Thursday, 17 October 2024

(10.00 am)

LORD HUGHES: Yes, good morning. Morning, Mr O'Connor.

MR O'CONNOR: Morning, sir. Our first witness this morning is Mr Wayne Darch. Perhaps you could be sworn , please.

MR WAYNE MARK DARCH (sworn)

Questioned by MR O'CONNOR

MR O'CONNOR: Thank you, Mr Darch. Do take a seat. Could you give us your full name please?

A. Certainly. Wayne Darch.

Q. Mr Darch, you have kindly prepared a witness statement for the Inquiry. It is -- if we could bring it up on screen -- INQ006058. I know you have a hard copy in front of you. Thank you. Do you see it on the screen there?

A. I do.

Q. If we just go forward to the last page of the statement, which is page 26, we see that it is dated 7 October of this year.

A. Correct.

Q. There is a signature there, although of course it is concealed on the published version of the statement, but can you confirm that that is your

statement?

A. I can confirm that is my statement.

Q. Have you read through it in preparation for coming today?

A. I have.

Q. Are the contents of that statement true to the best of your knowledge and belief?

A. They are.

Q. Thank you very much.

Mr Darch, I'm going to ask you some questions, first of all a little bit about your career history. We have quite a lot of detail about that in your statement and, sir, may I invite you to adduce the entirety of Mr Darch's statement into evidence?

LORD HUGHES: Yes.

MR O'CONNOR: Thank you.

I will simply touch on a few points about your career history, Mr Darch. Your current role, is this right, is as Deputy Director Operations of the South Western Ambulance Service NHS Foundation Trust?

A. That is correct.

Q. Referred to for brevity as SWASFT, yes?

A. SWASFT.

Q. In 2018, of course the time with which we're concerned, you were head of Preparedness, Resilience and

Response for the same organisation; is that right?

A. I was the head of Emergency Preparedness, Resilience and Response.

Q. With that small correction, that was your role?

A. Yes.

Q. In total, I think we see from your statement that you have been in the Ambulance Service for very nearly 28 years.

A. That's correct.

Q. The roles we have just mentioned that you have been undertaking for the last few years and currently are strategic management type roles, is it right that you spent some of those 28 years as an ambulance emergency technician?

A. I started off as a control assistant working in our 999 control centres. I undertook a number of different roles over the course of my career, including training as a technician. I responded in that capacity as a responding officer, rather than on a double crewed ambulance, which would be the traditional route, but nonetheless that was the case.

I didn't continue down a clinical route and, as you will see in my statement, I am not a registered clinician because I took other opportunities through the

leadership and management route.

Q. Yes. Just give us an idea. We have in our minds the 28 years of your total service, how many of those years were spent as an emergency responder?

A. Six or seven.

Q. Right. But presumably much earlier in your career --

A. Much earlier, yes.

Q. -- and for a large part of that more recent time you have been occupying the type of management and strategic roles that you have mentioned?

A. That's correct, yes.

Q. Thank you. Now, as you know, Mr Darch, and certainly some people in this room know, we will be hearing in the days ahead -- in fact , today and tomorrow and then further when we resume our hearings in London -- from a number of ambulance staff who actually attended Dawn Sturgess, Charlie Rowley and Sergei and Yulia Skripal, and of course we will be asking them about the details of what they did on those occasions and we will be taking them to the contemporaneous documents and so on. That's not what I want to do with you today of course. The purpose of you coming to give evidence today is to give us some insight into the management, policy, and training content of the

Ambulance Service over the period with which we're concerned. Do you understand?

A. I do. Thank you.

Q. I want to start, if I may, with the question of what understanding or training ambulance staff had of or for nerve agent, organophosphate poisoning before the Skripal poisoning in March 2018, and we will work then forward in the chronology, okay?

A. Okay.

Q. I think it's important for me to ask you right at the start about the rarity of this type of poisoning, organophosphate/nerve agent poisoning. We will be hearing in due course from an expert witness, Mr Faulkner -- and I know you have read his report -- he will be giving evidence about pre-accident -- sorry, pre-hospital care generally and he asserts in his statement that -- something to the effect of the vast majority of ambulance technicians, clinicians would never see an organophosphate poisoning case in their entire career and he says that in his long career he had only seen one.

Obviously I'm not asking for an exact answer, but, roughly speaking, does that chime with you or do you think he's got it way out?

A. No, absolutely, I agree with Mr Faulkner's

assessment of that. A number of our clinicians will go a whole career without witnessing or attending an organophosphate or nerve agent poisoning, whether accidental or deliberately. In contrast to that, our clinicians will regularly attend opiate overdoses, but, yes, I mean, the incidences of nerve agent or organophosphate poisoning I absolutely agree with Mr Faulkner's assessment.

Q. In the six or seven years that you were --

LORD HUGHES: Forgive me, Mr O'Connor. Had there ever been a nerve agent poisoning experience in this country?

A. Not that's recorded since the Second World War, as far as I understand it, sir.

LORD HUGHES: Right. But you bracket it with organophosphate poisoning.

A. Yes.

LORD HUGHES: Which is what, fertilisers basically?

A. Yes, that's right.

LORD HUGHES: And that happens occasionally, does it?

A. Occasionally but extremely rare. Again, as Mr Faulkner states within his statement, almost unlikely that our clinicians would attend such a scenario.

LORD HUGHES: Right, thank you very much.

MR O'CONNOR: I'm going to ask you in a moment about the training that ambulance staff had for this type of incident, but before we do, just help us generally, is it -- are there other examples of extremely rare but if they do happen high consequence incidents that ambulance staff are trained for, or is this an outlier?

A. No, it's not an outlier. We train for marauding terrorist attacks and other high consequence incidents, so high consequence infectious disease, for example, and we have specialist resources that respond to those, but there is a baseline level of training and education that is provided to all of our responding crews, as well as staff within our emergency operation centres who take the 999 calls and then coordinate the response thereon in.

Q. Thank you. If we can go to page 8 of your statement, please. We will bring it up on the screen. This is a part of your statement -- we can see from the heading at the top -- where you describe the guidance that's been issued to ambulance staff for organophosphate/nerve agent poisoning and you refer further down the page to the treatment, the DuoDote pen, which administers atropine, does it not?

A. It does.

Q. That is the sort of basis or the vehicle for the training that was given prior to 2018?

A. That is correct.

Q. You refer to a clinical note issued by the -- by SWASFT that was circulated, from memory , I think in 2017. Let's bring it up on screen, please. It's INQ000627.

Mr Darch, this is a clinical notice and it goes with a medicines protocol which I'm going to take you onto in a moment. Just describe in a sentence or so, will you, what this document is, who it went to, why it was circulated.

A. Okay, so I will start with the why it was circulated first, if I may. Late 2016, NHS England National Emergency Preparedness, Resilience and Response team --

LORD HUGHES: Sorry, say that slowly, will you, Mr Darch?

A. In late 2016, the national NHS England EPRR team, Emergency Preparedness, Resilience and Response team, wrote to all English NHS ambulance services confirming that they had accepted a recommendation through the national clinical reference group for DuoDote, which is the atropine that's been described, to be carried on all frontline emergency vehicles and there

is a breakdown within that communication which is further detailed within the clinical notice, as is presented on the screen.

The purpose of the clinical notice is to confirm internally our intention to follow that direction and is a direction to operations officers who are our frontline, first line supervisory level officers, and to all clinical staff that this is being distributed and that they should familiarise themselves with the medicines protocol which describes the circumstances in which the DuoDote should be administered.

LORD HUGHES: Now, it goes to -- so this goes to or went to, did it, the people at the bottom of the page?

A. That's right, that's correct.

LORD HUGHES: What does "All clinical staff" mean?

A. All clinical staff are paramedics and their colleagues that work operationally on the frontline, regardless of whether that's on a double crewed ambulance, a rapid response vehicle, which is a car, our command vehicles and it is also of relevance to our clinicians that work within our emergency operation centres.

LORD HUGHES: Right.

MR O'CONNOR: Thank you, Mr Darch. We can see just underneath the table there the instruction, as you have

said, to people who receive this document to refer to the separate medicines protocol. Let's turn that up if we may. That is INQ000623. Staff who follow that instruction would have seen this document; is that right?

A. That is correct.

Q. Before we look at the detail, can you give us an idea of -- if you were a -- in those years when you were a first responder, how many documents like this would you have been receiving? How much training of this sort do you expect staff to undertake?

A. We receive regular updates at the time. They -- I mean, in terms of the frequency, I don't recall, if I'm honest, but I would have had time to have accessed and referred to this particular document.

Q. Presumably these documents get circulated by email. Do they receive them sort of every day, every week, every month?

A. Maybe a few a week at the time. It depends on other circumstances with regards to other medicines or clinical guidelines that are needing to be refreshed or issued. This was clearly a new medicine. We circulated it through email at the time, but we had also just gone live with an application that our colleagues can access through their mobile phones or iPads or other forms of

devices, and this would have been available on our intranet, but publicised well, that it was there to be referred to.

Q. Having sent out the instruction, do you have a method for monitoring whether staff have actually done what they have been told to do, that is to read the clinical notice and the protocol?

A. With regards to that specific question, at the time we didn't have that technology available and the app didn't allow us to do that. However, since then we do now have the ability to be able to do that.

What I would say is that once we issue updates or new protocols, there are arrangements for training for our colleagues which happens over a period of time. So, for example, if this protocol was issued today , some colleagues may be on a training programme tomorrow that would have access to training in that respect, some may receive that further down the line in 11 months' time, for example.

Q. Thank you.

LORD HUGHES: Do they come in for training every now and then; is that what you're telling us?

A. Annually, yes, sir.

LORD HUGHES: How often?

A. Annually.

LORD HUGHES: Annually?

A. Yes.

MR O'CONNOR: Mr Darch, let's just look at the content of the protocol, if we may, and we see, don't we, towards the bottom of the page that we're looking at, where it says "Clinical situation", there are three -- there are a series of, in fact, three sort of signs, symptoms that are said to be indicative -- clinical features that are indicative of organophosphate poisoning and the instruction says that at least one of those must be present in order to justify using this treatment and we will see similar lists in other documents: bronchorrhea, bronchospasm, that's a respiratory difficulty; is that right?

A. As I understand it.

Q. Also severe bradycardia, low heart rate.

Then if we follow it down onto the other side of the page, other signs may include excess secretions, respiratory depression and altered level of consciousness.

As I say, we will see similar lists of the way in which patients with organophosphate poisoning present in other documents and so some of those symptoms are familiar. It's right also, isn't it -- and you have already made the point -- that some of those symptoms

overlap with the way in which people suffering from opiate overdose present?

A. Mm-hm.

Q. In particular, respiratory depression, altered levels of consciousness and so on.

A. Correct.

Q. While we're on this second page, can we just cast our eyes down, if we see the heading on the left "Cautions" and the second bullet point, do you see that, it starts:

"When symptoms of poisoning are not severe ..."

Then:

"DuoDote should be used with extreme caution in people with heart disease, arrhythmia, recent myocardial infarctions ..."

And so on.

An indication there that -- well, you tell us your understanding of that?

A. It's not quite a contra-indication, but clinicians should use extreme caution when considering DuoDote for patients with those clinical conditions.

Q. It's not -- with generically heart problems, the instruction is not saying "Don't ever use it" but it is saying --

A. Use it with caution.

Q. -- use with caution. According to your statement, that is the training, the guidance that was in play relating to this type of condition prior to March 2018?

A. That's correct, so if I can just expand on that, if I may. All new staff coming into the organisation and at the time through the training that I have already described, clinicians undergo a period of training which covers the clinical symptoms of organophosphate poisoning, nerve agent poisoning, and also the detail around the medicines protocol that we have just reviewed, as well as the application of the DuoDote itself. So that at the time was the baseline standard training.

Q. Yes. Now, I want to move forward in the chronology then to March 2018 and the Skripal poisoning. As I have said, we will be calling evidence from ambulance technicians and indeed others who were present, so I don't want to ask you about the detail of exactly what happened, but perhaps you will agree or disagree with this summary. Both Yulia and Sergei Skripal were attended to and were, in fact, assessed by the ambulance crews there to be suffering from an opiate overdose, and so they were both given naloxone, which is a drug intended to combat that sort of condition; is

that right?

A. That's correct.

Q. They were showing symptoms that, broadly speaking, were consistent with both nerve agent poisoning, organophosphate poisoning on the one hand, and an opiate overdose on the other, for example respiratory collapse and also miosis, pin prick eyeballs, correct?

A. Correct.

Q. Also, they were seen to be suffering excess secretions, so sort of salivation, foaming at the mouth, that type of symptom, which we often see referred to as a symptom which is a distinguishing point because it is a symptom of organophosphate poisoning but not seen with opiate overdose, correct?

A. Correct.

Q. It was also the case that atropine was, in fact, administered to Sergei Skripal by one of the ambulance staff present by accident. He intended to give an administration of naloxone but picked up the wrong bottle and in fact gave him some atropine; is that right?

A. Correct.

Q. We will hear from Mr Faulkner, the expert, who says that that actually -- that that would clearly have

helped Mr Skripal and may even have saved his life.

But it is also fair to say that we will hear from Mr Faulkner that he is not critical of the fact that the ambulance staff on that occasion didn't diagnose organophosphate poisoning, but instead diagnosed opiate poisoning for the very reason we have been discussing, because it is so rare and there is an overlap of symptoms.

A. That is correct.

Q. With that summary in mind, I want to move on and ask you some questions about how the Ambulance Service, your own trust, responded to the Skripal poisoning and what guidance and learning took place after March or during and after March 2018 and let's go, if we may, to page 18 of your witness statement.

We can see, just about a third of the way down, there's a headline "Reviews, learning and changes to policy/procedures" and then a little bit further down a heading "Guidance disseminated following the Salisbury incident"; do you see that?

A. I do.

Q. In fact, it is at paragraph 105.1, so immediately underneath that heading, that you refer to something that took place on 9 March, so the week

after -- I think that was the Friday after the Sunday poisoning, a step taken by you to circulate throughout your organisation a piece of advice that had come in from the NHS and Public Health England about nerve agent poisoning. Let's have that document up on screen please, it's INQ000660.

You refer to two documents in your statement. They are very similar, aren't they? One was intended, I think, for GPs and one for hospitals?

A. That's correct.

Q. This is the slightly shorter version.

A. This is the GP version.

LORD HUGHES: This is which?

MR O'CONNOR: This is the GP version, sir. One might think that's more appropriate, the detail that's added for hospitals would not necessarily be something that ambulance technicians would find useful; is that fair?

A. There is crossover between the two documents, so there are aspects of the emergency department guidance that would be relevant to the ambulance pre-hospital environment.

Q. Well, let's just look at this for now in any event, Mr Darch. What we see there -- we see the headline "Diagnosis and early management in

organophosphate chemical incidents". There are a series of visual indicators. "Step 1, 2, 3 plus triggers", can you just explain what that means?

A. Yes, absolutely. So safety triggers for emergency personnel, "Step 1, 2, 3". Essentially, if it we're responding to an incident that has one patient, we would deal with that as normal essentially; two patients we would approach with caution; and with three patients we would essentially respond with specialist responders and seek specialist advice and then there are a number of plus triggers which include evacuation and accessing, as I say, specialist support and advice.

Q. Those are generic considerations, they're not specific to this type of case?

A. No, they're generic and they're applied across the emergency service spectrum.

Q. Then I won't read them out, but a series of again fairly -- I don't want to use the word "obvious" but signs of something that's gone seriously wrong: dead or distressed people and animals, obvious presence of hazardous materials, unexplained vapours or mists.

Then immediately below that, clinical symptoms, as I say, similar although not quite identical to the types of symptoms that we saw on that medicines protocol.

A. Yes.

Q. This was a document which you received and is it right that you, on your own initiative, decided to send it to everyone in the trust, or at least was it all clinical people within the trust?

A. No, it wasn't all clinical people. I did circulate this, along with the guidance that was issued for emergency departments as well because, as I say, there were aspects within that guidance that were applicable to particularly paramedics within our workforce, and that document makes reference to the significant crossover of the symptoms between opiate overdose and organophosphate or nerve agent overdose and describes the stepped approach to the treatment of those patients.

In the absence of any guidance forthcoming that was specific to the Ambulance Service or to the pre-hospital environment, I took the decision to circulate the guidance that was available.

Q. Yes. I mean, that was a point I wanted to come onto because, as I mentioned, that was a key learning point from the Skripal incident, wasn't it --

A. Yes.

Q. -- the risk of misdiagnosing which would lead, other than by the fortunate accident of Mr Skripal getting the atropine, to not using the DuoDote pen when

it was needed?

A. That's correct.

Q. Did you consider not just circulating the hospital guidance which mentioned the risk of that confusion, but circulating a sort of internal specific piece of guidance, drawing your staff's attention to that very aspect of the Skripal case?

A. We didn't issue new guidance. We reminded colleagues of the existing guidance that was in place at that time, which, as we have seen from the other documents we have referred to this morning, were consistent.

LORD HUGHES: I'm sorry, Mr Darch, you will have to forgive me, you circulated this; is that right?

A. That's correct.

LORD HUGHES: Along with, you said, some other documents which particularly referred to the overlap of symptoms between, on the one hand, opiate poisoning and organophosphate poisoning.

A. That's --

LORD HUGHES: What was that document?

A. That document was a Public Health England document and it was the diagnosis and early management of organophosphate chemical incidents, but specific for hospital emergency departments and I understand that

that's Inquiry reference 000659 --

MR O'CONNOR: Let's bring it up on screen. Mr Darch is right, it's 000659.

LORD HUGHES: That's a PHE document -- or NHS document, is it?

A. PHE.

MR O'CONNOR: What we will see is it's similar -- it starts in a very -- I think almost identical way to the document we have just been looking at, but then it goes on to provide more detail; is that right, Mr Darch?

A. It does from recollection.

LORD HUGHES: So where does it --

MR O'CONNOR: It's not up yet, sir, I don't think.

LORD HUGHES: I'm sorry, wrong document.

MR O'CONNOR: We're waiting for 659. That's still 660.

LORD HUGHES: Yes, that's 660.

MR O'CONNOR: We see, as I said, Mr Darch, the first page or so of this document are very similar if not identical to the document we were just looking at, but I think you -- will you take us to a later page in the document which makes the point about overlapping symptoms of opiate overdose?

A. It may not be that document.

(Pause)

It may have been the wrong -- just bear with me, I just need to refer to a further Public Health England document, which, if I may, give you an alternative Inquiry reference number.

Q. Yes. I must say I had read this document and I hadn't seen the point you wanted to make about it so it may be that we're at cross-purposes.

A. It's in 657.

LORD HUGHES: Oh, not 659? Right, let's have 657 then.

MR O'CONNOR: Shall we pull that up on the screen?

A. The document that I'm referring to was issued in July 2018, but that was an update --

LORD HUGHES: In when?

A. In July 2018 but that --

LORD HUGHES: Dr Darch, just take it gently, please. I need to know exactly who got what, when?

MR O'CONNOR: Can I suggest, if we could go back to Mr Darch's witness statement, please, and go to page 20. If we look at paragraph 108.2, is that the sub-paragraph which refers to the document you're describing, Mr Darch?

A. It is, yes, that's correct.

Q. We can see from the title just above it, and also from the date, that this was, in fact, guidance

that was circulated not between the Skripal and the Amesbury incident, but after the Amesbury incident?

A. That's correct, yes.

LORD HUGHES: Well, you were being asked originally, you see, Mr Darch, about what, if anything, went out to people after the Salisbury incident --

A. Yes, that's my --

LORD HUGHES: -- and it must be obvious to you before the Amesbury incident.

A. Absolutely, sir. That's my error.

LORD HUGHES: Don't worry.

A. The two documents that we were referring to were the documents that were published on 10 March.

LORD HUGHES: Don't worry. Those are, 660, is that right, the public health document about nerve agent/organophosphate poisoning.

A. Correct.

LORD HUGHES: And?

MR O'CONNOR: 659, which was the similar document which went to hospitals.

A. That's right.

Q. But is it right, Mr Darch, that in fact neither of those documents refer to the misdiagnosis point?

A. Correct.

Q. In fact, you refer in your witness statement to a number of other generic documents relating to organophosphate poisoning that were circulated around this time, but my suggestion is that in fact none of them refer to the misdiagnosis point. Do you agree with that?

A. I do agree with that, yes.

LORD HUGHES: Right. So who got the two documents that they did get after the Skripal event, that is to say 660 and 659, which describe the symptoms of organophosphate/nerve agent?

A. They went to all staff as listed within my statement, sir.

LORD HUGHES: Meaning?

A. Meaning all staff, all of our colleagues.

LORD HUGHES: Right.

A. It was issued across the organisation.

LORD HUGHES: If I'm an ambulance man I will have had it, will I?

A. Yes.

LORD HUGHES: Thank you.

MR O'CONNOR: So they will have had that high level document describing the symptoms, but they wouldn't have had their attention drawn to the risk of misdiagnosis in that document.

A. In that document, that's correct.

Q. I would like to take you to another document , please. If we could have INQ000724. Now, this document, Mr Darch, is the debrief that your organisation conducted, it's the report of the debrief into Operation Fairline which was the name given to the response to the Skripal poisoning, yes?

A. Correct.

Q. We know that this document itself wasn't published until quite a lot later, it was October 2018.

A. The first edition was published prior to October, but the final version was published in October 2018, having concluded Operation Fortis and the multi-agency debriefs that we heard earlier on in the week.

Q. Certainly this document though, much later?

A. That's right.

Q. Let's go, if we may, to page 18 of this document. This is annex A to the document, Mr Darch. We can see it is headed "Mike Killoran debrief report". We don't need to go there, but I will just record that we see that this debrief report was, in fact, dated 27 March 2018, so it was much more rapid?

A. That's right.

Q. We assume that when that was undertaken the

results of it were circulated within the organisation?

A. They were indeed.

LORD HUGHES: I'm sorry, Mr O'Connor, you've lost me. I've got a document in front of me, it hasn't got a date on it.

MR O'CONNOR: No, well --

LORD HUGHES: But it has it somewhere else, has it?

MR O'CONNOR: We can look, sir, it's internal page 23 of this document.

LORD HUGHES: Thank you.

MR O'CONNOR: At the bottom. Do you see there, Mr Darch?

LORD HUGHES: So Mr Killoran's report, 27 March .

MR O'CONNOR: It's an earlier report annexed to the final report; is that fair?

A. That's correct.

LORD HUGHES: What happened to that? Did people see it or not?

A. Yes, they did.

LORD HUGHES: Who, who saw it?

A. The contents of this report are largely not concerning clinical matters --

LORD HUGHES: No.

A. -- but are concerning policy, process and procedural issues as a result of the consequence

management aspects of the response to the initial Operation Fairline.

This was shared with our command teams and tactical advisors, who this particular document was specifically relevant to.

LORD HUGHES: Right, and, Mr O'Connor, do you want us to look at this because it contains something material to the point you were dealing with before, or not?

MR O'CONNOR: Yes, there's one part of it I would like to ask you about, so if we can go back to page 18, please. Obviously I have heard what you say, Mr Darch, that this wasn't aimed at frontline staff, but if we just look at the last of those paragraphs, please. This is the executive summary. We see Mr Killoran says:

"At the time of the incident the crews were completely unaware of the cause of injury/illness ..."

This is the Skripal incident, isn't it?

"... and this was not revealed until some 15 hours later. The debrief will detail the staff concerns and suggest some changes to working practice in incidents such as this."

This is a reference to the fact that the staff on the ground didn't diagnose organophosphate/nerve agent poisoning, but my suggestion is that it doesn't then

take that issue forward and recommend any further training, any guidance, there's no action point to try and deal with that problem within this debrief from March 2018.

A. I think -- on reflection I think that's a fair comment. There was also a significant delay in ourselves within the Ambulance Service being aware that the issue that our colleagues had attended on the Sunday was indeed of, you know, organophosphate or nerve agent related incident, which is what that also refers to.

Q. Just drawing this together, Mr Darch, do you think it's fair to say that more could have been done in that period between March and June to draw your staff's attention -- not just refreshing their guidance on organophosphate poisoning, but drawing their attention to this particular learning point from the Skripal poisoning?

A. We shared as much information as we could, as I have described, and there are a number of documents there that were disseminated following the Salisbury incident, but of course we could always do more and if the Inquiry considers that we should have done more, then clearly we will take action to address that.

LORD HUGHES: Well, I think you're being asked whether you think you should have done more.

A. I think we --

LORD HUGHES: Or whether at the time it was as best you could do.

A. My perspective is at the time we did the best that we could with what we had available to us.

MR O'CONNOR: Are you saying that you didn't know before the Amesbury incident that the staff in Salisbury had misdiagnosed the Skripals?

A. Sir, I refer to my earlier comment, if I may. The incidents of nerve agent poisoning that crews would be -- you know, would come across is extremely, extremely rare and, as you will know from witness statements from colleagues that you will speak to in the coming days, we responded to the symptoms that we believed were of an opiate overdose nature.

It was some hours later, indeed well into the Monday, that it was known that this was not an opiate related incident, but as I think Mr Faulkner makes reference to in his statement, he is not critical of the diagnosis or the action that our crews took at the time and I would support that.

Q. I'm sorry to interrupt you, but I want to come to the point. We have all agreed that Mr Faulkner -- and it may be in due course the Chair -- is not critical of the misdiagnosis at the time, but very shortly

afterwards you, as an organisation, were aware that there had been a misdiagnosis and my question is: should you have done more to circulate that particular learning point within your organisation because we haven't been able to find a single document where that's done in the three or four months before the Amesbury incident?

A. We did share as much information as we possibly could, but to answer your specific question, no, we didn't, and we could have done better there.

Q. All right. Let me move on to a slightly different topic. Of course one of the reasons why spreading this knowledge would have been a good idea was because of the risk that it might happen again. That must be right, mustn't it?

A. Yes.

Q. In particular, if that risk crystallised, if there was another nerve agent incident, then your staff very likely would be at the sharp end of that?

A. Correct.

Q. Was that risk something that you as an organisation were made aware of or considered?

A. We did consider it and that's in part the reason that I circulated the guidance that was available, notwithstanding that it was not addressed or intended for the Ambulance Service, but for emergency

departments and GPs, to our colleagues.

We also -- or I also re-issued the initial Operational Response Guidance, again on 10 March, and there was guidance that was received into our organisation that was specifically intended for ambulance services that used NHS pathways as a triage system. We're a MPDS service, medical priority dispatch triage service, but again, in the absence of guidance or additional information for MPDS services, I took the information that was available and circulated that.

In terms of being aware of potential or -- either secondary or tertiary incidents, I don't recall specific discussions regarding that. However, I was made aware yesterday evening of some emails that were circulated on 15 March which I was not in possession of -- and over the course of last night I have rechecked to confirm that position -- but the actions that were contained within the documents that were shared with me yesterday evening were the actions that I took on 10 March, some five days earlier.

Q. Well, you have mentioned that email, so let me ask you about it. If we could have, please, INQ004704 on screen. This is an email -- it's not easy to work out exactly who sent it or received it for obvious reasons, but we can see that it is dated Thursday,

15 March, so ten days or so after the Skripal poisoning. It would appear that it's an internal DHSC email and if we can go over to the second page, please, we can see that it's -- the title is "Salisbury nerve agent attack: Risk of secondary incident" and just underneath that, "Reasonable worst case scenarios ... and mitigation". And a list underneath, a numbered list, the first number being a second, targeted attack, so in other words another targeted attack like the Skripals, but then second and third:

"Accidental discovery of discarded agent by ..."

Either humans, or third, animals.

If we cast our eyes down towards the bottom of the page, we can see that the analysis of the second type of incident, that is in an accidental discovery of a discarded source of material by humans, and we can see what is being anticipated is up to six members of the public being exposed to source material used and then discarded after the Salisbury incident, up to four emergency services personnel exposed to the nerve agent?

LORD HUGHES: This is all someone's stab at a hypothetical possibility, is it?

MR O'CONNOR: It's a reasonable worst case scenario.

LORD HUGHES: Worst case scenario.

MR O'CONNOR: A scenario against which to plan.

LORD HUGHES: Right.

MR O'CONNOR: One fatality, nine other casualties requiring prolonged hospital treatment, and so on.

Then if we go over the page again, please, we see further analysis in a grid and consideration being given to what first responders need to know in planning for that sort of scenario.

My question, Mr Darch, is perhaps an obvious one, which is in your sort of managerial/strategic role within the Ambulance Service that must have been the most likely to have been involved in this sort of secondary incident, coming across a discarded container, do you think you ought to have seen this sort of planning document so that you could have been involved in that planning?

A. Absolutely, yes.

LORD HUGHES: You didn't see this at the time? It's an internal departmental document somewhere, is it?

A. That's correct. The first time I saw this document was yesterday evening.

LORD HUGHES: Right, and you say now that you would like to have done?

A. I would have, yes.

MR O'CONNOR: If we can go back to the first page

of the document, just the text of the email please, we can see that whoever it was that wrote it, says:

"Please find attached a first stab at the [reasonable worst case scenario] for a secondary nerve agent incident ..."

There's then in brackets "For health sector only". Were you the health sector?

A. We are part of the health sector, yes.

Q. Then:

"Suggest that this is not forwarded further than necessary ..."

I think you have made your position clear, but do you regard yourself as having been one of the necessary recipients of this analysis?

A. Absolutely.

Q. If you had, what would you have done differently?

A. We would have -- we would have followed the action that it describes on page 2, I think it was, but in terms of the actions -- could we possibly go to page 2? But in terms of the actions around reaffirming initial operational response and dissemination of guidance, we -- that's the action that we undertook on 10 March.

LORD HUGHES: Well, actually this page isn't about

actions, is it, it's about what the worst case scenario is?

MR O'CONNOR: I think it's the next -- it's the grid that Mr Darch is referring to.

LORD HUGHES: It's the grid. Yes.

A. Yes, so if you look at the actions that are required in terms of reinforcing initial operational response with regard to remove, remove, remove, protocols, we did that on 10 March and the learning from the 4th was disseminated, as I said earlier on, following the distribution of the Public Health England guidance that I previously referred to.

MR O'CONNOR: You have referred to that second bullet point:

"Learning from 4 March should be rapidly disseminated ..."

Do you think, if you had seen this sort of document, which I assume would have made the risks feel much more real to you --

A. Yes.

Q. -- you might have thought again about, for example, disseminating the learning point about the crossover symptoms between opiates and nerve agents?

A. Yes, absolutely. This would have been extremely helpful.

Q. Thank you, Mr Darch. I want to move finally on to two other topics, which I think I can ask you about quite briefly, and they relate first to the treatment of Dawn Sturgess and, second, to the treatment of Charlie Rowley. As I have said with my earlier questions, of course we will be coming to the paramedics who themselves undertook that treatment, so we will ask them the detailed questions. I want to fore shadow some of the sort of larger issues that will come up with you now.

In terms of the treatment of Dawn Sturgess, one of the features of her case was that while the paramedics were treating her, they were told, by her boyfriend, Charlie Rowley, that Dawn didn't take drugs and that was inconsistent with the views they were forming about what might have caused her condition because they were working on the basis that this may well be an opiate poisoning case.

As I say, we will ask them about exactly who heard what and what they were thinking, but from your sort of managerial perspective, what guidance or training is there within the Ambulance Service about how paramedics treating a patient should sort of feed into their analysis information like that that's given by family members or people who are with the victim?

A. I think the first thing that's important to say is clearly Dawn was in cardiac arrest at the point at which we arrived and therefore the treatment of the cardiac arrest is first and foremost in -- one, in achieving a return of spontaneous circulation and secondly, sustaining it stably.

Clearly, any information that is available to ambulance crews at the scene are important and should be taken into consideration. There are a number of causative clinical conditions which, as I have mentioned I'm not a registered clinician so I'm not able to go into, that they would be considering in terms of addressing the potential causes of the cardiac arrest and therefore that -- those principles, but at the same time taking into account any observations that they make of the scene, but also information that they are given from either, you know, witnesses, relatives, friends, other bystander, clearly they will take into consideration. But as you have already mentioned, my colleagues that attended the incident will be able to detail that.

Q. Just to pick you up on that though, you say "clearly" they would take that into consideration. Of course we will ask them whether they did or not, but you from your standpoint, is your position that they should

have taken that into consideration?

A. Yes.

Q. Is that their training?

A. That's their training, yes.

Q. Right. Then lastly, Mr Darch, Charlie Rowley, who of course became ill later on the day, different paramedics and ambulance staff attended him. We will hear that there was a rather different sequence of events there and in fact the paramedics who attended Charlie Rowley did form the view that he was suffering from nerve agent poisoning, but there was then a difference of opinion with police officers who attended and, in very brief summary, the police officers did not accept the diagnosis, the views of the paramedics, and proceeded essentially on the basis that they were content that this was an opiate poisoning and there were various steps that followed as a result.

We will get into all of the detail of that with the people who were there, but again from your sort of managerial perspective -- first of all, let me ask this: is that something that happens very often, that police officers or, for that matter, a different emergency service, override the clinical views of the attending paramedics?

A. It is possible, but in my experience not

frequent.

Q. Knowing what you know about what happened that night, is that something that you understand and that you think was reasonable, or do you think -- or not?

A. From my perspective, I think it's evident that there was a breakdown in the application of the JESIP, the Joint Emergency Services Interoperability Principles, which essentially are where you have a multi-agency response to an incident, the three blue light services in particular, should co-locate, they should communicate, which allows them then to jointly coordinate the response, having a shared situational awareness and a joint understanding of the risk, which allows the multi-agency partnership to develop a joint plan to respond to the circumstances that they are facing.

On that particular evening, I think there was a breakdown of the application of those principles on this occasion.

Q. Thank you. Mr Darch, thank you. Those are all the questions I have for you. There will be some other questions, sir.

LORD HUGHES: Yes, and I have one first, please.

In relation to Dawn Sturgess, you have been asked about the impact of being told by a partner present that

she wasn't a drug taker. Your ambulance people are dealing with a woman in cardiac arrest. Supposing that it had never occurred to them that any drugs might have been involved, would it make any difference to the way that she is managed?

A. As I have said, sir, I'm not able to answer the clinical specifics, but the priority is, in dealing with the cardiac arrest, to achieve a return of spontaneous circulation.

LORD HUGHES: Which eventually they did.

A. They did, yes.

LORD HUGHES: As it were artificially. Yes, all right. Thank you very much indeed.

Mr Mansfield. Mr Mansfield, there are clearly some questions which you will need to ask. I have seen the request to do so. I rely on you, with all your experience, to confine them to the things that need to be asked, and to bear in mind the difference between requests for information which will help me, and comment which will come later.

MR MANSFIELD: Yes, I will make that distinction. I'm grateful.

LORD HUGHES: You will bear in mind the timetable, but I'm not proposing to break until 11.15; you have until then.

MR MANSFIELD: I think that's within the time framework you have in mind.

LORD HUGHES: So be it.

Questioned by MR MANSFIELD

MR MANSFIELD: Good morning. I represent the family of Dawn Sturgess and the first thing just -- this is an observation, it's not a question, just so you see the context. The family do appreciate what the paramedics did to help her, even though in the end, of course, we know how it -- what the outcome was, but they do appreciate that and want that known to you.

However, they also -- and I think you know this from other sources --

LORD HUGHES: Mr Mansfield, forgive me, we're on questions.

MR MANSFIELD: Coming now.

LORD HUGHES: Sooner rather than later, please.

MR MANSFIELD: Yes. They also would like to think of the future. The questions that I have -- it's the context for the question, so you know.

The first question is really the one we have just finished with. I want to follow that up, if I may, for a minute. Because if we're thinking about the future, we don't want a situation in which two emergency services say one thing, in this case that in fact it's

another Novichok, putting it shortly, and another emergency service, if you like, saying "no", overriding it, as you have just heard, saying it's drug related.

Now, has there been discussions in order to ensure that this sort of situation doesn't arise at the command level, or any other level for that matter?

A. Yes.

Q. Right. Is there provision now -- I would ask, for the public benefit, basically how is that going to be resolved? At command level, ground level; how is it going to be done?

A. We're six years down the line now and the principles of JESIP are, as I understand it, embedded in all of the blue light emergency services, but also across the wider partnership of the Local Resilience Forum which we heard about earlier on in the week .

The national JESIP team routinely undertake assessments of all blue light services, periodically throughout the calendar year, which assess whether the principles are embedded or not. My understanding is that the principles of JESIP are now firmly embedded in blue light organisations and in my experience working at the tactical and the strategic level, particularly in response to the incidents in which we're discussing, and other incidents, that is my experience, that JESIP is

understood, works well when it is utilised.

Q. In that context, are there practical exercises in this which you can monitor whether the understanding is being implemented? In other words, the situation that was confronted in this case might arise again in the same way?

A. Yes, both through table top and live exercises.

Q. Because one of the things -- and this is another general question which reflects back -- it's quite clear that after the Salisbury attack there were -- and they're in the documents, I am not asking for them to be brought up -- numerous references to debriefs, are there not?

A. Yes.

Q. Throughout March, a whole set of dates, then another lot in June. You recall that?

A. I do.

Q. Now, in relation to those debriefs -- this is another aspect, the key learning curve -- in any of those debriefs were the points that have been put to you about the key learning, namely distinguishing between symptoms, signs and causes; were they discussed? Was training discussed in any of them?

A. Yes.

LORD HUGHES: Hang on, Mr Mansfield. That's two or three questions. Are you on the question of the possible overlap between opiate --

MR MANSFIELD: Yes, I am.

LORD HUGHES: Right. That's what he wants to know, Mr Darch: did any of the debrief documents address the overlap in symptoms and the risk, therefore, of mistaking one for the other?

A. Yes, they did and since the Salisbury and Amesbury incidents there has been a number of changes to national guidance that addresses those which are detailed within my statement.

MR MANSFIELD: In relation to that, as well as what was happening at the time in March and June, it's a question of compliance and monitoring whether it's actually happening, because you can have a lot of documents, nothing actually happens on the ground. How is the monitoring of this documented information being carried out?

A. Could you clarify the question? Are you referring to the implementation of the learning from the debriefs?

Q. Yes, that's right.

A. Yes. From my organisation's perspective , we declared both incidents to our commissioners and to our

regional NHS England team as a serious incident. What that means is that we have external oversight and scrutiny of ensuring that the learning is taken forward, is implemented and is embedded and we are not able to only internally sign off the implementation of that learning, that requires external overview and assurance that that has indeed been taken forward.

Q. One of the key points after Salisbury, which obviously was a shock for everybody's system at that time -- I want to ask you about this point, namely a secondary -- not necessarily a secondary incident, but Novichok having been left somewhere, discarded. Now, was that a talking point amongst these briefings that you had?

A. I recall some conversation at the SCG around the search for potentially missing substance, but I wasn't specifically into the detail of that and, as I have mentioned, with regards to the document that we have just reviewed from the Department of Health, I think it was, that wasn't shared with me either.

Q. Were you provided with any advice on this topic, namely the real risk that some has been left, either in the Salisbury area or even a little wider than that, because Novichok was found in London?

A. No --

Q. Traces of it.

A. Not that I recall.

Q. Well, I want to ask you -- in a sense it's a key learning aspect of this. Is it right that at the time we're talking about, that's between the Skripal and the Amesbury events, there were a large number of organisations at your level which had a function of sharing important information in order to inform public and inform first responders, weren't you?

A. Yes.

Q. A large number of groups, about seven altogether.

A. Yes.

Q. Yes. I can run through them , but I don't want to take up a lot of time, but if you agree there's about seven of them.

The question I have is: can you explain then how it was then, hopefully not in the future, that the discussion about discarded Novichok which could affect the local population wasn't a matter of prioritisation or discussion? Can you explain that?

A. No, simply because I wasn't involved in those specific conversations and information, as I have already alluded to, wasn't shared with me.

Q. Did it occur to you personally -- I'm not

saying it's your responsibility, but whether you, given your situation right here, whether you thought that that was a priority, that there might be more in the city somewhere and the sooner it's found, the better, but people doing the looking, as well as the public, need to have -- and your first responders -- need to be aware there could be another incident in that sense?

A. Of course it was a consideration and I recall it being a consideration, which is why we circulated the guidance that we did, which I have already discussed today.

However, my considerations were in the context of advice at the time from public health experts that the risk was extremely low.

Q. Right. Well, I want to deal with that because I'm going to suggest one of the problems after the Salisbury attack was a mindset that because Novichok was rare or virtually unknown, or because nerve agent poisoning was rare, there was a mindset that it wouldn't happen again, wasn't there?

A. I don't know if there was a mindset that it wouldn't happen again, but I think in the context of the public health advice that the risk was low, you know --

Q. But then -- I'm sorry to interrupt, but at that time, straight after the Salisbury attack, was it

really being considered that the risk of more being found -- not another attack, but being found in Salisbury -- was regarded by public health authorities as low risk?

LORD HUGHES: Well, you must tell us about what you understood for your people, Mr Darch. Public health may have had to think about all manner of things, including, one would have thought, the fact that some of the Novichok which had affected the Skripals might well be around in the area.

MR MANSFIELD: Yes.

LORD HUGHES: But what's the answer to the question: were you applying your people's minds to the risk of not just the stuff being -- having contaminated other bits of Salisbury or beyond, but the specific risk of discarded material?

A. Okay, so I don't -- I don't recall considering specific risk as a result of discarded material, but I did consider the importance of ensuring that responding crews were aware of the signs, symptoms and how to treat as such.

LORD HUGHES: Thank you.

MR MANSFIELD: In terms of organophosphate poisoning, of course in terms of that there are numerous other ways in which -- the Chair has mentioned

fertiliser, but pesticides can give rise to it and also flammable retardants can give rise to it, plastics can give rise to it. There's a wide range of sources for poisoning of that kind, is there not?

A. That's my understanding, yes.

Q. What I want to ask you, backing on to that, is in relation to making distinctions and understanding signs and symptoms, to your understanding is there one distinctive feature or sign or symptom that relates to Novichok poisoning as opposed to any of the others, or are they all very similar?

A. I think there's significant crossover, as we have previously discussed.

Q. Yes, well, I'm only wanting to ask if the documentation that has been made available to first responders from now on gives them a clear indication that "If you see X, then that is Novichok, but if you see Y it may not be". In other words, making a significant distinctive feature so that somebody can tell on the spot, or at least have a notion?

LORD HUGHES: Is this a question specifically about Novichok or about nerve agents generally?

MR MANSFIELD: Well, I will make it about nerve agents generally.

LORD HUGHES: Right, so the question is, is it: Is

there any reliable means of distinguishing on the spot between Novichok or other nerve agents on the one hand, and organophosphates and some other sources on the other? Is that it?

MR MANSFIELD: Yes, that's it.

A. Yes is the answer and that's contained in updated JRCALC guidelines for clinicians. In 2018, a terminology called CRESS, which looks at conscious levels and a number of other symptoms, were not included in the clinical guidance at the time. It now is and it assists clinicians to be able to diagnose and differentiate between different types of toxidrome.

Q. To make it clear, it wasn't available at the time of Amesbury, but it is now available?

A. That's correct.

Q. Now, part of the situation after Salisbury was a number of members of your organisation, in other words paramedics, as well as doctors and others, were at Salisbury as well as at Amesbury, were they not?

A. They were.

Q. They were in a very strong position, since it had been established by then that it was Novichok, a particular version at Salisbury -- was there an attempt by you to organise internally gatherings, seminars and practicals involving the people who had

been actually on the ground? Did that happen?

A. There were a number of sessions that happened that did involve some, not all, of those individuals, yes.

Q. Did you attend those? Do you know what actually happened when they did them?

A. I didn't in person, no.

Q. Was a record kept of what happened on those occasions?

A. There should be, yes.

Q. Now, in relation to one particular meeting -- I think you went to it -- there was a meeting held at Porton Down. That's important, is it not?

A. It is. I know the meeting you're referring to, sir. I didn't attend it in person.

Q. I'm sorry, I didn't catch that?

A. I didn't attend that in person, but I'm aware of the meeting you're referring to.

Q. You're aware of it. There are two questions arising out of that. One is that the meeting took place on 19 April 2018, but the report indicating what had been discussed at Porton Down wasn't published until the day after Dawn's death. Did you know that?

A. I was aware of that.

Q. Can you help as to why that was delayed for

that period of time?

A. I'm afraid I can't. I wasn't involved in the meeting and it wasn't my document to publish.

Q. No, I appreciate --

A. So I'm unable to help you, I'm afraid.

Q. I'm only asking for information just so we can put it together, as it were.

Were you aware of what, in fact, was discussed at Porton Down in that period?

A. No.

Q. Did you become aware -- once the report was published, did you read it then?

A. Yes.

Q. Right. Now, one of the things I want to ask you, because of a witness that's coming, to see whether you know anything about it, there seems to have been for some a reticence to reveal details about Novichok poisoning. Did you run into that difficulty yourself? A reservation about either talking about it or certainly making it public?

A. Yes, I did.

Q. You did? Now, where did you run into it? At Porton Down or somewhere else?

A. No, it was at the SCG, so on the Tuesday, I was informed of an organophosphate poisoning, but the

details surrounding Novichok was not shared with me.

Q. Was not shared --

LORD HUGHES: Sorry, the details surrounding what, the type of material?

A. The type of material, so I knew it was an organophosphate, but I didn't know that it was Novichok.

MR MANSFIELD: Yes, I understand that. Well, I think one can understand the materials point, but what about -- I'm going to put it this way: the presentation of the symptoms and signs, the treatment which needs to be urgent and so on, that sort of thing, was that discussed at Porton Down?

LORD HUGHES: He wasn't there.

A. I wasn't there, so I don't know.

MR MANSFIELD: No, but he read the report.

LORD HUGHES: Mr Mansfield, I'm sorry, there's a limit to how far you can take this with this witness. Moreover, you need to keep an eye on the clock.

MR MANSFIELD: Do you also accept, therefore, just in this context, that since you were dealing with this between the two situations, that is Salisbury and Amesbury, that protection of the public is important?

A. Yes, I agree.

Q. I appreciate it's not your responsibility, but you are sitting on seven different organisations which

have a responsibility, each of them, towards the public. Was there any discussion --

LORD HUGHES: Mr Mansfield, he isn't sitting on any of them. Please confine the questions to material that -- information that this witness can give. We don't need --

MR MANSFIELD: It does.

LORD HUGHES: I don't know -- it is whether it helps me that matters. I do not need repetition of the assertions that have been contained in your questions. I have understood them.

MR MANSFIELD: I do understand.

The question I would seek to ask is for the future if we have a number of organisations such as this and that protection of the public, as you have agreed, is important, these are matters that need to be discussed at the level of the organisations I haven't read out in detail, it does need to be discussed; do you agree?

A. I do.

LORD HUGHES: It is not for him to say. It is for me -- it might be for me to say, but it certainly isn't for him to say.

MR MANSFIELD: Well, he is a leader in the field. That's the only reason I'm asking. He is a leader and an influential one.

LORD HUGHES: No, please don't argue the point, Mr Mansfield.

MR MANSFIELD: All right, I won't.

May I just have one moment?

LORD HUGHES: Of course.

MR MANSFIELD: Most of the other questions have already been asked by counsel that we submitted, so I don't think there's anything else I wish to ask.

LORD HUGHES: Just check.

MR MANSFIELD: Yes, thank you very much.

LORD HUGHES: Thank you very much indeed, Mr Mansfield.

Have we finished with Mr Darch, Mr O'Connor?

MR O'CONNOR: Yes, we have, sir.

LORD HUGHES: Thank you for your help, Mr Darch. You need not stay. 11.30, please.

(11.17 am)

(Short Break)

(11.29 am)

LORD HUGHES: Yes, Mr O'Connor.

MR O'CONNOR: Sir, Deputy Chief Constable Mills is in the witness box and you will recall that he has already sworn and already --

DEPUTY CHIEF CONSTABLE PAUL MILLS (still under oath)

LORD HUGHES: Yes, you are still on oath, Mr Mills,

of course.

A. Thank you, sir.

Questioned by MR O'CONNOR

MR O'CONNOR: Mr Mills, you have already given outline evidence this week about Wiltshire Police structures, about the response of the constabulary to the 2018 poisonings, Operations Fairline and Fortis and so on, and we will return in due course, in London in fact, for you to provide some detailed evidence about Wiltshire Police's response to the Skripal poisonings.

The purpose of asking you to come and give evidence today is for you to provide some context, as I said to Mr Darch, to the evidence we will hear today and tomorrow and early on in our hearings in London about the emergency services' response to Dawn Sturgess' poisoning and also Charlie Rowley's poisoning, and some sort of policy level context into which we can put that evidence.

As I said to Mr Darch, of course we will ask the witnesses themselves who were there, and we're very conscious that you weren't, about what they did, what they were thinking, what decisions they made. We won't trouble you with those matters.

I would like to start then, if I may, with the general issue of the training, guidance available, the

preparedness, if you like, of Wiltshire Police to face an organophosphate poisoning after the Skripal poisoning.

LORD HUGHES: Which of the statements would you like me to have open, Mr O'Connor?

MR O'CONNOR: Sir, I'm going to be referring Mr Mills to his third statement, the sort of compendious -- the summary statement of his earlier two.

LORD HUGHES: Is that 6117?

MR O'CONNOR: Yes, it is.

In fact, Mr Mills, I would like to start by taking you back to some questions you were asked when you gave evidence earlier this week and I hope that we're going to be able to bring the transcript up on screen. It was Tuesday, 15 October, and if we could have the internal pages, the small internal pages, 21 and following, on screen.

This is just -- you were asked some questions by Ms Whitelaw on this topic, Mr Mills, and I think it's fair if we just remind ourselves of what you said then and then I will ask you some further questions.

You see that -- yes, the small page numbers at the bottom of the pages -- at the bottom of page 21, Ms Whitelaw said:

"**Question**: Importantly, the item or items used to

deliver the poison in the Skripal poisoning had not been located at the time of --"

You said:

"**Answer**: No, they hadn't."

She went on to say:

"**Question**: ... Dawn Sturgess' poisoning. Indeed, you didn't know in June/July 2018 whether there was a vessel or container that had been discarded still in or around Salisbury or in Wiltshire or in the country?"

You said: "We did not know".

Ms Whitelaw put it to you whether you agreed that in those circumstances Wiltshire Police ought to have been advised to be particularly alert to any signs of nerve agent poisoning from March 2018 onwards. Then we can read your answer. You gave some context. You referred to a CBRN document and I'm going to show you in a minute the CBRN document which I think was the one you were referring to.

You said that that document said that this was an isolated incident. You referred to the fact that the intelligence -- and that there wasn't believed to be a further risk.

Then I'm just casting my eyes down. If we can go to page 23, which is at the bottom of the page, picking it up a couple of lines in you said:

"**Answer:** From a local level, yes, I absolutely reflect that we didn't put anything further out. Clearly police officers are trained in relation to generic responses, but I do believe in hindsight it would have been sensible just to have put some advice and guidance out, just confirming that which was already there."

That was the evidence you gave earlier this week. Thank you, we can take that down.

Now, I said that I would bring up what I thought was probably the CBRN document you were referring to in the course of that answer, so could we have on screen, please, INQ006069. Mr Mills, I know you had a look at this document earlier this morning. Is this either the very document you had in mind or a close relation of it?

A. I believe, sir, this is the source document and what I have seen is a secondary document which in essence is a PowerPoint presentation which covers the main points which are made in this document.

Q. Just to be clear, this was in -- we know from other evidence that this document was circulated March/April, I think it was, 2018, certainly between the Skripal poisoning and the Amesbury incident. Do you think you would have seen it during that period?

A. I hadn't seen it up until recently, sir.

However, what I can say to be more precise is that the version I have seen, the PowerPoint presentation, was dated in March, sir.

Q. Right, so --

LORD HUGHES: Not the document, but a PowerPoint presentation of the same material?

A. Same material, sir, and that was dated in March.

MR O'CONNOR: 2018?

A. 2018.

Q. The substance wasn't known to you in 2018 at the time?

A. No, it was not.

Q. No.

A. And I was -- sorry, forgive me, I may have misunderstood that question, sorry.

Q. Perhaps I will try that again. We have agreed that you hadn't seen this very document until, I think, this morning, but you said that you had seen the substance of it in a PowerPoint demonstration?

A. Yes, that is recently in the preparations for the Public Inquiry, sir. Certainly between the material period of the Skripal attack, before the attack in Amesbury, I had not seen this document.

Q. I'm grateful. That's now clear.

But just to look briefly at this document, because you did pick out some aspects of it in the answer you gave to Ms Whitelaw, first of all there is the -- in red at the top, there is the restricted handling. It's only to go to certain tactical commanders. Perhaps that's why you didn't see it at the time, I don't know.

A. Yes, certainly in my witness statement, sir, I do tell at the time I was not what's called a CBRN commander. My apologies, sir, in relation to again all of the acronyms, so chemical biological radiological and nuclear commander in policing, similar to the other emergency services, what you have is a specialism in relation to such events and that follows what we call the gold, silver and bronze model. So gold is strategic, silver is tactical and bronze is operational. Officers are trained specifically within that discipline and there's also, of course, what's called tactical advisors who actually assist commanders. That's what exists and this is who this information was meant to be for and circulated to.

Q. Moving on to the paragraph below the red words at the top -- and again this was -- you gave us a flavour of this in your answer to Ms Whitelaw earlier this week, we see the assertion that:

"Whilst we are aware of no intelligence or

information to suggest that this incident ..."

That's the Skripal incident:

"... is anything other than isolated to the identified victims, the National CBRN Centre has a duty to support, strengthen and assure UK capability and resilience to respond to CBRN events."

Now, you have made it clear now that you didn't see this document back in March 2018, but does that description of the existing intelligence match what you understood to be the case then or not?

A. Yes, it was my understanding at that point in time that this was an isolated incident, that the Skripals, or indeed Mr Skripal, had been targeted and there was no more information intelligence that I was aware of, notwithstanding the need to know basis, which indicated there was a wider potential threat of a further attack.

Q. Thank you. Then just looking down the page a little more, if we may, do you see that there's a grid, a sort of ready reckoner of signs/symptoms of nerve agent poisoning? As I said to Mr Darch earlier this morning, one comes across repeatedly in it these documents little summaries of the types of symptoms to look out for, not always identical, but there's a common theme to most of them and here we see another go at

trying to condense what the signs and symptoms that might be obvious to responders are.

A. Yes, I can see that, sir.

Q. I don't want to ask you about the detail of that because you're not a medic, but when you said to Ms Whitelaw earlier in the week that on reflection it would have been a good idea to circulate to Wiltshire Police some further guidance just perhaps refreshing and emphasising training that they had already had, is it something like this that you would have had in mind or not?

A. So obviously -- I will go back to the top of this document which is in red that obviously talks about it not being circulated further without express authority and obviously then goes on to talk about the symptoms, what I was referring to at that point in time are really sort of three pieces of what I would call core training doctrine. There's, firstly, as was alluded to by Mr Darch, there's the JESIP principles; secondly, there is the initial operational response, 1, 2, 3, plus, which we heard about from Mr Darch, that's to assist first responders who may come across a CBRN incident in terms of their decision-making; and then there is what I would call a more command level document and that is -- it was issued in 2016, it's the CBRN,

it's JOP, sir, but the JOP stands for joint operating principles and there are 24 of those and again they come, together with the JESIP principles, to help the emergency services work together if there is a potential CBRN incident to help guide the response.

Q. Is your evidence now, Mr Mills -- we have understood that no guidance was sent to police officers between March and June 2018. Is your evidence now that looking back you don't think it was a good idea to send out some guidance to police officers on what to look out for in terms of signs and symptoms of nerve agent poisoning?

A. No, I'm not saying that, sir. I think there's firstly three fundamental core pieces of training doctrine which we should have reminded our officers and staff of. However, what I reflected on Tuesday was in hindsight it would have been helpful for us, notwithstanding as we have heard this morning this crossover with symptoms with opiate poisoning, to have put these out as well to help and assist decision-makers if they were to come across such an incident in the future.

LORD HUGHES: First, you needed to and did emphasise the joint operational features, JESIP, JOP and so on, but you're being asked about advice to your

frontline policemen, wherever they may be, about symptoms; do you follow?

A. Yes, I do, two points, if I may --

LORD HUGHES: Did you have this information about the likely symptoms?

A. It was in the CBRN community, so as I explained the gold, silver, bronze commanders who are specialist in this area and the tactical advisors. Building on my evidence from Tuesday, in hindsight I think we should have pushed back against the element which is in red there to provide some advice and guidance around signs and symptoms that may assist officers or staff who had to attend such a potential incident in the future, notwithstanding that the likelihood was considered low.

MR O'CONNOR: Tell us if you can't answer this question, Mr Mills, but there's nothing sensitive about the signs and symptoms of organophosphate poisoning, is there?

A. No, there's not. Looking at those, sir, not at all.

Q. Thank you. We can take that down. Can I go now to your witness statement, please, Mr Mills, and it's the 6117 reference. It is page 29 of that statement, if we may. We see at the head of that

page -- it's headed "Policies and guidance" and at paragraph 124, you record that you have been asked:

"If any internal policies or guidance were distributed within Wiltshire Police advising on the symptoms of nerve agent poisoning and how to respond to them."

Then at paragraph 125, you say this:

"Due to the unique and exceptional circumstances relating to the targeted attack on the Skripals and the absence of any intelligence or information to indicate the likelihood of any further nerve agent related incidents, Wiltshire Police did not proactively provide any advice to officers and staff who may attend any subsequent reported future incidents which could be linked to the symptoms of Novichok or a wider poisoning."

A statement there, we have already established, no guidance sent out and further down the page, we will come to it, there's a passage where you describe, as you said to Ms Whitelaw, you wish you had.

A. Yes.

Q. Just coming back to paragraph 125, if we may, I want to ask you about that word "unique". Was the Wiltshire Police understanding after the Skripal poisoning that it was properly to be regarded as

a unique incident, in the sense it had happened, it was very rare and that nothing like that was going to happen again?

A. If I may, sir -- and sorry to depart from the statement -- but I do think in my first statement, at page 51, paragraph 182, it is worthwhile me just setting out again nationally what happened in policing further to the attack on the Skripals because I think it goes to some of the elements you have spoken about.

Q. Mr Mills, do you mind if you would just answer my question first. You have used the word "unique" about the Skripal incident in that statement that we're just looking at. Was it the understanding and the approach of Wiltshire Police during this period that the Skripal poisoning was a one-off, not to be repeated event, or not?

A. It was my understanding at that point in time this was targeted against the Skripals and again, the information that I was talking about was circulated to policing, which says it should be made clear there is no information to indicate any further threat from the agent at this time. This was circulated by Deputy Assistant Lucy Dorsey to all 43 police forces in England and Wales.

Clearly further to what we have been discussing in

the last couple of days, what that doesn't talk about is the potential for a discarded item in terms of the administration of the poison to be picked up.

Q. Yes, and you make a similar point, just further on in that same paragraph. You talk about an absence of intelligence or information to indicate the likelihood of any further nerve agent related incidents. I'm going to come to ask you about the discarded container in due course.

We have also heard, Mr Mills, that at this time, March/April, there was a great activity in Salisbury working on what you describe as consequence management, looking for scenes that were contaminated, decontamination when those scenes were discovered. Doesn't it follow from all of that, leaving aside any intelligence about future targeted attacks, but surely it follows from all of the activity that was going on in relation to suspected and actual contaminated scenes, there must have been a possibility of another incident, mustn't there?

A. Clearly there was and hence the tragic death of Ms Sturgess. In relation to my role -- and I can only talk about my role, firstly as the corporate witness of Wiltshire Police and then secondly as the Strategic Coordination Group chair -- we didn't have

specific information to indicate there was a likelihood of another attack -- and I think "attack" is the important word -- at that point in time.

Then, in relation to my role in the partnership setting as the multi-agency Chair, again clearly there is a degree of foreseeability, as we look back at this now, that that was not something that we were actively discussing within the Strategic Coordination Group.

The final element of that, I would say, sir, is around that role of working with different colleagues, so very early on we established that working with public health colleagues they would inform us of the risk and the appropriate communications to put out relative to that risk which was assessed and, forgive me, my final point on this would be I would take us back to what I said on Tuesday around that local meets national structures. At a local level I had the scientific advisory cell assisting me, but they were receiving help and assistance from what's called SAGE, sir, which you will remember is the Scientific Advisory Group in an Emergency, and really you have two elements going on there in consideration of the here and now risk, but also potential future risk.

Q. Can I move to a related subject and we need to go back to the witness statement, please? We were just

looking at paragraph 125 and if we could go on to the next paragraph, paragraph 126. In the first sentence there you refer to JESIP principles, HAZMAT and so on. Then, picking it up in the second sentence, three lines down, you say:

"In relation to identifying specific Novichok symptoms, as detailed in the expert medical reports to the Inquiry, there are a number of similarities and crossovers between the medical signs and symptoms of a Novichok poisoning versus that of an opioid drug poisoning."

We're back in territory that we have heard about already this morning. Can I ask you this: was that something that you were aware of in March/April 2018?

A. Not -- it's difficult, sir, with the passage of time. These are six years' worth of incidences. What I was aware of, as I put within my statement, that the only place at that point in time that it could be identified that someone had been subject of a nerve agent attack was in a hospital setting. This is conclusively further to drugs work which had been undertaken --

LORD HUGHES: That's where you can make a diagnosis in a particular case. The question is whether you were, at that time, March/April, aware of what I'm loosely

going to call the crossover point.

A. By definition, sir, incident number 1 was initially assessed as a fentanyl incident in relation to the Skripals, and then subsequently over the course of that four-day period then went from that initial hypothesis to Novichok. I was aware at that level that it was quite difficult to identify in the early stages of this what somebody had actually been infected with.

LORD HUGHES: I see.

MR O'CONNOR: Just to be clear, no one is -- or could possibly expect, well, even paramedics and certainly not police officers as first responders, accurately to diagnose these things. The learning, as you say from the Skripal incident, is that to be aware of the risk that something that looks like it might be an opioid poisoning could be something else.

A. 100 per cent, sir.

Q. Is that something that -- well, I think -- just let me ask you this: is that something -- that learning something that was disseminated to Wiltshire Police officers in March, April, May, 2018?

A. I return to my previous point, no, it wasn't, sir.

Q. Do you think it ought to have been?

A. Again, I return to my previous responses on

this. In hindsight, I think we should have put some advice and guidance out to staff, reaffirming their training, as I have spoken about, in relation to IOR specifically, steps 1, 2, 3, because that is the doctrine that's in place and it would have been sensible to additionally have put something out, high level as we saw in the document you showed me earlier, which details -- notwithstanding they are not medically trained -- the types of symptoms that may present in a secondary incident.

Q. Well, yes, but there's something else, isn't there? There's the symptoms of organophosphate poisoning, such as that grid we saw a moment ago. That is existing training, if you like, certainly for paramedics, but there's the specific learning point which emerged from the Skripal case very clearly that there is a risk of crossover.

Now, that's not something we find in the CBRN document, my question to you is whether that is an additional thing that ought to have been, with hindsight, disseminated to Wiltshire officers?

A. I'm cautious in relation to that, sir, I have to say, and I go back to the doctrine which is in place and the IOR doctrine because what it doesn't do -- and specifically now as a CBRN commander I'm aware of

this -- is start talking about symptoms.

When you read it, what it starts talking about is the number of people actually presenting and it's unclear why they potentially have become unwell and I think that's helpful for frontline responders because what it's asking them to do is to work through the steps to consider how many people are presenting and whether or not it's unexplained and then gives them advice around how they should actually proceed going forward.

I think for the Police Service that is appropriate. When you start getting much further than that, you're going outside of what actually policing is there to actually do.

Q. Well, we will come a little bit later in my questioning to what actually happened with Charlie Rowley and the actions of the Police there and we may come back to the question then of whether they would have benefited from being told about the risks of confusing opiate poisoning with nerve agent poisoning, but we will come back to that, Mr Mills.

I would like now to show you some documents about -- I said I would come back to the issue of the discarded container, and the context for these questions is the evidence we will recall that you gave to Ms Whitelaw earlier in the week about your role in the

follow-up, if I can put it that way, to the Skripal poisoning, Chair of the SCG, consequence management was a term that you used, was it not?

A. Yes, it was, sir.

Q. Let's look, first of all, if we may, at document INQ004837. We will see here -- this is the minutes of SAGE on 9 March, so the Friday after the poisoning on the Sunday.

A. Yes.

Q. Now, just to be clear, you weren't on this occasion or ever, I think, someone who attended SAGE?

A. I never attended SAGE.

Q. In this period that we're talking about, did you receive SAGE minutes?

A. No, I did not.

Q. When you were giving evidence to Ms Whitelaw earlier in the week, you talked about your own Scientific Advisory Group, which I think had the acronym STAC?

A. That's correct.

Q. In general terms, can you remind us of what the relationship -- first of all what STAC was and what its relationship to SAGE was.

A. Yes, certainly. One of the first things that I did in both incidences -- and this is standard

practice around how you would look to respond to anything where there is a particular scientific or technical considerations -- is I appointed at a local level the STAC. Just to remind all of us, it's the Science Technological Advisory Cell. Sits locally, was chaired by the local representative from Public Health England, with some other members on there as well, and the role at a local level was to assist me in terms of scientific considerations and understanding.

Just to put that into context, the closure report for Operation Fairline I asked for a summary report from the Chair and it detailed that they had considered over 50 thematic issues and subdivided down to 125 thematic scientific issues as a result of the response, so in normal circumstances, sir -- this was isolated and I will perhaps take it outside of what we're dealing with today.

Let's say a fire, there's a big fire in the centre of Salisbury, there may be issues in relation to the plume from the fire. What I would look to do is I would call on the local STAC and I would ask them for advice around do we need to evacuate, those sorts of things. That's at the local level in what I would call a normal major incident response. We will obviously go on to then talk about the levels due to the uniqueness of this

that had to be put in above that.

Q. With that in mind, let's look at this document and we can see then at a meeting really within days of the Skripal poisoning, we see from the minutes, at point 2, under the heading "Public health issues", point (c) below that -- or, rather, perhaps I will just read paragraph 2:

"It was agreed that there are currently 3 public health areas of risk that need to be addressed as initial priorities for police and others ..."

Then the third of those is:

"Where the substance has been deliberately placed, but as yet undiscovered."

Now, Salisbury and the surrounding area may, of course, not have been the only location in which Novichok could have been deliberately placed, but will you agree it was certainly a leading contender?

A. Yes, absolutely.

Q. Perhaps the most obvious place, if we go to the principles --

A. Go to the principles of searching, you start from the point of the crime scene and work outwards.

Q. You have described your public health consequence management role, both in the SCG and also just now with the STAC, were you aware that the week

after the poisoning SAGE identified as one of the three public health issues questions around where the substance had been deliberately placed?

A. No, I was not.

Q. Did you work it out for yourself?

A. I have reflected on this, sir. I think very much the work that we were doing at the local level was focused on the consequence management around the impact of this incident. Just to give an example -- and it's at number 1 -- we had to do things like contact tracing whereby there is over, I think it was, 350-odd people that we had to contact trace around people that may have come into contact with this. But in terms of that forward facing element, no, we did not discuss anything in relation to the forward facing risk which is identified there at points 2(b) and (c).

Q. I'm going to come to --

A. 2(c), should I say.

LORD HUGHES: It's (c), isn't it?

MR O'CONNOR: Yes.

LORD HUGHES: We can label it "Discard"?

A. Yes.

MR O'CONNOR: I'm going to come in a moment and show you the reasonable worst case scenario document that I showed Mr Darch and I think you were in the room

at the time, so you will know what's coming. Just before we leave this document, do you think it would have helped you performing your duties on the SCG to have been kept in the loop on SAGE's thinking on this matter?

A. Yes, I do, sir, and I think there's a contextual bit here as well around the dates, 9 March. Again in my first big statement, if I can call it that, probably poor terminology, what I talk about is early on trying to get this connection from what normally is just a localised STAC, up into SAGE, around incredibly difficult scientific advice. One of the reasons that the Health Emergency Response Cell was put in place -- I believe I'm correct around the dates here, sir, but I believe it is around 12 March -- was to try and get that join up. This meeting had obviously already taken place before that, but yes, absolutely, I'm sat there as the SCG Chair. One of my responsibilities locally is around working with partners around the public health risk, to have known that that thinking was going on would have been very, very helpful.

Indeed, you can see that in incident number 2 where, sadly, the events in relation to Ms Sturgess and Mr Rowley have taken place. We then very quickly put in place, through public health nationally, advice around

"If you didn't drop it, don't pick it up". Again, our job at the local level was then to what I would call operationalise that and get it out into the community.

Q. Do you think if you had been aware of this sort of thinking as early as a week after the first incident, that type of advice, "If you didn't drop it, don't pick it up", might have come earlier and in fact before the Amesbury incident?

A. Yes, and I sit here six years later and, yes, I now think it's -- it's an obvious question, isn't it? You go through the search activity which has been undertaken. If you get to the point then that you exhaust that and you can't reasonably find it, then it is absolutely an obvious question, is it not, around "Okay, what is the risk here now to the public and what can we reasonably do to try and mitigate that risk".

LORD HUGHES: Did you just say "search activity"?

A. Yes, which was undertaken by Counter Terrorism Policing, sir.

LORD HUGHES: Not your force, but it was going on, was it, all around you?

A. So just to give you some further detail on that, sir. You have heard from Mr Murphy -- and you will hear from Mr Murphy again -- he was leading an investigation, a criminal investigation. Within that he

would have had, talking on his behalf, a search strategy and Wiltshire Police's job -- and you can see it from my strategic objectives -- is to assist him in terms of the delivery of that.

What did that look like in practice? I believe we did give him what's called a -- sorry, again acronyms, a POLSA, which is a police search advisor to assist him and his team, and we also have trained people that can do searching. We would have assisted in terms of providing some resource to assist him around what that strategy was and how he delivered that.

LORD HUGHES: If there's a search going on, what are you searching for?

A. I think it goes to point 2(c), doesn't it, sir? 100 per cent --

LORD HUGHES: It does. Well, it sounds like it anyway.

A. Obviously clearly a question for Mr Murphy, but we're searching for what has been brought into the United Kingdom, has been placed, ultimately what we understand, on the door handle and then potentially, as one of the hypotheses, has been disposed of or discarded of before the individuals left the country.

MR O'CONNOR: I suppose the question is what -- you said that you would have been assisted -- we will come

onto the reasonable worst case scenario document, but you said you would have been assisted to have known about SAGE's thinking as demonstrated in these minutes. Would it actually have added to your knowledge or understanding of the situation, given that you knew there were searches going on?

A. I think it's quite a difficult one to answer, but my responsibility, working with all of the different partners, is to think through the risk. The reason that I asked for a summary closure report at the end of the Operation Fairline from the STAC Chair was they had, as I have touched on, these 125 sort of different thematic issues that were dealt with, or sub-thematic issues. What I wanted to assure myself of at that point in time was we hadn't left any of those -- we hadn't completed the loop on any of them.

Absolutely, if I had been aware of that and that would have featured locally, that would have been a question to ask ourselves quite early on: what are we doing to actually mitigate this risk?

Q. Well, let's move to look at this other document which we have already seen once this morning. If we may, it's INQ004704. You were watching, as we looked at this, Mr Mills, so we can take it fairly briefly. If we go to the second page, we will remind

ourselves that this was described as a "reasonable worst case scenario". Are you familiar with that -- with the term "reasonable worst case scenario"?

A. High level, sir, yes, not in the context of the response to this incident.

Q. Have you seen before a situation in which someone comes up with a hypothetical set of events which are to be used as a basis for planning for an incident in the future?

A. Not in my training, sir, but I'm aware of the concept.

Q. You are aware of the concept. You have seen this document and we looked this morning with Mr Darch, towards the bottom of this page, against number 2, the "Accidental discovery of discarded source material by humans" and the details of the scenario then, quite alarming:

"... six members of the public exposed ... up to four emergency services personnel are also exposed ... 1 fatality; nine other casualties ..."

And so on. Obviously that is just a scenario, but that is what these analysts came up with.

Then if we go to the next page, we see the grid and at the top, underneath there where it says -- well, it says "Consequence management" and then again:

"The following consequence management issues are identified for the health sector for both scenarios", which includes accidental discovery of a discarded container by a human.

First of all, the same question again, or two questions: did you see this document at the time?

A. I've never seen this document up until the last 24 hours.

Q. Do you think that in performing your duties in the SCG and more generally in consequence management in Wiltshire after the Skripal poisoning, it would have been helpful to see this document?

A. Yes, I believe that it would because again it comes back to risk assessment, doesn't it: what is the risk which is presented, both in terms of the initial response, but also a potential forward facing risk?

Q. It is fair to say that this document focuses itself on health provision and health support, so not a police piece of analysis, but is it right that your SCG group covered health considerations?

A. Yes, it is, at a local level.

Q. Just looking at the top line, or set of lines, on this table against "First response", we looked with Mr Darch at the "Action required" bullet points on the right-hand side:

"Learning from 4 March should be rapidly disseminated to ensure effective and safe first response."

The police -- your police force would be likely to be a frontline responder in any second event, just as much as the Ambulance Service, would it not?

A. Yes, agreed.

Q. I ask, had you seen this document, would it perhaps have given you thought about providing some further guidance of the type we were discussing ten minutes ago to your officers, drawing on the learning from the Skripal incident?

A. Sorry, sir, I interrupted you. I think what we see here is a read-across, so we see a read-across to the national CBRN advice which came out that we looked at, one of the first documents this morning in my session, which talks about reinforcing the IOR, which is the steps 1, 2, 3, plus, and remove, remove, remove, which again is protocols that come from the CBRN world. That did take place limited to the CBRN community, but again, returning to the point that I have spoken about, yes, in relation to Wiltshire Police as an entity, thinking about what more could we have done to actually have informed our first responders, then absolutely I reiterate that in hindsight it would have been

sensible for us to have provided in addition to IOR and remove, remove, remove some advice around signs/symptoms.

Q. Just generally, before I move on, Mr Mills, perhaps you could go back to the first page of this document. This is the email which attached the reasonable worst case scenario and the grid that we have just been looking at, but we can see, if we just zoom in on the text of the email, that whoever it was in the Department of Health and social care who put this together and then sent it to someone says:

"Suggest that this is not forwarded further than necessary ..."

Now, I think you have already made it clear that you would have been helped by this document. In due course, the Chair is going to have to think about any recommendations that he might want to make. In general terms, do you think that there was a problem in the response to the Skripal poisoning that information within all the different organisations that were responding wasn't shared as widely and as fully as it should have been?

A. So I touch on in my first statement that -- I'm going to use hopefully not poor terminology, but I would describe it, in that first sort of ten days, the

responsibility of the local STAC around providing scientific advice meets actually the national advice which was being considered, or national considerations that were considered at SAGE, felt a little bit clunky. You can see me proactively raise that as an issue and certainly over the course of the first weekend, what I looked to do is work with partners from the Home Office to try and bring together something which will try and bridge this gap which ultimately ends up being the HERC.

Q. Thank you. I would like to move on --

LORD HUGHES: Just before you leave that topic, Mr Mills. This is something that, for all I know, may be addressed subsequently, but you were there.

What was the effect on the public in Salisbury of the events of 4 March?

A. Significant, sir, at a number of levels. I think, firstly, I would use the word fear around what they were seeing because this was very visual around the number of sites that we had to lock down, the resources that we then needed to lock those down, and then the activity which needed to take place within those in terms of visual CBRN response.

I think fear is the first one and then there's probably some wider ones around actually the wider

impact on things such as the economy in terms of local businesses, et cetera, and they subsequently became the work of the recovery group which I set out earlier on in this week to try and pick up some of those issues.

Before that, what we certainly have in policing is we have something that's called a Community Impact Assessment, sir, and that's looking at actually what is the impact here in the local community and what can we do to try and assess what that is , but also bridge the gap.

To give you some practicalities with that, what we were doing through the police Gold Commander was putting in place visibility, things like mobile police stations, we also did joint patrols with local public health officials. We had leaflets made up and we had all of these officers that were on cordons who could actually be not just standing there, but actively providing information to the public. Those sorts of things were the types of things that we tried to do to mitigate the impact of this.

LORD HUGHES: Right. Was there or was there not -- I have absolutely no idea -- any discussion about where the balance lay between warning members of the public on the one hand and reassuring them on the other?

A. In terms of discussion around that, sir, no,

but absolutely a consideration. What we also held was a number of public meetings where we had representatives from the emergency services, from Public Health England, from Wiltshire Council, and I sat on a number of those.

It is a balance and it also became a balance around scenes as well, when you're shutting scenes down. Every scene that you shut down you have to do on a basis of what's the information and intelligence around a threat because the more scenes that you have -- notwithstanding it wouldn't have stopped us -- the impact on the public at that point in time in terms of the fear factor grows every single time that you take that activity.

Back to your point, sir, around balance, absolutely there was a balance in that regard.

LORD HUGHES: When, after the Amesbury incident , you issued the warning, homely warning to people "If you haven't dropped it, don't pick it up", you have told us that that hadn't been considered before the Amesbury incident; that's right, is it?

A. That's right, sir.

LORD HUGHES: It wasn't a question of it having been thought about and decided it might be alarmist, or anything like that?

A. Certainly not at the local level, sir. I can't account for the national level.

LORD HUGHES: No, right.

After Amesbury, was there any discussion about the -- any, as it were, the pluses and minuses of giving that advice, or was it all plus?

A. Sorry, could you just reframe that for me?

LORD HUGHES: Certainly, yes. When, after Amesbury, you issued that homely advice, was the thinking that there was no difficulty about it, it was obvious, or was there any discussion about possible pluses and possible minuses in doing it?

A. There wasn't a discussion about pluses or minus, sir. You can see --

LORD HUGHES: There was or wasn't?

A. There wasn't, sir, no.

LORD HUGHES: No, that's what I thought. Thank you very much.

MR O'CONNOR: Thank you. I want, Mr Mills, to move on to two last issues. They are related. The first is the question of Wiltshire Police's understanding in sort of June 2018 of Charlie Rowley's involvement in drugs. I can do this, I think, by going to your statement please, the same statement, 6117, and starting on page 8. I'm just going to direct your attention to certain paragraphs and ask if they are accurate, Mr Mills.

Before we do this, we will recall your clear statement in evidence to Ms Whitelaw that we are talking about Charlie Rowley. As far as Dawn Sturgess was concerned, you indicated that the suggestion at the time that she was a known drugs user was inaccurate and shouldn't have been made.

A. That is correct, sir.

Q. But let's now focus on Charlie Rowley and at paragraph 27 of the witness statement you deal, do you not, with his criminal record in relation to drugs and you say he had numerous convictions for possession of class A and C drugs?

A. That's correct, sir.

Q. Then at paragraph 28 -- I'm not going to read it out -- the point made there is that two of the officers who were, in fact, involved in the events, in fact both of them will come and give evidence themselves, in slightly different ways were aware -- had a background knowledge of Charlie Rowley's involvement in drugs.

A. That's correct, sir.

Q. Then if we look down to paragraph 30 you refer to intelligence reports, in other words not convictions, but pieces of information that had come into the police's possession, you say:

"Between January 2017 and July 2018 ... 17 separate intelligence reports relating to Charlie Rowley and the purchase, supply and consumption of controlled class A drugs, namely heroin and crack cocaine."

Not things that had been established in court, but intelligence that you had received?

A. Yes, that's correct.

Q. Thank you. Now, as I said, relatedly I now -- and I think finally -- want to ask you some questions about the Wiltshire Police response to the Amesbury event and in particular to Charlie Rowley becoming unwell. If we can go, please, to page 10 of your witness statement, we will recall that you were asked some questions again about this incident by Ms Whitelaw and she took you up to a certain point in the narrative and you looked with her at some of the logs that were created that evening.

A. Yes.

Q. Again, I will try and go through the witness statement and summarise the position and then ask you about them. If we can pick it up at paragraph 37, please, we see that at 18:58 Wiltshire Police received a call from the Fire Service asking if it they were going to attend what appeared to be a HAZMAT incident, and the police's position was that they weren't being

asked to attend at that stage.

A. That was our understanding.

Q. Then if we look down at paragraph 38, a few minutes later, at 19:02 hours, police communications centre received a call from the Ambulance Service. This was the one about the special job, talking about two patients displaying excess drooling, sweating, unresponsive and the Ambulance Service, we see at the bottom of that paragraph, at that point saying there was going to be a significant response from them and the Fire Service?

A. That's correct.

Q. If we can look over, please, at paragraph 39, a few minutes after that, so seven minutes after that, this is 19:09, the Fire Service on this occasion called again. They are talking about this incident. At that stage, police attendance was not required, yes?

A. That's correct.

Q. Then, at paragraph 40, you refer to the fact that the Force Incident Manager that evening, Inspector Andy Noble, who we infer was in that headquarters and was aware of the calls that had been coming in, undertook a background search, or maybe asked others to undertake a background search on the address which revealed recent intelligence relating to drugs connected

to the occupant of that property, that is Charlie Rowley. As a result he, that is Inspector Noble, directed that Police should attend and officers were dispatched?

A. That's correct.

Q. Then, I think that may have been as far as you got with the story with Ms Whitelaw, so let's take it on, please, to paragraph 41, a few minutes after that, the Ambulance Service this time made further contact with the communications centre and stated that the patients were presenting with similar symptoms to the Salisbury incident, so for the first time, I think, raising a concern about nerve agent expressly.

"The Fire Service were now in attendance and were treating the incident as if there was a suspicious substance at the location. The Ambulance Service requested that cordons were put in place and for a police commander to lead with the fire/ambulance a JESIP response. The police call handler stated that this would be added to the log and passed to their boss ..."

That's Inspector Noble?

A. Yes, that's correct.

Q. Then we see his response in the next paragraph:

"Based on the intelligence, ... Inspector Noble formed the opinion that this incident was most likely owing to drugs. [He] noted the apparent nervousness of the other emergency services but remained of the opinion that this was drug related and was to be treated as such."

A. Correct.

Q. Mr Mills, I'm very well aware that the story continued and we will be hearing all about it from those who were involved, DS McKerlie, the officers at the hospital, Dr Jukes and so on, but I just want to ask you about this stage of the decision-making process and in particular Inspector Noble's decision at that point not to treat this incident as a suspected nerve agent incident, but simply to instruct that it be treated as a drugs incident. I want to ask you about the JESIP principles and if we can go back in your statement, please, to page 5, you have set them out there.

What I want to suggest to you is that that decision, which we have just seen by Inspector Noble, really didn't comply with any of the JESIP principles because what JESIP requires is first of all co-location, Inspector Noble took his decision from his headquarters, communication, coordination, a joint understanding of the risk and shared situational awareness. What

I suggest is that really Inspector Noble simply seems to have countermanded the concerns of the Ambulance Service and the Fire Brigade without doing any of those things, he simply formed a view, having read some intelligence reports, and didn't engage or discuss or really make any attempt jointly to understand the situation with the other services involved. Is that fair or not?

A. There are elements within the log, the police log on this, which refers to the summary that we're talking about. He talks about the use of IOR1, 2, 3 and safety advice to first responders. He talks about considering a site survey and then after that potentially looking at fire undertaking a site survey and then CBRN tactical advice.

I'm in agreement with you around the application of the JESIP principles. Really, for me, that's the first part of what kicked in there with Inspector Noble was, it was right for him to have a hypothesis --

LORD HUGHES: Sorry, say that again? Say that again, that last bit?

A. It was right for him to have a hypothesis based upon the intelligence which he had read, sir, and at that point in time we have resources that are going to the scene that have further information over and above what we have spoken about to date in the

chronology. If I deal with the respective elements of it, so -- and I do deal with this in my supplementary statement.

The co-location bit for me, that would be at the scene. It's often called what's referred to as a blue light huddle. I know we're not going much further than Inspector Noble here, but what you would have expected at the scene was this blue light huddle to come together and that would have been the fire commander on the scene, it would have been Acting Police Sergeant McKerlie because he was the most senior one on the scene at that point, and it would have been the ambulance commander, and they would have co-located together. So moving on from that they would have --

MR O'CONNOR: Well, just pausing there, if I may. What your expectation would have been that, when Sergeant McKerlie arrived at the scene, he would have sought out the ambulance and fire brigade commanders, discussed with them, tried to understand their concerns and attempted to reach a joint decision of the risk.

A. Yes, and I'm just briefly going to refer to what I would call a triangle of considerations in relation to JESIP. The first one is, as absolutely set out at 16, those are the main principles of JESIP.

The second, what they call core component, is

something called METHANE, which I would say that's a descriptive -- I can say what it is, if you wish, sir -- if I perhaps describe it as it's a descriptor early on around shared situational awareness around lots of major incidents. If so, what the type of incident is, number of casualties, types of emergency services that are required. But really, really critical to this -- and I think this is critical throughout everything that you will consider from this point onwards -- is the joint decision-making model.

That has five elements which I will briefly run through and it comes back to this co-location/communication element that you consider what's the information and intelligence that we have available? So that would have been from the initial incident in relation to Ms Sturgess, it would have been in relation to what the police were aware of in terms of the drugs intelligence and it would have been the assessment of the commanders from fire and ambulance at the scene and then latterly, as we go through this chronology, what we were hearing from the hospital.

For me that was the critical information intelligence which was available to actually jointly come together to consider how do we actually move forward in this circumstance.

MR O'CONNOR: If, in due course, we hear evidence from the paramedics who had formed their clinical judgment that this was a nerve agent case, if we hear evidence that the police officers who arrived on the scene were dismissive of their concerns, your view would be that that was quite wrong, would it?

A. What I refer to in my statement -- I think I used the term that the police officers were overly confident -- I don't believe it was wrong for them to have a hypothesis based upon the recent intelligence that they were aware of through the single lens of the Police Service in Wiltshire, that this potentially could have been a drugs-related incident.

However, applying JESIP, if we look back at the principles, back to the blue light huddle, they needed to communicate with their fellow first responders to understand what was the other information and intelligence which was available.

Q. Not just other intelligence that is available, but if a police officer meets a clinician who has reached a clinical judgment in a case, that's something that they are bound to give great weight to, isn't it?

A. It's certainly a consideration for them but I think it is a two-way process whereby it is also contingent upon the Police Service to share what

information it has to inform that joint understanding and joint situational awareness. It is only through -- many of this guidance around JESIP is brought about from the learning of other major incidences. It is only by having that shared situational awareness that collectively what the guidance says is commanders should come together and agree what steps should actually be taken.

Q. I'm going to just make one last -- I'm going to ask you one last question because we will hear from the officers who were there and the paramedics about how the situation developed and whether there was that joint discussion or not, but what we know now, with hindsight, is that the paramedics were right --

A. Yes.

Q. -- and that this was a nerve agent incident and that, in fact, the police officers who, as we may hear, insisted that it be dealt with as a drugs incident were wrong. We know that, don't we?

A. Yes, we do, yes.

Q. We also know that, as a result of that state of affairs, police officers from your force, Wiltshire Police officers, were instructed to and did go into that flat and undertake a search of it and, as we know from the evidence we heard yesterday, that was a flat which

not only contained a bottle of Novichok inside it but had been contaminated in various areas by Novichok, yes?

A. Absolutely, sir, and --

Q. In fact, what took place was something just as dangerous, if not more dangerous, than the search of Christie Miller Road four months earlier, except that on that occasion, that recent occasion, the police officers had actually been warned that it was a nerve agent scene but went ahead anyway.

A. Two elements to that, sir. At the centre of the joint decision-making model is the principle of working together to save lives and reduce harm. That is absolutely why, in terms of that scene element, that co-location, the blue light huddle, was really important that that took place and because we also have to overlay the initial operational response. That talks about 1, 2, 3 that I spoke about. Number 2, so what do we have at this point in time? We have two casualties, one in the morning, one in the evening. What the IOR actually says is, based upon that, to proceed with normal protocols but with caution. Again this comes back to the centre of this around the communication element. It is only by the respective commanders having that conversation and communicating that we agree collectively how we should proceed and actually move

forward.
Q. That's what should happen?
A. That's what my statement refers to, yes.
MR O'CONNOR: Thank you very much, Mr Mills. Thank you, sir.
LORD HUGHES: Mr Mansfield.
Questioned by MR MANSFIELD
MR MANSFIELD: Good afternoon, officer. I represent the family of Dawn Sturgess and I want to, if I may, just some follow up points arising from the matters you have mentioned.
Can I deal with the last one first as I did with the last witness. This is for the purposes of the future. It's one thing to have a hypothesis -- you mentioned that Police are entitled to have a hypothesis -- the problem is if that hypothesis becomes set in concrete and determines a situation, it can be very dangerous, can't it?
A. Well, I would agree, sir.
Q. I want to see whether a position that was faced in here -- if you have a police officer or senior officers forming a view, a strong view that it is drug related but you've got two other emergency services thinking otherwise, particularly as they were certainly the paramedics, they had been at Salisbury so they knew

what it would look like -- if you have a disagreement of that kind, then you have a discussion. How is this resolved? In other words, the Police stick to their view that, in fact, it's drug related and the others stick to their view; what happens in the protocols for the future?
A. In relation to what we were dealing with at the time, that was the importance of JESIP, the joint decision-making model. At this point in time, we were only dealing with hypotheses because we could have nothing more than hypotheses at that point, plus the clinical diagnosis.
LORD HUGHES: Yes, but come on, what he is asking is this: JESIP requires consultation on the spot --
A. Yes.
LORD HUGHES: -- joint decision-making. What happens if you have two irreconcilable views?
A. Then that comes back to the heart of JESIP. It's around actually communicating, it's AROUND commanders being together and using the information/intelligence. What comes after that is a threat assessment and also considers what's the powers and policies in place here?
The key powers and policies that should have been considered was that under the joint operating principles

for CBRN one of the first ones -- and it says any of the emergency services can consider that they are dealing with a potential CBRN incident and then the IOR should be put in place. That really should have then led to everything --
MR MANSFIELD: That becomes the priority?
A. Yes. Yes.
Q. Takes precedence over the other, because there are risks if you don't do it; is that right?
A. Absolutely.
Q. Because of cordons, other people, the public being involved, people going in the flat?
A. Yes.
Q. If there's a possibility that it's a chemical incident -- and I'm putting it shortly -- then that takes precedence from now on, so this situation that occurred in this case won't occur again.
A. Since then we have continued, as you heard from Mr Darch, across the emergency services and the Local Resilience Forum, to embed JESIP. Some of the learning coming out of the learning report was around further embedding that not only across the emergency services, but the Local Resilience Forum, but also across other partner agencies.
We have done a lot of that and again, as Mr Darch

referred to, again looking to embed JESIP. I mean, it's really the heartbeat of a civil contingencies response, to embed it such that it becomes second nature to not only first responders but also commanders.
Q. Right, that's one matter. Another matter, please. It relates to this situation and the use of intelligence. May I just ask you this: since that day, has there been a review conducted by Wiltshire Police on the whole of this incident in relation to the use of intelligence, its reliability, robust approach, those sort of questions? Has there been a discussion along those lines?
A. Not that I'm aware of, sir.
Q. Why not?
A. Because in relation to intelligence and information in the Police Service, it basically has a grading structure which is set nationally. So let's say you get a piece of information or intelligence in, it's given that grading, and then really the mechanisms exist in relation to the JDM. Number 1 is information intelligence. It's to consider what potential information/intelligence you have, set against what other information/intelligence is available. So we haven't undertaken a review. I don't believe there's a requirement to undertake such a review.

Q. Yes, the question really is whether you have reviewed it in the light of the fact that intelligence can be and was in this case, as far as Dawn is concerned, you have apologised for it, wrong?

A. The intelligence wasn't wrong. The assessment that it led to was wrong for that first period of time in terms of the response.

Q. There was no intelligence about Dawn Sturgess , was there?

LORD HUGHES: He has always said that, Mr Mansfield. There's no question of there being bad intelligence about Dawn. There was intelligence about the house and about Rowley's friends and relations , and a deduction was made that applied to Dawn.

MR MANSFIELD: The question really is: has a review been made that that is a risky approach to the situation where the officers concerned are not medics?

A. No, there hasn't, sir. They are not medics and officers every single day we happily now have to consider information/intelligence to help inform a response.

Q. Yes, I understand. The position now -- and I'm going to ask this as a general question -- are Wiltshire Police officers being trained and informed about the presentation and treatment of Novichok cases?

A. No, they're not, sir.

Q. Whose decision is that?

A. I will return to my evidence earlier. If we look at the structure of policing nationally, we have the national CBRN centre that sits across the Police Service, the Ambulance Service and Fire Service. Part of the review, or the various reviews that took place, was for the CBRN centre to consider whether or not there was a requirement for any specific further information, further to the learning coming out of this, and as it stands at this moment in time, what is available to the Police Service is still the IOR1, 2, 3 plus steps and also the CBRN joint operating principles. They still exist today.

Q. Is that matter being reviewed in the light of the MI5 indication last week of what's going to happen on the streets of the United Kingdom? Is that matter being reviewed, that police officers on the frontline need training in these matters?

LORD HUGHES: That's well beyond this Inquiry, Mr Mansfield.

A. To help the Inquiry --

LORD HUGHES: No, Mr Mills, you need not answer that.

A. Okay, thank you, sir.

MR MANSFIELD: Does it follow from your answer that you yourself have not been trained or informed about the presentation and treatment of Novichok cases?

A. Through my lived experience I'm aware of what that looks like, but in relation to specifically have I had anything that has come centrally from the national CBRN centre as a -- not only as a police commander but also a CBRN Gold Commander, no, I have not.

Q. A different topic, but it relates further back, as it will, within the narrative here. I want to deal with -- you have dealt with it in some detail, I'm not going over it -- the question of discarded Novichok.

The simple question is this: during this time, just after, if you can put yourself back into Salisbury just after the Skripal attack, did it occur to you personally, as a senior police officer, that there might be more Novichok left over or discarded or however you describe it?

A. In relation to my role in the SCG and my work with the STAC, no, it didn't. Yes, was it always there in terms of a potential risk at the back of my mind when you go through the search activity --

Q. Yes, but --

A. -- and when you don't find it, then clearly it is a risk -- I guess two hypotheses again: they have

either taken it with them or they have discarded it locally or somewhere else in the United Kingdom or --

Q. You see this is not the same question as being advised, being told, being kept in the loop, getting lots of paperwork. This is you as a straightforward police officer, if you don't mind me putting it that way. Are you -- were you not aware that it would be possible for, therefore, a member of the public to be seriously damaged by this?

A. Clearly, as I look back in hindsight now, hence why we are sat here today, yes, I have to concede that in relation to the model that I was operating in. In terms of the advice I was getting from the STAC and from Public Health England and above, that was not articulated in terms of a risk in the investigation.

Q. Yes, looking back now, again with a view to the future, does that surprise you that you didn't and no one else seemed to have broached it with you either?

A. Looking back now, sir, yes. Yes.

Q. Sir, there's one document that I would just like -- I have notified of all the documents, but this is one that's just come up this morning, so it's INQ004745, I think it is.

LORD HUGHES: 4745?

MR MANSFIELD: Yes. Sorry, they have been

notified.
LORD HUGHES: We've got it, that's all that matters.
MR MANSFIELD: Yes. I just want to ask you about this document. Would you like a second just to look at it?
A. I have certainly taken in the front of it, sir.
Q. They are minutes of a meeting and you will see the date is 9 March 2018, so it's between Salisbury and Amesbury, if I can put it that way.
LORD HUGHES: It's very soon after Salisbury, isn't it, it's within the week?
MR MANSFIELD: Yes, within a week.
LORD HUGHES: It's Public Health England meeting of some kind.
MR MANSFIELD: It is SRG, which is the response group. Are you familiar with the SRG?
A. No, that's new terminology to me, sir.
Q. No. I'm not suggesting it doesn't suggest that you are there, but were you ever shown any information according to this -- the point about the document is it records that the investigation by police has identified other potential sites for discarded Novichok.

LORD HUGHES: Well, you will have to take us, Mr Mansfield -- you will have to take him, won't you, to the bit you want him to look at. Come on.
MR MANSFIELD: Page 4, please, at the top. I wanted him to just see if he had seen the document first of all.
LORD HUGHES: Of course.
A. I can confirm I haven't seen the document. Are you referring to the top box, sir?
MR MANSFIELD: Yes. If you look at the top, this should be page 4:
"Police have identified ..."
The first few words. You see that?
A. Yes.
Q. From what you are saying you haven't seen this document before; is that right? The second question is have you been -- were you informed on around 9 March, 10 March, somewhere in that region, about the fact the Police had identified potentially, I don't put it higher than that, sites?
A. No, sir. Again, my reading, if I can put some context around the word "Police" there, that would be the Counter Terrorism Policing investigation. I referred earlier to the search strategy. I can't speak on behalf of Commander Murphy , but I would

imagine -- and I'm surmising -- that this relates to his investigation and hypotheses around potential depositions --
Q. Yes, can I ask this then. What at that time, that is between Salisbury and Amesbury, in that period, with Counter Terrorism being involved, did you have a close working relationship with them?
A. As outlined in my statement, yes, I had periodic calls with the head of Counter Terrorism Policing, Senior National Coordinator across both incidences and we also had somebody from the investigation who would sit on the SCG meetings and provide updates relative to what that audience was.
Q. Yes, so would you describe it as a close relationship?
A. I would describe it as an effective relationship, yes, where we had good relations with them.
MR MANSFIELD: Right. Thank you very much.
LORD HUGHES: Thank you very much indeed, Mr Mansfield. Anything else?
Where would you like me to go now, Mr O'Connor? Somewhere else?
MR O'CONNOR: I think lunch would be a good place for us all to go, sir.

LORD HUGHES: All right. How full is this afternoon?
MR O'CONNOR: Full.
LORD HUGHES: Pretty full? Then we had better say 2 o'clock, hadn't we? I'm so sorry, 1.45.
(12.46 pm)
(The lunch break)
(1.46 pm)
LORD HUGHES: Yes, Ms Whitelaw.
MS WHITELAW: Good afternoon, sir.
Good afternoon, my name is Francesca Whitelaw and I ask questions on behalf of the Inquiry, as I think you know. Thank you for attending today to give evidence.
MR MARK ALAN MARRIOTT (affirmed)
LORD HUGHES: Now, Mr Marriott, either stand or sit as convenient, but most people are sitting.
Questioned by MS WHITELAW
MS WHITELAW: Could you give us your full name, please?
A. Mark Alan Marriott.
Q. You should have in front of you a 13-page witness statement dated 19 July 2018, the reference for the transcript is INQ005000.
A. Yes, I have that.
Q. Have you had an opportunity to read that

witness statement?
A. I have.
Q. Are you able to confirm that the contents are true to the best of your knowledge and belief?
A. I can.
Q. Thank you. Sir, with your permission, the whole statement will be adduced in evidence and appear on the Inquiry's website.
LORD HUGHES: Yes.
MS WHITELAW: May I, before we start, just make a similar warning to the one I gave previously for the benefit of Dawn Sturgess' family in particular. This evidence is going to be dealing with the emergency response and the treatment of Dawn. It may well be distressing for some to listen to or to read and the opportunity to leave if anybody wants to, or not to watch the proceedings, is now.
LORD HUGHES: You will have the point. Don't feel obliged to stay unless you want to, but it will have to be detailed. Right.
MS WHITELAW: Mr Marriott, were you, in June 2018, a paramedic employed by the South Western Ambulance Service.
A. Yes.
Q. Is that still your job?

A. Yes.
Q. We can perhaps tell from the uniform. At the time that you made your statement, had you been employed by the South Western Ambulance Service for about 10 years?
A. Approximately, yes, I think it was.
Q. Prior to that, I think you had ten years' experience working as an intensive care paramedic in the northern territory in Australia; is that correct?
A. That's correct, yes.
Q. Prior to that, 11 years' experience with the London Ambulance Service; is that right?
A. That's correct, yes.
Q. In what role or roles did you work for the London Ambulance Service?
A. Initially, when I joined the London Ambulance Service, it was prior to there being a paramedic programme within the UK, so initially I was just employed as a qualified ambulance person and until the introduction of the paramedic programme which came about in the very early 90s, and so I was a very early uptaker of the UK paramedic programme and I qualified with the London Ambulance Services and trained with the London Ambulance Service as a paramedic.
Q. Thank you. I'm going to move on to your

training and if you do need to refer to your witness statement, please do.
You say that around seven years prior to the date of the statement, so about 2011, you completed a chemical biological radiological and nuclear training in a location, we don't need to say the name of the location, but that this consisted of casualty retrieval from hazardous areas; is that correct?
A. That's correct, yes. It was just for a casualty retrieval programme. It was a volunteer scheme. They asked for staff if they wanted to be involved within that retrieval programme and I uptook it and was shown how to don protective suits and how to retrieve patients from hot zones and so forth.
Q. Did that training include recognition of nerve agent or other hazardous chemical poisoning symptoms?
A. I can't fully remember because it's such a long time ago what the content of it was, so I can't remember. It was such a long time ago.
Q. When you were working for the South Western Ambulance Service prior to the time of these events, you indicated in your witness statement that you completed local based training updates relating to changes of procedures, equipment updates, new techniques and clinical updates. How was that training delivered?

A. A lot of it was -- in the early days, it was face-to-face and we would go up to one of the training centres and, depending on what the content was, whether it be a two or three-day course, but a lot of it was face-to-face. Generally they did send down some literature which was prior learning so that we could update ourselves prior to being there what the content of it would be, and we also have an online -- what we call ESR, which is electronic staff records, where we can log on to a training account and it will show us what areas we need to keep ourselves updated on.
More recently, that has been the way things have been done. So yes, that's how I update --
Q. Do you receive email briefings as well?
A. What, sorry?
Q. Do you receive email briefings as well?
A. Yes, we do periodically, to say that there has been a clinical or procedure update and it would ask staff to update themselves with whatever was being updated, and we do have access to an application which is on particular types of electronic devices that we can read the latest updates and keep ourselves updated with that.
Q. Thank you. I think we will come back to that in a moment. You say in your witness statement that

since the Salisbury incident you received new guidance. First of all, by "the Salisbury incident" presumably you mean the poisoning of the Skripals in March 2018; is that correct?

A. Yes, I believe that after the Salisbury incident that we did receive some information on station. It would generally come -- if I remember, it came in a paper type format which was --

LORD HUGHES: Sorry, in what kind of format?

A. Sorry?

LORD HUGHES: You said it came in a particular format.

A. A paper format. A printed paper format.

LORD HUGHES: Thank you.

A. I think normally what happened is the particular officers who were on duty at that time, they would be informed that there was an update. That officer would then print-out that document and would place it on the station information table , and it would generally be a document attached to it that would say: "All staff please read and update yourselves" and there was quite often a little document attached to that where -- with the staff names' members on so they could sign to say they had received and updated themselves on that document.

MS WHITELAW: Thank you. Can I ask you specifically in relation to this new guidance that you were talking about post Salisbury? First of all, can you tell us what that guidance broadly was and if you need to refer to your statement --

A. Yes, I'm sorry I can't remember what the particular document was, but I do remember after the Salisbury incident that there was an update, and what the content of it was I cannot remember at this stage, but I think it probably would have been advising staff to perhaps --

Q. Well, perhaps I can help you. If you've got your statement in front of you -- have you? Do you want to just look at it, and page 4. We appreciate you made this statement some time ago, so just -- do you want to read the first paragraph to yourself just to refresh your memory?

A. What page, sorry?

Q. Page 4 of the statement. There's a page number at the top right-hand corner and in fact probably the bottom right-hand corner as well. Just read the first paragraph to yourself.

A. Sorry, what paragraph?

Q. The top paragraph. It starts: "I have received new guidance ..."

A. Okay:

"I have received new guidance since the previous incident in Salisbury, and the effects, signs and symptoms of a Novichok exposure, and the 1-2-3 step approach to dealing with casualties, this is, in basic terms, when you are dealing with a patient that is unresponsive, take caution, in the event of two patients being unresponsive, exercise extreme caution , and where there are three patients unresponsive, evacuate the area and seek guidance ..."

So that would be pretty much what I already knew anyway.

LORD HUGHES: What, the 1, 2, 3 mantra? The 1, 2, 3 rule?

A. Yes.

LORD HUGHES: Yes, well, I think we have heard that. But what you say there is that you had new guidance dealing with the 1, 2, 3 rule, but also with the effects, signs and symptoms of Novichok exposure. Now, is that -- do you remember getting that or not?

A. Yes, I mean, as I say, that's what I would have known already and I think the document probably come out to remind staff to be aware of that again.

MS WHITELAW: Do you think your memory was probably better in 2018 than it is now in relation to those

documents?

A. Yes, yes.

LORD HUGHES: Forgive me, Mr Marriott, have you just said that everything there is something that you would have known beforehand in any event?

A. Sorry, I didn't quite hear you. Can you say it again?

LORD HUGHES: Yes. Did you just tell us that the things that were in the guidance were all things that you knew already?

A. Yes.

LORD HUGHES: Including the symptoms of Novichok?

A. Yes.

LORD HUGHES: Where had you got that from beforehand?

A. Well, I knew the signs and symptoms of organophosphate poisoning and Novichok poisoning which we would have received -- they may have not called it Novichok, they may have just said that there will be a chemical attack, or what type of symptoms somebody would have got had they have been poisoned by a particular substance.

MS WHITELAW: You think you knew about hazardous chemical poisoning symptoms --

A. Yes.

Q. -- before March 2018 even?

A. Yes, yes. We would have known -- we would have had information -- we would have had training to say, you know, what could happen or what the signs and symptoms of some of those things would be.

Q. Well, you say perhaps -- if we look at the next paragraph, there's just two lines in the next paragraph, where you say:

"I am trained, that with any suspected exposure to hazardous material, to seek guidance for safety purposes, it is not specific to Novichok in isolation, it is relevant to all chemicals."

A. Yes, yes, it would be relevant to all chemicals because, obviously at the point when I received that training, Novichok wasn't the word we were familiar with, but we were aware that there were particular nerve agents.

Q. But once we get to March 2018, there's an awareness of Novichok arising out of the Skripal poisoning, so do you think when you got that guidance after Salisbury there was specific mention of Novichok?

A. I don't remember thinking that. It's always in the back of your mind, but ...

Q. So you don't actually remember now --

A. No.

Q. -- whether it was a specific. Do you remember now -- we know the Salisbury poisoning were in March, Dawn Sturgess was poisoned at the end of the June. Do you recall when in that period you received this new guidance that you mention in your statement?

A. No, I can't remember.

Q. Do you recall if the guidance you received after March 2018 included the potential for confusion of symptoms between drug overdose and nerve agent poisoning?

A. No, I don't remember.

Q. Do you remember guidance identifying how you should treat suspected nerve agent poisoning?

A. Yes.

Q. Was that specific to Novichok after March 2018?

A. Well, I would say not specifically Novichok, but any nerve agent or organophosphate poisoning. Had I have attended a patient who were presenting with those symptoms, I would probably have been alerted that there was potential for a poisoning.

Q. When you say you knew how to treat it, are you referring there to the 1, 2, 3 step approach or something else?

A. Yes, yes, I would do, yes. I mean, if

I was -- yes, I mean, there's always the 1, 2, 3 step approach, yes, certainly, yes.

Q. In your statement -- and you have also mentioned it just now -- you say that "Within the past month", so that was within a month of July 2018:

"... all South Western Ambulance Service have access to an online mobile phone application, which essentially gives an aide memoire for clinical guidelines on various topics, including CBRN ..."

Do you know if you had that at the time of Dawn Sturgess' poisoning?

A. I think I probably did have it, yes, and I also think it was available on our electronic patient care record as well. I believe it was available on there that we could pull up those guidelines.

Q. Did you have occasion to use it when you attended Dawn Sturgess?

A. I -- I mean, I -- yes, I used it all the time, that particular app.

LORD HUGHES: That wasn't the question, I don't think, Mr Marriott. I think what the lady would like to know is whether you consulted it when you went to Muggleton Road.

A. I don't think I did use it when I went to Muggleton Road, no.

MS WHITELAW: I'm going to bring up on screen INQ00623 please. Sorry 000623. A document which we saw this morning. Were you watching the evidence this morning?

A. I was.

Q. So you will have seen this. This is a South Western Ambulance Service medicines protocol. Page 1 , it says 5 January 2017 is the issue date. Were you aware of this protocol prior to June 2018?

A. Yes.

Q. If we look at the clinical situation, again we have seen that this morning, it sets out a number of symptoms there. Can you see that on the screen in front of you?

A. I have only got page 1 at the moment.

Q. Yes, page 1. We will then go over to page 2. Can you see page 2? Are those symptoms that you were aware of in June 2018?

A. Yes.

Q. If we go to page 5, please, if we could make the bottom step 1, 2, 3, bigger.

LORD HUGHES: What number is this one, Ms Whitelaw?

MS WHITELAW: This is 000623.

LORD HUGHES: This is still 623, is it?

MS WHITELAW: Yes, it is just page 5 of that

document.
LORD HUGHES: I do beg your pardon.
MS WHITELAW: Is that the step 1, 2, 3 that you were referring to previously?
A. It is.
Q. If we could make that smaller again and the DuoDote auto-injector, were you aware of that as well in June 2018?
A. Yes, it's something that we carry on the vehicles.
LORD HUGHES: Sorry? What did you say?
A. It's something we carry on the --
LORD HUGHES: You had them on the vehicles?
A. Yes, we carry more than one. I think there's four on the ambulances we carry.
MS WHITELAW: Thank you. We can take that down now, please. We're now going to move to what happened on 30 June. You deal with this in your statement from page 4. If you need to refer to it, please do.
What shift were you working on Saturday, 30 June?
A. I believe it was 06:00 to 18:00 day shift.
Q. What vehicle, what type of vehicle were you scheduled to work in?
A. It was a Skoda Scout RRV. I believe the number was -- our call sign was 303.

Q. Thank you. I think you said RRV; is that rapid response vehicle?
A. Rapid response vehicle.
Q. Was that single crewed?
A. It was, it was just myself.
LORD HUGHES: What is it, a car, Mr Marriott?
A. Yes.
MS WHITELAW: In your vehicle was there a mobile data terminal?
A. There was.
Q. I think you refer to that as MDT?
A. Yes.
Q. Can you just tell us what that is, please?
A. A mobile data terminal is where we receive all the information of the particular incident we're being deployed on. It has a screen which is situated in front of the driver on the dashboard. When a call comes in, we receive notification on our handheld radio and it will also simultaneously alert on the screen. Do you want me to carry on?
Q. Well, I'm going to ask you next if there was a EPCR, an electronic patient care record as well?
A. Yes, that's a separate device, that's where we -- that's located in the back, in the boot space, and it's something that we -- it's called -- it was in those

days called a Panasonic Toughbook and it had a handle on it and it was very similar to a mobile tablet/laptop which we would carry in onto a call, where we would enter all the electronic patient care report on.
Q. Thank you. You were on shift 6 until 6. Was the call to Muggleton Road your first call of the day?
A. I believe it was. It was an unusually quiet day, so I think that was my first call of the day.
Q. Thank you. Could we go to INQ000653 please. Do you recognise this as the call log?
A. I'm not familiar with call logs because I don't really ever see these, but I have only seen it very briefly in a printed format. There's lots of numbers and things on there. I'm not completely familiar how it flows.
LORD HUGHES: This is back at HQ, is it, somewhere; is that right?
A. Yes.
LORD HUGHES: Okay.
MS WHITELAW: If you could sit slightly forward. I think the microphone is having some difficulty picking you up. Thank you very much.
Just a couple -- we tried to decipher -- sir, this isn't easy to read and for your reference, sir, the report of Mr Mark Faulkner does give a summary of the

call log, that's INQ005942, page 37. Sir, you may in slower time find it easier to refer to that, but I will just try and pick out some key timings.
It looks at though at 10.14, if you look on the screen in front of you, there was a 999 call. Could you just look at the screen and just tell me if you agree with that.
LORD HUGHES: I'm sure you're right, Ms Whitelaw, and I have seen the time cited as 10.14 elsewhere, but where is it on this document?
MS WHITELAW: Yes, sorry, page 1. We're on page 4. Could we just skip back to page 1 first. My fault.
LORD HUGHES: No, no.
MS WHITELAW: At the top we see 10.14.25.
LORD HUGHES: 10.14 "New call".
MS WHITELAW: 999, and that's the date as well.
Then if we go to 10.16 -- sorry, I should say page 4 to get to 10.16 and I'm looking for 10.16.04 "Resource allocation 303". The highlighting is very helpful for this document, thank you. Do you see that there? You mentioned your call sign was 303 , so does it look like --
A. Yes, I think I'm looking at the right place, yes, 303 RRV.
Q. It looks as if you are allocated there at

10.16 and then do we also see there, just below that:

"43-year old. Female. Conscious. Breathing. Caller statement ... fitting."

Then page 5, please, we should see "Crew 1" at the top, a few lines down, "Marriott Mark". That's your name. "Qualifications (P)"; does that mean paramedic?

A. It would be, yes.

Q. Then "Resource 303 - time dispatch MDT ... 10.16.08". Just below that for the -- thank you. A bit further down:

"RRV SALN 208 10.16 now allocated."

A. I think that means Salisbury North. That would indicate the location where I was at the time.

Q. Thank you. Does this suggest that you initially received the call at about 10.16?

A. Yes.

Q. In your witness statement, you said it was about 11.10, but you couldn't be sure without checking for the log.

A. Yeah, I do believe I got the time wrong because I couldn't remember the time of day, for whatever reason, but obviously this doesn't lie and this is the correct information so that was a mistake by me.

Q. No, and you do say in your witness statement you must check the call log to be sure, so that's fine.

A. Okay.

Q. If we could go to page 11, please. I think we should see 303 on scene at 10.23. It's only a few lines down. 10.23.35:

"At scene: resource 303 now 199.0 metres from scene".

Then time arrived at -- a few lines down:

"303 time arrived scene ... 10.23.35".

It looks as though you received the call about 10.16 and you were there by 10.23?

A. I think that time is what they call an auto at scene time, so when you're within a certain distance to the job, I think it does say there 199.0 metres, it would automatically put us at scene even though theoretically we may be, for instance, in the car park. There may be several flights of stairs or somewhere to find. So I think it generalises, it just puts us approximately in that area.

Q. Yes, of course. Thank you.

LORD HUGHES: It rather looks, Mr Marriott, as if this log picks up some of the transmissions from what I think you called your mobile data terminal in the car. They're linked, are they?

A. Yes, they are.

MS WHITELAW: We have seen on the call log it said:

"43-year old female. Conscious. Breathing. Caller statement ... fitting."

Is that the information you would have received on your MDT?

A. That would initially be the information that would come on the screen, but that is periodically updated, so I would expect this being the type of the call it was, the operator would have continued on the line with the caller and as more information would be coming in, they would update us accordingly. So it would update as more information would come in.

Q. Thank you. You say in your witness statement that you received the call as a category 1 call. That was a top priority with an immediate response?

A. That's correct.

Q. Which means life at risk without an immediate response, does it?

A. Yes. It was immediate response.

Q. Do you remember if you received any other information before you attended the call?

A. Possibly I may have received some verbal communication. I do believe possibly I may have been told that it was a new build and that the location wasn't completely verified.

Q. In your witness statement, you said you

received a call on the radio from your ambulance control --

A. Yes.

Q. -- where you were advised the call is believed to be a query cardiac arrest?

A. Yes, so it may well have -- yeah, I think that is correct, I would have done. As I say, sometimes it would be verbal and then another time it may just be a text update.

Q. Also in your statement you say when you received the call you were at one of your designated standby points in Fountain Way Campus, Wilton Road Salisbury. Was that about seven miles away from Muggleton Road? If you don't know, that's fine.

A. Yeah, I'll have to take your word for it, yeah, but it --

Q. You say you responded within about 30 seconds of the call?

A. I believe -- when the nature of a category 1 call does come in, yes, we're pretty much up straight away and out the door as quickly as possible. That's the whole purpose of being a rapid response vehicle.

Q. I think there was a slight delay finding the property, you indicate in your witness statement, because of a problem with the sat nav and you asked

somebody who was outside if they knew where number 9 was. Do you remember that?

A. Yes. It is a problem because when a new build does occur, we don't get the updates -- our mapping system isn't updated and incidents in the past I have found I couldn't find properties because it wasn't mapping. So I've known it take six months before we actually get the updates on the mapping --

Q. Is that better now; you said in the past?

A. I think it probably is similar today. Quite often now we get additional information on what3words we use and we use Google Maps as well as the SWASFT system and one may be more ahead than the other, but when you're working solo, you don't -- you cannot do that because you're driving, so it can be problematic.

Q. Well, we know from the log you at least in that area 199 metres away by 10.23 and it looks like that's the time that you also got to the scene. I want to ask you a few questions about when you first arrived.

You described it in your statement, you have indicated new build property, appeared to be a one storey flat.

You said:

"The door was open on my attendance and I could see the door was open."

Is that right?

A. That's correct, yes.

Q. Could you describe what happened when you arrived at the front door and you deal with this at page 6 of your witness statement because I appreciate it was a long time ago.

A. Can I just refer to my statement?

Q. Of course you can, at page 6, and it's the second paragraph, the larger paragraph at the top of the page.

(Pause)

A. So as I have indicated here, I collected my equipment as I arrived at the door and then, as I say, the door was open. I shouted "Hello". I heard a male voice say "Up here". I walked up the stairs. I turned to the right. I didn't -- as I state here, I didn't smell anything in the air and at the top of the stairs I turned right. I stood in the hallway looking at the bathroom and I saw a female patient who was laying supine on the floor and that means she is on her back, within the bathroom. Her head was towards the door, the bathroom door that would have been. There was a male partner who was in the hallway directly outside the door. He had what I believe to be a mobile phone in his hand and then I said to him "What's happened?" and he

replied "She collapsed". That was the end of the verbal conversation at that point.

I looked down at the female patient. I noticed she was cyanosed, that means her skin is very blue which would indicate a lack of or no blood supply.

Q. What was your assessment of her condition at that point?

A. When I looked -- at that point I thought it's probably -- I noticed she wasn't breathing and, as I say further in my statement, I would have bent down or kneeled down besides her and I would have felt for a pulse. But my initial assessment was that she was in cardiopulmonary arrest.

Q. You said you knelt down and felt for a pulse. Was that in her neck?

A. That's correct. It would have been what we call her carotid pulse.

Q. Was that present or absent?

A. It was absent.

Q. What did you do next?

A. I then commenced what we would call basic life support because even though I had advanced skills , I couldn't give those advanced skills because I had to focus on just chest compressions and the importance is just to continually press down on the -- on somebody's

chest, on their sternum, on their heart, approximately 100 times a minute, to restart the circulation and that is the important -- so that's initially what I started to do.

Q. What else did you do at the same time?

A. Say again, sorry?

Q. What else did you do? Do you remember making a request to speak?

A. Yes, I would have -- at that point I would have called for back up, or updated my control and said words to the effect of "Yes, this is a confirmed cardiac arrest, I need back up", which I think they would have automatically sent anyway, and other resources would have been also advised, like aerial support, advanced life support.

Q. You say in your statement the operator advised you that a crew would be with you shortly?

A. Yes.

Q. While you were giving basic life support , what conversation did you have with the male partner who we now know to be Charlie?

A. Again, I will just refer back to my statement.

Q. Yes, of course, page 6, and it's the big paragraph three paragraphs up from the bottom.

A. So:

"While doing the compressions, I said to the male partner 'Are you the partner?' he replied 'yes'. I said 'What happened?' he replied 'She was complaining of a headache, said she was going to have a bath, I heard a noise that sounded like she was gurgling. I went in and found her collapsed in the bathroom, she was foaming at the mouth.' I asked the male partner 'When did she collapse?' he replied 'Ten fifteen minutes ago', he was a bit flustered, he seemed a bit jiddery, [and quite] muddled in himself."

He didn't really give me much of a clear history as to what the events were or what the reason was for the cause of the collapse.

Q. What was your assessment of what he told you and in terms of the description of Dawn Sturgess?

A. What was -- sorry, say again?

Q. You said he told you she was complaining of a headache, was going to have a bath and he had heard gurgling and found her collapsed in the bathroom and foaming at the mouth, so that information, what did that tell you, if anything, about her condition or --

A. My initial thoughts -- yes, I mean, again you go in with an open mind because it could be anything, you don't know what you're going into, so as the information comes in, you make your assessment and at

that point I considered that she had a headache, it was acute by the sounds of it, that means it was sudden, she collapsed and lost consciousness and I believe she would have been foaming at the mouth. So my initial thoughts were this was a cerebral incident in terms of a brain injury or something. So I thought maybe she'd had a stroke or something like that which maybe would cause her to lose consciousness, and that cerebral irritation probably would have caused a seizure. That was my initial thought, that I thought this was a cerebral retail incident causing a cardiopulmonary arrest.

Q. Did you also ask Charlie Rowley, as we now know him to be, the male partner, what her medical history was?

A. I did but he couldn't tell me.

Q. Just going back to what you said about Charlie Rowley being a bit flustered and juddery and a bit muddled, did it appear to you that he was unwell in any way at that point?

A. I had never met Charlie before, I wouldn't know what his normal demeanour was, but no, I think to me I looked at it from the perspective that this was his loved one or his partner who collapsed and I assumed that he was very distressed because of that. And having seen this many a time, I thought perhaps this is why he

can't give me information because I have been to calls before where patients can't tell me anything because of their mental state at that particular time. So that's why I considered that -- I didn't think he was unwell. I just think he was very muddled because of what was going on.

Q. Did it occur to you he might be under the influence of something or not?

A. Not at that point, no.

Q. I think there came a point when you broke away from doing chest compressions; is that right?

A. Yes.

Q. What was the next step of the treatment you applied?

A. Well, I carried on with the -- if I could just refer to my statement, sorry.

Q. Yes, of course. It's page 7 we're on now at the top.

A. So I broke away from the chest compressions, as I said, and turned on what we commonly call the shock box, which basically is a very portable defibrillator. Everybody used to just call it a shock box. I exposed the chest. I remember that she had, I think, a very light fitting top on, so I exposed her chest by -- I believe I must have cut the dress off and then

I attached the paddle to her chest, or the pads, the adhesive gel pads to the chest. Then I followed the prompts on the machine that gave me a verbal indication of no shock indicated. This would only occur if there was not a shockable rhythm and in that case there was no shockable rhythm which would generally mean that it was cardiac standstill or what we call asystole; it was just a flat line at that point.

I carried on when chest compressions and at some point a little bit later that's when my colleagues arrived.

Q. Can I just ask you, you said you cut the top dress off. What was she wearing; do you remember?

A. I think it was just a dress. I don't think she had a bra on. I think it was just -- I think it was just a dress that we removed, yes.

Q. Do you remember trousers underneath, or not?

A. She did have some trousers on, yes.

Q. So there came a point when your colleagues arrived. Was that ambulance colleagues in the first instance?

A. Yes.

Q. We won't go back to the log, but we're going to hear some evidence from one of your colleagues, but at 10.33, I think ten minutes later, they arrived. Was

that Keith Coomber and Glen Davies; do you remember?
A. Say again, sorry?
Q. Was it Keith Coomber and Glen Davies?
A. Yes, it was. Keith and Glen, yeah.
Q. You knew both of them, did you?
A. Yes, I did.
Q. I think they are lead paramedics; is that correct? Or they were at the time lead paramedics?
A. Glen was the lead paramedic.
Q. Does that mean any advanced clinical skills?
A. No.
Q. Is it a management role?
A. No, exactly the same, it was purely for administrative type of duties and things and maybe they do something like advise new starters and things like that, but it was really administrative, but clinically we were both the same level.
Q. Thank you. What did you tell them by way of handover? Do refer to your statement if you need to. I think we're still on page 7 here, about paragraph 3.
A. I gave Keith and Glen a handover of essentially what had been disclosed to me by the male partner Charlie and the present clinical symptoms the female was presenting with, and that is her being in cardiopulmonary arrest and asystole, meaning a flat

line. So that's what I had told them. At that point, I didn't know the cause of what the cardiac arrest was.
Q. Did Keith Coomber take over the chest compressions?
A. Yes, he did.
Q. What did you do then?
A. This is when I started doing some airway maintenance, so this would have involved me tilting Dawn's head back and lifting her jaw forward so to try and obtain a patent airway. By patent we mean try and clear it by stopping any obstruction from the tongue.
Then we have a tube, what we call an i-gel, and that's lubricated and then put into Dawn's mouth and it lifts the tongue and enables a patent airway so that we can then ventilate her.
Q. Was she then connected to oxygen?
A. Yes, it would be -- well, it would be -- we would have attached a bag up to that, an oxygen bag, or not an oxygen bag, but a silicon bag that we would squeeze. Initially it would be at atmospheric air , but we would attach an oxygen cylinder which has a reservoir bag on the back which would then push 100 per cent oxygen into Dawn.
Q. Did you help Keith Coomber complete standard chest compressions? If you can't recall, it's

paragraph -- it's on page 7 still, halfway down.
A. Yes, Keith and I were -- yes, completed standard chest compressions. So what that means is a ratio of 15 to 2, so Keith would do 15 compressions and on the 15th compression I would do two inflations and then Keith would carry on with 15. So that is a national guideline standard of the ratio that you should adopt when doing cardiopulmonary resuscitation.
Q. I think Keith Coomber inserted a cannula into Dawn Sturgess' hand; is that correct? Hand/arm it says in the statement?
A. Sorry, what was that you said?
Q. Did Keith insert a cannula into her hand/arm?
A. Yes, that's right. Keith put a cannula into Dawn's hand.
Q. Did you notice if her hand was sweaty at all? If you don't remember, do say.
A. I don't recall. I mean, it was a very hot day. Environmentally it was a very hot day and we were hot. So no, I didn't notice.
Q. What was she given in terms of treatment then and again do refer to the statement if you need to?
A. We would then give adrenaline, 1 in 100,000, 1 milligram of adrenaline for every 10,000 mils of saline. So that is basically what we would give first of all to

try and reverse the effects of the cardiac arrest.
Q. That's part of normal advanced life support; is that correct?
A. Yes, that would be the initial drug of choice first of all to try and restart a heart and I think I have also noted here that a saline drip of sodium chloride was also administered. That would be purely there to keep a patent intravenous flow so we can keep referring back to that intravenous access for more drug therapy.
Q. Did there come a stage when the shock box, the defibrillator, indicated that the patient was shockable?
A. Again, I'll just refer to my statement here.
Q. Yes, do.
A. At this point, I think we had -- looking at my note -- the shock box indicated via verbal command that the battery was low and Glen obtained an additional shock box which was then connected to the pads which were already on Dawn, so it was just a matter of swapping them over. Periodically the batteries do deplete over a period of time.
Q. Does it tell you immediately when the battery is going low? You said a verbal command.
A. Yes, there is a verbal command on there. Because it was an old system, an old type of

defibrillator, it wasn't always a completely accurate gauge. You would have a LCD display that may say that it was completely full and then it may just deplete very quickly. These devices weren't left on permanent charge at all, they just had batteries in them and periodically they would change, I believe, when the vehicle went for servicing and that. But the vehicle --

It would have been checked at the start of the shift when we just turned the shock box on and it would indicate that the battery was full or half, but within a useable level, but, as I say, they weren't completely very accurate, the older devices.

Q. You say you changed the shock box to a different one that Glen Davies got hold of and then was there a verbal command that the patient was shockable?

A. Yes, it was. I believe what we -- we had to do to make a heart shockable, it has to fibrillate before we can defibrillate it and the only way to fibrillate the heart is to oxygen it. So that's why we were doing the aggressive chest compressions to get the blood flow going through the heart and that's what we done, along with the adrenaline as well. That would be working to get that flowing through Dawn's blood system because we have to make sure that by doing those

compressions that blood does flow through, and at that point she was shockable and a shock was delivered as per the instructions on the --

Q. What was the result of that?

A. We got what we called ROSC, or return of spontaneous circulation. Again, you can have an active heart rate on the machine, but sometimes there's an electrical mechanical dissociation between the two, so you can have an electrical activity, but there won't actually be any physical movement. So I have to make sure that we did actually have a pulse and I felt again for a carotid pulse and I could actually see a pulse as well, I could see a pulsating in Dawn's neck. So I was happy that we had got return of spontaneous circulation.

Q. You say the monitor attached to the female patient also confirmed sinus rhythm. What does that mean?

A. Sinus rhythm indicates that the -- the pacemaker site is a sinus pacemaker which is on the top of the heart. So that would indicate that the rhythm there is coming from the top of the heart and working its way down through the middle of the heart to the base of the heart, so it's what we call NSR or normal sinus rhythm.

Q. I think you then tried to obtain some more

details from the male partner, Charlie Rowley; is that correct?

A. Yes, at that point we were happy that we had stabilised Dawn to the level that we could then try and engage with Charlie a little bit more to find out what the lead-up of the events were and why Dawn had collapsed and try and obtain as much history as we could.

Q. Could you just by reference to the bottom of page 7, the last paragraph and going on to page 8, tell us what it was you asked and found out from Charlie Rowley?

A. I broke away:

"I broke away, and left Glen Davies and Keith One, who continued ALS, I then spoke to the male partner, he was standing in the hall, at the lounge/kitchen area end, I said ['Can you tell me what her name is or her] date of birth [or] any information on why she is like this?'"

He did reply her name was Dawn Sturgess and it's a name that I hadn't heard before and I was just trying to get some clarity on how it was spelled.

Charlie replied "No, I'm dyslexic, I can't do numbers".

"I looked on the window sill and saw a letter, it

had a name [on] it, I said to [Charlie 'Is it] Dawn Sturgess? Is that her?' referring to the name on the letter, he replied 'Yes'. I said 'Does [Dawn] have any medical condition?' he replied 'Not as far as I'm aware of'."

He said she had some tablets. He pointed to some tablets on the window sill. I can't remember what those tablets were. The conversation lasted about 15 seconds.

Q. Did you look at what the tablets were at the time?

A. I can't remember. They may -- they may have been completely irrelevant.

Q. Did you return to assist the ambulance crew at that point?

A. Yes. I carried on with the crew and I believe that we lost -- Dawn's pulse stopped again and again we continued with CPR. I checked the machine. More adrenaline was given as per our guidelines and again we got return of spontaneous circulation and that's -- yeah, we got return of spontaneous circulation back again.

Q. Then you deal with in your statement what we have already spoken about, you have already explained the battery -- sorry, no, this was the -- you said you previously replaced your shock box with Glen Davies'

because of the battery pack and --

A. Yes, this --

Q. Sorry, go on.

A. Glen Davies, he's had his EPCR, electronic patient care record, and what we call the brick. In those days we had an electronic patient care -- it was different on the ambulances as to the cars. If you were on an ambulance, your electronic patient care record is, as it says, an electronic patient care record, but it also doubles as a patient monitoring device for monitoring their vital signs, which wasn't the greatest situation because it was very difficult to flick between the two sometimes. And we had a device what we used to call "the brick" because it would look like a square house brick and that connected to the electronic patient care record via a cable. On the side of this brick we had a connector, one would be for blood pressure, one would be for saturations -- oxygen saturations, and we also had -- we could monitor patient's carbon dioxide levels as well. So that's what we were referring to there.

Q. So, sorry, let's -- just to be clear about this point, so now what I think you say in your statement is that Glen Davies' electronic patient care record and brick, the communication box between the

medical monitoring devices and the electronic patient care record, was faulty, so you had to go and get --

A. Yes, yes.

Q. So you couldn't monitor the patient's CO2 levels, so you had to go and get another device; is that correct?

A. That's correct, yes.

Q. Is that two devices you had to replace, first of all the defib and then --

A. Yeah, because -- because there was only one ambulance there, there was nowhere else to replace that device with, so effectively he could do no monitoring through his electronic patient care record because that brick wasn't working for whatever reason.

Q. But it was a monitoring device rather than a device delivering treatment.

A. Yes, it was a monitoring device. So what I done at that point, if I just refer to my statement.

Q. Yes, it's about four paragraphs down on page 8.

A. Yes, I returned back to my car and took what we call a life pack 12, which is again a defibrillator, cardiac defibrillator, and it has the capabilities to do all the necessary patient monitoring devices on it, so because Glen's connection had failed, I went down and

grabbed mine quite quickly, so then we continued to monitor --

Q. What did that tell you in relation to the ECG monitor?

A. It would tell me -- well, I could monitor the blood pressure, I could monitor the CO2 levels --

Q. But in terms of what you actually saw, I think halfway down your statement you say there was nothing remarkable on the readings on the ECG; is that right?

A. Yes, I think that's right. Let me just refer to that.

Q. Yes, halfway down page 8 --

A. Yes, I would have done an ECG.

Q. What about Dawn Sturgess' condition you address there?

A. Sorry, say again?

Q. You address Dawn Sturgess' condition at that point, when you say halfway down:

"I got back to airway management ..."

A. Yes, so we got back to airway management and I was bagging Dawn, that means that I was squeezing the bag that had the oxygen in -- I mean, this would have been continuous anyway, but we generally do take turns so we don't get fatigued in doing one particular treatment continuously. She was nice and pink in colour

and, as I say, we could see her chest was rising well. I noticed her right-hand -- my right-hand glove had split at the top, the thumb, and I had some mucus which had come from Dawn's mouth onto my hand/glove. This would have occurred when I was doing some airway management.

Q. Did you change your glove?

A. I believe I did.

Q. Did you experience any symptoms of being unwell in the days after treating Dawn Sturgess?

A. Myself?

Q. Yes.

A. Not that I can remember.

Q. Thank you. Then I think there next came a point -- and we will hear subsequent evidence it was about 11.05 I think -- that critical care paramedics arrived; is that correct?

A. That's correct. The critical care crew arrived. Again, this consisted of another Keith, which I referred to as "Keith 2" in my statement, and another unknown paramedic who I hadn't met before and a female which I later learned was a -- I believe a critical care nurse who was there on an observer capacity that particular day.

Q. Did they take over the ROSC care, the return

of spontaneous circulation?

A. Yeah, initially I would have given them a handover, a clinical handover, and I would have told them what had occurred or what we thought had occurred and what we had done to -- what treatment we had done for Dawn in terms of we had put a IV in, she has had several shocks, what drugs she had, what airway maintenance she had and probably what are the baseline observations in terms of ECG, whether she had blood pressure, oxygen levels and what happened *(unclear)* we would have noted which would have been important for them to know.

Q. Yes. When -- were you aware of the critical care paramedics giving naloxone?

A. I think -- I believe they may -- yeah, possibly. I cannot remember. But I do know that if -- part of our protocol, when we get a patient who is in cardiopulmonary arrest, we always have to consider whether there is an opiate possibly. If we don't know, if we didn't know whether it was an opiate involved or not, we could give that drug because if there was an opiate involved, it would -- it would stop the effects of that opiate. But if there wasn't an opiate involved, it would have no detrimental effects on the patient. But I never thought that there was any -- my initial

thoughts were that I always thought this was a cerebral episode or a neurological episode, and I thought it may possibly have been a seizure caused by a brain injury or something.

Q. Once the critical care paramedics arrived, I think you had an opportunity to speak to Charlie Rowley again and you deal with this at page 9. Halfway down page 9. What did you ask him at that stage?

A. On page 9?

Q. The paragraph starting: "I changed my gloves ..."

A. Yes:

"I changed my gloves, at this point there was a lot of involvement in treating [Dawn], I said to The Male Partner 'Are there any prescriptions, or hospital details?' and Charlie replied 'I don't know', I said 'do you mind if I have a look around for something?' ..."

Because part of our job is trying to investigate, find out what has occurred.

Again, Charlie didn't reply and he did look a little bit confused at that time which again I think possibly may have been down to how he was feeling. I looked around and I could only see a letter from Wiltshire Council, but that only gave me her name and nothing else. Initially, I was looking around to see

whether there was a hospital letter or something, or even a prescription to see whether there was any particular medication Dawn was taking.

Q. But you didn't find anything?

A. I didn't find anything.

Q. Did you see any drug paraphernalia?

A. No.

Q. Were you aware of Charlie Rowley saying anything to Keith Coomber about Dawn not taking drugs?

A. No, I never knew -- I never -- no.

Q. Did Charlie Rowley tell you at any point that Dawn had not taken any drugs?

A. No, and I don't think I ever asked that question either.

Q. Just to cover the treatment once the critical care paramedics had arrived, you said at the end of page 8 that we connected a ET CO2 probe to check her oxygen levels checked her blood glucose nothing remarkable.

And I think you noticed a suction unit being brought in; is that right?

A. I believe so, yes.

Q. What's that used for?

A. The suction would be to maintain a patent airway because 90 per cent -- I would say in my

experience 90 per cent of patients who are in cardiopulmonary arrest have some fluid coming out of their mouth or their nose.

Q. So secretions are common in cardiac arrest then?

A. Yes, yes.

Q. Very common if it's 90 per cent.

A. It's very common having fluid loss, yes.

Q. Do you remember noticing excess secretions in Dawn's case?

A. I do remember fluid coming out of Dawn's mouth, yes.

Q. I think you helped take her on a scoop stretcher to the ambulance?

A. That's right, yes.

Q. I think you noticed that she lost control of her bowels at that point?

A. That's correct, yes.

Q. I think you suggest she was wearing trousers at that point?

A. Yes.

Q. Once she was taken into the ambulance , you say:

"I had no further contact with her at that point."

So is it right you weren't involved in her care in

the ambulance?

A. Yes, I handed over to the other team, the critical care team, they took over from there.

Q. When you helped to transfer her into the ambulance, were you aware that she was bradycardic and hypotensive?

A. Sorry, she was?

Q. Bradycardic and hypotensive, if I pronounced that correctly?

A. No, I don't think so.

Q. Did you notice a white frothy liquid rising in the i-gel?

A. Possibly, but it wouldn't have been abnormal to have a white frothy type of fluid in an i-gel because again probably 90 per cent of the cardiac arrests that we go to would have fluid in an airway. That's the whole idea of us having a suction unit, to remove that.

Q. You have explained that when you first came you thought it might be a stroke and you thought it was a brain seizure of some sort and by the time you put her in the ambulance, what were your thoughts as to what might have caused the arrest?

A. Again, I was still thinking on the basis of -- we didn't know, none of us knew and I think I did say that it was an unknown cause, but there was nothing with

clearly indicating what the cause of it was because Charlie couldn't give us much information at all, or couldn't find any medical notes to say that Dawn had a pre-existing medical condition. My personal thoughts were again I always thought it was a neurological episode and I thought, as I say, she possibly could have had a stroke which could have precipitated a seizure and also collapse.

Q. Did you consider any of her symptoms to be particularly unusual in the context of cardiac arrest?

A. Did I -- say again?

Q. Any of her symptoms to be particularly unusual, given that cardiac arrest obviously unusual, but in the context of cardiac arrest, anything in her symptoms that you thought was particularly unusual in your experience?

A. No, there was nothing which was really red flagging to me at all.

Q. It may be obvious from what you have said, but presumably then you didn't consider that organophosphate poisoning was a possible cause at all?

A. Anything is a possible cause. You know, when we get on scene it's -- you have to find as much information as you can and think -- but there was nothing at that point saying to me that this was

a poisoning.

MS WHITELAW: Thank you very much. Those are all my questions. There will be some more questions for you.

LORD HUGHES: Do you have anything, Mr Mansfield?

MR MANSFIELD: Yes.

Questioned by MR MANSFIELD

Good afternoon. I represent the family of Dawn Sturgess. Just a couple of questions.

First of all, before you went on this particular day, were you ever alerted to the fact that Novichok might still be present in the Salisbury area?

A. Not by my ambulance control, but it was always at the back of my mind being a healthcare professional and because of events prior to meeting -- attending Dawn, it was -- anything could be possible, so I was -- I would have been, as I say, maybe a little bit more guarded, I would consider those things.

Q. From what you're saying then there hadn't been any official training or information about Novichok before you went, or the presence of it?

A. Only the update that we had received after the Salisbury incident, just to the update that we've got to remind staff of the procedures of hazardous chemicals.

Q. One final question on that and that is: was

the issue about a possible crossover or misdiagnosis of a nerve agent reaction with an overdose of drug, was that something that you had been discussing at all?

A. No, I don't think so.

Q. No. One final question altogether and that is you came to the conclusion, and you maintained that throughout, that you thought it was a neurological episode?

A. That's correct.

Q. Now, was that an instinctive reaction or was there a feature of this one that you thought led to that conclusion?

A. I think it was a feature because the information I got from Charlie was that it was acute, it was sudden, she was complaining of a headache, again which was acute, and that she had been foaming at the mouth, so those are factors which can be indicative of a neurological episode.

MR MANSFIELD: All right. Yes, thank you very much.

LORD HUGHES: Thank you, Mr Mansfield.

MS WHITELAW: Sir, I don't know if this would be time for an afternoon break?

LORD HUGHES: Yes, it would.

Mr Marriott, we are grateful. Thank you very much

indeed. There's no need to stay unless you want to and of course you are free to do so.

3.15, please.

(2.58 pm)

(Short Break)

(3.16 pm)

LORD HUGHES: Yes, Ms Pottle.

MS POTTLE: Sir, the next witness to be called is Keith Coomber.

MR KEITH COOMBER (affirmed)

LORD HUGHES: Thank you, Mr Coomber. Yes, by all means sit down if that's comfortable.

Questioned by MS POTTLE

MS POTTLE: Good afternoon, Mr Coomber. My name is Émilie Pottle and I ask questions on behalf of the Inquiry. Thank you for attending to give your evidence this afternoon.

Could you give your full name, please?

A. Yes, my name is Keith Coomber.

Q. Mr Coomber, you have made two witness statements in this case, I believe. The first is dated 6 July 2018 and the second is dated 13 July 2018. The references for those statements are INQ4550 and 4560. If we can bring up -- yes, 4550 and 4560 on the screen, you should see that, Mr Coomber, on the screen in front

of you.

A. Yes.

Q. Okay. If we begin with 4550, if we just turn to the last page, yes, so we can see this is the main statement, if I can put it that way. It is four pages long. Do you recognise that statement, Mr Coomber?

A. Yes, I do.

Q. Have you had a chance to review this statement --

A. Yes.

Q. -- before giving your evidence?

A. Yes.

Q. Is it true to the best of your knowledge and belief?

A. Yes, it is true.

Q. Is there one correction you would like to make?

A. No, I would just like to state that I was in sort of a state of shock at the time of the statement.

Q. I see.

A. Just through going to a cardiac arrest and a few days later being told it's a major incident of Novichok.

Q. I see. Well, we will go through the statement in detail in a moment.

A. Yes.

Q. And you can make amendments that you feel are necessary, but just before we do that, the second statement is -- if we can just pull that up -- 4560. It's just a single page and it just corrects a typo, confirms that the date is 30 July 2018.

A. Mm-hm.

Q. Sir, if you are content, could both of those statements be adduced into evidence?

LORD HUGHES: Yes, it is "June" for "July", isn't it? Yes, of course, both statements.

MS POTTLE: Mr Coomber, before I ask you about the poisoning of Dawn Sturgess and your role, I would just like to ask you a bit about your qualifications, if I could. In 2018, when you responded to the call at Muggleton Road, you were an advanced technician working for South Western Ambulance Service; is that right?

A. That's correct, yes.

Q. Can you just tell us in a few words what the role of an advanced technician is?

A. I have just got additional skills than a normal technician, sort of cannulation.

Q. Okay. In relation to a paramedic --

A. I'm not registered --

Q. What would you say -- pardon me?

A. I'm not registered.

Q. Not registered, okay. So would your level of training be the same as a paramedic or a bit lower?

A. A little bit lower.

Q. A bit lower, okay. So would you normally -- we know that on the date in question you were crewed with Glen Davies who was a paramedic?

A. Yes.

Q. Would you normally be crewed with a paramedic, if you --

A. Not normally -- well, it changes, whoever -- I've been doing shifts along with ECAs. They even put technicians on the car as well.

Q. Okay, so not always with a paramedic?

A. No.

Q. How long have you been an advanced technician?

A. I have been with the Ambulance Service since about 2005.

Q. So nearly 20 years?

A. About 20 years.

Q. Yes, okay.

If I can ask you then -- before we move on to the events in question -- I want to ask you a bit about your training and guidance that was given to you on organophosphate poisoning.

A. Mm-hm.

Q. We heard this morning from Wayne Darch that a clinical notice regarding DuoDote auto-injectors was emailed to all paramedics, he says, prior to the Skripal poisoning and all clinical staff were asked to familiarise themselves with it. The clinical notice itself asks clinicians to look at the medicines protocol for a DuoDote auto-injectors and if we can just pull up that medicines protocol now. Thank you very much. For the transcript that's INQ623.

We have looked at this document twice already today, but Mr Coomber, could I ask you: do you recognise that document?

A. Yes, I do.

Q. Did you see it prior to June 2018?

A. Yes.

Q. You did, okay. I'm just going to take you through it in a bit more detail now. So if we look at page 1, it sets out the clinical diagnosis of nerve agent poisoning and sets out a number of features, including bronchorrhea, which is the production of excess watery sputum. Chronic spasm, which is difficulties with breathing; is that right?

A. Yes.

Q. And severe bradycardia, so that's a slow heart

rate?

A. Slow heart rate, yes.

Q. Then it says "Other signs may include", and if we can move on then to page 2, so the other signs are excess secretions, for example, tears, respiratory depression and altered level of consciousness and convulsions.

Then the protocol says that:

"Toxic doses may cause CNS ..."

That's central nervous system; is that right?

A. Yes.

Q. "... CNS stimulation ..." which can cause, for example, restlessness and confusion, but that can give way to depression, so central nervous system depression, which would cause coma, circulatory and respiratory failure and death. So if we're considering Dawn Sturgess' case, she had, we now know, circulatory and respiratory failure caused by that poisoning.

If I can then ask to move to page 5 of the protocol, so this is the final page of the protocol which I think we saw just a moment ago with your colleague, Mr Marriott, and if we can just focus in on the bottom of that page, the grid. Yes, sorry, that's a little too focused, if we can zoom out just a little. I want both grids, I should have said. Perfect.

Here we have quite a clear exposition of the signs and symptoms of the poisoning, so for breathing, chest tightness, wheezing, respiratory arrest, bradycardia, pinpoint pupils, miosis, seizures or unconsciousness, sweating, fasciculations. Can you help us with what fasciculations are?

A. That I'm not sure.

Q. We will hear, sir, from an expert in pre-hospital care in due course.

Then also finally other nausea, vomiting, faecal and urinary incontinence are the other signs and symptoms.

I know that I'm asking you about events that occurred quite a long time ago, but you recognise the document. Do you think, before you attended to Dawn Sturgess at 9 Muggleton Road, you were familiar with the signs and symptoms of nerve agent and organophosphate poisoning?

A. Yes, because I would have read the notice and signed for it.

Q. You did, okay.

A. Yes.

Q. I see. Now, I want to ask you about information received after the Skripals' poisoning but before the poisoning of Dawn Sturgess. So, you know,

you weren't involved in these events, but of course in March, Sergei and Yulia Skripal had been poisoned in Salisbury and we heard this morning from Mr Darch that some guidance which had been intended for emergency departments had been emailed through, he says to all staff, and I just want to show that to you and ask if you remember seeing it. That is -- the reference is INQ659. Perfect, thank you very much.

We need not take a long time with this, but it is a document which sets out a reminder for clinicians for recognising the signs of organophosphate poisoning, and it begins on the first page with recognising the release of the chemical and the step 1, 2, 3 plus triggers.

Just to spend a little time on that, the step 1, 2, 3 plus triggers, those numbers refer, don't they, to the casualties?

A. The number of patients, yes.

Q. Number of patients, exactly. So in your case when you were responding to Dawn Sturgess, you only had one patient?

A. Yes, step 1.

Q. Yes, exactly, okay. If you had had three patients at that address, then this sort of protocol, the step 1, 2, 3 protocol, would have required you to seek specialist responders; is that right?

A. Yes, that's right.

Q. Okay, but you weren't there obviously when you were attending to Dawn on her own.

Then the other sort of indicators would be dead people and animals, unexplained signs of irritation on the skin and the eyes and the airway, the presence of hazardous materials and unexplained vapour, mist and clouds.

Then the clinical symptoms -- they begin on page 1 and if I can take us now to page 3, which just sets out the acute effect of exposure, and we need not take a long time because they are the same as the ones that we saw on the DuoDote protocol. Yes, there we go, so increased salivation, chest tightness, rhinorrhea. Rhinorrhea, is that secretions from the nose?

A. Yes.

Q. Bronchorrhea, bronchospasm, miosis, so the pupils that are constricted. We also see as the acute effects you can have hypoxic -- this is the very last bullet point:

"Late complications ... may result from aspiration or hypoxic brain injury from early loss of consciousness and respiratory failure."

Which we know is what happened in the case of Ms Sturgess.

Okay, so do you recall getting this by email?

A. I don't recall it, no.

LORD HUGHES: You don't recall having it or don't recall how you got it?

A. As I say, it was six years ago. A lot has sort of happened in that time , but it would have been on the table, I would have read it and signed for it.

LORD HUGHES: Okay.

MS POTTLE: In any event you confirmed that with the DuoDote protocol you remember that you knew the signs and symptoms at the time.

A. Yeah, the DuoDote that's on the ambulance along with the card as well.

Q. With the card?

A. With the card.

Q. You could refer to that at any time when you were out on a call?

A. Yes.

Q. Great. Then I will move now to the events on 30 June and please refer to your statement if you need to --

A. Yes.

Q. -- because it was some time ago. On that date, you were on duty as part of a double crewed ambulance?

A. Yes.

Q. Partnered with Glen Davies. He was driving.

A. Yes.

Q. Your ambulance was call sign 312; is that right?

A. That's correct.

Q. I'm going to take you now not to the call log, because it can be a little difficult to make sense of, for me anyway, but I'm going to take you instead to the distillation of the call log by the expert, the pre-hospital expert, Mr Faulkner, and that is INQ5942?

LORD HUGHES: 5942?

MS POTTLE: Yes, 5942, page 37. It should come up on your screen in just a moment.

A. Yes.

Q. You were call sign 312, so we can see here at 10.16, it says:

"Resource call sign 312 ... allocated to incident."

A. Yes.

Q. Actually at the very top, we can see the call was received at 10.14, so you were allocated two minutes later?

LORD HUGHES: No, that's -- sorry, 312, yes.

MS POTTLE: Yes, so 303 is Mr Marriott , who we just heard from.

LORD HUGHES: That's right, yes.

MS POTTLE: Actually at the same time you were allocated to the incident and we can also see at the top of the page that it was a category 1 call, that's the highest level of priority; is that right?

A. That's correct.

Q. At that time, the complaint is given as "fitting". Then we can move down the page. At 10.23, it says "Call recorded as cardiac arrest", so it is still a category 1.

Do you remember on the date in question whether you were receiving that information as it came through?

A. It had initially come through as a fitting, but en route to Amesbury it went down to a cardiac arrest.

Q. Okay. Did you -- Mr Marriott told us that he had a mobile data terminal in his RRV. Do you have a similar set up in the double crewed ambulance?

A. Yeah, we have radio plus the MDT.

Q. Okay, and then as the information changes, does that new information come through on the MDT?

A. I think that came through via radio --

Q. Okay.

A. -- to confirm cardiac arrest.

Q. That is dispatches from the control room

keeping you informed of what's happening ; is that right?
A. Yes.
Q. Okay, I see. If we continue down the page , we can see at -- it says 10.29:
"Notes added stating 'cardiac arrest confirmed by RRV'."
That would be Mr Marriott?
A. Yes.
Q. He confirmed it and then you -- it says your call sign arrives four minutes later at the scene. Does that accord with what you remember? You arrived after Mr Marriott was there?
A. Oh, he was first on scene, yes.
Q. Okay. Then before we go into a bit more detail, can I ask, the call log also sets out when the first set of observations are recorded, when adrenaline was given and when other medical interventions happened. How does that information end up on the call log? Are you in control -- are you in contact with the control room?
A. I don't --
Q. -- on the scene or --
A. No, that doesn't make no sense to me.
Q. If you can't help us with that --
A. We just arrived at 10.33, so I can't see any

drugs being given at that time.
Q. No, okay. Don't worry, if you can't help us with the call log, that's -- you must simply tell us what you yourself saw and what you know about.
A. Yes.
Q. So then you arrived at the scene. Mark was already there. Can you just paint the picture for us. When you arrived at the address we know you went up the stairs, you went into the bathroom. What did you see at that stage?
A. I went up the stairs, turned right. Mark was at the head on his knees, doing CPR. He give me a quick handover. I squeezed through the doorway and I went -- moved her left arm to give me some room. I knelt down on her left-hand side and commenced with CPR to give Mark a rest, as per protocol.
Q. If I can just pause you there. When you say he gave you a quick handover, do you remember what he told you?
A. Collapsed, query cause and she was in cardiac arrest.
Q. So you knelt next to her , you moved her arm so there was space for you?
A. Yes.
Q. And you started to help him. What were your

actions to help him?
A. To get the heart going, cardiac arrest.
Q. Did you start bagging her or were you doing compressions?
A. No, I was on the chest.
Q. You were on the chest.
A. Freeing up for the -- to get the airway.
Q. I see. Mr Marriott told us that when he was on his own he could only do basic life support?
A. That's correct.
Q. But then, when you arrived, you and Glen, that it was possible to do advanced life support?
A. Yes.
Q. Can you just help us with what the difference is between basic and advanced?
A. Basic is applying pressure to the heart, onto the chest. You're acting as the heart, keeping the heart going, and also you've got a bag where you're giving oxygen as well -- well, oxygen as well, yes. With advance that's giving the drugs.
Q. I see, okay. You cannulated Dawn Sturgess, that's right, isn't it?
A. That's correct.
Q. Was that to her hand?
A. No, into the ACF, up into her arm.

Q. I see. Sort of her elbow area?
A. Yes, that's correct.
Q. Did you notice when you were doing that whether her skin was sweaty at all?
A. No, no.
LORD HUGHES: No, you didn't notice or no --
A. No, I didn't notice.
LORD HUGHES: There's no reason why you should, I just want to know what the "No" means, that's all.
A. Yes.
MS POTTLE: Okay. Can we pull up Inquiry reference 655. Mr Coomber, I'm going to take you in a moment to this document which is -- I believe it's the electronic patient record.
A. Yes.
Q. Is that right?
A. Yes.
Q. If we could -- can you help us, how is this document completed?
A. I didn't do this one, but normally at the top you just write in explaining what you did, what you have seen on the scene, and the next one is sort of like a primary survey --
Q. Can we just -- sorry, I know I said page 2, but can we begin just at page 1, just to help. Yes, so

this is what you were talking about, I think, the primary survey.

A. Yes, on arrival, with the free text.

Q. Can I just ask, before we get into the details of what's included in the form, because it's called an electronic patient record, that suggests that it's not done by hand?

A. No, not anymore. It's all electronic now.

Q. Yes, exactly. Mr Marriott was, in his evidence, telling us about an electronic patient record which was like a sort of tablet?

A. Yes.

Q. Is this something that's completed that you type up when you're on the scene, or is there automatic --

A. Depending on the condition of the patient. If the patient needs all your help, you're concentrating on the patient and you do the paperwork later.

Q. Of course. In Dawn's case, when you were assisting Dawn, I think the expert notes that there's some inconsistencies in the record, he hypothesises it's because you were probably helping Dawn rather than filling in --

A. That's correct, yes.

Q. Is that what happened?

A. Yes.

Q. Okay, I see. We had the primary survey here which says that the presenting condition is cardiac and it says "OOH cardiac arrest". Can you help us with that, what does that mean? Is it out of hospital?

A. Out of hospital cardiac arrest, cardiac arrest before ambulance arrival.

Q. Okay. Then if we turn to page 2, it says:

"Collapsed in toilet went into arrest. RRV on scene. B(i)s commenced ..."

What's BIs?

A. I think that's meant to be BL, basic life support.

Q. I see:

"... ambulance arrived ... ASU in attendance ..."

Who is ASU?

A. That I'm not sure.

Q. Then "Extricated on scoop. ALS continued ..."

ALS is advanced life support; is that right?

A. That's what -- yeah, as I say, I did not write this one, so the abbreviations are going to be a bit different.

Q. Of course. It says actually Fred Thompson completed the EPCR.

Sir, we're going to hear from him tomorrow

morning --

A. Right.

Q. -- so I don't think -- I'm not going to trouble you too much more, Mr Coomber, with this document, but just to say that we can see here on examination underneath that box on page 2 they say that the pupils were sluggish, left size 1mm, right side 1mm, so that would be miosis; is that right?

A. Yes, pinpoint.

Q. Yes, so 1mm is quite small?

A. Yes.

Q. There are some indication of the drugs given, that's on page 3, and then the treatment. If I can just ask you then to put that document to one side -- we can take it down now. If we can get back then to the medical treatment that you remember giving her, so you cannulated her to give her some drugs, that would be part of the advance life support. You had been helping with compressions. You did eventually achieve a resumption of spontaneous circulation?

A. Yes.

Q. That's right, isn't it? Okay. Can you help us with -- you might not be able to, but with the time that that happened because the patient record says that it was about 10.51. Does that sound right to you?

A. That's about right, yes.

Q. I would ask you now to look at document INQ5294, page 3. This is a debrief that was conducted by SWASFT of the incident. It took place -- the debrief took place shortly after. You attended this debrief; is that right?

A. Yes.

Q. Yes, Okay. The incident 12043565, that's the response to Dawn Sturgess at 9 Muggleton Road.

We can see that they record your ambulance, 312, was second to arrive on the scene. You enter the property wearing gloves, and then there's the equipment that you brought, including the suction kit and the i-gel unit was placed by Mr Marriott.

Then if we look at the fourth paragraph, it is what I'm interested in, it says:

"Once [double crewed ambulance 312] were in scene, advanced life support was commenced. The patient was cannulated in the left arm. Medicines were administered via this route. The patient then had a return of spontaneous circulation. However, after a while the patient had a VF cardiac arrest. After one shock, the patient's rhythm went to ..."

How do I pronounce that?

A. Asystole.

Q. So:

"... after one shock, the patient's rhythm went to asystole, but after further advanced life support there was a further return of spontaneous circulation."

Does that accord with your memory of what happened?

A. No, I can't quite remember that. I remember her having one shock and went back into -- she went into ROSC, return of spontaneous circulation.

Q. Okay.

A. But we had HEMS arrived, critical care. When the critical care arrived, I went down to get the ambulance ready for extrication.

Q. I see. So you continued providing care until the critical care team arrived?

A. That's correct.

Q. I would just like to ask you now about the interactions you had with Ms Sturgess' partner, Charlie Rowley. Do you remember speaking to him about Dawn Sturgess' condition?

A. I think that went all through Mark.

Q. I see.

A. I didn't see much of Mark -- not Mark, Charlie. If I did, it was only for a fleeting few seconds because I was busy on Dawn.

Q. I see. Do you recall Charlie Rowley

confirming that Dawn Sturgess did not take drugs? Do you recall that?

A. I don't recall that, but if I did ask, it was just a rule of elimination because it was just trying to find out why she collapsed.

Q. Okay. Did you form a view, while you were treating her, what the cause of her symptoms was?

A. Again, I was going down the neurological route.

Q. When you say neurological route, what kind of conditions were you considering?

A. Sort of -- like Mark said, it's sort of like seizure type, brain injury.

Q. Okay. Do you recall noting that she had miosis?

A. Yes, pinpoint pupils.

Q. And that didn't cause you to think that it could be a drugs overdose?

A. It goes through your mind, loads of things are going through your mind all at once and you have just got to eliminate things, hence why we have given naloxone.

Q. Do you remember the suction machine being used to remove excess secretions in her airway?

A. I might have been downstairs then getting the

ambulance ready.

Q. Okay, so you don't remember that?

A. No, but suction was used on her in the back of the ambulance, but I don't remember it being used up in the bathroom.

Q. Okay. Mr Marriott told us that it's very common for there to be excess secretions. Is that your experience?

A. Yes, it's boiling down to sort of fight or flight syndrome. Your body is trying to concentrate on providing energy, blood circulation to the important organs of the body, so you vomit, you lose secretions, faecal matter.

Q. So the systems that you would have been aware of when you're treating Dawn Sturgess, the excess secretions, the incontinence of faecal matter, and the miosis, did you consider that those were an unusual constellation of symptoms or not?

A. No, no.

Q. Can you help us as a working paramedic of 20 years' experience now, how -- whether those are symptoms that you would expect to find in somebody who was in cardiac arrest or not?

A. Everybody's different, but I have been to cardiac arrests where there's been huge amounts of

vomiting. With Dawn there was no vomiting. Everybody sort of portrays differently.

Q. I see. You mentioned a moment ago that naloxone was given to Dawn.

A. Mm-hm.

Q. Did you notice whether that had any effect on her?

A. I don't know. We were too busy then trying to get her out of the house and into the next level of care.

Q. I see. Just help me with this, the naloxone, was that given by you before the critical care team arrived or was that given afterwards?

A. I give it as they arrived because I put it past them. I said "Is it all right to give her that?" and they said yes.

Q. Okay, I see. You gave that to her for what reason?

A. If it was opiate.

Q. I see. If it wasn't opiates, was your understanding that there would be any negative consequences for her?

A. It's not going to do anything bad, but it will help reverse the causes if it was.

Q. Okay, and you didn't notice whether there was

any impact on her?
A. No.
Q. Okay. Arrangements were made eventually to move Dawn onto a scoop stretcher so that she could be put into the ambulance; that's right, isn't it?
A. Yes.
Q. What was your role in that part of her care?
A. HEMS, the critical care, they took over the care for Dawn then. I was just assisting with lifting and assistance in the back of the ambulance.
Q. Did you help carry her down the stairs?
A. Yes.
Q. Then when the ambulance -- when she was put into the ambulance were you in the back of the ambulance with her?
A. Yes.
Q. Did you stay with her until she arrived at hospital?
A. Yes.
Q. Okay. When she was in the back of the ambulance, she was intubated; is that right? Do you recall?
A. Vaguely I can recall, but Fred, he was up at the head end and I was bandaging the -- because she started sweating and losing the vasofix for the cannula,

so I was bandaging the cannula in place.
Q. Okay. At that stage, when she was in the back of the ambulance you noticed that she was sweating?
A. Yes.
Q. That's why she lost the cannula that you had put in earlier?
A. She didn't lose the cannula, but she was losing the vasofix.
Q. That's the adhesive, is it?
A. It's just like a sticky plaster sort of thing.
Q. Would it be unusual for somebody to be sweating after cardiac arrest?
A. No, not really.
Q. Mr Coomber, I can say that the Inquiry is going to hear expert evidence from an expert paramedic, Mr Mark Faulkner, and I can say that he has concluded that the care given to Dawn by paramedics on that day was of a reasonable standard and he doesn't criticise the care provided, but I would like to ask you that by the time you were in the back of the ambulance and you noticed the sweating and the miosis, the respiratory arrest and the cardiac arrest, did you think at that stage that her symptoms might be caused by organophosphate poisoning?
A. No. No.

Q. Okay. At that stage at the end, what was your thinking as to the cause of her symptoms?
A. I was still going down a neurological event.
Q. I see. Thank you very much. I have no further questions for you, but there will be some questions.
A. Thank you.
LORD HUGHES: Thank you, Ms Pottle. Are there any -- yes, Mr Mansfield.

Questioned by MR MANSFIELD

MR MANSFIELD: Good afternoon. I represent the family of Dawn Sturgess. I just want to ask you about a document that was on the screen a moment ago. I don't ask for it to come up again. This is the debrief that we have just seen.

Can you help on this, that when you get back to the hospital with Dawn, can you recall how long after your arrival back at the hospital that the debrief is carried out and who carries it out?
A. No, I can't remember that one.
Q. Can you give us an idea of how long after you returned? Is it something that's done fairly soon?
A. It depends on the trauma.
Q. You mean how serious it is?
A. Yes.

Q. Right, well, this is pretty serious, so is the likelihood that those dealing with Dawn would want to know from you and obviously anyone else, all of you, the crew, as much as you could tell them about the circumstances?
A. They will only give us the information as they receive it back from the hospital.
LORD HUGHES: What's the purpose of the debrief, Mr Coomber, as you understand it?
A. It's sort of welfare really, keep you in the picture, to make sure you're okay and because of the seriousness of this, it just wanted to put everything together.
LORD HUGHES: Right, and is there always a debrief when you get back with a patient?
A. Not always, no.
LORD HUGHES: When there is -- well, was this one that same -- where are we -- morning, I think, or some time later in the day?
A. This was not -- no, it wasn't the same day .
LORD HUGHES: Not the same day?
A. No. I think you will find there's a date on the debrief.
MR MANSFIELD: 4th, at 6.30, apparently this one.
LORD HUGHES: 4 July?

MR MANSFIELD: Yes.

LORD HUGHES: So a few days later.

MR MANSFIELD: Yes.

LORD HUGHES: Thank you.

MR MANSFIELD: Does -- the reason I'm asking you is obviously information you had could have been important for the doctors. Does any doctor come and see you , or consultant come and see you, or registrar come and see you saying, you know, "What happened?" and so on, to get information because they're dealing with --

A. Again, that would be boiling down to the person who handed over and I believe it was Fred Thompson who handed over the patient.

Q. Right, so it's part of the handover.

A. Yes.

Q. Because we saw on the -- again I'm not asking for that sheet to come back. On that same sheet, the debrief sheet, that's where it also shows that Charlie Rowley had been saying and telling people that -- more than just you, two other people -- that Dawn had not taken drugs, but can you help any more about that?

A. It's just asked for a role of elimination. As Dawn collapsed, it's just a question asked to find out why she collapsed.

MR MANSFIELD: Yes, I understand. Yes, thank you

very much.

LORD HUGHES: Thank you, Mr Mansfield.

Mr Coomber, thank you very much for your help. There's no need to stay unless you wish to. Thank you.

Where do we go from there, Ms Pottle? Is that the end of the day?

MS POTTLE: Yes, that is the end of the witness testimony for today.

LORD HUGHES: Well, we will have to put up with that as best we can. Tomorrow morning at 10 o'clock please.

(3.57 pm)

(The Inquiry adjourned until 10.00 am on Friday, 18 October 2024)

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