 a train where there are no clinicians involved and  
12 people have gone round and labelled them, where it would  
13 be of use to ambulance staff to go in and just take that  
14 patient.

15 The reality, certainly for the events of 7/7, were  
16 these were relatively contained in a small area and any  
17 question could be asked as to who was what priority.

18 Q. Can I just mention and ask for your evidence on this:  
19 one of the aspects that's always -- and one reads about,  
20 is that it is effective because, if drugs have already  
21 been administered and it's on the label, by the time  
22 there's admission into hospital, the treating physician  
23 knows what drugs have already been given and when.

24 A. Yes, in theory.

25 Q. Apart from that, because obviously you're not likely to

1 have the same person taking the patient, the casualty,  
2 into the hospital, can you see any other formal reason  
3 why it would be of assistance at the hospital?

4 A. No, because when the patients get to hospital, they are  
5 retriaged.

6 Q. Obviously, the difficulty is knowing what drugs have  
7 already been administered?

8 A. Yes, so the benefit is, if a patient has been given  
9 drugs that may make them drowsy or sleepy, it's  
10 important that the doctors know that.

11 LADY JUSTICE HALLETT: Dr Davies, I'm getting the  
12 impression -- and please say if I'm getting the wrong  
13 impression -- that, the old adage, "a little learning is  
14 a dangerous thing" and a little training is a dangerous  
15 thing. Is that a fair assessment of what you're saying?

16 A. I mean, I think triage systems, triage labelling, is  
17 very much set up for mass, mass casualty situations, and  
18 I don't think their application to all incidents has  
19 been completely thought through. There are certain  
20 incidents where they aren't going to help, they may  
21 potentially hinder. But there are incidents in very  
22 large numbers where they could be beneficial.

23 But it goes back very much to my point that our  
24 understanding of major incidents and research round it,  
25 is still very primordial, and what we need is to

1 understand these issues more through academic research.

2 MR SAUNDERS: Her Ladyship heard evidence -- I hope this is  
3 an example -- from Dr Mackenzie on Day 36 explaining  
4 that he and his team had arrived and he deployed  
5 Dr Bland and Paramedic Nation to reconnaissance and to  
6 return.

7 A. Yes.

8 Q. Bearing in mind that this was now an hour into the  
9 situation, is that an explanation as to why he would  
10 want to know from somebody as senior as Dr Bland what  
11 the position was with those persons who were still below  
12 ground?

13 A. Yes, it's important. It's important that the medical --  
14 the doctor on the surface that's in charge has a good  
15 understanding of the number and severity, as the  
16 ambulance incident officer, both of them must have  
17 a good understanding of the number and nature of  
18 casualties.

19 Q. We've also heard reference to the "golden hour".

20 A. Yes.

21 Q. Now, is that something that you, as a clinician, would  
22 ever want to use or would ever want to be associated  
23 with, triage and treatment within that first period of  
24 time?

25 A. I think it is broadly accepted amongst specialists in

1 trauma that the golden hour exists, that in that first  
2 hour of serious injury you have an opportunity to get  
3 things right or wrong, and the more you get right at  
4 that point, the better the survival. Trying to correct  
5 problems further down the line becomes less fruitful.

6 Q. We had exactly the same, I think, the evidence in  
7 respect of Tavistock Square, Dr Teasdale's evidence,  
8 coming as it did, their arrival some 35, 40 minutes  
9 after the bus that was blown up, having been told by  
10 Dr Harris, again, who was team leader, to go to  
11 retriage. That seems to be the theme, does it, that  
12 your teams will go in to retriage rather than  
13 immediately treat?

14 A. Yes, because fundamentally, for survivability for the  
15 whole incident, you need to get the right patients to  
16 the right hospital in the right time and sorting them  
17 out in some sort of priority is the -- probably the most  
18 important issue and this concept of retriage takes place  
19 all the way down the patient's path all the way to the  
20 point of getting into intensive care.

21 Q. We've heard two different timings. One witness --  
22 forgive me if I can't remember the name -- who said that  
23 triaging can take between 30 and 40 seconds, and the  
24 suggestion it can be done as quickly as 10 seconds, and  
25 your evidence today which is you can look at someone,

1 you don't need to worry about going through the  
2 algorithm --  
3 A. No.  
4 Q. -- of breathing, airway, breathing, circulation. You  
5 can just look with your experience and know what has to  
6 happen?  
7 A. Yes.  
8 Q. So from that one takes that there is no optimum time,  
9 it's more to do with the experience of the clinician  
10 observing --  
11 A. That's exactly right.  
12 Q. -- and knowing how to prioritise from there?  
13 A. That's exactly right.  
14 MR SAUNDERS: Would your Ladyship forgive me for one moment?  
15 Ms Thomson has done so much on this, I'm sure I've  
16 missed something.  
17 LADY JUSTICE HALLETT: Of course. Whilst Mr Saunders is  
18 checking that, Dr Davies, I can't remember, I haven't  
19 got the document in front of me, were you asked -- I use  
20 the term globally -- was London's air ambulance asked to  
21 assist the Greater London Assembly inquiry?  
22 A. Yes, we were.  
23 MR SAUNDERS: In fact, one of the recommendations, my Lady,  
24 is at [INQ8310-39].  
25 It will come up on the screen in front of you,

1 Dr Davies. It's recommendation 32, the recommendation  
2 was that the London Ambulance Service review its  
3 mechanisms for finding out and recording the identity of  
4 seriously injured patients. I think it came on to deal  
5 with, did it not, HEMS as well, "request that the London  
6 Ambulance Service come forward with possible solutions  
7 in time for our follow-up review ..."

8 I think HEMS had dealings with that part of --

9 LADY JUSTICE HALLETT: No, well, I wasn't meaning --  
10 I appreciate how important this was to the bereaved  
11 families, but I was thinking more of the actual response  
12 and the question of -- well, all the matters we have  
13 been exploring today. Did the London Air Ambulance  
14 Service or Charity give evidence to the Greater  
15 London Assembly on the kind of matters we've been  
16 exploring?

17 A. No, not at all.

18 LADY JUSTICE HALLETT: Not at all?

19 A. No.

20 LADY JUSTICE HALLETT: They were only asked to deal with  
21 this kind of thing, the question of tracking the injured  
22 and deceased?

23 A. We were primarily asked about the communications --

24 LADY JUSTICE HALLETT: Right.

25 A. -- issues.

1 LADY JUSTICE HALLETT: I think that was actually the main  
2 thrust of the review, wasn't it?

3 MR SAUNDERS: Yes. Did you not attend one of the committee  
4 reviews, Dr Davies?

5 A. Yes.

6 Q. I think it was the chair, Richard Barnes, whom  
7 your Ladyship has heard about, and I think one of the  
8 reasons you were asked to attend is because of your vast  
9 experience -- we've only touched on some of the major  
10 incidents you've attended, but it includes Paddington --  
11 so one of the reasons they were asking for you was about  
12 the Gold structure as well, communication and the  
13 difficulties getting back to Gold?

14 A. Yes, communications, yes.

15 Q. You were able to -- there were no specific difficulties  
16 because of the seniority that you had at scene --

17 A. Yes.

18 Q. -- and were able to deal with because your teams were  
19 spread --

20 A. Yes.

21 MR SAUNDERS: -- as her Ladyship has already heard, over  
22 each of the main sites?

23 My Lady, that reference to Dr Davies is INQ8311-126.  
24 Page 124 of the hearing on 11 January.  
25 Thank you very much, my Lady.

1 LADY JUSTICE HALLETT: Thank you, Mr Saunders. Mr Coltart?  
2 Questions by MR COLTART  
3 MR COLTART: Just two topics, thank you, Doctor.  
4 Can we return to the issue of patient distribution?  
5 A. Yes.  
6 Q. I wonder whether we could have on screen your report,  
7 which is [LAS653-4].  
8 If we highlight the middle of the page, please.  
9 Mr Saunders took you to paragraph (h) when he was  
10 asking you questions:  
11 "We indicated to Control that we would need  
12 a hospital liaison officer deployed to Royal London, but  
13 Control indicated that the number of incidents may  
14 preclude this."  
15 A further doctor arrives at 9.40.  
16 A. Yes.  
17 Q. Then you say this at (j):  
18 "Mobile telephone communications were also proving  
19 extremely difficult. Despite good signal strength,  
20 establishing a dial tone was virtually impossible."  
21 You eventually managed to speak by phone to  
22 a Mr Alistair Wilson, a consultant at the A&E at the  
23 Royal London. You discussed the position at Aldgate,  
24 casualty numbers and so on, and thereafter you couldn't  
25 get your phone to work.

1 Then at (i) -- forgive me, (l), you say this:  
2 "At approximately 09.45, I had a discussion with  
3 Jonathan Edmondson and the AIO re removal of 70 or so P3  
4 patients. We tried contacting Gold Control to help us  
5 decide which hospital to send the patients (given there  
6 were multiple unknown events) but radio communication  
7 was ... impossible. Given the paucity of LAS vehicles  
8 and the risks at [the] scene we elected to move all the  
9 casualties by London buses to the  
10 Royal London Hospital."  
11 I think three busloads went. Does that ring a bell?  
12 A. Yes.  
13 Q. Were dispatched to the Royal London Hospital. Just in  
14 terms of the effect which that had at the  
15 Royal London Hospital, could we have on screen, please,  
16 [BARTS17-1]?  
17 We can see that this is the Royal London Hospital  
18 initial report into the events of 7 July, and if we move  
19 through to page 3 [BARTS17-3], could you highlight the section which  
20 is headed "Patient Flow", please:  
21 "There could be more communication with the Trust to  
22 aid communication between NHS organisations during major  
23 incidents so that the patient load can be spread between  
24 more organisations. This would enable effective  
25 management of patient flows to prevent overloading. The

1 Trust received three London Transport buses of P3  
2 patients."  
3 So there was a concern, wasn't there, at the  
4 hospital, of quite so many patients arriving all at the  
5 same time?

6 A. I mean, I actually don't think that that represents the  
7 sort of consensus view from the hospital in terms of  
8 patient flow. I think undoubtedly there are always  
9 people in an organisation responding like this that have  
10 a personal view on what was acceptable or what was not  
11 acceptable.

12 From our point of view, at the scene, we -- or  
13 I specifically knew exactly the capability of the  
14 hospital, because this is the hospital at which I'm  
15 a consultant, and myself and Alistair Wilson wrote the  
16 emergency plan that year. So we were well aware of what  
17 our capability and capacity was for patients in a major  
18 incident, and that included this volume of P3 patients.  
19 So we weren't, in essence, operating outside of our  
20 envelope in terms of capability.

21 Q. I don't want you to think for a moment that this is  
22 a criticism of the decision which you took on the day.

23 A. Oh, right.

24 Q. That's not the point I'm rather inelegantly seeking to  
25 make. But under other circumstances, it could have

1 serious ramifications, couldn't it, if a large number of  
2 patients are going to a particular hospital which then  
3 struggles to cope in circumstances where other hospitals  
4 are waiting for patients to arrive?

5 A. I think I could acknowledge that in theory, but actually  
6 if you ask patients, cohorting patients is a very  
7 important issue when it comes to major incidents, and  
8 that's certainly been recognised in the past, that  
9 patients, if they are decanted to many different  
10 centres, not only does it make the work of the police  
11 more difficult, but actually how those people are  
12 represented in that hospital is very different to being  
13 part of a cadre of patients who are treated at one  
14 institution.

15 So, for example, at a bus crash on the M25 recently,  
16 at night, I went to where there were 50 plus patients.  
17 They were decanted to literally eleven different  
18 hospitals, and the debriefs from those incidents quite  
19 clearly indicated that some patients felt very isolated  
20 being the only patient in that particular hospital with  
21 injuries that pertained to the bus crash. That actually  
22 there is -- part of the healing process is about being  
23 together.

24 So I don't think the answer is as simple as  
25 necessarily decanting patients around various

1 institutions. It would depend very much on the size of  
2 the incident and the severity of their injuries.

3 Q. I'm going to persevere, I'm afraid, just a little  
4 further. Could we have a look at [LAS197-2]?

5 This was the NHS HOT debrief on 11 July 2005.

6 I should say immediately that you don't appear on the  
7 list of attendees.

8 A. Yes.

9 Q. But I'm going to ask you to comment on a particular  
10 section of it. If we turn through to page 5 [LAS197-5], please, of  
11 the document, and highlight the bottom half of the page.

12 These were the observations made at that debrief  
13 meeting about communications with the London Ambulance  
14 Service on the day, and the various comments which were  
15 made were as follows:

16 "There was no Gold doctor/medic at the scene or  
17 contactable at all. This needs to be formalised."

18 "London Ambulance Service liaison officers should be  
19 present at each Trust. However some Trusts didn't have  
20 one straightaway and some not at all."

21 "Communications from the London Ambulance Service  
22 was dreadful with Trusts being put on alert, told to  
23 expect 700 walking wounded but nothing arrived.

24 However, other Trusts were overwhelmed."

25 That must be a situation best avoided, is it not,

1 during the course of a major incident?

2 A. I think if it were true, yes, I think the phrase  
3 "overwhelmed" isn't genuine or true, or the plans for  
4 these institutions are designed to deal with those sorts  
5 of numbers, and I think that's one of the key issues for  
6 emergency planning and preparedness in the future, is  
7 actually people crystallising what is overwhelmed and  
8 what isn't overwhelmed. Teaching hospitals of the  
9 nature of Barts and the London do plan to accept that  
10 number of P3 patients and to be catered for and allow  
11 the treatment of priority 1 and priority 2 patients.

12 Q. Just to approach the same issue from a different angle,  
13 it's not just a question of numbers, is it? It's  
14 a question of priority of patients. So by way of  
15 example, if we could go back to [BARTS17-2], this time --  
16 this is the report from the Royal London Hospital -- and  
17 enlarge the top half of the page, you see there a total  
18 of 27 patients admitted to hospital, trauma and  
19 admissions wards, ITU and one died in theatre.  
20 The patient who died in theatre was a lady whose  
21 interests I represent called Susan Levy. You had  
22 directed Alistair Mulcahy to dispatch her to the  
23 Royal London Hospital from King's Cross because the  
24 information which you had received was that  
25 University College Hospital, just round the corner,

1 could not take any more priority 1 patients.  
2 Now, we now know from other evidence which we've  
3 heard that the ambulance liaison officer at  
4 University College Hospital was a lady by the name of  
5 Stephanie Adams and she was trying, but failing, to  
6 convey to Gold control that UCH could, in fact, take  
7 more patients including P1s. All right?  
8 Now, you weren't to know any of this on the day, you  
9 can only act on the information you had available to  
10 you, and equally, I should say there's no evidence at  
11 all that it made any difference to the clinical outcome  
12 in Mrs Levy's case, but that, again, is a situation to  
13 be avoided, isn't it, P1 patients being transported  
14 further than they need to go in order to receive  
15 hospital treatment?  
16 A. Further than they need to go. The issue is not really  
17 about distance. It's about the capability of that  
18 institution and, as has been recognised in the last  
19 year, that Barts and the London Hospital is now one of  
20 the trauma centres, major trauma centres, for London,  
21 and UCH is not, and that is because of its performance  
22 and abilities on dealing with trauma patients.  
23 So I would -- and today we would be triaging  
24 patients past hospitals to get them to the right  
25 hospital that maximises their chance of survivability.

1 So it isn't just an issue of distance, and it may be  
2 a few minutes more to that hospital, but their chances  
3 of survival are far greater.

4 So I accept your point in theory, but it doesn't  
5 always hold that patients should just be decanted to the  
6 nearest hospital, because we do know that your chances  
7 of survival are far greater at certain institutions.

8 Q. To put your mind at rest, Dr Mulcahy gave precisely the  
9 same explanation in relation to Mrs Levy about the  
10 Royal London capabilities, but in principle, as you say,  
11 if you've got two hospitals with equal capabilities, one  
12 much closer than the other, you want to send them to the  
13 closest of those two hospitals?

14 A. I think in what you've just presented to me then, yes,  
15 without a doubt. If you know both have actioned their  
16 plans and they're both of the same capability to  
17 minimise the surge, you would decant them to both.

18 Q. Thank you. A completely separate topic and, I suspect,  
19 much shorter. Could we have up on the screen, please,  
20 [BARTS13-1]?

21 This was the HEMS debrief which you did attend, and  
22 in fact, I think you chaired it. If we turn through to  
23 page 3 [BARTS13-3] and enlarge the top half of the page, please,  
24 there's some discussion at the debrief about  
25 communication capabilities on the day.

1 David Gaunt says he drove past three of the sites,  
2 red base, which is Central Ambulance Control, told him  
3 to go to the Royal London Hospital, he wasted 45 minutes  
4 getting through to anyone but had received many text  
5 messages stating "contact us".

6 Mr McGovern indicated that he was on T-Mobile, which  
7 appeared to fair better than the other networks on the  
8 day, and he had uninterrupted coverage.

9 Then can I ask you about Dan Ellis? He had attended  
10 at the Russell Square incident. He stated there had  
11 been a recent discussion about mobile phones and that  
12 this had been swept under the carpet.

13 Now, taking this in stages to an extent, do you  
14 recall Mr Ellis making that observation at the debrief?

15 A. No, not at all, sorry.

16 Q. Were you aware of any discussion which had taken place  
17 about the perils of relying upon mobile phones in the  
18 weeks, months or possibly years leading up to 7 July?

19 A. I think one of the recommendations -- and  
20 Dr Fiona Moore may be better placed to answer this --  
21 that at previous incidents there had been a move away  
22 from radio communications to the use of mobiles  
23 historically, and that an emphasis had been put back on  
24 radio communication, the reason being that communicating  
25 with Gold control by phone, not everyone got to hear the

1 whole discussion. If you do it by radio, everyone hears  
2 the discussion, and that, by force of necessity and  
3 speed, people would be using phones sometimes to make  
4 certain communications just to speed the process up,  
5 because people would be talking on the radio and you  
6 want your opportunity to use the radio and it may not  
7 come.

8 So people would just use the phone.

9 It may refer to that issue, that historical issue,  
10 which I think came out of the Paddington debrief.

11 Q. We may explore that a little further with Mr Killens  
12 when he gives evidence, I anticipate now this afternoon.

13 But as far as Mr Ellis is concerned, I mean, his  
14 observation seems to suggest that someone had raised --  
15 someone within the HEMS team had raised a concern about  
16 the use of mobiles, but they felt as if it hadn't been  
17 given the attention which it deserved.

18 Do you, yourself, have any recollection of any such  
19 discussion?

20 A. The only other issue that I think I -- that may pertain  
21 to, which I've referred to in my report, was the use of  
22 ACCOLC -- I'm sorry for the acronym --

23 Q. No, we're familiar with that one, thank you.

24 A. -- that that was an issue that wasn't particularly clear  
25 at the time, so he may be referring to that.

1 MR COLTART: All right, okay. Thank you, Doctor.

2 LADY JUSTICE HALLETT: Yes, Ms Ormond-Walsh.

3 Questions by MS ORMOND-WALSH

4 MS ORMOND-WALSH: Just a few questions, if I may.

5 Dr Davies, during your evidence, you have mentioned  
6 a few times the question of surge capacity. I think the  
7 transcript a couple of times says "surgical capacity".  
8 That's page 16, line 4, and page 49, line 7. Would you  
9 just help us with what that is, please?

10 A. Surge capacity refers to the issue of the frequency with  
11 which patients arrive at a particular point.

12 So -- and it's really important that everyone  
13 understands their own surge capacity, whether it's at  
14 the emergency department or in theatres or at the  
15 intensive care unit.

16 You can have 25 patients arrive in an hour, and you  
17 may be able to -- not be able to deal with that, but  
18 actually, if half that number arrive in the first half,  
19 and half after, you may be able to deal with that flow  
20 rate.

21 So the issue refers specifically to the rate of flow  
22 of patients arriving at your particular point in the  
23 patient's pathway, and you need to know how many  
24 patients your resus room can take per half hour or per  
25 hour.

1 Similarly, theatres need to know how many patients  
2 they can take into theatre per hour or two hours,  
3 depending on the type of operations.

4 So it's one way of defining your capacity in a more  
5 functional way. So rather than just say we can accept  
6 194 patients, 194 P1 patients is very different to  
7 194 P3 patients, and it's very different if they're  
8 spread over four hours rather than one hour. So it's  
9 a tool that's used in our circles to describe your  
10 ability to cope.

11 Q. We know, on July 7, that most of the patients went to  
12 the Royal London Hospital. I know you weren't there,  
13 but you must know now how the Accident and Emergency  
14 coped. Can you give us a picture of that day in the  
15 Accident and Emergency and how the department coped?

16 A. I was very lucky in so much as the one time my phone did  
17 work was to speak with Alistair Wilson, who was the  
18 Commander in the emergency department at the Barts and  
19 the London, and it was much to my relief that the plan  
20 had been activated and he confirmed that the plan had  
21 been activated and that the various facets of it, both  
22 within the hospital and in the emergency department,  
23 were prepared to receive patients.

24 Both he and I, having worked together for many years  
25 and trained under Alistair, know intimately what the

1 hospital could cope with, hence the reasons for triaging  
2 patients as and when we did.

3 I think a reflection of the department's ability to  
4 cope on that day is made by the fact that we reopened  
5 for normal business by lunchtime the same day. So the  
6 flow rates or the surge capacity that we're used to in  
7 our hospital was easily matched and that we were able to  
8 carry on for our normal function by midday.

9 So I think he and the rest of the hospital did  
10 incredibly well.

11 Q. Alistair Wilson is, in fact, the founder of HEMS; is  
12 that right?

13 A. He is, yes.

14 Q. He's one of the most experienced A&E consultants in the  
15 country?

16 A. Yes, without a doubt, he has a wealth of knowledge on  
17 trauma and, indeed, pre-hospital care issues and major  
18 incidents. He himself has been involved in many major  
19 incidents and has run many major incidents at the  
20 hospital.

21 Q. The few days after July 7, is it true that volunteers  
22 came in, staff came in, on their days off and helped  
23 with the extra work?

24 A. Yes, as always with major incidents, the problems and  
25 issues echo on for many days, and we were very lucky

1 that staff would literally come in when they were  
2 off-duty to help with the increased workload in  
3 intensive care and in theatres, in the ensuing few days.

4 Q. I'd like to ask you a question about your involvement in  
5 LESLP and the meetings and the decisions in LESLP.

6 What percentage of the HEMS doctors have military  
7 backgrounds, that they have worked in war zones?

8 A. Probably in the region of 20, 30 per cent. We're very  
9 lucky at our unit that we attract very senior doctors  
10 from literally all over the world that come to get  
11 experience with us. A significant proportion of those  
12 come from military backgrounds and with them they bring  
13 an expertise on ballistic injuries, explosions. Indeed,  
14 our understanding of chemical incidents comes from the  
15 doctors that treated the patients at the Sarin attack in  
16 Tokyo, and they are military doctors, and they have  
17 contributed massively to our organisation.

18 So as an organisation, we have an understanding of  
19 what is, in many ways, warfare-type issues, are part of  
20 our makeup.

21 Q. Does that mean that you would be particularly useful in  
22 respect of being more involved with LESLP?

23 A. Well, yes, certainly, because there is a background of  
24 military experience and, in particular, care under fire  
25 and those sort of conditions, that we are aware of and

1 their expertise is ingrained in our unit, yes.

2 Q. Just one question about secondary devices.

3 The situation now, is it clear now what to do in  
4 relation to a risk of secondary devices? Is there clear  
5 guidance for you?

6 A. I mean, I think this is a particularly onerous position  
7 for every member of the emergency services, which is the  
8 issue of secondary devices and whether a scene is or not  
9 clear from that particular threat, and I think it would  
10 help all involved if there was a clarity on how and when  
11 an incident can or cannot be cleared of secondary  
12 devices.

13 I think, in our naivete in the past, that we  
14 expected multiple sniffer dogs and robots to appear and  
15 clear a scene and it is quite -- the reality is that  
16 that isn't the case, that there is an ever-present risk  
17 of secondary devices that face all of the emergency  
18 services, and I think it is important that documents  
19 like LESLP are crystal clear on issues like that  
20 because, when people hesitate to go into the Tube or go  
21 down on to the platforms, it's issues like that that  
22 just suddenly stick out and make everybody freeze, and  
23 unless it's absolutely clear, you could wait for quite  
24 a while for a robot or something to come and clear the  
25 scene, but the reality is it isn't going to happen.

1 So a clarity on issues like that and CBRN I think  
2 are really, really important, because it allows people  
3 to move forward in an informed way. They know the risks  
4 and they either accept them or don't accept them.

5 MS ORMOND-WALSH: Thank you. If you just bear with me for  
6 a moment. Thank you very much. Thank you, mm-hmm.

7 LADY JUSTICE HALLETT: Thank you. Mr Watson?

8 Questions by MR WATSON

9 MR WATSON: May I just ask you just two matters on behalf of  
10 the Ambulance Service? You've explained that your  
11 service is not a distinct emergency service in the  
12 technical sense.

13 A. That's correct.

14 Q. But you work in, as it were, a complementary and  
15 collaborative way with the Ambulance Service?

16 A. Yes.

17 Q. You've told us, for example, that, not only in  
18 a practical sense, but in a policy sense, you have  
19 worked alongside Fiona Moore in promoting the potential  
20 role of your particular service, yes?

21 A. Oh yes, yes.

22 Q. It's right to say that she is one of the consultants who  
23 is operative within the HEMS organisation, she wears two  
24 hats?

25 A. Yes, it's an extremely close working relationship.

1 Q. Not only is she the medical director for the Ambulance  
2 Service, but she's part of your team, if I can put it  
3 like that?

4 A. Yes, that's correct.

5 Q. When an incident occurs, the team that is deployed, if  
6 it is deployed, from HEMS is deployed, as you've told  
7 us, under the direction or coordination of the  
8 paramedics sitting in the Ambulance Control room --

9 A. That's absolutely correct.

10 Q. -- and it's probably silly to try to swap terms in terms  
11 of whether it's ordering, requesting, collaborating; it  
12 is an exchange of information?

13 A. Yes.

14 Q. It's not done on a military -- in a military sense?

15 A. No.

16 Q. But it would be right to say that from the perspective  
17 of the Ambulance Control room, the HEMS deployment is  
18 part of the deployment that they are directing to any  
19 particular incident. It's taken into account and  
20 coordinated from within that control room.

21 A. Yes, yes.

22 Q. Thank you. Just one other very minor matter. You were  
23 asked at the outset of your evidence about the blue  
24 light training.

25 A. Yes.

1 Q. Lest there be any misunderstanding, the five days that  
2 I think HEMS offers for paramedic training, I think, for  
3 blue light qualification, does that come on top of --

4 A. Oh, yes.

5 Q. -- a basic training they've already had?

6 A. Yes, absolutely, the ambulance personnel go through that  
7 basic training, and we have additional training because  
8 driving a response car is different to driving an  
9 ambulance and, also, at night-time, the length of the  
10 blue light runs are far greater than normal ambulance  
11 response would be.

12 Q. The basic point is the five days is a sort of special  
13 add on to the basic training they've already received --

14 A. Yes, absolutely.

15 Q. -- which, you may or may not be aware, is in the area of  
16 three weeks?

17 A. Yes, absolutely.

18 MR WATSON: Thank you. Thank you very much. No further  
19 matters.

20 LADY JUSTICE HALLETT: Thank you. Any other questions for  
21 Dr Davies?

22 Dr Davies, those are all the questions we have for  
23 you. Thank you very much indeed for all the help you've  
24 given me. On 7 July, you and the rest of the London Air  
25 Ambulance Service played a vital role in saving lives.

1 I don't know how many lives you saved, I can't count  
2 them, but save lives you did, and in terrible  
3 circumstances. So thank you to you and to the rest of  
4 your team. I've said it before to members of HEMS and  
5 I say it again. From everything I've heard, the London  
6 Air Ambulance Service is an excellent service, and  
7 I appreciate I haven't heard all the arguments and  
8 I don't have to make the difficult decisions about  
9 resources, but I have no doubt that everybody who's  
10 listened to the evidence throughout these proceedings  
11 would agree that you deserve proper funding and proper  
12 recognition.

13 If I feel, at the end of having heard submissions  
14 there is something I can do about it, I shall.

15 A. Thank you.

16 LADY JUSTICE HALLETT: Thank you.

17 A. I appreciate it.

18 LADY JUSTICE HALLETT: Right, 2.00.

19 (1.00 pm)

20 (The short adjournment)

21

22