Explosive results: Learning from the 7/7 Inquests

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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
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
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
CARNAGE
Over 40 dead, hundreds hurt as terrorist bombs hit London

Convoys of ambulances took away the victims for hours

The paramedic: Woman lost a foot and she went into cardiac arrest
**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
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.
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.

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**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
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
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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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”
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
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