(2.00 pm)
MR KEITH: My Lady, may I invite you to call Jason Killens, please?
MR JASON KILLENS (affirmed)
Questions by MR KEITH
MR KEITH: Good afternoon. Could you give the court your full name, please?
A. I'm Jason Killens, Deputy Director of Operations at the London Ambulance Service.
Q. Mr Killens, may I commence by acknowledging, as I've done with the very senior witnesses from your fellow emergency service organisations, the courage, skill and industry of the individual officers and staff who attended the 7 July atrocities on behalf of the London Ambulance Service?
A. Thank you.
Q. You have taken the care and trouble to prepare, along with Dr Moore of the London Ambulance Service, the medical director, a very detailed, dare I say it, lengthy statement, Mr Killens, and in that statement, have you set out to address as many of the issues which have arisen in the course of these proceedings as you felt able but including answers to the provisional index of factual issues that my Lady has raised, answers to supplemental questions posed of you by the Inquest team,

answers to what is known as the Salmon letter, the letter that your organisation received in relation to matters of potential concern, as well as some other ancillary issues which have arisen in the last few weeks?

A. Together with Dr Moore, that's correct, yes.

Q. Is it proposed that you deal with the majority of this statement, but Dr Moore may be best placed to deal with those aspects that are concerned primarily with the medical aspects, such as triage and medical equipment and the medical treatment given in certain instances?

A. Yes, that's correct.

Q. My Lady, if my Lady approves, I'm going to use the statement as a template, because there are so many different issues in it that may be the best way of doing it. Let me start, please, on page 11 of the statement, LAS752-11.

A. My Lady, are you content for me to refer to a hard copy of the statement?

LADY JUSTICE HALLETT: Of course, certainly.

MR KEITH: It's page 11, Mr Killens, of your hard copy. You commence the statement, Mr Killens, by setting out, as we can see at the bottom of the page, something about the figures that were available in the morning of 7 July, in particular the staffing numbers and the

resources that were available to the London Ambulance Service and, in essence, can we see that there were a number of ambulances and Rapid Response Units technically available, but due to a variety of operational reasons, such as absence of staff or a need to clean ambulances or to change uniforms and so on and so forth, a different, lesser number was available on duty that morning?

A. That's correct, yes.

Q. In fact, I think these numbers require some slight alteration, do they not?

A. They do, yes. The penultimate sentence on page 11, this is 2.1.2, "This left 209 resources" that should in fact read 206, and further down "Therefore, at 08.50, the LAS had 82" that should read 79.

These new figures have emerged as a result of subsequent checks of data and resourcing available on the day.

LADY JUSTICE HALLETT: By "resources" you mean what I'd call vehicles?

A. My Lady, yes, so ambulances, fast response cars and so on.

MR KEITH: They come in various different shapes and sizes, do they not, and we'll see in a moment the sorts of resources that you can make available?

A. Yes.
Q. So the total technically available was 252 resources but, for operational reasons, some 209 were in fact available, of which some were then actively deployed on non-7/7 calls and that left, as you say, 79 still available for potential deployment to other emergencies?
A. 206 available pan-London, 79 available to deploy.
Q. Yes. Over the page, we can see you make reference to some Motorcycle Response Units and Pedal Cycle Response Units that were also available, and importantly, at 2.1.4, does the London Ambulance Service have the ability to call upon additional resources not ordinarily available?
A. We do, yes. Either through mutual aid arrangements with surrounding ambulance trusts or through the voluntary sector St John Ambulance or the British Red Cross.
Q. Were additional resources called upon that day?
A. Resources from ambulance trusts surrounding London were deployed on 7 July, yes.
Q. We'll see in detail how that system worked.
A. Yes.
Q. But that explains, does it, why more resources appear to have attended call-outs in relation to the 7/7 atrocities, more resources were made available than those that would ordinarily appear to have been

available on paper?
A. That's correct, yes.
Q. There are certain obligations imposed on the London Ambulance Service, are there not, in relation to the speed with which it would ordinarily be expected to respond to a call; is that correct?
A. There are, yes, and in section 2.2.1 at page 12 of the statement we're looking at here you can see the national standards for response as in -- as set out in 2005, essentially for calls which are immediately life-threatening, an 8-minute response was required within 75 per cent of occasions and, for category B calls, those that are life-threatening but not immediately life-threatening, within 14 minutes in 95 per cent of occasions.
Q. Obviously, the London Ambulance Service received a number of calls on the morning of 7 July. Were they all categorised as category A or were they categorised as category A and B? Paragraph 2.2.8 might be of help to you.
A. In relation to the 999 system or service across London on that day, we would have received a number of calls which would have been categorised differently in relation to the calls received for the incidents involved in the bombings, they were categorised as

either A or B.
Q. Could we have the bottom of LAS752-13, please? Thank you. Why was it that the Liverpool Street and Aldgate call-outs were technically categorised as B?
A. The -- forgive me, the system is somewhat complicated. The telephone triage system in the 999 call-taking area provides a category based on the symptoms which are advised by the caller. If there are no symptoms advised, no priority symptom advised, such as heavy bleeding or someone who is unconscious, the call would receive a lower category than that of A and, in the case of Liverpool Street, my recollection is there is no priority symptoms on that call log, so a transport accident was categorised as category B.
Q. Did it matter, in the event, that two of the call-outs -- that's to say Aldgate and technically Liverpool Street -- were categorised as B?
A. No, sir, no.
Q. Because, in the event, you responded, of course, to further calls from the actual scenes, from members of staff and from the other emergency services?
A. We did, yes. If, at the time, there were a number of calls holding in a control room, so there were more calls than there were resources to send, it may be that a category B call would receive a response after

a category A call. You'll remember the priority system assigns a priority to the patient in the highest clinical need, those category A calls, but on this day, on this occasion, it would have made no difference.

Q. On page 14 you set out something of the spare capacity that existed on 7 July. I needn't ask you to address us in detail on that, but there were a number of duty station officers, managers and training officers and the like whose assistance was technically available to be called upon?

A. Yes.

Q. You then turn to the major incident plan. Could we have INQ9002, please, on screen, at page 8?

This is the major incident plan for the London Ambulance Service. We can see at paragraph 1.2, "Definition of a major incident". Could you just define that for us, please, Mr Killens?

A. Essentially, a major incident is one where, for the Health Service or for the Ambulance Service specifically, where the nature and severity of the patients presenting outstrip the immediately available resources to deploy, and, therefore, special arrangements are required. It's worth saying here that a major incident for us may not necessarily be so for other services.

Q. Indeed. The plan sets out not just a definition, does it not, but also how to declare a major incident, page 9, the following page, please, "Declaration of a major incident", paragraph 1.3, and the plan emphasises, does it not, the key decisions that need to be addressed quickly by whoever is leading the London Ambulance Service response because that will then impact upon whether a major incident is required to be declared?

A. Sir, yes.

Q. Does the plan also set out, page 12, the obligation upon the first ambulance or response, at paragraph 2.3 there?

A. It does, yes.

Q. What is the importance of having the first ambulance or response driver not get engaged with the application of medical treatment, but to be concerned instead with the accumulation of information and the organisation of the people as they arrive?

A. It's important for the first response, the eyes, if you like, of the organisation which attend the scene first to make an assessment of that scene and the number of patients and, therefore, the number of resources which may be required to support the response to that incident early. That needs to be done quickly, and you'll see here at 2.3, the fourth bullet down, it talks about the

provision of a CHALET or METHANE report, essentially they are --

Q. We've heard of those acronyms.

A. It's important that those reports are provided to the control room early in the incident, by the first response that's there so additional resources can be activated.

Q. We, or rather my Lady has heard quite considerable amounts of evidence about whether or not a sufficient number of resources were made immediately available or as available as could reasonably be expected, at the scenes, and in particular, Mr Killens, at Edgware Road one of the first ambulancemen there, I think it was Mr Baker, at 09.16, requested as many ambulances as could be mustered. And at 09.24, the London Ambulance Service Silver, Mr Swan, similarly requested more ambulances, I think he used the phrase, "At least 10 more ambulances are needed", and in evidence he referred to how, initially, there were insufficient resources and that they could have done with more ambulances at that particular scene.

Did the major incident plan in 2005 provide for an automatic escalation, an automatic provision, of a number, a predetermined number of ambulances and officers to attend a major incident?

A. It didn't, no.
Q. Why was that, do you think?
A. The major incident plan in 2005 was predicated on our experience over a number of years of managing single-sited incidents where, whilst communication difficulties sometimes took place, our communication was far easier, and it was -- the resources required at those incidents, being single-sited, one incident, was more obvious.
The lessons from 2005 tell us that we need to make available a predetermined attendance and, indeed, we've done that subsequently.
Q. Do you, for my Lady's note, page 102 of the statement, LAS752-102, set out now the current process which is that on receipt of a certain type of call -- for example, an explosion on the transport network -- a major incident in effect, there is now a predetermined response called, I think, colloquially, as 20:10, that's to say 20 ambulances and 10 ambulance officers?
A. Yes, indeed, as soon as a major incident is declared by the service, 20 ambulances -- a minimum of 20 ambulances and 10 officers are deployed to that scene. Of course, if more are required or requested, they will be sent. But the initial response now is 20 ambulances and 10 officers to the scene.

Q. If we see over the page at page 103, paragraph 19.3.3, in addition a Medical Incident Officer will be dispatched along with the Medical Emergency Response Incident Team, MERIT, which Dr Davies spoke of, as well as a Hazardous Area Response Team.
A. Yes.
Q. Mr Killens, the London Ambulance Service, as we will see in a moment, gets called out to incidents on the Underground with worrying frequency, I think there are many thousands of call-outs, and there have been thousands of call-outs over the years, and the London Emergency Services Liaison Panel planning provided for catastrophic and major incidents, which necessarily envisaged multiple incidents such as the ones with which we are concerned on 7 July, multiple bombs, multiple attacks.
There is no reason in practice why there could not have been a predetermined response in the light of a major incident before 7/7. Can you help us a bit more as to why the current process had not been put into place then? Why was a trick missed, in essence?
A. I think our experience of responding to incidents on the Underground system, or indeed the rail network per se, was to go to a single patient, generally someone who has taken ill on a train or has suffered an injury, perhaps

slipping down an escalator or so forth, and we hadn't experienced difficulty with responding to incidents where multiple patients presented on the network.

Q. So in practice, it had never occurred?

A. It had never occurred, and, as I say before, our experience and our methodology at the time was based on responding to a single site where information about the nature and severity of the incident was available from the outset.

Q. Had not the possibility of a multiincident, multifaceted major incident, been picked up in table-top planning exercises or, in fact, envisaged by the LESLP panel itself?

A. I think it's right to say that the concept of multi-sited incidents had arisen following Madrid and following the Civil Contingencies Act in 2004 --

Q. Precisely.

A. -- and we had begun a process to enhance our infrastructure to deal with such incidents, but regrettably, of course, that wasn't delivered prior to these incidents taking place.

Q. The Civil Contingencies Act 2004 I think received royal assent in November of 2004, did it not?

A. I understand that's the case, yes.

Q. As you describe in your statement, it imposed an onus or

an obligation upon the emergency services to respond to four simultaneous incidents, did it not?
A. That's my understanding, yes.
Q. Whereas previously, before the Act was passed, the onus, such as it could be imposed in legal terms, had only been to respond to one incident. Is that correct?
A. The methodology and infrastructure was based on responding to one incident at a time.
Q. Why was the London Ambulance Service not ready to deal with perhaps -- or not ready -- not as far forward in its planning for four incidents by July 2005 as it might have been?
A. Work had already begun on designing a new control room to manage such incidents, and I'm sure we'll come to, later, the infrastructure that was in place then and now.
Q. We will.
A. They are significantly different, and the capacity of that infrastructure was the point or the requirement, if you like, to manage effectively multi-sited incidents. That process had begun prior to 2005 but wasn't complete at the time.
Q. We'll return to the question of control room and the Gold Suite and how the system now works later. But they were merely one of the most technical, complex parts of

changing your systems to a response that would deal with four incidents as opposed to one.
Something such as assessing whether or not it was feasible to have a predetermined ambulance response of the type now in place, 20:10, could presumably much more readily have been put into place. Why was that not done before July 2005?
A. It would have been possible to put in place such a predetermined attendance. The experience we'd had was that resources were requested by the officer at the scene, the person responsible, the ambulance incident officer, as we've heard, and he or she would have requested the number of resources that they required to manage that scene. The difficulty, of course, as we now know in July 2005, is communications.
Q. Because without a predetermined response, Mr Killens, all the officers who so properly called in to say "We need more" were all utterly dependent on the communication system working?
A. That's correct, yes.
Q. As we'll come to in due course, although technically the system worked, insofar as the mobile data terminals in the ambulances and the radio system, the way in which it was deployed that day meant that a lot of the messages didn't get through?

A. That's correct, yes.
Q. You turn then in the statement at page 16 to training, and provision generally specifically for training for terrorist incidents. We can see that you've set down there the training for emergency medical technicians. My Lady's heard some evidence in relation to the differences between EMTs and paramedics, but in essence, the core EMT programme comprises 12 to 16 weeks of training, whereas the paramedic training comprises two years of operational experience and then a core, ten-week programme?
A. Yes.
Q. And there's obviously refreshers and update training. Over the page --
LADY JUSTICE HALLETT: Sorry, just before you go on, just one thing that had occurred to me when I was noting how people have strange titles, do your other agencies all know what an emergency medical technician is, Mr Killens, because what concerns me is that I think we all know what a paramedic is and we might probably follow a paramedic grade 1, grade 2 or 3, but I don't know if many of us know what an emergency medical technician is.
A. I think the agencies which we regularly work with, police and fire and some others, would understand the

difference between an EMT and a paramedic through their experience, operational experience on the road, as it were. We have in the recent past changed, as you've described, to a student paramedic, 1, 2, 3, 4 and so on.

LADY JUSTICE HALLETT: Oh, you have?

A. So it is far clearer now to understand the difference between the two.

LADY JUSTICE HALLETT: Thank you. Delighted to hear it.

MR KEITH: You're not out of the woods yet, Mr Killens. Over the page, on page 17, you state this:

"It is recognised that at the time of the London bombings, we had not delivered the planned update training to front line staff, including aspects of major incident management due to operational pressures."

Could you explain to my Lady what precisely you mean by that, in particular what was the planned update training that had not been completed and what were the operational pressures that had precluded you from carrying out the training?

A. I'll take the training aspect first and then come to the operational pressures second.

In the paragraph immediately above that, 2.5.4, it sets out that a CPD programme, a continual professional development programme, encompassed major incident training or a refresher session on major incident

training. All front line staff -- so that's EMTs and paramedics -- should have been subject to that training. The operational pressures aspect is the fact that we're an organisation which, if you'll forgive me, runs hot, so we're an organisation with not a lot of slack in the system and, in 2005, pressures on us to deliver emergency services within those nationally mandated response times that we discussed earlier were such that some difficult decisions had to be made around responding to those calls, those emergencies, as required or curtailing some training in other areas of activity.

LADY JUSTICE HALLETT: So the response times weren't just targets; they were mandated, were they?

A. They are mandated in terms of the response for those categories of patients. Each ambulance trust around the country is measured on their delivery and performance managed against them if you are not delivering those standards.

LADY JUSTICE HALLETT: Then, are there targets, as far as training is concerned?

A. They are not -- there are clearly requirements in terms of training, both statutory, mandatory and so on. At the time, it was felt that it was more important, more appropriate, to deliver the front line service to those

standards than it was to continue with that training.
LADY JUSTICE HALLETT: So you were forced to juggle resources, in other words?
A. Yes, as a result of the fact that we are an organisation that runs hot with limited spare capacity.
MR KEITH: You thought it fit to draw my Lady's attention to this by putting it in a statement. May we presume from that, that that might have had an effect upon the ability of members of the London Ambulance Service staff to respond to the declaration of a major incident, or do you feel that this was a training that, on paper, very valuable, might not have had much effect in terms of their response on the day?
A. I think it's right to say that we could never deliver sufficient training or we would want to deliver as much training as we possibly could to all staff. We have to recognise that there are decisions that need to be made and pressures brought to bear.
In relation to this particular piece of training, it may have helped some individuals. However, I think the core training delivered in those initial 12 to 16 weeks is such that all staff would recognise the role that's required of the first and subsequent resources at the scene and would have a working knowledge of the structure which needs to be put in place in the

immediate time after the incident is declared to manage it as we go forward.

So I think the impact would have been limited.

Q. In terms of the declaration of a major incident, the most obvious facet of that protocol or that procedure was, of course, the declarations themselves made by various members of the LAS. Perhaps I could ask you this, Mr Killens: at Aldgate, Mr Edmondson, whom, of course, you know, suggested the declaration of a major incident on the way to Aldgate.

A. Yes.

Q. Could we have LAS565-9 to remind ourselves? It's the call EP5 at 09.15.

Then three minutes later, a paramedic -- I think it was called a Physician Response Unit --

A. Yes.

Q. -- Mr David Parnell, who was the Bronze medic, at 09.18 -- page 12 of the document, please -- so just three minutes later, declared a major incident at Aldgate at 09.18 on channel 7. We can see there the fourth column. But didn't make what's known as a CSCATT report.

Then at 09.24, Mr Edmondson, acting on his original instincts -- page 20 of the document, please -- on a different channel, channel 10, declared a major

incident. EP5 there we can see.
So at that one scene, there was a certain element of crossed wires, because neither of those two gentlemen knew of the prospective or the purported declaration of a main incident by the other, even though they worked for the same organisation.
Might the refresher course in major incident training have assisted in avoiding that sort of crossed wire?
A. I think that's unlikely on the basis that, as we've heard in other evidence, the immediate time after the declaration is somewhat confused, and you will have noted indeed here Mr Edmondson makes his report on channel 10, which is the -- at the time was the operating channel for the central area and Mr -- the PRU, sorry --
Q. Mr Parnell --
A. Thank you. Parnell, indeed, yes --
Q. -- was on channel 7?
A. -- two separate locations in the control room. So in the immediate time after the incident is declared, that's not surprising and, of course, the structure which we set to put in place is designed to begin to control that as we go forward.
Q. Would this be a fair summary, Mr Killens: the training

made -- or the absence of that particular refresher course may not have had an adverse effect on the response of individual members of your service to the declaration of a major incident, but, as we can see from the difference in the radio channels and the multitude of declarations, something went quite significantly wrong in the means by which individual members of staff could communicate with the control room and the control room and the Gold Suite in its response didn't have quite as good a picture of what was going on as it might have done?

A. If I may, I think there are two issues in your question there. The first one is that, in the immediate time after the incidents have taken place, resources from a number of geographical areas will begin to merge at one scene and they, through routine operating, communicate with the control room on different radio channels.

So it's inevitable that different messages will be passed by different people saying broadly the same thing in those immediate minutes after the incident.

In terms of the control room, it's right to say -- and, indeed, we touched on it earlier -- that the configuration of the Gold control room on 7 July 2005 was such that it inhibited the swift passage of messages

to and from the scenes such that --
Q. Is that because there was one radio operator working two channels --
A. That's correct, yes.
Q. -- and the build-up of calls was such that a significant number of calls, including important calls, didn't get through to their destinations?
A. Indeed, yes, we recognised that that was the case, and the way the control room was set up, the Gold control room, limited their ability to receive and pass messages.
Q. King's Cross and Russell Square similarly, Mr Killens, could we have LAS565-17? 09.21, the Rixons -- I think Paul and Stacey from memory -- on channel 11, G101: "Afraid going to have to declare a major incident."
At 09.28, 7 minutes later, EC45, Mr Taylor, made a CHALET report, page 23, not by using channel 11 to the Central Ambulance Control, but by telephoning the FRU desk, the Fast Response Unit desk, and then 11 minutes or so after that, LAS565-32, page 32, an ambulance, E107, Desmond and Sinclair, used a different channel, channel 10, on the radio transmission, to make a CHALET report likewise, all for the same location.
It does indicate, does it not, whether it be down to the communication structure in place at the time or the

difference in channels or just the lack of communication between people physically present at the scene, quite a high level of confusion?
A. I think it's right to say there was a high level of confusion. In the immediate time following the incidents, the structure which we seek to bring to the incidents is such to bring organisation to chaos, if you like, and each of these resources that were responding are likely to have gone to different locations at the same incident, and we heard earlier, certainly in the case of King's Cross, where there are multiple entrances, multiple locations to King's Cross, and it's highly probable that these resources would not have seen the other resources that were there and, therefore, would not have been aware of those declarations being made.
Q. But if there had been a very -- a clearly defined rendezvous point or if there had been a radio communication system that allowed Silver or Bronze commanders to speak to each other, or if there had been clarity of the radio communication channels back at the Central Ambulance Control room, then the lack of -- the lack of clarity would have been avoided, would it not? No one, either at the scene or in the Central Ambulance Control room, recognised that there was information

coming in from different sources trying to cover the same ground and that people were not, in fact, communicating with each other.

A. It was recognised in the control room that there were similar messages coming in, and, indeed, at time, after these messages we're looking at here, when the Gold control room was opened and the incident channels became operable, resources were moved across to those channels and that's the process where we were seeking to put order around what was going on.

The initial response to these major incidents is very confused, and what we're seeking to do is bring control and organisation to that incident scene.

Q. What was the effect on the day, Mr Killens, of the way in which the radio and communication system was configured? Were there delays in the arrival of the second wave of ambulances, the subsequent ambulances, after the initial call-outs?

A. Can I just clarify, you're talking about the radio configuration in the main control room or in the Gold control room once it was opened?

Q. In fact both, because one opened up after the other, of course, and there were then other issues and other delays feeding into that process.

Were there delays in relation to the dispatch of

subsequent ambulances, in particular to King's Cross/Russell Square?

A. Yes.

Q. Were those delays avoidable?

A. The configuration of the Gold control room led to delays in the dispatch of ambulances, yes.

Q. There was no insuperable technical problem, was there? The actual hardware of the radio system worked?

A. Yes.

Q. The mobile data terminals in the ambulances worked?

A. Yes.

Q. The flaw, if flaw it be, lay in the way in which the service used that system. There was a choke point because of a shortage of radio operators in the Central Ambulance Control?

A. A bottleneck occurred in the control room.

Q. Yes, so it was an avoidable delay?

A. In as much as the capacity of the total infrastructure in the Gold control room at the time would have enabled more radio channels to be used. However, with the volume of messages being passed, it is highly probable that there still would have been delays or confusion in managing those messages.

Q. Do you accept, Mr Killens, that the system was recognised in the London Ambulance Service afterwards as

not having worked as well as it was expected to have worked?
A. Yes.
Q. That was down to the way in which the system was being operated, being configured, by the LAS?
A. Yes.
Q. Thank you.
LADY JUSTICE HALLETT: What are we talking about? I'm sorry, the use of the expression the "configuration" is confusing me. Are we talking about just not enough operators, control room operators, is that what you mean? Just not enough staff or --
A. Forgive me, my Lady, I think there are two issues in this. Perhaps if I can turn to some photographs which appear at the back of my statement. If I go to page 125.
MR KEITH: We have photographs of the old and new control room, is that what you're referring to?
A. Yes. It's not particularly clear in the copy there.
LADY JUSTICE HALLETT: I think there are some colour -- I don't know if my Lady would be assisted by the original colour one. (Handed).
A. So this photograph we're looking at now is a photograph of the Gold control facility as was then.
LADY JUSTICE HALLETT: Right.

A. So there are two issues wrapped up in your question, my Lady. The first one is that two radio channels were configured to be used by one single operator, so one member of staff, which led clearly to lots of messages coming across both those radio channels and an inability of that operator to process them quickly enough.

LADY JUSTICE HALLETT: Right.

A. Then the second one, you'll see from the photograph itself, is that, due to the infrastructure in place at the time, it was not possible to put large numbers of people into that facility to manage larger volumes of radio channels or messages.

LADY JUSTICE HALLETT: Sorry, say that again, I've just been handed another copy.

A. There are two issues. One is the two --

LADY JUSTICE HALLETT: Right, space. So lack of space?

A. Yes.

LADY JUSTICE HALLETT: Right.

MR KEITH: What, in practical terms, were the consequences, Mr Killens? What sorts of messages weren't getting through, if they weren't getting through, and/or, if they were delayed, what sorts of delays are we talking about?

A. Well, I think there would be -- due to the configuration -- the "space", as my Lady has helpfully

put it -- there were three issues, I think, that fall out from this. One is the request for assistance from the scenes were not heard or processed sufficiently or quickly enough.

MR KEITH: What do you mean "heard or processed"? Do you mean the Gold members of staff or the members of staff in the control room, in the Central Ambulance Control room, did not understand or appreciate what information was being received?

A. These are messages from the scene, so ambulance staff and officers at the scenes. Their messages to the control room, the Gold control room, may not have been heard or would not have been processed quickly enough.

Q. So they weren't even appearing in the Central Ambulance Control?

A. That's possible, yes.

Q. Right, what else?

A. Those that were heard may have received a delayed response or not been acted upon at all.

Q. So when somebody could get hold of a radio and could get on to the channel and get a message through, the message went to the control room, the Central Ambulance Control room, but was not acted upon?

A. Because of the volume of messages they were dealing with, it's probable that those messages, some of those

messages, may not have been acted upon.
Q. Yes.
A. Information being passed from the control room out to responders, so this is ambulances or cars that are out on the street going to the scenes or managers/officers at the scenes may have been delayed; in other words, because the radio channels were so busy, colleagues may not have been able to get those messages out in a sufficiently timely way.
I think the third issue which arises is one around the -- again, a configuration issue, but more of a technical issue, and this is around the CAD system, so the computer-aided dispatch system, where calls generated by the police, Metropolitan Police, would have presented in the main control room and not in the Gold control room. So there was a lack of information being passed there.
Q. We'll come back to that, but you've done a second statement, have you not, in relation to the CAD system in place at the time?
A. I have, yes.
Q. For all those reasons, important, significant information from the scenes was, in part, not being relayed back and, even if it was, it was not being acted upon and, hence, your acceptance of the delays in

getting resources back to the scenes?
A. Yes.
Q. Could we have a look, please, at LAS371-2? We'll just have a look at a couple of the documents. This is a summary of identified concerns with the response by the Central Ambulance Control during 7 July 2005, dated four or five weeks later. Do you recognise the document?
A. I've seen the document, yes.
Q. The document recognised, did it not, that as a result of the way in which the Central Ambulance Control was able to operate that day, there were, as we can see there, some very significant delays in certain -- I don't say all, but certain of the aspects of the response. Is that correct?
A. Yes.
Q. The delay in activating the officer at Pinner to King's Cross, to which my learned friend Mr Coltart made reference many weeks ago in the course of examination?
A. Yes.
Q. The 30-minute delay in dispatching the first ambulance to Russell Square, the ambulance came across as a running call and it then seems to have taken a further hour before more ambulances were deployed, and then the delay in the dispatch of ambulances to Tavistock Square.

If you go down to the bottom of the page, you will see that the report noted that:

"Information flow ... was, in fact, fairly good. Reports, updates and requests for resources have been documented through the primary incident log, though critical information had not been actioned or in fact 'flagged' with the CAC [Central Ambulance Control] Incident Commander or overall LAS Command structures. These issues seem partly due to log entries being made throughout the control suite with no single person or technical alerting system indicating the critical information."

Is that a reference to the second point you made, which is, even where the information did come through, it was coming through in such volume that no one was able to say "That point is important. We need to get on with that point, and not that one"?

A. Absolutely right. There were a number of critical messages, as you defined them, which were received in the control room, which it's my understanding, due to the volume of information that was being processed, they weren't acted upon as quickly as perhaps they should have been.

Q. Then somebody had to try to go back through the radio transmissions and try to work out what actually was

being called in?
A. Yes.
Q. Other critical information was recorded on scraps of paper rather than on log systems, and in relation to the logs, how many logs were being run?
A. Could you clarify the question for me? Do you mean electronic logs or --
Q. Yes, how many electronic logs were being run?
A. My recollection, there are two CADs which contain details of logs for the incident.
Q. How did it come about that there were two running simultaneously? Was that a reflection of the original calls or is that the system that is normally put in place, when there is a major incident declared?
A. Standard practice at the time would be for messages associated with a particular call to be noted on the electronic log of that call.
Q. Then over the page, please:
"Radio traffic was busy [the last bullet point] ...
The fact that there was one radio operator allocated to use the two incident channels and, therefore, four incident sites ..."
Because the four sites were routed through two channels.
"... added to information flow delays and problems

with decision-making and critical information passing. This situation remained throughout the incident with no intervention."

A. I think that's right, and if we look at 6.1.10 of the statement, page 64, if I could take you to it --

Q. Yes.

A. -- I do recognise there that the way in which the control room was set up and the multi-sited nature of these incidents impeded the ability of the service to respond to them.

Q. Yes. The loggist herself -- LAS86-2, please, could we just have the bottom half of the page without the names in the top, thank you very much.

At paragraph 3:

"I was the incident radio loggist, which meant I am the person who is meant to the log every radio message received or transmitted throughout the incident. This was impossible as, not only was I radio logging, but I was also the incident loggist as well ... so on top of the radio traffic, I was having to try and log all the phone calls, faxes, memos, verbal updates as well on to the same log.

"Although I work in CAC and am level 2 Gold control trained, I am not a trained typist (I use two fingers and a thumb). Surely common sense would dictate using

someone who can type properly ..."

That wasn't an ideal situation, was it, Mr Killens?

A. No.

Q. How was it that one person, working under, no doubt, unbearable pressure was left having to deal with all the logs in this way, following a declaration of a major incident?

A. The -- it would be difficult for me to say what was in the minds of the staff in the control room at the time. What I will say is that we had been used to running single-sited major incidents or the concept was a major incident was a major incident, and it may have been that these separate sites may not have been considered as separate main incidents in their own right, and, therefore, the view may have been taken that the Trust was responding to one major incident rather than four.

Q. Over the page, please, page 3, the loggist goes on to refer at the top of the page that information wasn't -- or perhaps not as much information as might have been available was placed on the status control board, the status board. I think the person who had the role of writing on the board couldn't reach halfway up it or more than halfway up it. She then makes references to people wandering in and out, staff, various senior members of the LAS, walking in and out, and then further

down the page, right to the bottom, please, she makes the point -- I think it's right that I emphasise it -- although she had those main sticking points, she was extremely proud that, as a service, to use her words, it was held together.

But it was obviously, in hindsight, not an ideal situation, as I've observed. What steps are now in place to ensure that a sufficient number of people are available inside what is now the Central Ambulance Control, although I appreciate it has a different name, to deal with major incidents as and when they're declared?

A. I think we fully recognise that the way in which the control -- Gold control room was configured on the day led to the delays we've seen and some of the issues we've just explored. In terms what's in place now, if we go back to -- if I could take the court back to those photographs, this time on pages 126 and 127 of the report -- of the statement, you will recall that the Gold control room at the time had something of in the order of four or five positions, this is on page 125. You'll see now, over on 126 and 127, that essentially the control room has the ability to house far more staff, has more technology in place to manage incidents, is capable of managing four incidents simultaneously,

has new technology, new infrastructure, new or upgraded access to our CAD system, which is touched on in the supplementary statement, and has the ability to electronically record all of the information which is coming in rather than use, as you would have seen, in the previous configuration white boards on the wall. So I think it's fair to say that --

Q. There is an entirely new system?

A. It's entirely different to that which was in place in 2005.

Q. The communications system, and in particular the ability of the communications system to communicate with other emergency services, has been highlighted by Sir Desmond Fennell in the Fennell Report after the King's Cross disaster. Do you recall that? Was the shortage of staff, or potential shortage of staff, something that was ever contemplated by the London Ambulance Service when dealing with and preparing for its own emergency plans in response to the Fennell Report? The simple point that there may not be enough members of staff available to deal with an emergency in the Central Ambulance Control?

A. In the control room itself.

Q. In the control room itself.

A. The staffing for the Gold control as was, now the

incident control room, is drawn from that which is on duty in the main control room dealing with the 999 system across London. So there isn't a dedicated team of people sitting, waiting to manage incidents as they occur. They're drawn from the core staffing that's on duty.

Our experience is that there is sufficient staff in that control room, CAC, as it was, to manage main incidents and, indeed, should it be necessary, we would reconfigure the main control room to release staff to manage incidents in the new incident control room.

Q. All right. Could we have, please, LAS752-23? This is the part of your statement, Mr Killens, that deals with the systems that were in place in Gold control and how -- when a major incident is declared -- there are phased levels of Gold control.

You've been concentrating mainly on Central Ambulance Control. When the major incident was declared, what is envisaged by way of Gold control taking over or establishing a unit all of its own?

A. The Gold control room, as was in 2005, was used on a day-to-day basis to manage non-urgent ambulance activity across the capital. So the room was in use, if you like, the accommodation was in use, and what would happen upon declaration of a major incident is that

those staff and the vehicles that they were controlling would be moved out and into an area in the main control room, and then specially trained staff would come in to operate Gold control.

They would, over a period of time, 10, 15, 20, 25, 30 minutes, begin to take control of the resources that were deployed to that incident from the main control room and then they would manage those resources in Gold control.

Q. What difficulties arose on that morning with the setting up of Gold control over that period of time?

A. There were some issues in relation to -- if my memory serves me correctly -- logging into the CAD system, the CTAK machines.

Q. What was the issue, Mr Killens?

A. Again, if memory serves me correctly, this is covered in a statement provided by one of our technical experts, but there were some issues around passwords and log-ins for our CAD system.

Q. The staff who came in to take over the running of the Gold control --

A. Yes.

Q. -- couldn't get into the very computer systems upon which the CAD entries operated?

A. And that's correct, and if we go a bit further into the

detail of that, that's as a result of not logging out from the main control room and, therefore, an inability to log into the system in the Gold control room.
Q. But how could that possibly have come about, Mr Killens? How could something so basic as that have occurred?
A. There were instruction cards or action cards, as we called them, available on the desks in the incident control room for staff to follow the instructions to log in to the system.
It appears, through the debriefing process, that some of those action cards, or the actions on those cards, were not followed and, therefore, difficulty in logging into the system took place.
Q. Was there an issue with the staff not being of a sufficient seniority? There were references to them having to have a certain number of pips before they could get into the system. Do you know what that was a reference to?
A. I'm not aware of that, no.
Q. You're not aware of that. All right.
So how long did it take those members of staff to get into the system?
A. I'm not sighted on the time it took either, I'm afraid.
Q. Presumably, until such time as they could log in, the assistance that Gold Command could bring to the existing

operational structure was hindered? It couldn't even access the main electronic logs governing the incident?
A. It would certainly have inhibited their ability to control those incidents, yes.
Q. Does the new system now resolve that problem?
A. It does, yes.
Q. Is it because they are the same staff and the computers are now all synchronised, or the equipment is synchronised so that they don't then have to move across and then log into a completely different system?
A. In simple terms, yes.
Q. I don't want to get into the mechanics or the detail, but do we have your assurance that the London Ambulance Service looked at this issue amongst the many issues you looked at and determined to resolve it?
A. I can assure the court that the changes made to the CAD system are now such that it is operable in the incident control room at the same time as the main control room and, indeed, at our fallback control room and also our new event control room. So it can operate in multiple locations at the same time.
Q. Could you turn, then, please, to LAS752-28? One facet of the difficulties encountered by the LAS that morning was the number of channels because, at that time, there were a number of different channels covering

different geographical areas, were there not?
A. Yes, there were.
Q. We've just seen reference in the course of the documents to channels 7 and 11 and 10.
A. Yes.
Q. How, in essence, did the system work in 2005?
A. In 2005, we'd recently introduced mobile data terminals, so these are the computers in the cab of the ambulance, if you like. I think it's important to set out, prior to that, details of emergency calls received over the 999 system would have been passed by voice, over the radio, into the cab of the ambulance, and obviously that takes time, and with something in the order of 3,000 emergency calls a day being handled, we couldn't do that on one channel operating across London. It simply wouldn't happen.
So there are a number of operating channels for core business. Each geographical area has one, and they would have been used for voice communication between the ambulance crews or fast response cars and the control room.
Q. The incidents, the bombs occurred in different geographical areas, of course?
A. Yes.
Q. Did that mean that members of the London Ambulance

Service would generally use the channel particular to the geographical area in which the bomb had detonated?
A. That's absolutely right, and a good example here, if I can, is King's Cross. King's Cross would have had, in the initial stages, resources operating on channels 7, 10 and 11, so those from east central, central and the pan-London fast response group. So you would have had three geographical areas responding to one incident.
Q. How on earth could the loggist at Central Ambulance Control or subsequently in the Gold control keep tabs on even the one incident at King's Cross?
A. And that's exactly why we need to remove the management of that incident from the main control room, put it into a specific facility with a specific team to deal with it and, in the time immediately following the incidents, put order around that initial chaos with the team at the scene.
Q. Was the geographical split in channels something again that was addressed before July 2005 following the Fennell Report?
A. Not that I'm aware of, no.
Q. My Lady has heard a great deal of evidence about the importance of the Command structure, Gold, Silver and Bronze. As a result of the communication difficulties, to which you've in part referred this afternoon, did

that Command and Control structure survive, did it work?
A. The Command and Control structure was seriously inhibited in its ability to function due to the communication difficulties which took place.
Q. Did it work?
A. In part, yes.
Q. Could we have LAS108-2, please?
This is a debrief from staff in the Central Ambulance Control:
"The beginning of the incident was organised chaos. There were communications issues throughout and, due to it being a multisite incident, there were two dynamic channels on one radio screen. Everyone was trying to pass information over the radio ... channels [were] blocked up ... There were no comms coming from Silver."
It appears that communication links between Gold and Silver were not just hindered but ruptured; is that so?
A. I wouldn't agree entirely, no. There were messages being passed from the scenes by the officers in charge, the Silvers, to the Gold control room and vice versa. What is clearly evident now is the configuration of the control room inhibited our ability to manage those messages and, therefore, the incidents.
Q. But, Mr Killens, surely the whole point about the Command and Control structure is that the person at the

top, Gold, by virtue of the strategic view, has to have complete sight of the important information, because he or she won't have access to everything at the Bronze level or the operational level, and so, if the system fails because communications are hindered, all the strategic decisions become open to doubt and to review, do they not, because they may not have been based on the correct information being received by Gold?

A. The decisions were made based on the information that was available at the time. It is right to say that there was information available which was not processed through the control room as it should have been because of the way it was configured.

Q. The next participant in this debrief refers to the problem you've already identified, which is that: "No one could log on to the computers in Gold control resulting in long delays in setting up. By the time the computers were logged in, the crews were calling over the top of each other and the channels were blocked. People were wandering in and out of Gold control. It was difficult to hear what was going on." Could we have the bottom of the page, please? Then at the bottom, there is a reference to Bow and no one being able to get through to Gold control until 12.00. What was Bow?

A. Bow is the fallback control room.
Q. So when a major incident was declared, it became appreciated that a fallback control room should be set up?
A. Consideration was given to moving the management of some of either core business, so the routine 999 system, or the incidents to the fallback control room.
Q. Was that a seamless process, Mr Killens?
A. It didn't happen.
Q. Why?
A. But consideration was given.
Q. People were sent to Bow?
A. Staff were sent to Bow.
Q. What did they do?
A. In readiness to prepare the control room for use.
Q. Why was it not then used? Was that because the incident rapidly was scaled down after about 11.00 or so?
A. That's my understanding, yes.
Q. All right. Over the page, we can see in the third reference:
"There were problems with Gold control not being able to get through to Bow, as well as Bow not being able to get through to Gold control due to the comms problems."
Then also the fifth entry:

"There were the same issues at Bow as there was in Gold control, with no one being able to log in to the computer systems and not knowing how to set up the mapping."

Do we take it that the fallback position, the fallback system which was then in Bow has also been radically changed since July 2005?

A. We do, yes. In 2005, the fallback control room was configured to operate in isolation, away from any other facility. Since then, enhancements to the CAD system mean that it can be operated in part across locations.

Q. On that occasion, of course, a great deal many members of staff then tried to use their mobile phones, did they not?

A. Yes.

Q. And we know that the mobile phone network became very badly congested and at times ceased operating altogether?

A. Yes.

Q. So not only did the main system -- the Central Ambulance Control -- suffer from a deficiency in communications because of the radio being clogged up, but there were delays in setting up the Gold structure and then the fallback, which is use a mobile phone, also became congested, did it not?

A. It did, yes. I think it's also recognised there was an overreliance on mobile phones to manage, not only day-to-day business, but incidents, major incidents, which again added to the communication difficulties on the day.

Q. All right. One final last area of difficulty faced by the London Ambulance Service was, of course, the historic problem with dealing with communications underground.

A. Yes.

Q. What was the system in place in 2005?

A. In 2005, there was no set up means, no live means, of us communicating underground using analogue radios. We were able to deploy what's known as a leaky feeder, and I think my Lady will have heard what that is before, but we were able to deploy leaky feeders to Underground stations which enabled our analogue radios to work. But obviously there is a need to deploy a vehicle with that equipment.

Q. The leaky feeder took some time to be put in place, did it not?

A. Yes.

Q. The question of difficulty in communications underground had been recognised for some years before July 2005, and we -- that was a problem faced by all the emergency

services, was it not?
A. Yes.
Q. Some members of the London Ambulance Service expressed concern, perhaps anger, in the course of the debrief process after July 2005 as to the fact that the difficulties in communicating underground had been understood for many years before 2005. Was enough being done at that time to try to get the new system of Airwave, which we have heard a great deal about, up and running and assigned to the London Ambulance Service?
A. I think it's right to say that Airwave was seen as the solution to communications underground, certainly the -- from an Ambulance Service perspective, the rollout was nationally managed by the Department of Health, and within that national rollout the LAS had a specific go live date.
We were not necessarily -- I certainly wasn't sighted at the time, and indeed I'm not now, on the process behind the decision-making of which Trust went live first.
Q. After 7/7, the London Ambulance Service insisted, did it not, on moving further up the list of organisations that were to receive the new Airwave system?
A. We certainly lobbied to be accelerated, yes.
Q. I think you had some measure of success in that.

A. Yes.
Q. By the time July 2005 occurred, there were very real difficulties with maintaining the old existing system, were there not?
A. Yes.
Q. I think there were even difficulties in maintaining the number of spare parts required to keep the system operating in places?
A. There was difficulty in maintaining the handheld analogue radios that were in service at the time, certainly the vehicle-based communications, I'm not aware that there was a shortage of spares or difficulties in maintaining those. I speak from my own personal experience there.
And in relation to the away-from-vehicle communications you will have seen that we introduced personal issue mobile phones to each member of operational staff to deal with the away-from-vehicle communications issue.
Q. All right. You have very fully and fairly described in your statement all these issues and difficulties, and I think you've also accepted in your statement that perhaps some of the material made available in 2005, both by way of answers to the London Assembly and by way of press statements, may have over-concentrated on the

technical side of the systems then in place rather than acknowledging, perhaps as fully as you might have done, the systemic problems that arose on that day?
A. Again, I think it's right to say that the statements -- the information provided to the London Assembly and the press statements issued at the time were accurate with the information that was available.
It's recognised now, with much more forensic analysis of the evidence which has become available to us, that they did not provide as full a response as they could have done.
Q. I won't task you, Mr Killens -- others might -- with whether or not the material was available at the time, but your statement acknowledges repeatedly that a full picture of the position was not given before, was it?
A. To the London Assembly.
Q. You've used the phrase "They did not provide a full picture of the telecommunications issues on the day", both to the London Assembly and to some of the press reporting at the time. These are your acceptances.
A. That's correct, and I think the context in which the submissions to the London Assembly were drafted and prepared is important in as much as they were responding to specific questions that were asked of colleagues at the time.

However, you know, we do accept now that they did not provide a complete picture of what took place on 7 July.

Q. I've counted eight references in your statement, Mr Killens, to an acceptance on behalf of the London Ambulance Service that, whilst answers were given that were accurate from a technical perspective, they did not provide a full picture.

A. Yes.

Q. You were "economical with the actualité", to use Alan Clark's famous expression?

A. I would not agree with you in that regard. The information provided to the London Assembly and the press statements issued at the time were done in good faith, there was no intent to deceive the London Assembly. I'm certain of that. Information which has come out in the forensic analysis of this leads us to accepting that they were not as full as they could have been.

Q. The upshot of all of this -- page 32 of your statement -- was that these overarching factors affected the performance on the day, and we can see there that you've set out a chart, and for my Lady's benefit, of course, the chart, whilst technically correct in respect of the response times, due to reasons of course not

wholly within the London Ambulance Service's gift or control, meant that, for example, in relation to Edgware Road, although there was a very speedy response, the first ambulance went to Praed Street rather than to Edgware Road Tube station. I think the first ambulance at Praed Street itself, as opposed to a Fast Response Unit, was 09.12. The first ambulance at Edgware Road was at 09.13. So we should read that entry, should we, for Edgware Road subject to that?

A. The --

Q. Again, you were called out to Praed Street.

A. The context in which this table is framed at 3.4.1 is in relation to the response times we discussed earlier.

Q. Yes. Over the page, Tavistock Square, of course, you've rightly observed that that crew came across the call as a running call. They were flagged down. I think that was Conway and Green in ambulance 8301.

A. Yes.

Q. I'm bound to say, perhaps it can be checked by your counsel, but our note of the evidence was that that crew attended at 09.57, not 09.51, and, therefore, the response time was a little more than a minute. I think it was several minutes. But I'll be corrected if I'm wrong.

Those figures reflect, as you've rightly observed,

the obligation on the London Ambulance Service to respond to certain categories of call within a certain amount of time.
A. Yes.
Q. Were there, in 2005, obligations in respect of secondary waves of resources or secondary call-outs, further ambulance provision, or not?
A. No, there weren't, no.
Q. Is that still the position?
A. It is, yes.
Q. In relation to the secondary wave of responses on 7 July 2005, that secondary wave was affected for the reasons you've described and there were delays, particularly in relation to King's Cross?
A. Yes.
Q. Can we now turn to a different topic. ESVs. On the same page, page 33, you turn to ESVs and you describe how they are unstaffed units used for multicasualty situations which can then be called upon and they carry additional torches, medical consumables, and so on and so forth, and you described how there are four ESVs strategically deployed in LAS's operational area. How did they respond on the day?
A. The movement of equipment vehicles to scenes would be such that the need would be identified, major incident

declared or someone at the scene, an officer at the scene, requests one. A suitably trained member of staff would be identified, the nearest person to that vehicle, they would be sent to collect it, and then it would be driven to the incident scene.

Q. How did they respond on the day?

A. Sorry, just rephrase the question for me.

Q. Yes. Are you aware of when the calls were made for ESVs on 7 July and to what extent they were able to respond?

A. I'm not aware of the time that they were requested. My understanding is that they did respond to the scenes.

Q. We think that from the evidence there was one call from an ESV at Edgware Road at 09.21 by Mr Buck -- I'll be corrected if I'm wrong -- and I think Mr Swan also made a request for an ESV about 10.00 -- sorry, at 09.24, but the ESV didn't arrive, I think, for about another 40 minutes. 50 minutes.

A. Mm-hmm.

Q. Would that be the sort of response time you would normally associate with an ESV or would that be the normal?

A. No, that would be the normal sort of response time. I would expect something between 30 and 60 minutes.

Q. Happily, on 7 July, there were a number of features which coincidentally assisted the London Ambulance

Service.
A. Yes.
Q. You had, of course, the great resource of having so many HEMS doctors all present in one place in the Royal London.
A. Yes.
Q. You had a number of your senior managers present at a management meeting in The Den, and of course, the Tavistock Square bomb was, in terms of the response, greatly assisted by the presence of the doctors in the BMA building.
Those were all fortuitous. Do you feel, in hindsight -- and I appreciate this is a matter of hindsight, Mr Killens -- that without those fortuitous events the response might have been more strained than in fact it was?
A. The immediate availability of such large numbers of HEMS doctors is clearly unusual, and I think, as we heard earlier today, and you've just described, they were on a training event. The normal provision would be there would be one that would have been available at the time. So that's unusual. Clearly that was helpful in providing additional clinical assistance to patients that resulted from the bombings.
In relation to our managers being together, our

senior managers being together for a conference, that was also helpful in as much as they were able to be deployed from a location around the Central London area, so they weren't coming from large, long distances from home and from peripheral stations and so on, so their response times were clearly reduced.

In relation to the BMA, again, helpful for patients, very helpful for patients involved in the Tavistock Square incident.

Q. My Lady's heard some evidence as to the involvement of Great Ormond Street Hospital staff.

A. Mm-hmm.

Q. Although you are not, of course, appearing on behalf of NHS Trusts, there was some correspondence earlier in the course of these proceedings which intended to indicate that Great Ormond Street Hospital had departed from protocol in taking in the wounded, in particular from the Russell Square Tube station.

A. Yes.

Q. Can you acknowledge -- because I think it will cause some good to come from it -- that the Great Ormond Street Hospital staff acted in a very praiseworthy and proper way in doing as much as they were able to do for the wounded passengers who were brought to their attention?

A. I think that's absolutely right. The intention, of course, in hospital trusts not deploying to scene is one of safety for the staff that are there, equipment and so on, and coordination of where patients end up being treated, but it's absolutely right to say that the support offered by staff from Great Ormond Street was gratefully appreciated.

MR KEITH: Thank you, because we won't be hearing from them directly.

My Lady, is that a convenient moment? I'm about to move to a completely new subject?

LADY JUSTICE HALLETT: Certainly.

(3.20 pm)

(A short break)

(3.35 pm)

MR KEITH: Thank you, my Lady. Mr Killens, just a handful of final areas, please, if I may.

SMS text messages, page 60 of your statement.

In July 2005, text messages through mobile phones were one of the main means of communicating incident messages, but they are obviously dependent on mobile phones.

A. They are.

Q. And the mobile phone system didn't work, because of congestion, terribly well on 7 July. Were problems or

potential problems about the use of the text system flagged up before July 2005?
A. They were, yes.
Q. In what way?
A. Through the submission of a risk assessment form completed by one of the emergency planning managers at the time to the risk management group.
Q. Stripping out the structure, those persons in the LAS responsible for highlighting potential problems and risks drew it to the attention of the correct people?
A. They did, yes.
Q. Could we have LAS733-2? Keith Grimmett, in particular, sent an email, did he not, on 2 March, attaching a risk assessment form relating to delays in delivery of time critical messages?
A. He did, yes.
Q. By which we presume he means important messages via the SMS messaging system. At the bottom, these words appear:
"John, we have experienced unacceptable delays which could have compromised operations for both Central Ambulance Control and Ops. It has been luck rather than judgment that we have 'got away' with it. A situation neither of us will be happy with."
What was done, do you know, to improve the position

after March 2005 when these warnings were flagged up?
A. I'm not aware of the action taken, save to say that there were some investigations around what systems were available commercially at the time to supplement or enhance SMS texts.
Q. The system was allowed to continue, but after 7 July, the service departed, did it not, from text and reintroduced pagers?
A. Texts still supplement now messages sent by pagers, yes.
Q. But the paging system had previously been utilised but had been withdrawn. It was then reintroduced?
A. That's correct, yes.
Q. May we take it there was a general acceptance that text messaging, because of its use of the mobile network, was not as reliable as a pager system?
A. There was a recognition that text messages could be unreliable, yes.
Q. Why was that not -- or let me put it another way. Why was that not appreciated until the early part of 2005? One might be forgiven for thinking that overuse of the mobile system, hence the ACCOLC route, must have been envisaged and appreciated and to some extent addressed before then?
A. ACCOLC had never been used, to my knowledge, until 2005.
Q. Even though it was available?

A. It was a system that was available but, to my knowledge, it had never been used. Our realisation around SMS text messages came from things such as mass gatherings where we did experience problems with the mobile phone network. It hadn't been envisaged, at that stage, that there would be a general disruption to the mobile phone network, and, therefore, SMS would be affected.
Q. Have you found, in hindsight, that the pager system now works better than the mobile text system had before?
A. The SMS technology has developed since 2005. Again, speaking from personal experience, it's often the case now that an SMS will arrive before a pager message does, even when they're sent at the same time.
Q. But there is, to use the jargon, resilience --
A. There is.
Q. -- with pagers that there is not perhaps sometimes with mobiles?
A. That's right. Of course, we do need to recognise that a pager is a send and forget system almost, so it sends the message and that's it. If it's received, it's received, if it isn't, it isn't. Whereas, with an SMS, it will be sent at a point later when service is resumed. The two complement each other.
Q. All right. Then turning to the radio system, my Lady's heard a great deal about Airwave, so I needn't, I think,

detain you for long in relation to this. The TETRA-based Airwave system was not only planned and introduced, but was being rolled out to organisations but had not yet been rolled out in general terms to the London Ambulance Service by the time of July 2005.
A. That's correct, yes.
Q. But immediately afterwards, using whatever powers of persuasion were open to you, you were able to secure the rolling out of 200 Airwave handsets to try to start it off?
A. Yes.
Q. And now, do all command level officers now have a personal-issue Airwave handset and all the front line resources, all the ambulances, all the crews, other than those on bicycles and motorbikes, have a TETRA-based Airwave main set?
A. They do. Motorbikes have them as well.
Q. The motorbikes have them as well?
A. Yes.
Q. Thank you very much. In relation to the Underground, the Airwave network works, of course, above and below ground?
A. Yes.
Q. And so you have that additional benefit, do you, of radio infrastructure below ground?

A. Yes.
Q. Do you set out now the current benefits, as far as the London Ambulance Service is concerned, of Airwave at page 66 of your statement, LAS752-66?
A. I do, yes.
Q. Better coverage, consistent hand-portable coverage, coverage in all stadia and other areas where the police provide additional coverage, London Underground, nationally, not just in London, better voice quality, increased capacity, improved reliability?
A. Yes.
Q. I think there are a number of additional functions as well. Is that correct?
A. There are, we've developed technology to utilise data transmission over Airwave as well.
Q. As a result, over the page, page 67, there is now a reduction in the operational reliance upon mobile and public telephone networks and, of course, better communications, we've heard, between bodies as well.
A. Yes.
Q. So you can participate in the talkgroup system, which is one of the main highlights of Airwave?
A. We can, yes.
Q. You do, though, refer at paragraph 6.6.3, page 67, to working with partners who use Airwave and providers to

ensure the system is as recipient and robust as it can be.
A. Yes.
Q. Mindful of the difficulties perhaps not appreciating the past of mobile networks and text messaging and communications in Central Ambulance Control, has the current system of Airwave been robustly tested in exercises so that you know it will work if ever the day is called upon that it has to confirm this sort of scenario?
A. I would go one further than that and say it's been robustly tested in live scenarios. Of course, the test must involve load testing. A good example here would be large deployments that we make to New Year's Eve, Notting Hill Carnival and other such pre-planned events where Airwave technology has been developed over the last couple of years and now provides a stable platform for us to communicate with our resources at such events.
Q. You have, of course, still the mobile data terminal system, of which we have heard, in the ambulances --
A. Yes.
Q. -- as a backup, or as a complementary system, and are you planning to develop Airwave further to allow direct contact between members of London Ambulance Service and clinicians?

A. In hospitals, it is possible through the facility to transmit data.

Q. The next point, please, if I may, concerns one or two specific issues which have arisen in the course of these proceedings.

Interoperability, to use yet another phrase that we've come to know well, page 72.

7.3.4:

"The London Ambulance Service interoperates with all partners in the event liaison team. [This is] a focal point for all inter-agency communications ..."

Then your statement goes on to refer to staff attending the Metropolitan Police Special Operations Room?

A. Yes.

Q. Call sign GT?

A. Yes.

Q. Do we take it that, as with other emergency services, a member of staff will go to the Special Operations Room and, therefore, have sight of what is going on in the Metropolitan Police Control Centre, so as to be able to relay information to the London Ambulance Service?

A. That's correct, yes.

Q. Does that mean that that member of staff can actually input material information into the London Ambulance

Service data system from the Special Operations Room, or do they have to call or, by other means, communicate with the Central Ambulance Control room to relay information back to it?
A. If you'll allow me, a then and now scenario develops here.
Q. Please.
A. In 2005, the method of communication from the LAS liaison officer at GT was telephone or radio, there was no "reach back" to our CAD system. Now, in GT, we have one of our CAD terminals, so the LAS member of staff is able to input data directly on to that system.
Q. How long does it take for that member of staff to get there in the event that the Special Operations Room is suddenly called upon to spring into life?
A. It's about three minutes, under emergency conditions, from our headquarters.
Q. Thank you. Identification, location of trains, page 73. Following 7 July, the LAS introduced into its gazetteer the station codes used by London Underground Limited and London Fire Brigade.
A. Yes.
Q. By that, do you mean, when there was a call to the London Ambulance Service from the LFB or the London Underground Limited, you used the same system to

know exactly where you are being called to attend?
A. Each entrance has -- it was referred to earlier, each entrance has, or location has, a unique reference number and we use the same system as London Fire.
Q. Was that code system in operation before 7/7?
A. It wasn't, no.
Q. So it's entirely new?
A. Yes.
Q. Traction current status. Page 74. You were asked to address the question of what processes were in place to ensure early confirmation of traction current status to members of the London Ambulance Service. One of the concerns which has brought itself to my Lady's attention is any possibility of delay whilst members of your service wait to see whether or not traction current has been confirmed to be off.
What steps, if any, have been taken to try to speed up that process to ensure that the members of staff attending get that confirmation as quickly as possible?
A. In relation to London Underground, the system is slightly different to that with mainline, but in terms of London Underground, our staff will liaise with the staff from the Underground network at the station. We would seek to confirm that traction current is off through them or through contact with our control room.

Ultimately, it's a matter for the attending staff. They will need to satisfy themselves through their scene assessment that the traction current is off prior to entering trackside.

Q. We know that the London Underground staff themselves may put down short-circuiting devices, SCDs. Are the London Underground staff trained to recognise SCDs and to look out for them so they can be satisfied that the traction current is short-circuited?

A. Part of the -- part of the initial training is a session on track safety, or trackside operating, and our staff will have been familiarised with what those short-circuit devices look like. They're not trained to deploy them or apply them themselves, but they will be familiar with what they look like.

LADY JUSTICE HALLETT: Is this all then and now, or is this now?

A. Both, both.

LADY JUSTICE HALLETT: What about staff satisfy themselves the current traction is off? Is that then as well?

A. It was, yes. I recall my basic training some years ago and recall a trackside safety session, and I'm certainly aware that staff undergo those sessions now.

LADY JUSTICE HALLETT: So they didn't have to get back to their own control room back in 2005, if they were

satisfied that there was a -- somebody from London Underground telling them it's off, that would be enough?

A. Yes.

LADY JUSTICE HALLETT: Thank you.

MR KEITH: You turn in detail, on page 77, to setting out the changes in relation to the Central Ambulance Control. Are those the changes that you summarised in the course of your evidence earlier this afternoon: the bespoke incident control room is now in place; there are, of course, the various assistances that can be gained from Airwave; you have a backup ambulance motorcycle response system to convey messages; and you go on, at page 78, to describe the additional number of computers now attached to wall boards for recording and displaying information and controlling the incident and so on?

A. Yes.

Q. Has that system been tested in any sort of multiincident event or table-top exercise?

A. Yes.

Q. Obviously there's been nothing comparable to the events of 7 July, but are you confident that the ability of the service to respond to multiincident events has improved?

A. I'm exceptionally confident that it's improved, and can

reassure the court that that's the case.
In relation to using or testing the incident control room, whilst, as you recognised, we haven't had major incidents on the scale of 2005 since then, what we have used that control room for is to manage large scale deployments, as I mentioned earlier, Notting Hill Carnival, New Year's Eve, civil disorders taking place around the G20 summit and so on. So we're confident in the technology and the systems in place in there.
Q. Dr Gareth Davies made reference to the possible changes in Command structure.
A. Yes.
Q. Can I ask you about that, page 100 of this statement? Is the London Ambulance Service currently reviewing its major incident plan with a view to making changes to the Command structure?
A. We are reviewing the major incident plan, a draft sits with me as we speak.
Q. Why? What is the intended purpose or the game plan?
A. The plan is subject to regular review. I've taken the view that it would be appropriate to delay ever so slightly the publication of the latest version to see if there are any additional lessons which we learn through the course of these proceedings.
Q. With a view to assisting that end, could I ask you to

explain to us, please, what the purpose is of that potential change, what are the perceived benefits of having a new, tactical Commander at Silver level or a variant in the tactical Commander's roles at Silver level?

A. The proposal -- it is a proposal. The proposal is to, in certain circumstances, have the tactical Commander, what we have previously referred to as Silver, remotely located in the new incident control room.

Q. As opposed to being at the scene of an incident?

A. Absolutely. However, there would be an officer in charge of each site, incident, sector, whatever it was. The purpose behind that is through experience, and especially with the new technology, which is now available to see the incident remotely, we have found that a Silver or tactical Commander is, in some cases, better informed and able to make more appropriate decisions remotely from the scene, and we will have heard -- we've heard earlier about Silver Commanders being distracted or brought into meetings and having to manage the scene proactively.

Our experience is in some cases -- not all, in some cases -- it's appropriate to have that person remote from the scene. So the proposal on the table is to -- is for us to consider adopting a position where, based

on the circumstances, we would say the Silver tactical Commander is either at the scene or remotely located.
Q. I'm no expert, and could not possibly purport to be one in Command and Control structures, Mr Killens, but you heard what Dr Davies said about the dangers of remote Command and Control. Does your proposal give sufficient weight to the fact that, as a matter of pure human response, if there is no Silver Commander on scene because he or she is remotely back at Central Ambulance Control, those persons who are at the operational level will always seek to try to put someone in the position of Silver control at the scene and seek guidance and control from whoever is there, and you will end up with a remote Silver Commander and a practical operational Silver Commander and then you will duplicate the position?
A. I think perhaps I didn't make the point sufficiently clear. The intention is to have, in certain circumstances, a tactical or Silver Commander remotely located. There would still be a nominated, clearly identifiable, localised manager or officer to manage that incident site. You'll forgive me for not making a policy decision here about how we go forward, subject to consultation about whether we do or don't.
Q. No, I'm not inviting you to. Mr Killens, we wouldn't

dream of inviting you to make those sorts of decisions on the hoof in the witness-box. It is merely that we have, if I may say so with respect to my Lady, heard a great deal about the way in which Command structures operate and you heard what Dr Gareth Davies said this morning about --

A. I did.

Q. -- remote control?

LADY JUSTICE HALLETT: And the importance of all the agencies following similar policies.

A. Hence, it's subject to consultation on how we go forward.

MR KEITH: And being present and being able to communicate and, of course, if your remote commander is not there, his ability to communicate with other Silver Commanders depends on an uninterrupted communication link.

A. I think, as technology has developed and changed, it's allowed to us think differently about how we may manage these scenes as we go forward.

Q. I won't presume to push further on that point, Mr Killens.

The final point, please. In relation to CADs, you've referred to the position that is now in place in relation to the link between the Metropolitan Police and the London Ambulance Service when they are using their

Special Operations Room call sign GT.
In your second witness statement, LAS790, I think it is, in our current system, you set out at page 2 how formerly, paragraph 9, there was no common interface between the CAD systems of the various emergency services generally in London, and so, if an incident was reported to the LAS and police attendance was required, messages would have to be sent through something called the CADLINK.
A. Yes.
Q. There was, it's implied in that, paragraph 10, also no ability to view the details of another service's CAD, and there was, in 2005, therefore, only an electronic fax link with some people, in particular City of London Police.
Putting aside the Special Operations Room, is there now a better system for communicating with the other emergency services generally?
A. No, the CADLINK remains as was then, so basic call details, location times, details of the caller, and a specific message is able to be passed between us and the Metropolitan Police through the CADLINK.
Q. How does that work in practice, then? Please assist us. You can contact the Met and say, "We're sending ten ambulances to Horseferry Road", and that will then

appear as a message in their own CAD? How does it work?
A. Okay, the CADLINK is designed to manage or to assist in the management, as a tool essentially, assist in the management of day-to-day operations in London through ourselves and the Metropolitan Police. It's not designed as an incident management tool. I think that's an important distinction to make.
We could send a message to the police that would appear in their control room saying, "We've sent ten ambulances to Horseferry Road", to use your example, against a specific call that already existed, or we could create an incident in the police CAD system that said "Outside XYZ address in Horseferry Road, we've sent 10 ambulances".
Q. How do you do that? How do you create the message in their system?
A. Send one of our calls over to them.
Q. By?
A. Electronic CADLINK.
Q. Right. So they have some sight on the most important issues affecting your service, if they need it?
A. Very basic information associated with that call, yes.
LADY JUSTICE HALLETT: That's new?
A. No, that was in place then, my Lady.
LADY JUSTICE HALLETT: That was in place?

A. Yes.
MR KEITH: Has it been extended? Is there a better sight of less essential information now or a more fluent link between organisations or not?
A. We've developed the system to ensure that update messages are passed to our crews via the MDT, the mobile data terminal, so an example here would be the call to Horseferry Road, new information is sent to us by the police, say with a rendezvous point. That would automatically be sent to the LAS resources assigned to that call now. That wasn't in place in 2005.
Q. So two ambulancemen attending a scene can now receive a broadcast message saying there are another ten on the way?
A. Indeed, and of course the link we've developed between that and Airwave, the handsets that the staff would now carry, would also display the text of that message. So it goes to their MDT and it goes to their Airwave handset simultaneously.
LADY JUSTICE HALLETT: Also, do you say, in the example you gave, "Meet at the front entrance to Horseferry Road Magistrates' Court"?
A. Yes.
MR KEITH: The second aspect of your statement that I want to look at briefly is this: it seems that, in 2005, when

the London Ambulance staff had moved away from the Central Ambulance Control into Gold control, there were no electronic means to enable resources to be dispatched by the mobile data terminal, which, of course, was your primary means of communicating with ambulance crews in their ambulances or their response vehicles.
Has that significant difference between normal Central Ambulance Control communication and Gold control been addressed?
A. It has. The CAD system has been updated to enable the use of mobile data terminals to dispatch calls and pass messages to the cab of the ambulance or fast response car from the new incident control room, and there are also other functions now available to ensure that new calls passed by the CADLINK present in the incident control room rather than the main control room as was the case in 2005.
MR KEITH: All right, thank you very much, Mr Killens.
My Lady, in the course of examining Mr Killens, I've made a reference, quite erroneous, to Salmon letters by way of a shorthand reference to the letters which contain no potential criticism but the letters which my Lady directed be sent out to list for all the organisations those areas in which my Lady would be most assisted by their responses to the various issues that

have arisen in the course of these proceedings.
I fell into the very trap that I invited Mr Killens to step over, which was to make policy on the hoof by referring to them as Salmon letters. They were no such things, but I know that my reference to Salmon letters has ruffled some feathers in certain places outside the court, because it denotes, as my Lady knows well, some level of criticism. There was to level of criticism and none was intended. It was my shorthand.
LADY JUSTICE HALLETT: Thank you.
MR KEITH: Thank you very much, Mr Killens.
LADY JUSTICE HALLETT: Mr Coltart?
Questions by MR COLTART
MR COLTART: Mr Killens, I ask questions on behalf of a number of the bereaved families, but I wonder whether I might make some preliminary observations before I ask you questions about a number of areas.
The first is this: that, as I hope we've made plain to all of the individual paramedics who have attended to give evidence during these proceedings, there is no criticism whatsoever of their enormous efforts on 7 July 2005, and we're all very greatly indebted to them.
A. Thank you.
Q. The same courtesy should be extended to the management

as well of the London Ambulance Service, because although there were difficulties, as we shall see, in the Gold Suite and elsewhere on the day, there's no doubt that everyone was trying their best in very difficult and trying circumstances.

The third point is this: that I don't seek to avoid the very extensive efforts which you have made to improve matters on behalf of the London Ambulance Service. Mr Keith has dealt with those, and no doubt Mr Watson may touch upon them as well, but again, those are appreciated, but of course, in gauging the extent to which they have been effective or not, it is necessary to examine quite how badly things did go wrong on 7 July and I want to ask you a few questions in relation to that.

So that everybody knows where I'm going, there are four areas I propose to touch upon: the Gold control suite; the effect that failings in the Gold control suite had on the ground; the extent to which those problems might have been foreseeable; and I'm going to deal briefly at the end with the accuracy or otherwise of the various public statements which were issued by the London Ambulance Service in the aftermath of the bombings.

So can we start, then, with the Gold control suite?

Have a look, please, at INQ9002-17.
If we enlarge, please, the bottom half of that page, we have what I hope is a useful summary of how it was envisaged or hoped that the Gold control suite would work on the day. This comes from your major incident plan in place at the time.
As you make clear:
"Gold control is the control room situated within the Central Ambulance Control complex for use during serious and major incidents. It is responsible for ..."
Then it sets out the various areas which we are familiar with, but including controlling deployment of resources to the incident, paging instruction procedures and facilitating requests of additional resources, equipment and personnel to scene, and there can be no doubt, can there, that it was anticipated this would be very much the nerve centre of the operation?
A. That's correct, yes.
Q. To gauge the extent to which performance perhaps didn't match up to anticipation, I'm going to ask us to examine the state of knowledge in the Gold Suite at 11.45 that morning through the eyes of Dr Ken Hines, who I think you will be familiar with, but he was the Gold doctor who was at Waterloo on that day.
A. Yes.

Q. We have a copy of his report at LAS48 starting at page 2, please.
We can see that, after the event, he, like so many others, provided a written report of his experiences on the day.
Just to shorten matters, he had been in Lincolnshire when the bombs went off. He was requested to attend Central Ambulance Headquarters in Waterloo --
A. Yes.
Q. -- and he arrived at 11.45 that morning. If we turn through, please, to page 5 of the document, we can see, if we enlarge the top half of the page to begin with, please:
"As he [he's written this in the third person, so as Dr Hines] walked through the front door, he was greeted by the chief executive, Peter Bradley, and asked to report to Martin Flaherty in the conference room being used as a Gold briefing room."
Just to get the names and the ranks measured up, Martin Flaherty was, I think, the assistant chief ambulance officer at the time, is that right?
A. Mr Flaherty was Director of Operations.
Q. He was Director of Operations?
A. Yes.
Q. He assumed Gold control at headquarters that morning?

A. I'll correctly you slightly, if I may, in terms of terminology.
Q. Yes, please do.
A. He was Gold medic and the Gold control was the room which physically we saw pictures of earlier.
Q. Thank you. Dr Hines talks about the other members of the Gold cell, as he goes on to describe it, a Dr Simon Brown and an Ian Todd. But if we go down the page, please, to -- we have the heading "Situation as at 11.45":
"Ian Todd reviewed the current situation. At this stage, there was confusion about the number of incidents and the mobile phones were totally overloaded and useless. At this point we believed the situation to be [as follows]:
"King's Cross: 100 walkers, 50 serious [and] 5 fatal.
"Aldgate: 7 fatalities, 59 with minor injuries conveyed on a bus to the Royal London and 10 conveyed by ambulance."
So far, to an extent, so good. There's bound to be a certain amount of confusion, isn't there, about numbers of casualties and so on at this stage? But then, if we carry on:
"Russell Square [it says]: explosion on a bus with

the top blown off. Believed to be a suicide bomber, some fatalities, casualty numbers not clear.

"Believed a second Underground incident at Russell Square with about 100 walking wounded."

So there's no reference here to Tavistock Square at all, is there?

A. There isn't, no.

Q. "Euston: a controlled explosion on a bus, no casualties."

So are we to assume from that that the understanding was there had been two separate explosions: one was a controlled explosion on a bus at Euston, and the other was the explosion on the bus at Russell Square which had blown the top of the bus off?

A. That's my reading of Dr Hines' report, yes.

Q. "Leicester Square: another possible incident but no details available."

It was thought, wasn't it, at one stage that there had been an incident at Leicester Square and, indeed, some ambulances were dispatched to Leicester Square to see what the position was.

But if we just look for a moment, please, at LAS691-2, if you enlarge the top half of the form to begin with, this is a report filed by a Mr Harte who was one of the ambulance drivers, paramedics, on the day.

If we go down to the bottom half of the page, please, he's got his incident log. He says he arrived at Waterloo at quarter past 10. He linked up with another paramedic:

"Requested by Gold to attend Leicester Square to assess reports of an incident there."

He arrives at 10.30 on-site with three Harley Street ambulances with seven staff:

"All normal - no incident apparent."

He phones in, do we see, at 10.40, to Central Ambulance Control, requested further instructions and was requested by Central Ambulance Control to attend Tavistock Square for a further incident. He was, in fact, then part of that first wave of ambulances dispatched to Tavistock Square at about 10.40 that morning.

So if we go back, please, to LAS48-5, the bottom half of that page, an hour before this meeting at 11.45, Mr Harte has radioed in from Leicester Square to say "There's nothing happening here, where do you want me to go?". He's been sent to Tavistock Square. But that information hasn't found its way, has it, to the Gold control room, or at least to the Gold Commanders?

A. It would appear that that's the case, yes.

Q. Does that give us an idea of the extent of the

disconnect between what was happening on the ground, as it were, and the information which was filtering its way through Central Ambulance Control and to the people who were making the decisions?
A. It sets out for us the volume of information which we were attempting to compute and understand, and also the communication difficulties which we've explored already in relation to the configuration of the control room, the impact of that is, of course, the delay in messages being passed or received, and the interpretation of those messages, or potential delays in them being acted on appropriately.
Q. This was a fundamental problem, wasn't it? If you didn't know that the bus had blown up at Tavistock Square, and if you didn't know that there were, in fact, no incidents at Leicester Square, it is impossible to make informed decisions about where your scarce resources are needed.
A. The picture, if you like, if I could describe it as such, the picture of London and what was happening and developing at the time was changing on a minute-by-minute basis, and it's right to say that, with hindsight, some decisions were made in the absence of information which was available.
Q. All your scenes had been cleared by now.

A. Mm-hmm.
Q. But you didn't even know where one of them was.
A. Mr Hines didn't know where one of them was, Mr Hines and Mr Todd. I'm not clear from this report where they were located and how frequently they were briefed.
What this says is that, at 11.45, Mr Hines and Mr Todd were not clear on the information as it was unfolding.
Q. We don't need to go to the back to the top of the page, but just to remind you, when he arrived, he was asked by Mr Flaherty to go to the conference room which was being used as the Gold briefing room. Is it fair to assume this reflected the state of the information as far as the others were concerned as well?
A. He would have gone in there and received a briefing. Whether he remained in there, I'm afraid I can't assist you.
Q. All right. Well, let's move on. I'd like to look in a little more detail, please, at the position in relation to Central Ambulance Control and the difficulties which they had encountered. We've looked at this document already with Mr Keith, but there are just one or two details, please. LAS108-2.
Just to get our bearings in relation to this debrief, it took place in the immediate aftermath of the

day, didn't it, about 6.30 that evening?
A. That's my understanding, yes.
Q. It was attended by, amongst others, Mr Flaherty and I think the Secretary of State for Transport also attended this particular debrief. Do you have any recollection of that?
A. I'm aware that a minister attended one of the debriefs. I can't say, without checking the records, whether it was this one or not.
Q. I think you can take it from me that it was.
A. Okay.
Q. But if I'm wrong about that, I'm sure I'll be corrected. In any event, if we could enlarge the top half of the page, please, Mr Keith looked at the passage dealing with the difficulties in logging on to the computers in Gold control and he asked you whether there was a seniority issue in terms of pips on lapels and logging on. Let's see if we can assist with that. I think if we look at LAS354-4 and enlarge the top half of the page, please, this is a summary of some of the other debrief documents which were collated in the aftermath of the event.
If we look, do you see the sentence which starts:
"The following are taken from 088 ..."
A. Yes.

Q. Which was a number ascribed to a particular debrief document. Look at the third -- sorry, look at the second, firstly, bullet point down:

"Two of the people designated to ... crucial roles at the start of the incident were not trained in Gold control procedures."

Can you recall who was it that was in the Gold control room who hadn't received any training in that role?

A. I'm not aware of the training records or status of the staff that were deployed into Gold control on that day. This is, of course, the control room, not the briefing room, if you like.

Q. Yes.

A. At the time, staff on the individual watches within the main control room, as I've described earlier, that provided the staff for the Gold control room, would have been trained on a watch-by-watch basis. I would need to check the training records to understand who was and who wasn't trained.

Q. There's probably no need to name names, as it were, but can you assure her Ladyship that all those who are now -- or would be in a similar situation again, would be properly trained in the Gold procedures which --

A. I can assure the court that they would be and each watch

operating in the main control room has a dedicated team of people who have received a number of days' training in the operation of the new incident control room and the procedures and the technology within it.

Q. Thank you. The next bullet point down is the one which really we came to look at in this document:

"It has been reported many times during major incidents in the past that Central Ambulance Control staff are unable to log into the Gold control computers unless they are two pips or above. This has been reported constantly since the Paddington train crash (five years ago?) and still it has not been fixed."

So why hadn't it been fixed, Mr Killens, by the time we got to the events of July 2005?

A. My knowledge of the issue with the CAD system, which is what we're talking about here, is it wasn't one related to rank, about access to it in the Gold control room. It was one of log-ins, and I think I touched earlier on the fact that staff were using the same log-in as they had in the main control room and, on some occasions, didn't follow the action cards which were provided, which led to difficulties in logging into the computer. So I don't recall it being a rank issue. It was one of following instructions.

Q. You've made reference, I think, in answer to questions

from Mr Keith about a technical report that was prepared. It was prepared, I think, by Mr Vic Wynn, does that ring any bells?
A. It does.
Q. For my Lady's note it's LAS386. He certainly alludes to the same problems that you have identified in terms of not following action cards, but it appears, doesn't it, from this summary, that there was an additional problem in relation to seniority?
A. It's been reported that that was the case, yes, as the document says.
Q. All right. If we could go back to LAS108, please, the bottom of the page, I just want to explore a little further with you the issue in relation to Bow and the role that Bow was supposed to play in the course of this incident. In fact, we might just start at page 3. If we could go over to page 3, top of the page, please, there's an observation from GS -- that was a gentleman by the name of Graham Seamons -- who says this:
"Eileen was under great pressure."
I think Eileen Reid-Keen was the poor operator who was trying to manage --
A. She was, yes.
Q. -- this enormous -- she has our every sympathy, I can assure you:

"Eileen was under great pressure. Bow was ready to help and take over two of the incidents to relieve the pressure of Gold control, but due to comms problems, Bow was not being used effectively."

The issue was this, wasn't it -- we can go to Mr Wynn's report and have a look at this in detail if we need to -- but the people at Bow had been provided with the wrong telephone number, hadn't they, in order to make contact with Gold control at Waterloo? Does that ring any bells?

A. It does, yes. There were some difficulties with the telephone system, and people -- operators logging into the telephone system in the Gold control room. Again, there were specific log-ins for that telephone system which generated specific incident telephone numbers. My recollection is that, again, the action cards on this occasion were not utilised, and there was difficulty in generating those incident telephone numbers as a result.

Q. This is what -- in fairness to you, this is what he actually says about it. He has a heading in his report "Calling from Bow to London Ambulance Service Headquarters":

"It was reported in the HOT debrief that staff at Bow were experiencing problems contacting staff in Gold

control. It transpires that staff were texted a long dial telephone number for Gold control. It is this number which staff were predominantly trying to use. This number cannot be dialled internally."

Then he said:

"They started to try from their mobile phones, but that was ineffective because of the congestion on the networks."

If we go back to LAS108, on that page, a little further down that page:

"Bow was never built into the major incident plans. If it had been, then things could have been planned and coordinated better. This is something to look into for the future."

If it was the fallback for the major incident procedure, how was it that Bow hadn't been built into the major incident plans?

A. Bow was designed as a fallback control system, essentially from business -- or for business continuity purposes, so in the event of losing the main control room at Waterloo through fire, flood, or failure of some critical system, the service could continue to operate from the fallback control room at Bow.

It's right to say that it was not configured in a way to run simultaneously with the control room at

Waterloo at the time.
Q. No one had been given any training, had they? I mean, if we look at the next entry from someone called VT, who was Vanessa Tur:
"As there has never been any practice for moving over to Bow, no one was entirely sure what they were meant to be doing and no one knew how to set everything up. There were the same issues at Bow as there was in Gold control, with no one being able to log in to the computer systems, and not knowing how to set up the mapping."
That was -- I mean, can we agree, that was a pretty unsatisfactory state of affairs?
A. I don't agree with the statement that's here from VT on the basis that the system, the control room at Bow was designed and configured to mirror that in the main control room at Waterloo.
So log-ins for, say, the CAD system would have been the same. I do accept, however, that in these circumstances, training was not provided for the use that had been identified on the basis that it wasn't part of the plan.
Q. In the end, the move to Bow didn't provide any significant assistance to you on that day, did it?
A. No operation in terms of the incidents or core business

was moved to Bow in the event.
Q. Let's just go over the page and look at a different topic, please. Could you enlarge, please, the top half of the page?
This is the very first entry on that page, RC is Robert Cox, who was the Central Ambulance Control Incident Commander on the day:
"The Command Unit was on its way to L1 ..."
Which I assume is one of your ambulance stations in the London area?
A. It is, yes.
Q. "... for an MOT when the incident happened. Therefore, it was not possible to get a team out straightaway. Red Major was dispatched ..."
Just pausing there, Red Major was one of your two emergency communication vehicles, wasn't it?
A. That's correct, yes.
Q. We'll have a look in a moment at what capability that vehicle brought with it. But:
"Red Major was dispatched, but no one could find the keys or the grab pack for Blue Major", which was the other emergency communications vehicle.
A. That's correct, yes.
Q. "There is a need to know", says Mr Cox, "where all the keys are for all the vehicles at any one [particular]

time."

I suspect we could agree on that?

A. We could, yes.

Q. "There is a need for more training in setting up the ECV. The Satnav was useless. The ECV was set up very quickly but no one knew what vehicles were on scene. There is a need for more experience in running the ECV."

Just while we're on this topic, I wonder whether we could just move to LAS386, please, at page 6, top half of the page, this is part of Mr Wynn's report, the technical report:

"The Red Major ECV was dispatched to site ..."

We know, in fact, it went to King's Cross, although I think -- although, again, I will be corrected if I'm wrong -- it didn't arrive until after the evacuation was completed, but:

"The Red Major ... was dispatched to site. However, the duty engineer was not advised, so an engineer was not able to travel."

We'll have a look at it in a moment, but it's a very large vehicle which has some state-of-the-art electronic communication equipment on it, doesn't it?

A. Mm-hmm.

Q. It needs an engineer in order to make it effective.

A. I would disagree in that regard as well, I'm afraid, on

the basis that I have experience of deploying with that vehicle, and I cannot recall an incident -- an occasion, sorry, where it's been necessary to have an engineer to ensure that it's fully functioning.

Q. It carries a leaky feeder on it, doesn't it?

A. It does, yes.

Q. Do you know how to set up a leaky feeder?

A. I do, yes.

Q. Do all the paramedics in the London Ambulance Service know how to set up a leaky feeder?

A. The control staff who are trained to deploy that vehicle do, yes.

Q. What about the staff -- because any member of the London Ambulance Service can drive the ECV; is that right?

A. Correct.

Q. But they don't all have the training to work the equipment that goes with it?

A. Those staff who operate in the rear of the vehicle are those from the control room, and they, by definition of the fact that they are able to be deployed as forward control teams -- that's what we call them, forward control teams -- have been familiarised with the equipment in the control vehicles.

Q. I think, again, I will be corrected if I'm wrong, but I'm not sure if a forward control team ever made it to

King's Cross. But in any event, returning to the document:

"We had an engineer en route to find and assist Silver operations on the ECV. However, after some time the engineer could not find the ECV or any other control. It transpires that the ECV had already returned to headquarters. The engineer was travelling alone and without operational assistance, so was effectively lost."

If we just, perhaps finally this evening, have a look at the capability of the ECV, could we go back to --

LADY JUSTICE HALLETT: Sorry, were you wanting a comment from the witness on what you're putting? I mean, you're reading out quite a lot and I'm not quite sure whether I am to be writing it down as accepted evidence or whether you're pausing for comment, or is it just setting a context for me?

MR COLTART: I think the witness has already provided some answers in relation to the requirements to have an engineer.

LADY JUSTICE HALLETT: I note down the answers when he slips in, but, for example, you read earlier a passage where it said, "Need for more training, Satnav useless", and I'm not quite sure whether I'm meant to be noting that

as accepted problems or whether Mr Killens is only managing to reply to things when he gets the chance.

MR COLTART: Yes, that is my fault, plainly, and I apologise.

LADY JUSTICE HALLETT: No, well, you're probably trying to get through it in a speedy way, Mr Coltart, which might come back to me. So --

MR COLTART: No, I think, in fairness to the witness, he will be in a position better to deal with some of those particular issues if we have a look briefly at the document we were going to, to deal with what was on the ECV and how that equipment might have been deployed.

So it's INQ9002, please, at page 19.

The bottom half of the page, please:

"The London Ambulance Service has two ECVs staffed by three controllers during an incident. These vehicles are painted white and bear the London Ambulance Service markings. They [have] blue flashing lights and a green and white chequered [border]."

Then we get a list at the bottom of the page, don't we, about what's on these vehicles?

A. Yes.

Q. So:

"Each vehicle has multichannel radio sets programmed to all ambulances' frequencies ..."

Just pausing there, would that get round the issue of different ambulance stations in different parts of London operating on different radio frequencies?
A. It wouldn't get round it, sir, no. What it means is that the radio equipment in the vehicle was able to communicate on all of those channels or frequencies that were in operation.
Q. So would it have assisted, perhaps, in coordinating others who weren't able to hear messages being sent or received from a different location because someone in the vehicle would be in a position to monitor all of those channels?
A. It wouldn't, no, on the basis that we used the example of King's Cross, as I described earlier, with ambulances on channel 7, 10 and 11 responding. One person in the back of that vehicle would not be able to monitor three channels effectively. So it wouldn't assist in that regard.
Q. All right. "It also contained hand portables", which I think were in short supply, weren't they, at a number of the incident sites?
A. They were, yes.
Q. "... maps and other sources of information. They also have the facility to set up a direct line telephone link between the emergency services at the scene of an

incident."

We've heard something in evidence over the last few weeks about field telephones, Matel hard line telephones. Is that a reference to the same --

A. Yes.

Q. So you had those as well?

A. Yes.

LADY JUSTICE HALLETT: Was this the tin cans on a string?

MR COLTART: It is, we're back to the tin cans, I'm afraid.

"They also have a facility to link into British Telecom phone lines. A mobile phone is fitted in each vehicle. Each vehicle also has a UHF radio set with multi-agency Command channel 69/70 for use by Silver officers at major incidents."

If we go over the page to the bottom of that page, and I can assure my Lady that there is a question coming in the foreseeable future, if we look at "Communications" at the bottom of the page:

"Managers deployed to a major incident will either have their own VHF portable radio or will be provided with a UHF radio from the Control Unit operating on closed frequency enabling them to maintain contact with each other and the Control Unit. Multi-agency channel ... are also available to allow the ambulance incident officer to maintain contact with his equivalent

('Silver') in the police and Fire Brigade."
Are we given to understand that there would have been a way, in fact, for the Silver Commanders from the various different emergency services to communicate with each other by radio at the scene if the lorry had turned up a bit earlier?
A. The technology existed to -- on the UHF system for officers from each of the three services -- police, fire, ambulance -- to communicate by voice.
My experience -- I can only recall from my experience -- is that that's never been used. It did exist and it could have been deployed if -- it could have been deployed by us, so we could have used it, if the Command vehicle, as you described, had arrived at the scene.
Q. They weren't located at Central Ambulance Control, these vehicles. Where were they located?
A. One was at Bow and I'm not completely sure where the other one was located, but certainly one was at Bow. I'm not sure about the other one, at the time. I know where it is now, but I'm not sure at the time.
Q. We've touched on the issue of leaky feeders. Let's assume that the vehicle at Bow had gone to Aldgate or that the other vehicle had gone to King's Cross and that they had arrived within a reasonable timeframe. Within

what period of time would it have been possible to set up the leaky feeder and thereby facilitate underground communications?
A. From arrival of the vehicle at the scene to completion of the setup depends on the distance that needs to be covered. Aldgate is clearly much simpler than King's Cross, so a very complex station. But in terms of Aldgate, one could have a leaky feeder set up within 10, 15 minutes of arrival.
Q. So even allowing for it taking a little longer at King's Cross -- as we know, the evacuation there wasn't completed until about 11.00 that morning -- it no doubt would have been of great assistance to all concerned if they'd had that ability to communicate from the tunnel up to the surface?
A. It certainly would have assisted the treatment and evacuation of patients, yes.
MR COLTART: Thank you. My Lady, I see the time. I have got a bit more to cover, I'm afraid. I'm entirely, of course, in the court's hands as to whether --
LADY JUSTICE HALLETT: How long do you think, Mr Coltart? You don't have to be rushed. So I just have a vague idea, that's all.
MR COLTART: I would have said certainly not less than half an hour and probably a bit longer.

LADY JUSTICE HALLETT: Mr Watson, you'll probably have some questions as well?

MR WATSON: Yes.

LADY JUSTICE HALLETT: Do we have other people who have questions? You might as well, Mr Saunders?

MR SAUNDERS: I might have, but it will be a few minutes.

LADY JUSTICE HALLETT: Very well. Tomorrow morning, please.

(4.35 pm)

(The inquests adjourned until 10.00 am the following day)