Monday, 28 February 2011

(11.00 am)

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

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

LADY JUSTICE HALLETT: Thank you.

DR GARETH EDWARD DAVIES (affirmed)

Questions by MR HAY

MR HAY: Good morning.

A. Good morning.

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

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

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

A. That's correct, sir.

Q. Can I start first by just acknowledging through you the integral role played by HEMS on 7 July 2005?
As the medical director, what are your responsibilities?

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

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

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

A. Yes.

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

A. Okay.

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

A. Yes, that is correct.

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

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

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

A. Yes.

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

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

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

I call it that, we've been calling it HEMS throughout the whole proceedings.
A. Yes, I understand.
Q. Can I start with an obvious question? What is its primary purpose?
A. HEMS' primary purpose is essentially to support the statutory emergency services around patients who have severe injury. So, on a day-to-day basis, we provide a very senior doctor and paramedic who have special training in trauma, injury that is, and we are tasked to incidents, the few incidents, that occur in London that require the specialist skills of that particular team.
Q. I believe you attend on average about 7 to 8 calls per day?
A. Yes, in the region of 7 to 8.
Q. HEMS has been in existence since 1988?
A. Yes, that's correct.
Q. You mentioned the makeup of the HEMS team --
A. Yes.
Q. -- an experienced clinician and experienced paramedic?
A. Yes.
Q. On any given day, how many teams are on duty?
A. Essentially, we aim to provide one team, so one doctor and one paramedic per 24-hour shift. Occasionally, there are times when we have spare doctors and

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

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

A. Yes, very definitely.

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

A. Yes, sadly, yes.

Q. And five fast response cars?

A. Yes.

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

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

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

A. Yes, in the region of that.

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

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

Q. HEMS itself is a registered charity?
A. That's correct.
Q. How is it funded?
A. It has several funding streams. It operates as a charity, which means that we have income from corporate donors, but also just charitable donations, but we are also supported through the NHS; for example, our paramedics that are seconded to the unit come from London Ambulance Service and the doctors come from Barts and the London NHS Trust. So it's very much a collaborative project.
Q. Your website tells us that in addition to the NHS funding, and also the corporate funding, there is still a deficit of about a million pounds or so that needs to be raised from other sources?
A. Yes, it's constantly an uphill struggle to try to acquire the funding necessary to deliver the sort of service we aspire to.
Q. The service itself has attended a number of major incidents over the years prior to 7 July.
A. Yes.
Q. Including the Southall, Paddington and Potters Bar rail crash --
A. Yes.
Q. -- and the Bishopsgate and Aldwych bus bombs?

A. Yes, that's correct.
LADY JUSTICE HALLETT: Did I read recently that you had secured some funding for a year or two to come, or was that wishful thinking?
A. That was probably wishful thinking. The actual position is that the group concerned have helped finance the aircraft for another seven years, they're not a corporate sponsor as such. So they've just helped with us the purchase lease on the aircraft. So it's not a new sponsor like -- replacing Virgin.
MR HAY: Just to give my Lady some idea of the amount of missions attended -- again, something I've taken from your website, but hopefully you can confirm this is correct -- in 2009, HEMS attended 672 road traffic accidents, 377 falls from height, 349 stabbings and 69 shootings.
A. Yes, it would be in the region of that. I couldn't say the exact numbers for that, yes.
Q. HEMS obviously works very closely with the London Ambulance Service.
A. Yes, very much.
Q. Can you just explain to us the process by which HEMS are called to attend any scene which they are required to?
A. Yes, the paramedics that are seconded to the charity have two roles. Firstly, they operate the dispatch desk

for the helicopter in the Ambulance Control room, and when they're not on the dispatch desk, they are either in the helicopter or as part of the team in the cars. Their role in the control room is essential, and a very difficult one. They have to sort out the seven or eight cases that exist, literally, in thousands of 999 calls that come in to that room on a daily basis, those small number of cases that would really benefit from the skills of the doctor and paramedic team, and it is a very onerous task because information is often scant to begin with, and they have developed good skills in identifying the cause as early as possible so that we can task the helicopter as quickly as possible. But it simply isn't a case that the helicopter attends every motorcycle versus pedestrian or motorcycle versus car, because there are literally dozens of those occurring on a daily basis in a city the size of London. So we have to tailor it to make sure we get to the right patient and that's their job.

Q. That sifting process, is that done entirely by the paramedic based at Ambulance Control --

A. Yes.

Q. -- or do the other call handlers working for London Ambulance Service feed in particular areas which they think may be of interest to HEMS?

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

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

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

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

A. Yes.

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

day, we know that there were more medical teams available than usual because there was a clinical governance day being run by HEMS.
A. Yes.
Q. That allowed you to employ -- sorry, to deploy 27 doctors and paramedics to the various scenes.
A. That's correct.
Q. Perhaps if we could just bring up [INQ8391-11], this is a page which comes from your report written after 7 July 2005.
A. Yes.
Q. I think that lists all the doctors and all the paramedics who attended the various scenes.
A. Yes.
Q. We can see there that, in Aldgate, yourself attended by road. At King's Cross, the attendance was by air. Edgware Road, also by air. Tavistock Square, by road, and Russell Square, by road?
A. That's correct.
Q. I've referred to the report and perhaps if we could just go to the first page of that report [INQ8391-1] just to confirm this is a report which you wrote after the events.
A. Yes, that is.
Q. Do you recall when you wrote it, approximately?
A. I think -- I cannot remember specifically, but it would

be a matter of weeks.
Q. We can see there under the heading "Source of Information" there's reference to the events of 21 July 2005. So presumably at some point shortly thereafter?
A. Yes, that's right, there was another incident.
Q. You tell us in your report that initially you were notified at about 9.10 of incidents involving power surges on the Underground?
A. Yes.
Q. That had come via the chief pilot who himself had been informed through the London Ambulance Service, but again, that call had come from London Fire Brigade?
A. Yes, that I think had come from the flight paramedic on the HEMS desk at the time, who I think had recognised something unusual was happening.
Q. You were told that there were multiple incidents at Aldgate and Liverpool Street?
A. Yes.
Q. King's Cross and Russell Square, Edgware Road, but you were also told there were incidents at Paddington and Leicester Square.
A. Yes.
Q. Can I ask, over the course of the morning, did you receive better information about exactly where all of

the incidents were occurring? Were Paddington and Leicester Square ever excluded, to your knowledge?
A. Not whilst we were operating at Aldgate. When we had finished dealing with the situation at Aldgate, we did receive information that King's Cross was still in need of support. So we mobilised there. But we weren't given a formal brief on the general situation and how the other sites were coping or, indeed, how many there were.
Q. You mention that you went to Aldgate and we've heard from Dr Lockey.
A. Yes.
Q. In respect of Aldgate, what I wanted to ask you about was, on your arrival -- and we know from the document we've just looked at that you arrived at just about 9.30 --
A. Yes.
Q. -- to what extent was there a Command and Control structure already in place from the other emergency services?
A. I think it's fair to say that the infrastructure to the incident was quite primitive at that point. There were a few cordons set up, but it was very much work in progress, trying to set up the necessary infrastructure to deal with that, and by the word "infrastructure" what

I mean is parking points, loading points, triage points, casualty clearing points, all of these crucial places and roles that help treat a main incident.
Q. As the person who is going to fill the role of Silver doctor --
A. Yes.
Q. -- how easy was it for you to find your opposite numbers in the Ambulance Service, in the Fire Brigade, in the police, and gather the requisite information you needed?
A. I think we were very lucky that that occurred very quickly, literally within a few minutes I established contact with the ambulance incident officer, and then we made contact with the other Silver Commanders. The scene wasn't widespread so people were localised around the entrance and foyer to Aldgate. So it happened reasonably quickly.
Q. From discussions with your colleagues who attended other scenes, was that something which they also experienced, or did they have greater levels of difficulty?
A. Well, I think you've heard from many of the doctors previously at the inquest that some of them did experience some problems in getting the Silver Command group together in as timely a way as might have wished.
Q. How quickly were you aware that the incident wasn't caused by a power surge but was caused by an explosion,

possibly a bomb?
A. I think we were of that impression on the way to the incident, that whilst it was passed over as power surges on the phones, that certainly paramedic Matt Fisher was giving the impression that this looked like it was something else, that it was either crashes or an explosion.
Q. I want to move on to a separate topic of communications. You've mentioned the phones there. We've heard much evidence about the communication difficulties which were experienced on the day.
A. Yes.
Q. It appears that HEMS was no different from the other services. Can we have your report back up, [INQ8391-9]? Just focusing on the bottom, we can see there in your report that you identified that one of the problems is communications.
A. Yes.
Q. "Staff at all the incidents reported tremendous problems with both radio and mobile telephone communications.
"Contact with Gold or CAC [Central Ambulance Control] was at best sporadic and for most of the teams nonfunctional.
"When mobiles did work, nobody answered the number identified in the initial text from Central Ambulance

Control and staff simply queued.
"There were insufficient UHF radios available at the majority of the scenes."
In your statements you've provided you've gone a little bit further and you tell us at paragraph 58 that the radio system would simply not carry the messages or only a very small proportion would get, through, approximately less than 10 per cent.
A. Mm-hmm.
Q. That reads as if you experienced considerable communication difficulties on the day. Would that be fair?
A. Yes, I think that is a fair comment. The plan obviously identifies that we should try and communicate with the whole chain of command and it was something that was difficult to do and, when the plan asks you to do that, it does cause apprehension if you can't do it.
Q. What, particularly, did you want to communicate to Central Ambulance Control which you weren't able to?
A. I think that's essentially about keeping the control room informed. I think from our point of view on the ground, there was no material issue that affected what we did or how we treated patients. Part of it is just a natural communication to let the control room know what is happening to us and what we're dealing with: it

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

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

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

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

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

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

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

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

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

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

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

doesn't it?
A. Yes, that's correct.
Q. In addition, you've also purchased your own analogue radios --
A. Yes.
Q. -- for line of sight communications at the scene?
A. Exactly.
Q. One thing I wanted to ask you about in respect of the Airwave digital radio system is something you say at paragraph 71 of your statement. You said:
"In theory, these radios allowed communications between the emergency services."
It was the words "in theory" I wanted to ask you about. From your experience, in practice, are the talkgroups widely used at all?
A. We have -- certainly not on an operational, day-to-day situation, it is not something that happens. The reason I put in the words "in theory" there is that there is a line of thought that that might not necessarily be good.
Q. What's that line of thought?
A. Well, quite simply, that you break down the Command and Control structure so that, if you have a member of the Ambulance Service or HEMS liaising with the police service or Fire Service at a local level, and other

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

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

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

A. No.

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

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

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

A. Yes.
Q. We've heard evidence from Dr Mackenzie in respect of King's Cross that there was, in some respects, a duplication of triage, that the paramedics triaged and then the HEMS team also triaged.
A. Yes.
Q. Similarly, at Tavistock Square, Dr Teasdale was asked to retriage. So that had already been done by the paramedics. I think it's fair to say that triage is a dynamic process.
A. Yes.
Q. The concern obviously about duplication of triage, is that that can lead to delay in treatment. But are there actually benefits of the HEMS team retriaging?
A. Yes, I think it's a very important part of the response, the role of triage, and I think, over the years, we have underestimated the importance of it in producing a plan that produces the greatest survivability and, historically, the person that did the triage may not be that senior or experienced. I think what medicine now understands is that triage should be undertaken by the more senior people in an organisation.
So the fact that patients underwent retriage is a good thing, because it is a dynamic process and patients can improve and patients can deteriorate.

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

be a danger of what is called over-triage, so assigning too high a priority to the particular patient?
A. Yes.
Q. Or undertriage, assigning too low a priority?
A. Yes.
Q. That of itself could have knock-on consequences for --
A. Triage can be a dangerous process unless it's done accurately. You may feel that simply labelling everyone as "very severe" is in the interests of every patient, and they'd all get to hospital as quickly as possible. But quite frankly, what that does is move the incident from the scene to the hospital. There has to be some sort of process of prioritising the patients.
Q. On 7 July, where HEMS took on a more active role in triaging at certain scenes, did that improve the overall response in terms of moving patients to hospitals in the right order, as it were, so limiting over-triage or undertriage?
A. Yes, it does affect your survivability and the mortality from the incident.
If you over-triage and you just move everyone to the hospital in a high priority category, then the hospital becomes swamped. There will be too many patients to go into the resuscitation room.
So the problem is just moved. It hasn't been

sorted.
So it is really important that senior people do that processing and, actually, that processing takes place on arrival at hospital, and then, when the patient is being resuscitated in the emergency room, that process then takes place again by a senior surgeon, and they decide the priority on which patient should go to the -- which patient should go to theatre first.
So over-triage is important to get right, just as much as undertriage. If you label a patient as not being severely injured, but it turns out that they were, of course they potentially come to harm by being not left at scene but delayed in the prioritisation.
Q. I'm not going to go to it in detail, but I think you contributed to an article in the Lancet about the events of 7 July 2005 in triaging.
A. Yes.
Q. The research from that article showed that, where HEMS did the retriage process, or the initial triage, there was a lower rate of over-triage than at other scenes where the role had been predominantly done by the paramedics?
A. Yes, and I think that's correct and simply represents the degree of experience.
Q. One of the things you mentioned was that obviously

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

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

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

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

A. Yes.

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

A. Yes.

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

A. That's correct.

Q. I suppose the first question is: why is that?
A. I don't think I can really answer that. I think it's simply a historical position.
What we do know is that pre-hospital medicine as a sub-specialty of medicine exists in the United States and in other countries. It just doesn't currently exist at the moment in this country.
LADY JUSTICE HALLETT: In whose hands lies that decision, Dr Davies?
A. In whose hands? That is in the hands of the General Medical Council who essentially accredit specialties and sub-specialties, and there's a legal process for defining a sub-specialty such as paediatrics, obstetrics, everyone recognises those sub-specialties. Not many people have heard of pre-hospital medicine as yet.
MR HAY: We've heard evidence that there is the possibility that pre-hospital medicine will become a sub-specialty.
A. Yes.
Q. I think the last point we heard was that it was at phase 2 of the application before the GMC.
A. Yes.
Q. I know nothing about the phases. What are the next steps which need to happen?
A. Well, unfortunately, it went into phase 2 but got

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

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

A. I think several issues. One of the most important is the recognition of need, because to many people their response to the issue of pre-hospital medicine is "Well, we have an Ambulance Service, why do we need pre-hospital medicine as a sub-specialty?". That's a difficult issue to get across to many people. Then I think there were issues regarding the assessment of the training programme and things, technical issues.

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

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

that are medical directors of ambulance services, they are all small in number at the present time. What it will allow is for people to go into those posts, or posts be developed for them to go into. So there are air ambulances up and down the country that currently don't have any doctors on them or they have doctors on them but they're unrecognised positions.

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

A. Yes, so it would cascade down, like every specialty in medicine. You're taught about paediatrics and obstetrics as a student. You would then be taught about pre-hospital medicine as a student, which is something that we do now at Barts and the London Trust, but is not very common throughout the rest of the country. I think the most important practical element of it is getting medicine in its wider sense to understand the needs of patients when they're not in hospitals. So the medical needs of patients that are at mass gatherings or football stadiums, the medical needs of patients in major incidents, the medical needs of patients that are treated by ambulance services. Not many doctors have an understanding of it in this country.

Q. Would that come down to decision-making? "Is this someone I can treat now on the scene, or is this someone I should be getting to a hospital as quickly as I possibly can?", and having to make that decision very, very quickly?
A. Some of it is about the medicine that's delivered, you're absolutely right, or deciding where patients should be treated. But some of it is also about planning, and organising, and predicting.
So if you take mass casualty medicine and stadium medicine, it's working out what sort of health load exists in an event like that. Medicine doesn't have a great handle on those issues at the present time.
A specialty of -- the sub-specialty of pre-hospital medicine will bring that into medicine and allow regions to cater for it, plan for it and, if you plan for something, you stand a better chance of treating it and getting a good outcome.
LADY JUSTICE HALLETT: Usually, if something sounds like a good idea and it doesn't go through, the nasty question of money raises its ugly head.
You haven't said anything about money so far --
A. No.
LADY JUSTICE HALLETT: -- apart from obviously funding the HEMS service, but you haven't said anything about money

when it comes to recognising it as sub-specialty. Does money play any part?
A. Yes, money will eventually play a part because the GMC may grant a sub-specialty recognition, but a budget doesn't come with it. So, for example, if a region such as Yorkshire wanted to create something like we have in London here, someone would have to fund the salaries of those doctors involved, so, yes, fundamentally there will be.
LADY JUSTICE HALLETT: You mentioned how one of the important aspects is planning. Have you been involved in the planning -- looking at your report, it doesn't suggest to me that you have been either involved sufficiently or involved at all -- in planning for, for example, things like the Olympics next year?
A. Yes, we have had some involvement in the issues around the Olympics and we've had regular meetings with the medical director involved with that.
We specifically are obviously only involved in a few events, most events in the Olympics are not life-threatening or present a major threat to patients, so there are a few that we will be engaging with as a charity to support them.
LADY JUSTICE HALLETT: I was thinking more if anything terrible, God forbid, happened.

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

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

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

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

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

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

MR HAY: There is one due to be published this year, my Lady. I think the eighth edition from recollection. I can't remember the precise date of the seventh

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

MR SAUNDERS: 2007.

MR HAY: 2007.

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

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

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

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

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

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

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

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

A. Yes.

Q. Has there been any response at all from any of those organisations?
A. In terms of getting funding, very, very little. I think we've moved a little bit lately in the last couple of months, that there is a plan in place that has some financial support to deliver a robust response, but it's actually -- it's not, in my view, sufficient to deliver the sort of response that we delivered on 7 July.
Q. Is the position today, God forbid an incident happened tomorrow, but there would be effectively one team, clinician and a paramedic, on duty?
If you then needed to muster more clinicians and more paramedics, how would you go about doing that in a very short space of time?
A. Well, I think we have, with everyone's efforts, nudged it to two teams that we could respond to two incidents with a Medical Incident Officer and a MERIT team or doctors working at the coalface.
Q. You've used the term "MERIT team", can you explain what that is?
A. Sorry, a MERIT team, the words stands for "Medical Emergency Response Incident Team", which is a bit of a mouthful and doesn't really make things very clear. But essentially, they are a mobile medical team that used to come out of hospitals, but I think the

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

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

A. Yes, I mean, these MERIT teams are deployed under the London Ambulance Service. One of them would be the HEMS team, and there is a second team on call to provide that Medical Incident Officer post and a MERIT team. But it's still very much contextualised in a voluntary capacity, and I think our passion was that we would try and produce something that was robust and part of the medical infrastructure and not based on people volunteering. Because we might volunteer, but there may be a generation that comes behind us that doesn't volunteer, and then we'd be vulnerable, I think. Fionna Moore and myself were desperate to get something in place that was robust and structured and

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

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

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

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

A. Yes.

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

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

Q. We moved on to resources --
LADY JUSTICE HALLETT: Just before you do, to put in place what you described as something robust and structured, are we talking many millions of pounds? Are we talking --
A. No.
LADY JUSTICE HALLETT: What sort of sums are we talking about, ever so roughly?
A. I think just under one, wasn't it? Just under one.
LADY JUSTICE HALLETT: Just under one million?
A. Yes, not a -- and --
MR HAY: Is that £1 million per annum, is that a rolling cost?
A. Yes, but actually, there were huge economies of scale in there, because those doctors don't necessarily have to sit at home doing nothing. They can contribute to the trauma system and we designed it such that those doctors would do trauma retrievals between hospitals in the trauma networks of London. So they wouldn't be sat idle, they would be contributing to the health economy all the time.
And, as I think I pointed out to you, in my report, this specialty or the issue of emergency preparedness is not a part of medicine that receives a lot of money for research and, like every specialty, you need to research

it for it to get better and to understand it.
So there is -- there's a huge vacuum there that, again, could be mopped up by those individuals looking at research into major incidents and how best to deal with them and make sure that medicine and everyone understands them better in the future.
Q. Going back to the plans which were submitted to the GMC, which were rejected, are there plans to submit again in the near future?
A. Yes. When I say it's been knocked back, we do have a second chance.
Q. Is there only a second chance, or is there a chance to keep on going?
A. I couldn't answer that specifically, but I ...
Q. Do you know when that application is going to be made again?
A. I haven't got the dates at hand, but it's literally measured in weeks and months, not -- it's not something, you know, six or seven months down the line.
Q. Two final topics, both fairly short. Can we just have up on the screen, please, [BARTS49-9]? I just want to ask you about paragraph 94 of your statement.
Towards the bottom, you say:
"Plans are not delivered by remote centres of Command and Control but by robust infrastructures at the

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

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

to get things right.
If that isn't there, and that isn't done well, then the chances of survivability are reduced because you won't have the right treatment, you won't -- you'll have delays from leaving the scene, et cetera.
Q. Dr Davies, a final, very discrete topic from me. You mention in your statement that, as far as you're aware, HEMS don't have a system for establishing the identification and location of trains on the Underground.
I think we're going to hear evidence that the London Ambulance Service in conjunction with London Underground now have a unique reference number for Underground stations which are provided. Presumably, if the London Ambulance Service have that, that's something which would then be passed to the HEMS paramedics sitting in the control room in any event?
A. Yes, I would hope so, yes. I'm not aware of it, but ...
MR HAY: Dr Davies, thank you very much. Those are all the questions that I have, but there may be some more for you.
LADY JUSTICE HALLETT: Before you are asked questions, Dr Davies, can we go back to liaison at the scene between the various people and getting the infrastructure in place?

When you arrived at Aldgate, where did you go to make sure you got the group of Silver together?
A. It's a very simple process of marching round, asking where the person in senior is or the Silver Commander for the police, and literally treading the boards to find those individuals and literally corralling them into a group and, at that point, most times we would move to a specific vehicle for a meeting, a command vehicle.
LADY JUSTICE HALLETT: I think I was told at some stage that there were meant to be specific rendezvous points in Underground stations. Was that system working, as far as you are aware, on 7 July?
A. Rendezvous points, no, I wasn't specifically aware of a rendezvous point other than the entrance to a ...
LADY JUSTICE HALLETT: So you would just go up to somebody in a Fire Brigade uniform or an ambulance uniform and say, "Where's your chap in charge?"
A. Yes, because there is a -- the reality of the situation is that the police, fire and ambulance all have their own roles and the individual commanders need to be making sure that their specific jobs are being done. It is at times quite difficult to get that Silver group together, because it may feel quite -- the need for it at times might not be obvious to the various

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

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

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

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

A. Yes, it --

LADY JUSTICE HALLETT: Am I being overly simple?

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

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

together.
Do I take it that, from your understanding of what happened at the other sites, your colleagues had even more trouble getting the various Silver Commanders together?
A. From what I heard from my colleagues, yes, some of them did experience problems getting the group together.
MR HAY: At your site, because Aldgate was a contained site, it was less of an issue, whereas at King's Cross, which was a much larger site, with different levels inside the Underground, outside the Underground station, it was much more of an issue?
A. Yes, I think that is partly it. But again, experience and authority helps. Getting more senior people into those roles, and being more motivated, making it happen, obviously helps the situation. So probably a mixture of both in reality.
LADY JUSTICE HALLETT: It's obviously something that training plays an important part in, and the evidence seems to suggest that an awful lot of people in senior management roles are going to a lot of meetings about emergency planning, but what I haven't been clear about as yet is the extent to which the training in how you should respond to a major incident, the training, and how important it is getting the structure in place about

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

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

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

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

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

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

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

MR HAY: No more questions from me, my Lady.
LADY JUSTICE HALLETT: Right. Mr Saunders?
Questions by MR SAUNDERS
MR SAUNDERS: As your Ladyship knows, Ms Thomson and I have been looking at triage and all of this as well as representing the families we do, and we've touched on a number of matters already between your Ladyship and Mr Hay.
Can I ask you this, Dr Davies, to start with: you went, first of all, to Aldgate?
A. Correct.
Q. At Aldgate, there had been no formal clearance of CBRN, chemical, biological, radiological, nuclear?
A. Yes.
Q. But that didn't prevent you and your team going straight to work, as it were?
A. Yes.
Q. We know for some of the organisations there were some difficulties if things had not already been cleared. But is the position this, that you, the HEMS team, took the view, because you saw police officers, firemen, and other clinicians already below ground, you decided that the problems were not so serious that it would prevent from you going down?
A. I mean, I think this makes a very good point about the

Silver level meeting and also makes the case for having MIOs and doctors involved, because --

Q. We're trying not to use acronyms. We're getting better, but after five months, we should be. But we are really trying, especially if I may say so --

A. Sorry.

Q. -- one of the issues -- I'm not in any way going to detract from what Mr Hay has said, and I have personally, on behalf of some of the families I represent, thanked those HEMS technicians, in particular Mr Nation and Dr Bland who dealt with Lee Harris, as you know.

A. Yes.

Q. But what we're trying to look at is, if her Ladyship felt she was in a position to make some recommendations, what issues maybe that you can assist us with. So we're trying to make sure we don't use --

A. So if I can perhaps answer that with what we did at Aldgate, which is we didn't have CBRN clearance and we didn't have secondary device clearance. If we move the secondary device issue aside for a moment, when it comes to CBRN clearance, there are certain toxidromes, what patients look like, in chemical attacks, and quite simply for myself and Dr David Lockey we were able to discuss with each other, discuss with the other

Silver Commanders, that actually this incident does not look like or have any of the features of a chemical incident, and we are both well-read on the attacks on the Tokyo subway of Sarin and what have you.
So we were able to make a measured judgment about whether we should continue working in the tunnels and allow other personnel down there or not and, of course, it is -- it's always a judgment of risk.
The problem is that, again, this is about learning, training and education. You're trained that a Sarin attack is a chemical attack, is a gas that is odourless and tasteless and colourless. Well, actually, if you look at all the incidents that have involved Sarin, it's a very putrid smell, the terrorists can't make it very purely. People know that they are in the middle of a chemical attack.
Q. Can I stop you just for a moment? It's all right, Dr Davies, one of the themes I suggest -- and I'll ask you in terms of something later -- is that, if you have a mandatory or prescriptive decision that some organisations have to follow and feel they're obliged to follow, is that part of the difficulty, whereas with HEMS, because you are much more senior, some of you, you are able to make decisions on the spot of what you say?
A. I think that is absolutely the point. The plan is but

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

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

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

A. Right.

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

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

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

"We indicated to Control ..."

A. Oh, yes, yes.

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

A. I do remember.

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

liaison officer?
A. Well, it is, I think, very much a historical position within a major incident plan that a member of the Ambulance Service will go to the receiving hospital. There is usually a radio point at that hospital where they can put in a radio and communicate perhaps back to the scene, or perhaps back to the Gold control. It is part of the plan. As I think I've intimated several times today, how useful that role now is, in hindsight, is debatable. Obviously, when a hospital is reaching its surge capacity that information would be useful. But my point is that you should know what the surge capacity of a hospital is, so in many ways it's a role that is becoming increasingly defunct. There may be other issues that may help the Ambulance Service per se.
Q. But for a situation like this -- as Mr Hay says, we all pray that it never happens again -- but in a situation like that, is it a role that would have assisted or would assist in the future, having somebody who is a hospital liaison, to ensure that the surge -- when you refer to "surge", it's the number of patients --
A. Yes.
Q. -- or casualties who are suddenly taken to a particular hospital? The idea is to spread it to different

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

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

A. Mm-hmm.

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

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

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

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

A. Yes, yes.
Q. -- there are, for good reasons often, a movement of Silver Command away from the scene in case of a secondary device?
A. Yes, yes.
Q. But the problem is, of course, if, like you, you've been to scene number 1, and are then going on, Silver Command has already moved on --
A. It has, yes.
Q. -- and you don't know where to go.
A. Yes.
Q. So you're wasting time --
A. Yes.
Q. -- unless you can be directed as to where Silver group are either themselves or the next group meeting taking place?
A. Are going to meet, yes.
Q. Thank you. In terms of the number of casualties, as we've heard, with King's Cross there was the need to, as it were, commandeer a bus because of the number of P3 casualties?
A. Mm-hmm.
Q. I think one of the things that was done -- I don't know whether it was by you, under your direction -- was that various doctors went on the buses.

A. Yes.
Q. That's part of the plan, I think, isn't it?
A. Yes.
Q. That even if you have P3s, they should be escorted by medically qualified -- and in that case I think it was Dr Weaver --
A. It was Anne, yes, yes.
Q. -- who was the senior doctor.
You've mentioned already part of LESLP, the London Emergency Liaison Panel. Our understanding is that the current update is waiting for this inquest to complete.
A. That's my understanding.
Q. So should her Ladyship have any recommendations or thoughts, it is actually in the process of waiting at the moment for this matter to conclude. It's quite clear that, having gone through, not only your statements, but the other material, that HEMS -- your body for which you're the clinical director -- are not consulted or are part of what they call the core group that contribute to that panel.
A. Yes.
Q. You've touched on it already, but is there, as far as you can see, any reason why you shouldn't be a main contributor?
A. No, perhaps just in the title, because the title is the

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

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

A. No, no.

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

A. Yes.

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

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

only be designated into the expectant category if there's the authority of a Gold medic.
Now, we know, because of what we've heard over the last few months, that there were problems with the communications here, there was no Gold medic at the scene. So how would it work in a situation like this? How does that sort of communication take place if somebody is triaging and they don't believe the person will survive, no matter what happens? Do they classify them as a priority 1 or are they entitled to use their discretion and to say that this is an expectant in those rare occasions?
A. I mean, that's probably an issue probably best dealt with by London Ambulance Service because it is not something -- it's not the authority that we give to people. I would only say that it's a monumental decision to make and it should be taken by the most senior person at scene, and the reality is that it is something that needs -- a judgment that needs to be made really in a matter of seconds.
It's not -- this isn't someone who's sat up and talking. This is someone whose life is ebbing away and unconscious and you can see that the totality of their injuries are not consistent with survival, and it's only a decision, I think, that can be made there. It's not

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

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

A. Yes.

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

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

Q. Because?

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

to help with issues. In that sort of scenario you are just simply doing your best.

You do have to -- I would hate it -- the court to go away with the impression that, when you go to these scenes, you walk round and you don't interact with any of the patients when you try to establish the triage category or the number of patients or their severity. It is a process where you do engage with patients and you get people to do bits that they can possibly do, and that's why you should have equipment with you. You don't know that someone in that carriage may be a member of St John ambulance or have some first aid training, so it's prudent to have your equipment with you at all times.

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

A. Yes.

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

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

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

Q. Either.

LADY JUSTICE HALLETT: Treating teams.

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

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

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

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

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

A. Yes.

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

because there was a team looking at the patients and they were all in such close proximity they were able to explain to each other. But as far as you are concerned, if there is no labelling taking place and you're coming after the initial triage, does it not, in fact, delay everything that happens with you, if you're the first doctor downstairs, as it were?
A. Would the label -- I mean, in effect, I wouldn't look at the label. If I was coming down to triage the patient, I would simply look at the patient, and people who theorise about these triage systems and the labelling do talk that the labels can potentially do as much harm as good, that once someone is a 3, they stay a 3. Human nature makes it very difficult to upgrade it to a 2 or a 1 and patients that you might have thought were quite bad, but actually have come round from the shock of the event, so what I --
Q. You can only go one way, can't you, with these labels, because they tear off, if somebody is a 1, they can never go down to a 2 unless you relabel --
A. Yes, yes.
Q. -- because you've already torn off 3s and 2s?
A. And that's --
Q. So you wouldn't be in favour of the mandatory labelling for all patients?

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

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

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

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

A. Yes, in theory.

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

have the same person taking the patient, the casualty, into the hospital, can you see any other formal reason why it would be of assistance at the hospital?
A. No, because when the patients get to hospital, they are retriaged.
Q. Obviously, the difficulty is knowing what drugs have already been administered?
A. Yes, so the benefit is, if a patient has been given drugs that may make them drowsy or sleepy, it's important that the doctors know that.
LADY JUSTICE HALLETT: Dr Davies, I'm getting the impression -- and please say if I'm getting the wrong impression -- that, the old adage, "a little learning is a dangerous thing" and a little training is a dangerous thing. Is that a fair assessment of what you're saying?
A. I mean, I think triage systems, triage labelling, is very much set up for mass, mass casualty situations, and I don't think their application to all incidents has been completely thought through. There are certain incidents where they aren't going to help, they may potentially hinder. But there are incidents in very large numbers where they could be beneficial.
But it goes back very much to my point that our understanding of major incidents and research round it, is still very primordial, and what we need is to

understand these issues more through academic research.
MR SAUNDERS: Her Ladyship heard evidence -- I hope this is an example -- from Dr Mackenzie on Day 36 explaining that he and his team had arrived and he deployed Dr Bland and Paramedic Nation to reconnaissance and to return.
A. Yes.
Q. Bearing in mind that this was now an hour into the situation, is that an explanation as to why he would want to know from somebody as senior as Dr Bland what the position was with those persons who were still below ground?
A. Yes, it's important. It's important that the medical -- the doctor on the surface that's in charge has a good understanding of the number and severity, as the ambulance incident officer, both of them must have a good understanding of the number and nature of casualties.
Q. We've also heard reference to the "golden hour".
A. Yes.
Q. Now, is that something that you, as a clinician, would ever want to use or would ever want to be associated with, triage and treatment within that first period of time?
A. I think it is broadly accepted amongst specialists in

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

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

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

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

you don't need to worry about going through the algorithm --

A. No.

Q. -- of breathing, airway, breathing, circulation. You can just look with your experience and know what has to happen?

A. Yes.

Q. So from that one takes that there is no optimum time, it's more to do with the experience of the clinician observing --

A. That's exactly right.

Q. -- and knowing how to prioritise from there?

A. That's exactly right.

MR SAUNDERS: Would your Ladyship forgive me for one moment? Ms Thomson has done so much on this, I'm sure I've missed something.

LADY JUSTICE HALLETT: Of course. Whilst Mr Saunders is checking that, Dr Davies, I can't remember, I haven't got the document in front of me, were you asked -- I use the term globally -- was London's air ambulance asked to assist the Greater London Assembly inquiry?

A. Yes, we were.

MR SAUNDERS: In fact, one of the recommendations, my Lady, is at [INQ8310-39].

It will come up on the screen in front of you,

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

I think HEMS had dealings with that part of --

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

A. No, not at all.

LADY JUSTICE HALLETT: Not at all?

A. No.

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

A. We were primarily asked about the communications --

LADY JUSTICE HALLETT: Right.

A. -- issues.

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

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

A. Yes.

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

A. Yes, communications, yes.

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

A. Yes.

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

A. Yes.

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

My Lady, that reference to Dr Davies is INQ8311-126. Page 124 of the hearing on 11 January.

Thank you very much, my Lady.

LADY JUSTICE HALLETT: Thank you, Mr Saunders. Mr Coltart?

Questions by MR COLTART

MR COLTART: Just two topics, thank you, Doctor.

Can we return to the issue of patient distribution?

A. Yes.

Q. I wonder whether we could have on screen your report, which is [LAS653-4].

If we highlight the middle of the page, please.

Mr Saunders took you to paragraph (h) when he was asking you questions:

"We indicated to Control that we would need a hospital liaison officer deployed to Royal London, but Control indicated that the number of incidents may preclude this."

A further doctor arrives at 9.40.

A. Yes.

Q. Then you say this at (j):

"Mobile telephone communications were also proving extremely difficult. Despite good signal strength, establishing a dial tone was virtually impossible."

You eventually managed to speak by phone to a Mr Alistair Wilson, a consultant at the A&E at the Royal London. You discussed the position at Aldgate, casualty numbers and so on, and thereafter you couldn't get your phone to work.

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

Trust received three London Transport buses of P3 patients."

So there was a concern, wasn't there, at the hospital, of quite so many patients arriving all at the same time?

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

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

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

A. Oh, right.

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

serious ramifications, couldn't it, if a large number of patients are going to a particular hospital which then struggles to cope in circumstances where other hospitals are waiting for patients to arrive?
A. I think I could acknowledge that in theory, but actually if you ask patients, cohorting patients is a very important issue when it comes to major incidents, and that's certainly been recognised in the past, that patients, if they are decanted to many different centres, not only does it make the work of the police more difficult, but actually how those people are represented in that hospital is very different to being part of a cadre of patients who are treated at one institution.
So, for example, at a bus crash on the M25 recently, at night, I went to where there were 50 plus patients. They were decanted to literally eleven different hospitals, and the debriefs from those incidents quite clearly indicated that some patients felt very isolated being the only patient in that particular hospital with injuries that pertained to the bus crash. That actually there is -- part of the healing process is about being together.
So I don't think the answer is as simple as necessarily decanting patients around various

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

Q. I'm going to persevere, I'm afraid, just a little further. Could we have a look at [LAS197-2]? This was the NHS HOT debrief on 11 July 2005. I should say immediately that you don't appear on the list of attendees.

A. Yes.

Q. But I'm going to ask you to comment on a particular section of it. If we turn through to page 5 [LAS197-5], please, of the document, and highlight the bottom half of the page. These were the observations made at that debrief meeting about communications with the London Ambulance Service on the day, and the various comments which were made were as follows:

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

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

"Communications from the London Ambulance Service was dreadful with Trusts being put on alert, told to expect 700 walking wounded but nothing arrived. However, other Trusts were overwhelmed."

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

during the course of a major incident?
A. I think if it were true, yes, I think the phrase "overwhelmed" isn't genuine or true, or the plans for these institutions are designed to deal with those sorts of numbers, and I think that's one of the key issues for emergency planning and preparedness in the future, is actually people crystallising what is overwhelmed and what isn't overwhelmed. Teaching hospitals of the nature of Barts and the London do plan to accept that number of P3 patients and to be catered for and allow the treatment of priority 1 and priority 2 patients.
Q. Just to approach the same issue from a different angle, it's not just a question of numbers, is it? It's a question of priority of patients. So by way of example, if we could go back to [BARTS17-2], this time -- this is the report from the Royal London Hospital -- and enlarge the top half of the page, you see there a total of 27 patients admitted to hospital, trauma and admissions wards, ITU and one died in theatre. The patient who died in theatre was a lady whose interests I represent called Susan Levy. You had directed Alistair Mulcahy to dispatch her to the Royal London Hospital from King's Cross because the information which you had received was that University College Hospital, just round the corner,

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

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

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

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

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

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

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

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

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

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

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

A. No, not at all, sorry.

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

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

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

So people would just use the phone.

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

Q. We may explore that a little further with Mr Killens when he gives evidence, I anticipate now this afternoon. But as far as Mr Ellis is concerned, I mean, his observation seems to suggest that someone had raised -- someone within the HEMS team had raised a concern about the use of mobiles, but they felt as if it hadn't been given the attention which it deserved.

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

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

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

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

MR COLTART: All right, okay. Thank you, Doctor.
LADY JUSTICE HALLETT: Yes, Ms Ormond-Walsh.
Questions by MS ORMOND-WALSH
MS ORMOND-WALSH: Just a few questions, if I may.
Dr Davies, during your evidence, you have mentioned a few times the question of surge capacity. I think the transcript a couple of times says "surgical capacity". That's page 16, line 4, and page 49, line 7. Would you just help us with what that is, please?
A. Surge capacity refers to the issue of the frequency with which patients arrive at a particular point.
So -- and it's really important that everyone understands their own surge capacity, whether it's at the emergency department or in theatres or at the intensive care unit.
You can have 25 patients arrive in an hour, and you may be able to -- not be able to deal with that, but actually, if half that number arrive in the first half, and half after, you may be able to deal with that flow rate.
So the issue refers specifically to the rate of flow of patients arriving at your particular point in the patient's pathway, and you need to know how many patients your resus room can take per half hour or per hour.

Similarly, theatres need to know how many patients they can take into theatre per hour or two hours, depending on the type of operations.
So it's one way of defining your capacity in a more functional way. So rather than just say we can accept 194 patients, 194 P1 patients is very different to 194 P3 patients, and it's very different if they're spread over four hours rather than one hour. So it's a tool that's used in our circles to describe your ability to cope.
Q. We know, on July 7, that most of the patients went to the Royal London Hospital. I know you weren't there, but you must know now how the Accident and Emergency coped. Can you give us a picture of that day in the Accident and Emergency and how the department coped?
A. I was very lucky in so much as the one time my phone did work was to speak with Alistair Wilson, who was the Commander in the emergency department at the Barts and the London, and it was much to my relief that the plan had been activated and he confirmed that the plan had been activated and that the various facets of it, both within the hospital and in the emergency department, were prepared to receive patients.
Both he and I, having worked together for many years and trained under Alistair, know intimately what the

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

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

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

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

A. He is, yes.

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

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

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

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

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

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

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

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

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

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

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

their expertise is ingrained in our unit, yes.
Q. Just one question about secondary devices.
The situation now, is it clear now what to do in relation to a risk of secondary devices? Is there clear guidance for you?
A. I mean, I think this is a particularly onerous position for every member of the emergency services, which is the issue of secondary devices and whether a scene is or not clear from that particular threat, and I think it would help all involved if there was a clarity on how and when an incident can or cannot be cleared of secondary devices.
I think, in our naivete in the past, that we expected multiple sniffer dogs and robots to appear and clear a scene and it is quite -- the reality is that that isn't the case, that there is an ever-present risk of secondary devices that face all of the emergency services, and I think it is important that documents like LESLP are crystal clear on issues like that because, when people hesitate to go into the Tube or go down on to the platforms, it's issues like that that just suddenly stick out and make everybody freeze, and unless it's absolutely clear, you could wait for quite a while for a robot or something to come and clear the scene, but the reality is it isn't going to happen.

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

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

LADY JUSTICE HALLETT: Thank you. Mr Watson?

Questions by MR WATSON

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

A. That's correct.

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

A. Yes.

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

A. Oh yes, yes.

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

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

Q. Not only is she the medical director for the Ambulance Service, but she's part of your team, if I can put it like that?
A. Yes, that's correct.
Q. When an incident occurs, the team that is deployed, if it is deployed, from HEMS is deployed, as you've told us, under the direction or coordination of the paramedics sitting in the Ambulance Control room --
A. That's absolutely correct.
Q. -- and it's probably silly to try to swap terms in terms of whether it's ordering, requesting, collaborating; it is an exchange of information?
A. Yes.
Q. It's not done on a military -- in a military sense?
A. No.
Q. But it would be right to say that from the perspective of the Ambulance Control room, the HEMS deployment is part of the deployment that they are directing to any particular incident. It's taken into account and coordinated from within that control room.
A. Yes, yes.
Q. Thank you. Just one other very minor matter. You were asked at the outset of your evidence about the blue light training.
A. Yes.

Q. Lest there be any misunderstanding, the five days that I think HEMS offers for paramedic training, I think, for blue light qualification, does that come on top of --
A. Oh, yes.
Q. -- a basic training they've already had?
A. Yes, absolutely, the ambulance personnel go through that basic training, and we have additional training because driving a response car is different to driving an ambulance and, also, at night-time, the length of the blue light runs are far greater than normal ambulance response would be.
Q. The basic point is the five days is a sort of special add on to the basic training they've already received --
A. Yes, absolutely.
Q. -- which, you may or may not be aware, is in the area of three weeks?
A. Yes, absolutely.
MR WATSON: Thank you. Thank you very much. No further matters.
LADY JUSTICE HALLETT: Thank you. Any other questions for Dr Davies?
Dr Davies, those are all the questions we have for you. Thank you very much indeed for all the help you've given me. On 7 July, you and the rest of the London Air Ambulance Service played a vital role in saving lives.

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

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

A. Thank you.

LADY JUSTICE HALLETT: Thank you.

A. I appreciate it.

LADY JUSTICE HALLETT: Right, 2.00.

(1.00 pm)

(The short adjournment)