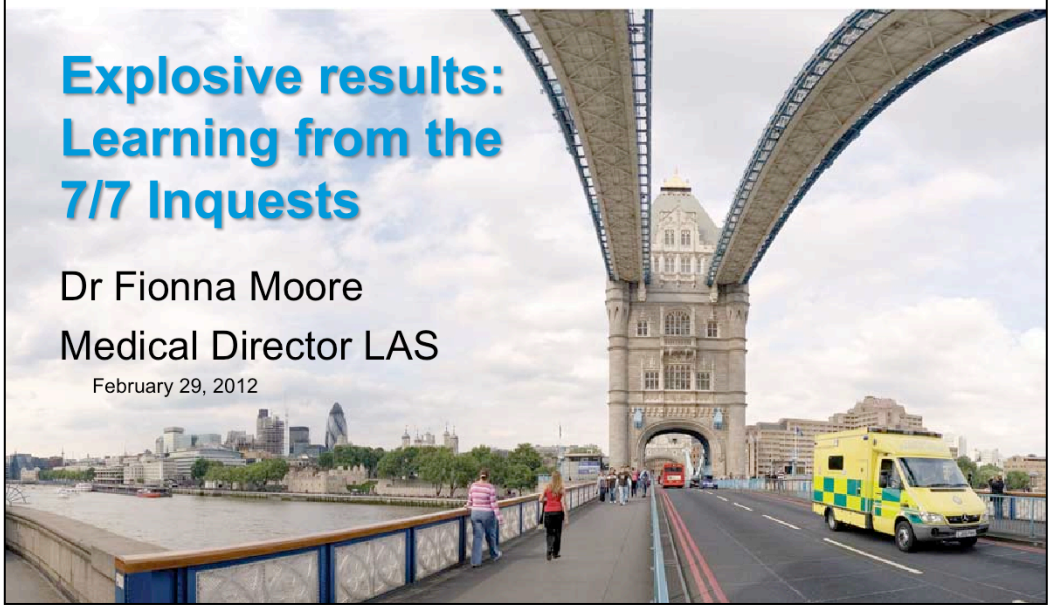
London Ambulance Service NHS
NHS Trust

Explosive results: Learning from the 7/7 Inquests

Dr Fionna Moore

Medical Director LAS

February 29, 2012



These are the locations of the three train based devices.

Kings Cross / Russell Sq was the deepest location

It took just under 13 minutes to be notified of all train incidents, reality actually shows that the 3 blasts on the underground all occurred at 08:50

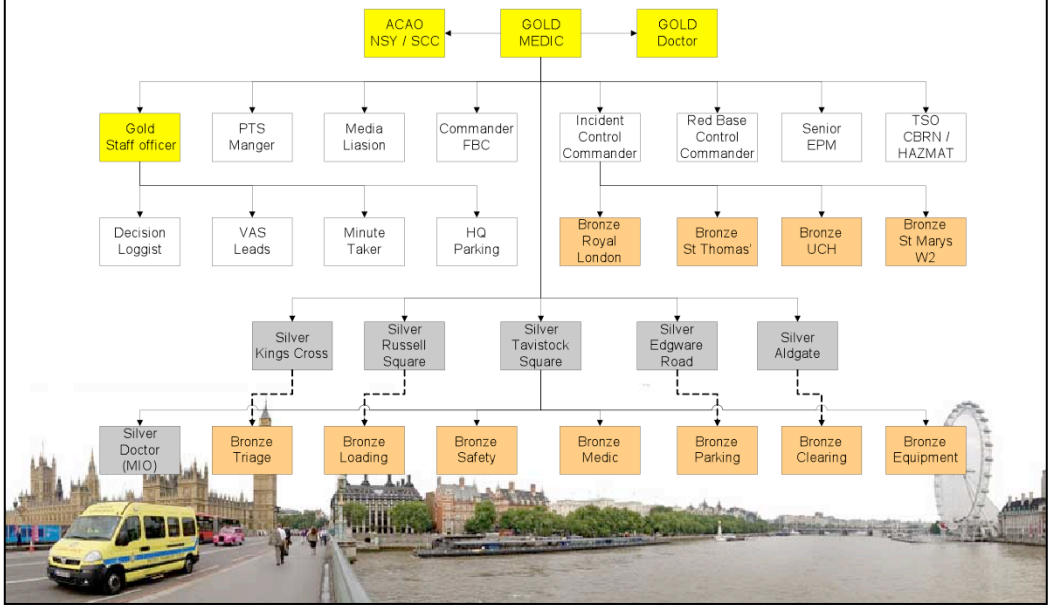

KING'S CROSS
WOBURN PLACE
ALDGATE EAST
RUSSELL SQ
LIVERPOOL ST
EDGWARE ROAD

Background (7th July 2005)

- 0850 hours, 3 explosions on the underground
- 0948 hours an explosion on a bus
- Reports of multiple locations, explosions and casualties (up to 10k)
- 191 ambulances and 46 response cars on duty
- 404 patients treated/conveyed
- 101 ambulances and 25 response cars deployed

Call taking upheld against the pressures of incoming

LAS Response



The is the organogram of the command and support structure that was in place on the day.

Yellow indicates the Gold level

White indicate the HQ based officers / manager

Grey indicates the AIO's at each site

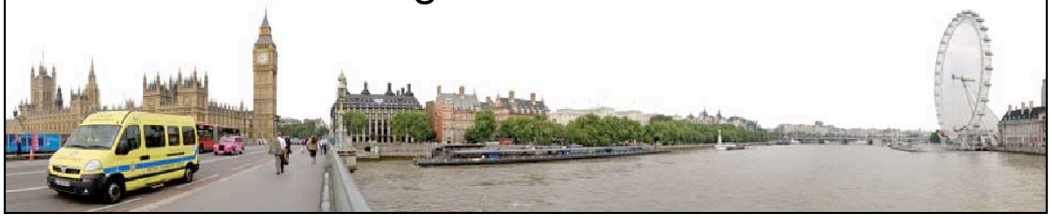
Orange indicates the Operational managers


ALDGATE STAT
AMBULANCE
LONDON
LONDON
LONDON AMBULANCE

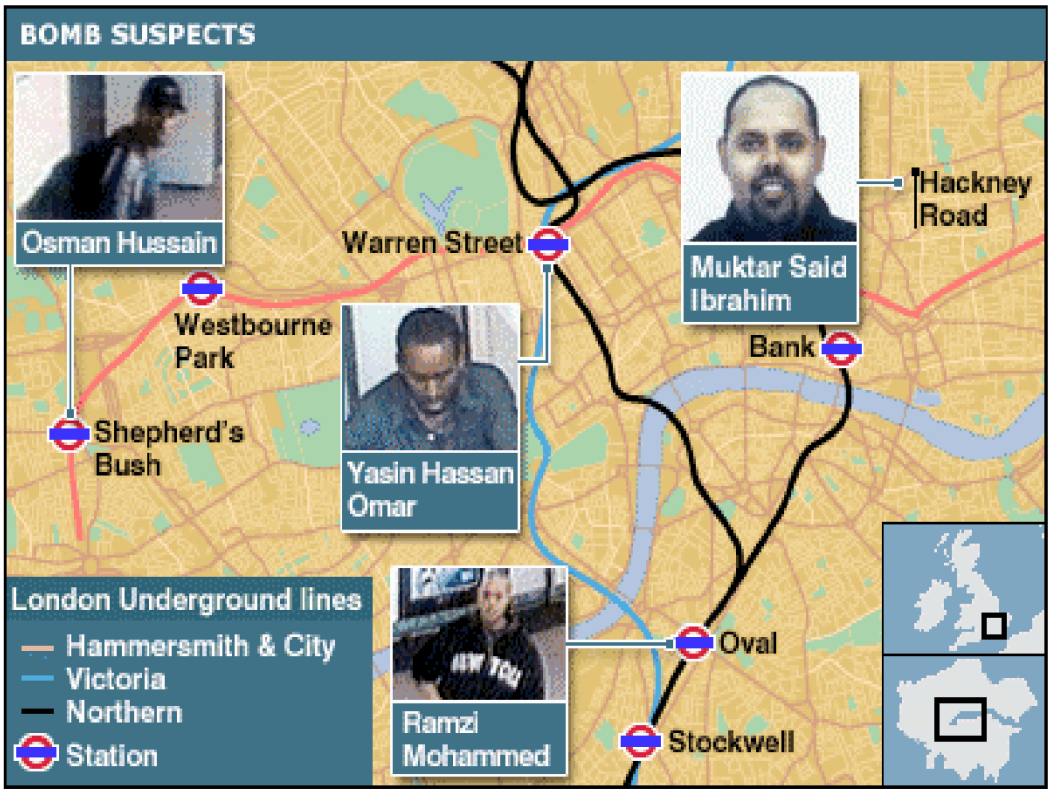

Evening Standard
CARNAGE
Over 40 dead, hundreds hurt as terrorist bombs hit London
Hospitals clear decks for victims
Major incident alert declared
Convoys of ambulances took away the victims for hours
King's Cross
The paramedic: Woman had lost a foot and she went into cardiac arrest
7/7

Before the Inquest

1. 21/7/2005 – further attempted attack
2. Return to normality
3. Internal and multi- agency debrief
4. National lessons identified
5. Greater London Assembly (GLA) enquiry
6. Media coverage



21/7 was a subsequent threat on London


BOMB SUSPECTS
Osman Hussain
Warren Street
Hackney Road
Muktar Said Ibrahim
Westbourne Park
Bank
Shepherd's Bush
Yasin Hassan Omar
London Underground lines
Hammersmith & City
Victoria
Northern
Station
Ramzi Mohammed
Oval
Stockwell

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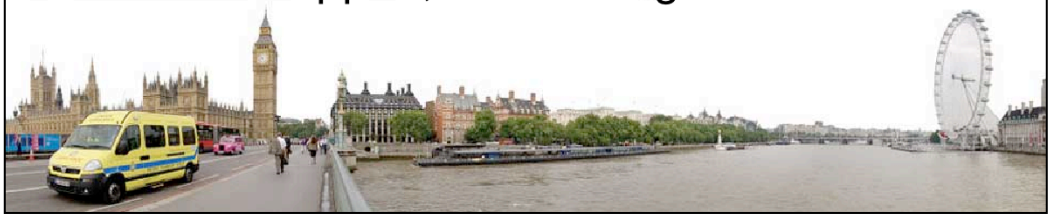
GLA enquiry; June 2006

- Chaired by Richard Barnes AM
- Critical of LAS
- Concerns over radios working
- Suggests LAS not completely open
- Recommendations

Reference was made to the recommendations from the Rule 43, these are being addressed by the relevant departments.

Preparing for the Inquest

1. Full time team appointed
2. Legal advice and team
3. Collation of papers for disclosure
4. Statements from witnesses
5. Scene conferences with staff
6. Staff support, counselling and welfare



The team was headed by an AOM, supported by a number of admin and ops staff.

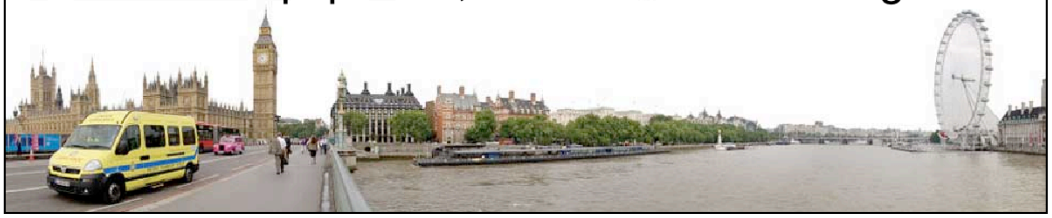
The team were further supported by individuals from the Trust's Legal and Communications Depts

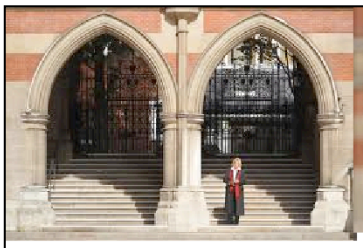
All papers / information relating to the incident was collated in a single location for it to be reviewed

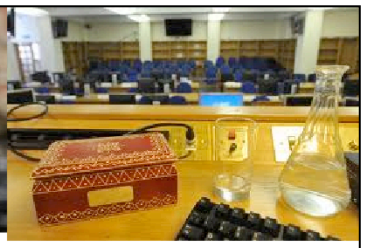
Statements from staff that attended were taken as required.

Pre Inquest Actions

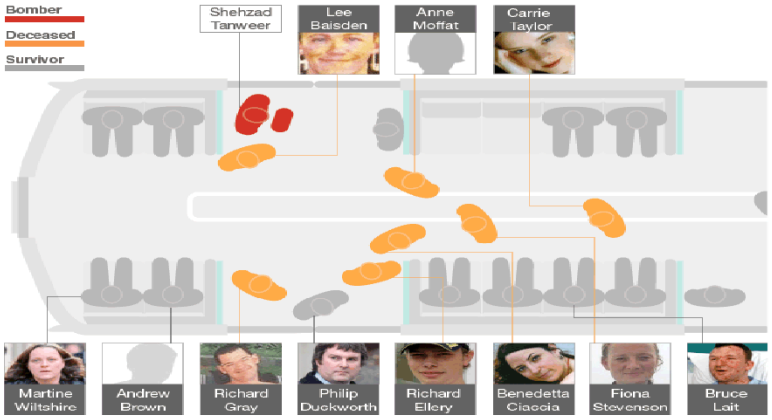
1. 250 point action plan
2. Commissioned Incident Control Room
3. Airwave radios (work on LUL)
4. Changes to Major Incident Plan
5. Testing and exercising multi sited incidents
6. New equipment, vehicles and training







6 years on – the Inquest



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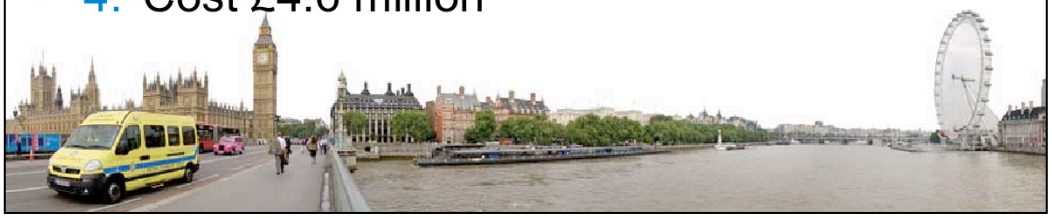
The Inquest process

1. 56 deaths to consider (52 members of the public)
2. Court of Appeal Judge acting as Coroner
3. Resumed 10th October 2010 – 5 years following bombings
4. Cost £4.6 million



As previously mentioned a number of staff members were required to give statements and evidence during the inquest

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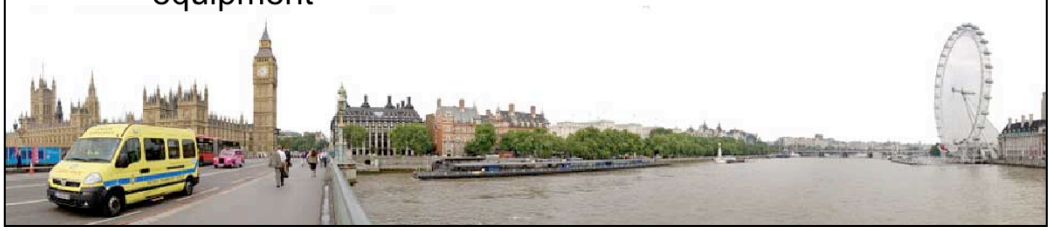
The Inquest process

1. Over 6 months of live evidence, 300 witnesses, 200 statements read
2. Public enquiry in all but name
3. Evidence available live to media
4. Criticism of emergency services

As previously mentioned a number of staff members were required to give statements and evidence during the inquest

LAS witnesses

1. Factual issues statement and evidence in court from LAS staff
2. Numerous Senior Managers and crew staff gave live evidence and faced cross examination
3. Command, control, operational and clinical views sought
4. LAS systems in place robustly questioned
5. Noted concerns of front line staff re: appropriate equipment

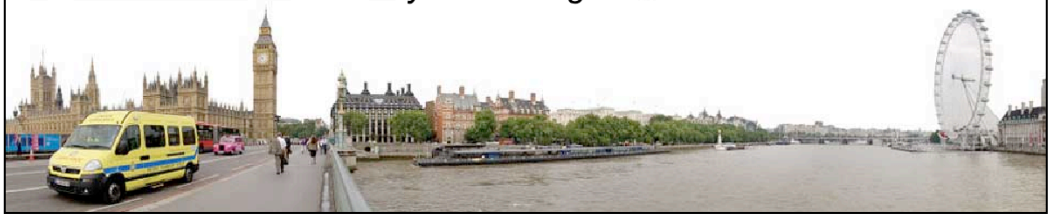


Outcome

52 innocent people were unlawfully killed

"I am satisfied on the balance of probabilities that each of them would have died whatever time the emergency services had reached and rescued them."

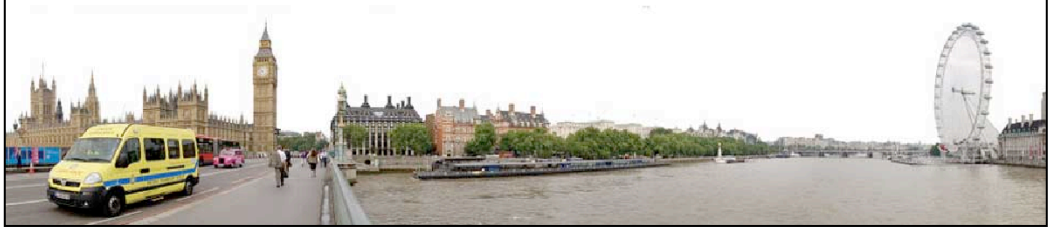
"I doubt that many lawyers will have been involved in such a consistently harrowing and difficult case"




The Royal Courts of Justice
gettyimages

Personal reflections

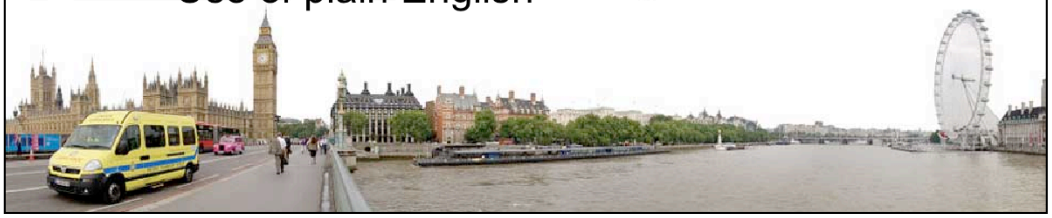
- Harrowing
- Opinion on survivability on each of 22 cases
- Immensely time consuming
- Preparation of Factual Issues statement
- Briefings from Legal Team
- Appearing in court – the LAS on trial.



Rule 43

1. 9 recommendations, 1 for LAS
2. Training, exercising and interoperability
3. Other key themes:

- Improving communication (radio and mobile), also including information processing, logging details
- Use of plain English



Recommendation 8

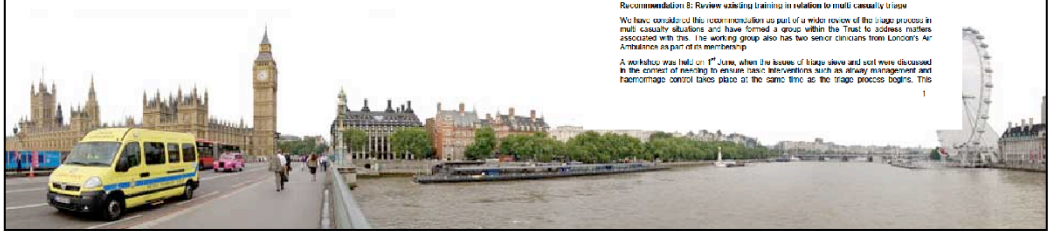
"I recommend that the LAS, together with the Barts and London NHS Trust (on behalf of the LAA) review existing training in relation to multi casualty triage (i.e. the process of triage sieve) in particular with respect to the role of basic medical intervention".

What did this mean for the families?

- Could more have survived?
- Should more patients have been treated?
- Was the triage process fair?
- What about covering the dead?

LAS response to rule 43

1. Welcomed forensic analysis of what we did
2. Helped identify new lessons
3. Use of plain English
4. Covering of dead bodies
5. Administration of drugs



London Ambulance Service NHS
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The Royal Courts of Justice
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29 June 2011

Dear Lady Justice Hallett

London Ambulance Service response to the Report under Rule 43 of the Coroners Rules 1984: London Bombings of 7th July 2005

Following the inquests into the deaths of the 52 members of the public on 7th July 2005 and your subsequent Rule 43 Report dated 6th May 2011, I write to advise you of the actions that the London Ambulance Service NHS Trust will be taking in regards to the recommendations made to us and to address other relevant issues contained within your report.

There was one specific recommendation made in regards to our Trust. This was recommendation 8 and set out *"I recommend that the LAS, together with the Barts and London NHS Trust (on behalf of the LAA) review existing training in relation to multi casualty triage (i.e. the process of triage alone) in particular with respect to the role of basic medical intervention".*

In addition, there were a number of areas in the report where you made reference to a desire for wider consideration, although you did not make formal recommendations in regards of these. I will discuss each of these in turn in this response so that you are aware of the actions we have taken or are planning to take.

Recommendation 8: Review existing training in relation to multi casualty triage

We have considered this recommendation as part of a wider review of the triage process in multi casualty situations and have formed a group within the Trust to address matters associated with this. The working group also has two senior clinicians from London's Air Ambulance as part of its membership.

A workshop was held on 1st June, where the issues of triage alone and sort more discussed in the context of needing to ensure basic interventions such as airway management and haemorrhage control takes place at the same time as the triage process begins. This

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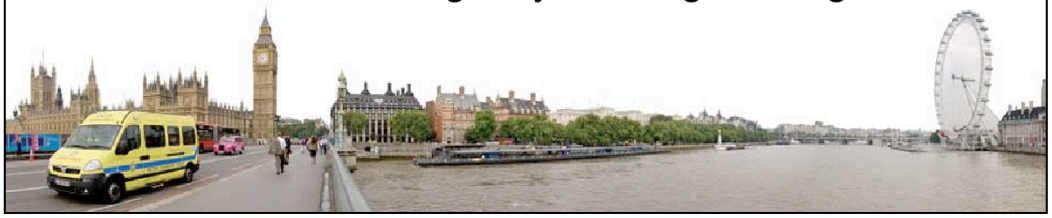
Lessons identified

- Changes to triage process to overtly require catastrophic haemorrhage control and airway management
- Introduction of 2 triage staff per site
- Enhanced multiagency working/training

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