

<p>1 Monday, 26 July 2021 2 (10.00 am) 3 (Proceedings delayed) 4 (10.18 am) 5 THE CHAIRMAN: Good morning, everybody. 6 I will just check whether Ms Murphy can see or hear 7 me. Ms Murphy? 8 MS MURPHY: Yes, good morning, I can indeed, thank you very 9 much. 10 THE CHAIRMAN: Not at all. 11 Yes. 12 MS BLACKWELL: May the witness be sworn, please? 13 THE CHAIRMAN: Certainly. 14 MS AMANDA DUNWELL (sworn) 15 Questions from MS BLACKWELL 16 MS BLACKWELL: Thank you. 17 Is your full name Amanda Dunwell? 18 A. It is. 19 Q. Were you previously known as Amanda Goodhead? 20 A. Yes. 21 Q. I think that is the name in which you made your witness 22 statement for this inquiry? 23 A. That's correct. 24 Q. Do you work for the London Ambulance Service NHS trust? 25 A. Yes.</p> <p style="text-align: center;">Page 1</p>	<p>1 Q. For how long have you worked there? 2 A. Now? 3 Q. Yes. 4 A. It has been nearly 16 years. 5 Q. Right. 6 As at 11 December 2015, what was your role within 7 the ambulance service? 8 A. I was a senior paramedic. 9 Q. For how long had you held that role at that time? 10 A. So the senior paramedic title, only a few months -- it 11 was a new role, which has since been closed, so I have 12 reverted back to being a paramedic, but I had been 13 a paramedic 10 years -- 14 Q. Right. 15 A. -- then. 16 Q. Thank you. 17 You were working on 11 December on an ambulance call 18 sign H102, alongside apprentice paramedic Sam Skillin, 19 is that right? 20 A. Correct. 21 Q. At 09.03 hours, whilst at Bounds Green ambulance 22 station, were you activated onto, is it CAD 1206? 23 A. That's correct. 24 Q. What does that stand for? 25 A. Computer aided dispatch, that is the job number.</p> <p style="text-align: center;">Page 2</p>
<p>1 Q. The information that you were given at that time was: 2 "30 year old male, gunshots, condition unclear at 3 present, location Olympus Grove, N22." 4 A. That's right. 5 Q. Did you then, together with Mr Skillin, make your way to 6 the location, as you were instructed, by your emergency 7 operations centre? 8 A. We did. We asked our -- well, the emergency operation 9 centre radioed us and asked us to hold back until they 10 knew that the police were on scene, so we that knew that 11 it was safe for us to arrive, so we proceeded not on 12 blue lights and sirens, just to get closer to the 13 location because we were quite near anyway, and then 14 once we were given the confirmation that the police were 15 on scene, proceeded to arrive on scene on blue lights. 16 Q. Is that procedure -- 17 A. Yes. 18 Q. -- that you wait until the police are on site? 19 A. That's right. 20 Q. Is that a usual procedure in circumstances like these? 21 A. Yes. 22 Q. All right. 23 You arrived on the scene at 09.12 hours, and were 24 you the first London Ambulance Service in attendance? 25 A. Yes.</p> <p style="text-align: center;">Page 3</p>	<p>1 Q. As you have indicated, there were police officers 2 present when you arrived? 3 A. That's right. 4 Q. Upon arrival, did you see the patient lying on the 5 tarmac with police officers standing around him? 6 A. Yes. As we have pulled up, next to the patient, there 7 was police officers standing around him and kneeling 8 next to him performing CPR. 9 Q. Right. How many officers were performing CPR? 10 A. I don't remember. 11 Q. Did you notice a large pool of blood to the patient's 12 right-hand side? 13 A. Yes, so there would have been one officer doing the 14 chest compressions, but there were others stood around 15 and another officer was holding an oxygen mask on to the 16 patient's face. 17 Q. Right, thank you. 18 In your witness statement, you say they had placed 19 100 per cent oxygen mask on his face that was attached 20 to an oxygen cylinder set to full-flow rate. 21 A. Yes. 22 Q. What is a 100 per cent oxygen mask? 23 A. So it is an oxygen mask that delivers between 10 and 24 15 litres of oxygen, it's usually used for patients who 25 are alive and breathing.</p> <p style="text-align: center;">Page 4</p>

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1 Q. That was switched to its maximum capacity?
 2 **A. Yes.**
 3 Q. You go on to describe that the patient was taking agonal
 4 breaths --
 5 **A. Yes.**
 6 Q. -- at a right of four per minute and was found to be in
 7 cardiac arrest with pulseless electrical activity.
 8 **A. That's right.**
 9 Q. What are agonal breaths?
 10 **A. So it is a brain-stem reflex in someone in cardiac**
 11 **arrest, they are not effective respirations, they are**
 12 **just gasping breaths of a dying person.**
 13 Q. You also describe that the patient appeared pale with
 14 peripheral cyanosis; what is that?
 15 **A. Essentially they looked pale and peripheral cyanosis is**
 16 **where your kind of fingertips start to look blue.**
 17 Q. Right.
 18 The police did not inform you of any of the events
 19 prior to the arrival other than the time of the shooting
 20 having been approximately 15 minutes before you arrived?
 21 **A. That's right.**
 22 Q. Yes.
 23 Did they tell you that he had a gunshot wound to his
 24 neck and a probable exit wound to his left wrist which
 25 had been dressed with a bandage?

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1 Q. Where would that take place?
 2 **A. From the inside of the lower leg.**
 3 Q. Was that successful?
 4 **A. No.**
 5 Q. Were you able to assess at the time why that was not
 6 successful?
 7 **A. So the drill that I was using was losing power on me**
 8 **trying to gain the access.**
 9 Q. Did you then attempt to gain intravenous access?
 10 **A. Yes.**
 11 Q. Was that successful?
 12 **A. No.**
 13 Q. Are you able to describe why that was unsuccessful?
 14 **A. So with someone who has lost that amount of blood, you**
 15 **get a circulatory collapse of the veins, which makes it**
 16 **very difficult to get IV access, which is why I went for**
 17 **the intraosseous first.**
 18 Q. Right. At that point, did incident response officer
 19 Carmel Walling arrive on scene?
 20 **A. Yes, so at the same time she arrived, my crewmate**
 21 **Sam Skillin indicated to me that he was having a problem**
 22 **with the airway, he was struggling to get the**
 23 **ventilation, the artificial ventilations to be**
 24 **successful. So as Carmel has arrived I have asked her**
 25 **to have a go at the IV access, because she is also**

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1 **A. Those were the words that they said to us.**
 2 Q. Okay.
 3 With the police officers performing chest
 4 compressions, alternating regularly, and Sam Skillin
 5 managing the airway with a bag valve mask initially,
 6 then a supraglottic airway you attempted to gain
 7 intraosseous access to the right proximal tibial
 8 tuberosity, I'm just going to ask you about those words,
 9 if I may.
 10 THE CHAIRMAN: I think supraglottal is above the tongue,
 11 correct?
 12 **A. So it sits above the trachea, it's an airway device that**
 13 **sits about the trachea.**
 14 THE CHAIRMAN: Thank you.
 15 MS BLACKWELL: Just to recap the types of treatment that
 16 were being provided to Mr Baker at this point, the
 17 police were performing chest compressions, Mr Skillin
 18 was managing the airway with a bag valve mask, what does
 19 that do?
 20 **A. So that delivers artificial ventilations.**
 21 Q. Right, then a supraglottic airway?
 22 **A. That's an airway device that sits just above the trachea**
 23 **to help provide more effective artificial ventilation.**
 24 Q. You attempted to gain intraosseous access; what is that?
 25 **A. That is access directly to the bone marrow.**

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1 **a paramedic and I have taken over the airway.**
 2 Q. Right.
 3 Did Sam Skillin identify to you that there was now
 4 reduced chest rise with the ventilations being given by
 5 him?
 6 **A. That's correct.**
 7 Q. You performed an endotracheal intubation?
 8 **A. Yes.**
 9 Q. What is that?
 10 **A. That is a plastic tube that goes directly into the**
 11 **trachea, goes through the vocal chords into the trachea**
 12 **and is a much better and more effective way of**
 13 **delivering artificial ventilation.**
 14 Q. Was the initial end tidal carbon dioxide reading
 15 1.1 kPa?
 16 **A. Yes.**
 17 Q. What did that indicate to you?
 18 **A. That there was a very low circulating blood volume.**
 19 **You can get a low end tidal CO 2 reading for various**
 20 **reasons, but if you know that the tube is in place,**
 21 **which you confirm by listening with a stethoscope to the**
 22 **chest, and you can hear good air entry, then it will**
 23 **have been the blood loss that he suffered.**
 24 Q. Right.
 25 I am just going to ask you about a detail that

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<p>1 appears in Mr Skillin's witness statement, we don't need 2 to display this, it is simply to confirm that at 3 paragraph 5 of his witness statement he says that 4 Mr Baker was unresponsive with a Glasgow Coma Score of 5 3. Could you explain to us what the Glasgow Coma Score 6 would be on the scale? 7 A. That is the lowest number there is, it means that there 8 is no motor response, there is no verbal response, there 9 is no eye movement. 10 Q. What does the scale run to? 11 A. 15. 12 Q. From 3 up to 15? 13 A. Yes. 14 Q. At about this time, did the Helicopter Emergency Medical 15 Service arrive? 16 A. Yes, as I intubated. 17 Q. As you were intubating, and I think you were also 18 present whilst the doctor from the Helicopter Emergency 19 Medical Service performed a thoracotomy, internal 20 cardiac massage and direct blood transfusion. 21 A. That's correct, I continued with the ventilations. 22 Q. Whilst that was all going on? 23 A. Yes. 24 Q. Thank you very much. I am not going to ask you any more 25 questions on that because, as you know, we are about to</p> <p style="text-align: center;">Page 9</p>	<p>1 hear from the doctor himself. 2 But I would just like to display for the sake of 3 completeness, IPC338, please, Mr Coates. 4 Page 2. 5 Thank you. 6 You will be grateful to hear I am not going to ask 7 you to take us through this, but could you explain to 8 us, please, what this document is and the manner in 9 which it is created? 10 A. So this is the patient report form that is written at 11 the time of the incident, whilst we were on scene. We 12 were in the ambulance. My crewmate, Sam Skillin, he has 13 written this. 14 Q. Right, and it looks as if there are a series of tick 15 boxes and then the second line up from the bottom, if we 16 look, sideways along, is that more of a running 17 commentary as to what has happened? 18 A. Yes. 19 MS BLACKWELL: All right, thank you very much. 20 Other than to put that into the record, sir, I don't 21 have any questions relating to it, nor do I have any 22 more questions for this witness. 23 THE CHAIRMAN: No, very good. 24 MS MURPHY: Sir, if I might. 25 THE CHAIRMAN: Yes, of course, Ms Murphy.</p> <p style="text-align: center;">Page 10</p>
<p>1 MS MURPHY: Ms Dunwell, on behalf of Jermaine's family, may 2 I extend to you and to your colleagues in the London 3 Ambulance Service their gratitude for your efforts that 4 morning. The family do fully appreciate the 5 circumstances must have been extremely difficult and 6 they are very grateful. 7 Thank you very much. 8 A. Thank you. 9 THE CHAIRMAN: You know, you may not be a senior by name but 10 you are certainly a senior by performance and thank you 11 very much indeed. 12 A. Thank you. 13 THE CHAIRMAN: The next witness is? 14 MS BLACKWELL: The next witness is Dr Danny Sharpe, sir. 15 THE CHAIRMAN: Thank you. 16 DR DANNY SHARPE (sworn) 17 Questions from MS BLACKWELL 18 THE CHAIRMAN: Yes. 19 MS BLACKWELL: Are you Dr Danny Sharpe? 20 A. I am. 21 Q. Dr Sharpe, I am going to ask you some questions about 22 your involvement in an emergency on 11 December 2015. 23 At that time, were you employed by the British Army? 24 A. Yes. 25 Q. Currently, as at that time, seconded to Bart's</p> <p style="text-align: center;">Page 11</p>	<p>1 Healthcare NHS trust and working with London's air 2 ambulance? 3 A. Yes, that's correct. 4 Q. What were your qualifications at that time, please? 5 A. In 2015, I had been qualified as a doctor for eight 6 years, at that point, I held membership of the Royal 7 College of Emerging Medicine and a diploma in immediate 8 medical care from the Royal College of Surgeons of 9 Edinburgh and I had deployed experience in Afghanistan 10 and East Africa at that point. 11 Q. Thank you. 12 Whilst on duty that day, were you tasked to 13 an incident at 0909 hours by the London Ambulance 14 Service? 15 A. Yes, that's correct. 16 Q. Thank you. 17 I am going to just display on the screen, so that we 18 can see, the background to the organisation, the witness 19 statement of Dr Thomas Peter Hurst, which is at LAA1, 20 and page 1. Can we highlight paragraph 2, please, 21 Mr Coates: 22 "London's air ambulance is a service operated by 23 London's air ambulance charity, Bart's Health NHS trust 24 and London Ambulance Service NHS trust. The service is 25 tasked by paramedics in the London Ambulance Service</p> <p style="text-align: center;">Page 12</p>

3 (Pages 9 to 12)

1 control room and responds by helicopter or fast-response
 2 car 24 hours a day. The service always sends a crew
 3 consisting of at least one doctor and one paramedic to
 4 every call. The doctors working for the service are all
 5 senior, being at least seven years post qualification.
 6 The paramedics are also senior, being at least five
 7 years post qualification. The accountability for
 8 patient care delivered by the LAA team is held by Bart's
 9 Health NHS trust. London's air ambulance responds
 10 almost exclusively to patients who have suffered major
 11 trauma (ie severe physical injury) and has pioneered
 12 a number of developments in the treatment of such
 13 patients."
 14 Could we now go to paragraph 6 of the same document.
 15 We are going to read from paragraph 6 to paragraph 9:
 16 "All injury-related 999 calls that are received by
 17 the London Ambulance Service control room are reviewed
 18 by a paramedic seconded to London's air ambulance, who
 19 has authority to launch the aircraft. Calls such as
 20 this meet our criteria for dispatch of a medical team,
 21 with a target time of seven minutes, and this was
 22 achieved.
 23 "London's air ambulance operates an MD902 aircraft
 24 which for Helicopter Emergency Medical Services (or
 25 HEMS) missions is always flown in a two-pilot

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1 Q. Were you conveyed from the place that the helicopter
 2 landed to the scene in a vehicle?
 3 **A. Yes, when we landed we were waved to by some police**
 4 **officers and we boarded an unmarked transit van, which**
 5 **was being driven by another police officer.**
 6 Q. You and who else?
 7 **A. The team consisted of myself, a London Ambulance Service**
 8 **paramedic, Clare Brady, and we also had a medical**
 9 **observer, Dr Ryan Newberry, who was visiting from the**
 10 **USA.**
 11 Q. The three of you travelled in the van to the scene?
 12 **A. Yes, I travelled in the front seat and my colleagues**
 13 **were in the rear.**
 14 Q. Thank you, when you arrived at the scene, at 09.22, you
 15 saw Jermaine Baker, and he was receiving treatment at
 16 the time when you arrived, is that right?
 17 **A. Yes, that's right.**
 18 Q. He was lying on his back and CPR was in progress, by the
 19 police and also the ambulance crew?
 20 **A. Yes, I have to admit I do not have a strong recollection**
 21 **of the first moment of arrival on scene, so I am not**
 22 **sure who was giving CPR but, yes, that was the general**
 23 **description of the scene.**
 24 Q. Thank you.
 25 Was your initial assessment that the patient,

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1 configuration. When operating from the helipad on the
 2 roof of the Royal London Hospital, fire safety is
 3 provided at all times by a team of two aviation
 4 firefighters."
 5 Thank you:
 6 "Our target time from activation to being airborne
 7 is two to four minutes and this was achieved. While
 8 responding to a HEMS mission, our aircraft receives air
 9 traffic priority and will be cleared to take a direct
 10 route to the incident site and to land at the captain's
 11 discretion. The overriding priority in selecting
 12 a landing site is the safety of the general public and
 13 the crew. In built-up areas of London, it is common to
 14 land a few hundred metres from the incident and to be
 15 conveyed that distance by the police, by other emergency
 16 services or to proceed on foot.
 17 "The exact landing site was not recorded but
 18 document LAA 34991/2 states that the landing was a class
 19 'C' landing, indicating that it was greater than
 20 200 metres from the incident and the medical team were
 21 conveyed to the scene by the Metropolitan Police
 22 Service. This process took a further three minutes."
 23 Thank you, you can take that down now.
 24 Does that accord with your recollection, Dr Sharpe?
 25 **A. Yes, it does.**

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1 Mr Baker, was in cardiac arrest?
 2 **A. Yes.**
 3 Q. You saw that he had sustained a large wound in the upper
 4 central chest, which was being compressed with a bandage
 5 and a Celox gauze?
 6 **A. Yes, that's right.**
 7 Q. Did you subsequently identify a second wound on the
 8 palmer side of the left wrist?
 9 **A. Yes.**
 10 Q. It may seem like an obvious question, what is the palmer
 11 side of the wrist?
 12 **A. The anatomical side of the wrist, according with the**
 13 **palm.**
 14 Q. Did you see superficial tissues had been removed and
 15 tendons were exposed in that area?
 16 **A. Yes, that's correct.**
 17 Q. Had the London Ambulance Service already intubated
 18 Mr Baker?
 19 **A. Yes, they had.**
 20 Q. By placing an endotracheal tube into his windpipe in
 21 order to breath for him?
 22 **A. That's correct.**
 23 Q. What did you then do?
 24 **A. So just to take you one step back, whilst we were on the**
 25 **way to the scene, I identified via the police driver**

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1 that a person had been shot and was in cardiac arrest.
 2 I then, through the window, spoke to my paramedic
 3 colleague and alerted her to the fact we were likely to
 4 need to perform this operation, the resuscitative
 5 thoracotomy, and my primary survey or my initial
 6 assessment confirmed that fact and so we proceeded to
 7 perform that operation.
 8 It is common in the role in which I was performing
 9 to keep some immediate equipment on your person,
 10 essentially in your pocket, you can begin that procedure
 11 with, whilst a more formal layout of surgical equipment
 12 is done by the paramedic, so I proceeded to open my
 13 personal kit and begin the procedure.
 14 Q. What did that entail?
 15 A. The procedure is done by making two holes in the chest
 16 wall, one on either side, and essentially connecting
 17 those holes using very, very sharp scissors and opening
 18 the chest in a linear fashion, horizontally across the
 19 chest.
 20 Then, at which point I am able to get hold of some
 21 rib spreaders from the paramedic, the chest is then
 22 formally opened and I can examine the internal contents
 23 of the chest and the heart specifically.
 24 Q. Right.
 25 Already when you are travelling to the scene, it

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1 penetrating injury by a small wound on the surface of
 2 the heart.
 3 Q. Yes.
 4 A. So in order to examine the surface of the heart, one
 5 must open that sack and remove the heart from within the
 6 sack.
 7 Unfortunately on this occasion, there was no injury
 8 to the heart and therefore removal of the heart from
 9 that sack did not reverse the problem.
 10 So that was complete, I observed the heart --
 11 physically observed the heart for a matter of seconds
 12 and originally there was no cardiac activity at all,
 13 there was no movement of the heart.
 14 Q. There was no movement of the heart?
 15 A. At that point, no. Within about 20 seconds, I witnessed
 16 one single beat of the heart, and so made the decision
 17 to continue escalating treatment and as such we started
 18 internal cardiac massage, and some blood was prepared
 19 for me to transfuse into Mr Baker.
 20 Q. That is what you did?
 21 A. Yes. And normally this would be given through a vein or
 22 occasionally into a bone through a needle into a bone,
 23 but on this occasion, I believe because Mr Baker had
 24 already lost so much blood, it was essentially
 25 impossible to put a needle into a vein.

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1 occurred to you that that was the most likely procedure
 2 that you were going to have to perform?
 3 A. Yes, so the idea of this procedure is that it is done as
 4 quickly as possible and the standard operating procedure
 5 suggests you really should be almost complete with the
 6 procedure by 90 seconds of arrival on the scene, so it
 7 is very quick decision making.
 8 The history of a gunshot wound and cardiac arrest,
 9 there is essentially no other likely treatment that was
 10 going to be successful, and so in order to progress that
 11 decision making more quickly, and allow everyone's
 12 mental model to be aligned, I started that process while
 13 we were on the way.
 14 Q. Once the chest had been opened, what did you do?
 15 A. So the next stage after the chest is opened is to
 16 examine the heart and it is commented in the notes that
 17 I have used the phrase "Deliver the heart". That
 18 essentially means to open the pericardial sack, which is
 19 a fine fibrous sack that sits around the heart and to
 20 remove the heart from inside that sack.
 21 The reason for doing so is the primary goal of this
 22 procedure to is relieve a -- what is described as
 23 tamponade, which is a tight fluid-filled pressure around
 24 the heart, stopping the mechanical beat of the heart
 25 from happening, that is normally caused particularly in

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1 So I took the step of inserting that needle and tube
 2 directly into his heart and transfusing the blood
 3 directly into the heart.
 4 Q. What, if any, reaction was there to that treatment?
 5 A. Unfortunately, although I could feel that the blood
 6 inside the heart was filling, there was no improvement
 7 in his clinical condition at all, and I examined him
 8 concurrently and found a -- what I believed to be
 9 a bullet track in an area of his chest which I could
 10 repair. It is not the function of this procedure to do
 11 extensive thoracic surgery, it's simply really to
 12 reverse any immediate problems.
 13 Q. No.
 14 A. And given the lack of any clinical improvement and
 15 a wound that I could not repair, I decided to cease
 16 treatment at that point.
 17 Q. Despite your efforts, you were unable to resuscitate
 18 Mr Baker and his life was pronounced extinct at 09.39?
 19 A. That's correct.
 20 Q. I am just going to finally display a document which is
 21 headed "HEMS mission report". You will have seen this,
 22 Dr Sharpe, it is at LAA3, please.
 23 Is this the report that was generated following --
 24 A. Yes -- sorry.
 25 Q. I was just going to ask you when this would have been

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1 generated, at the time or subsequent to your treatment?
 2 **A. This would be subsequent, the document that is generated**
 3 **at the time is under pamphlet 6.**
 4 Q. Yes, and we can display that too, I think. It is LAA4,
 5 please.
 6 Thank you.
 7 The document on the right-hand side of our screen,
 8 is that completed contemporaneously?
 9 **A. Correct, yes.**
 10 Q. By you?
 11 **A. Yes.**
 12 Q. Thank you.
 13 Then the report, the printed report on the left-hand
 14 side, is a subsequent record that shows us the time that
 15 you were called out, a description of the scene, the
 16 history and the primary survey?
 17 **A. Correct.**
 18 MS BLACKWELL: Thank you very much. We can take those down,
 19 please.
 20 Sir, that completes my questions of Dr Sharpe, do
 21 you have any questions?
 22 THE CHAIRMAN: I have no questions.
 23 MS BLACKWELL: I think Ms Murphy may have something to say.
 24 THE CHAIRMAN: I think she may.
 25 Ms Murphy.

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1 the afternoon of 14 December 2015, by Superintendent
 2 Simon Dobinson, and Police Sergeant Mick Burke, because
 3 she was an experienced family liaison officer. She did
 4 not know W80 prior to this.
 5 Her primary responsibility was to W80's partner.
 6 Whilst W80 was missing, she tasked Temporary Chief
 7 Inspector Paul Thornhill to search for W80 and/or his
 8 vehicle at the MPS training centre at a location and any
 9 MPS ranges, this search had a negative result.
 10 She handed over her role to Temporary Superintendent
 11 Chris Nelson on the afternoon of 15 December 2015, but
 12 maintained an overarching view of W80 and his partner's
 13 welfare.
 14 DCC Gyford learned that the IPCC had shown post
 15 mortem examination photographs to W80 during his police
 16 interview and that, as a result, W80 had suffered
 17 distress. She escalated this to the DPS who sought
 18 advice from the National Crime Academy. This practice
 19 is not thought to be in line with correct procedures.
 20 In her previous experience, including time as
 21 a detective in the murder squad, she had never been
 22 presented with circumstances where it was appropriate to
 23 show post mortem photographs to a suspect in a major
 24 inquiry.
 25 THE CHAIRMAN: Are we to know why it happened in this case?

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1 MS MURPHY: Thank you very much, sir. Dr Sharpe, if I may
 2 please extend the gratitude of Jermaine's family for
 3 your efforts and those of your colleagues in London's
 4 air ambulance. The efforts you made that morning, it is
 5 a reassurance to the family that nothing further could
 6 have been done.
 7 Thank you very much indeed.
 8 **A. Thank you.**
 9 THE CHAIRMAN: If I may say so, Doctor, it is a reassurance
 10 to the entire community.
 11 Thank you very much.
 12 MS BLACKWELL: May this witness be released please?
 13 THE CHAIRMAN: Of course.
 14 Thank you very much indeed.
 15 **A. Thank you, sir.**
 16 MR MOSS: Sir, there is now a small amount of evidence to
 17 read into the record, which is two witnesses that relate
 18 to what you have heard last week and a report of one
 19 witness for this week.
 20 Evidence of MS JANE GYFORD (read)
 21 MR MOSS: In relation to last week, I am going to read
 22 a summary, first of all, from the evidence of
 23 DCC Jane Gyford. DCC Jane Gyford acted as the senior
 24 leadership team lead for the post-incident procedure.
 25 She was asked to attend the home address of W80 on

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1 MR MOSS: Not from the evidence of that officer, sir. There
 2 may be a witness to whom we can put that question but
 3 not --
 4 THE CHAIRMAN: Because in many years' experience in criminal
 5 cases, which I know is shared by certainly Ms Blackwell
 6 and possibly others in this inquiry, unless there is
 7 an issue to which this line of questioning goes,
 8 photographs of this kind are no more shown to suspects
 9 than they are to juries, for the best of all reasons.
 10 In America, the United States of America, the more
 11 graphic the better. I like to think that in this
 12 country we concentrate on what matters and not what
 13 shocks.
 14 MR MOSS: It seems, sir, that your experience on that side
 15 of it is the same as the experience of DCC Gyford, who
 16 has not heard of this either.
 17 THE CHAIRMAN: Thank you.
 18 Evidence of MS JUDY LEVOIR (read)
 19 MR MOSS: Sir, I next turn to the evidence of Detective
 20 Sergeant Judy Levoir, and again I will read a short
 21 gist:
 22 "the detective sergeant, together with DC
 23 Hepplewhite, attended the home address of W80 on
 24 15 December to conduct enquiries in relation to the
 25 whereabouts of W80. She returned on 16 December with DC

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<p>1 Hepplewhite and DC Stewart. They were present when W80 2 called the home phone and provided his location. 3 Detective Sergeant Levoir travelled with another officer 4 to pick up W80. They were joined by another car from 5 SCO19, DC Hepplewhite remained on the phone with W80 to 6 keep them updated on his location. When they reached 7 W80, he was placed into the SCO19 vehicle and taken 8 home. When he reached his home, he was treated for 9 an injury to his wrist." 10 Evidence of PROFESSOR RICHARD M LYON (read) 11 MR MOSS: Sir, then carrying on from the evidence that you 12 have heard this morning, I will read a few paragraphs 13 from the report of Professor Richard M Lyon. 14 Professor Richard Lyon is a consultant in emergency 15 medicine and pre-hospital care and he was instructed by 16 the inquiry to provide opinion on the care given to 17 Jermaine Baker in Bracknell Close and to comment on 18 whether Jermaine Baker's injuries were survivable. 19 Sir, I will read a few paragraphs. 20 Paragraph 2.1 and then I will read from 21 paragraph 2.3 to 5.1. 22 2.1 first, and it's headed "Summary": 23 "In my opinion, the MPS police officers and police 24 medics adopted a systematic approach to caring for 25 Mr Baker. There was evidence that they exposed him in</p> <p style="text-align: center;">Page 25</p>	<p>1 order to conduct a thorough clinical examination and 2 assessment. An attempt was made to optimise the 3 patient's airway using a standard oropharyngeal adjunct 4 and oxygen. A step wise approach was taken to managing 5 Mr Baker's chest wound and the police medics had 6 appropriate first response equipment, including chest 7 seals and haemostatic dressings. In my opinion, the 8 care provided by the police officers on scene was 9 appropriate and of the standard expected of serving 10 firearms police officers in 2015. 11 "In my opinion, and experience, the MPS police 12 firearms service was one of the first to use specialist 13 medical equipment in the form of haemostatic dressings 14 and chest seals. The first response medical equipment 15 used in this case should be commended. 16 "In my opinion, from the injuries that Mr Baker had 17 sustained, it would not have been possible to control 18 the degree of haemorrhage purely with external 19 compression and it would not have been possible to 20 prevent his death once these injuries had been 21 sustained." 22 Sir, I then pick it up at 2.3 under the heading of 23 "Pathophysiology": 24 "The gunshot wound sustained by Mr Baker caused 25 a catastrophic injury to his vasculature in his neck,</p> <p style="text-align: center;">Page 26</p>
<p>1 resulting in catastrophic haemorrhage. The wound 2 sustained on the wrist would have contributed to this. 3 The severe haemorrhage would have resulted in Mr Baker 4 rapidly losing consciousness. The end tidal carbon 5 dioxide level at the time of intubation indicated that 6 Mr Baker had already lost a significant amount of his 7 circulating volume of blood at the time of intubation. 8 "Mr Baker then suffered a cardiac arrest as a result 9 of hypovolemia from catastrophic haemorrhage." 10 2.4, "Overall medical response": 11 "In my opinion the MPS police officers administered 12 immediate high quality first aid care, provided CPR as 13 well as applying direct pressure to the wound site and 14 used appropriate medical equipment. The response of LAS 15 was rapid, with an ambulance being dispatched within 16 three minutes of the shooting and arriving on scene 17 within 10 minutes. The response of London's air 18 ambulance HEMS team was rapid. The MPS specifically 19 requested HEMS attend the incident. HEMS were activated 20 seven minutes after the shooting and were on scene 21 within 22 minutes of the shooting. 22 2.5, "Immediate first aid provided by MPS": 23 "In my opinion, based on the material provided to me 24 by the inquiry, the first aid assistance provided to 25 Mr Baker by MPS police officers on the scene was</p> <p style="text-align: center;">Page 27</p>	<p>1 appropriate and was of an expected standard of serving 2 police officers at the time of the incident. 3 "In my experience from 2015, police firearms medics 4 were trained in advanced first aid techniques and 5 equipped with emergency medical equipment, such as 6 tourniquets, haemostatic dressings and chest seals. In 7 my opinion there was clear evidence of a structured 8 approach to the first aid given by MPS police officers 9 to Mr Baker. 10 "In my opinion, Mr Baker suffered a catastrophic 11 penetrating injury to major vessels in his neck as 12 a result of a gunshot wound. This would have led to 13 immediate catastrophic haemorrhage, leading to a rapid 14 loss of consciousness and cardiac arrest within a matter 15 of a few minutes prior to the arrival of emergency 16 medical services. 17 "In my opinion, the police officers performed to 18 a high standard of emergency medical care, following the 19 gunshot injury they immediately placed Mr Baker on the 20 floor and removed his clothing in order to perform 21 a full examination. An officer put immediate pressure 22 on the wound with a gloved hand in an attempt to control 23 the bleeding. The officers should be particularly 24 commended for a thorough patient examination, including 25 looking on Mr Baker's back for an exit wound. The</p> <p style="text-align: center;">Page 28</p>

7 (Pages 25 to 28)

1 medical response pack was immediately requested.
 2 An attempt was made to control the bleeding from the
 3 very first opportunity by putting direct pressure on the
 4 wound with tactical gloves. When medical equipment was
 5 brought to the patient within a very short space of
 6 time, attempts were made to control the bleeding using
 7 both chest seals and haemostatic gauze. Haemostatic
 8 gauze is a military-grade dressing, containing
 9 a chemical that promotes blood clotting. In my opinion,
 10 due to the catastrophic bleeding encountered from the
 11 neck it would not have been possible to completely
 12 control the haemorrhage. In my opinion, the fact that
 13 the police officers were equipped with haemostatic
 14 gauze, used it quickly and applied continuous direct
 15 pressure to the wound gave Mr Baker the best possible
 16 chance of survival. The police officers should also be
 17 commended for undertaking a thorough examination, also
 18 finding the wound on Mr Baker's wrist and treating this
 19 appropriately with a trauma dressing.
 20 "In my opinion, Mr Baker's rapidly entered a state
 21 of traumatic cardiac arrest as a result of hypovolemia
 22 from catastrophic haemorrhage.
 23 "The police officers correctly recognised the
 24 deterioration in clinical condition and commenced
 25 cardiopulmonary resuscitation, CPR. They should also be

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1 as a gunshot is an indication for pre-hospital
 2 resuscitative thoracotomy, this procedure can only be
 3 provided by highly trained doctors working within
 4 a high-performing enhanced care team, such as the
 5 London's air ambulance. Performing a resuscitative
 6 thoracotomy on scene was the only chance that Mr Baker
 7 would have had of surviving this incident.
 8 "HEMS also gave Mr Baker a pre-hospital blood
 9 transfusion at the scene in an attempt to replace the
 10 blood that he had lost, pre-hospital blood transfusion
 11 is only available in certain regions of the UK and
 12 Mr Baker's chance of survival would have been increased
 13 by having this available.
 14 "Survival from traumatic cardiac arrest is known to
 15 be very poor. The highest reported survival rate in
 16 patients undergoing pre-hospital resuscitative
 17 thoracotomy from a case series published in 2011 in
 18 London was 18 per cent.
 19 "However, all of these survivors had cardiac
 20 tamponade, a condition where blood accumulates in the
 21 pericardial sack around the heart and prevents it from
 22 beating. This condition can be effectively treated by
 23 resuscitative thoracotomy. Mr Baker did not have
 24 a cardiac tamponade, he was exsanguinated.
 25 Exsanguination is associated with a particularly poor

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1 commended for continuing to apply direct pressure to the
 2 wounds whilst administering CPR. In my opinion, there
 3 is noting further the police officers could have done to
 4 prevent Mr Baker from going into traumatic cardiac
 5 arrest."
 6 Section 3, "Care provided by the London Ambulance
 7 Service":
 8 "In my opinion, the medical care provided by the
 9 London Ambulance Service paramedics was appropriate and
 10 of an expected standard of care. LAS responded rapidly,
 11 arriving on scene within 10 minutes of the initial
 12 request. They immediately recognised Mr Baker was in
 13 traumatic cardiac arrest on their arrival and continued
 14 with appropriate resuscitation. They successfully
 15 intubated Mr Baker and ventilated him.
 16 "In my opinion and experience, it is not uncommon to
 17 find gaining intravenous access difficult, particularly
 18 in a setting of traumatic cardiac arrest."
 19 Section 4, "Care provided by London's air ambulance
 20 Helicopter Emergency Medical Service":
 21 "In my opinion, the care provided by the London's
 22 air ambulance HEMS team was appropriate and of
 23 an expected standard. Mr Baker was in a state of
 24 traumatic cardiac arrest on arrival of HEMS. Witnessed
 25 traumatic cardiac arrest from a penetrating injury such

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1 survival rate. In a case series from 2017, which
 2 included gunshot wounds, the overall survival rate was
 3 3 per cent of the stabbing victims but none of the
 4 gunshot wounds victims undergoing pre-hospital
 5 resuscitative thoracotomy survived. In my experience
 6 and review of the medical literature, the survival rate
 7 for a patient who had received a gunshot to the chest,
 8 had an out-of-hospital cardiac arrest from hypovolemia
 9 and who underwent pre-hospital thoracotomy is less than
 10 1 per cent.
 11 "In my opinion, every attempt was made to
 12 successfully resuscitate Mr Baker, but his injuries were
 13 catastrophic and there was nothing that could have been
 14 done to prevent his death. In my experience, based on
 15 research available in 2015, the survival rate for
 16 patients who underwent a pre-hospital resuscitative
 17 thoracotomy following a gunshot would be less than
 18 1 per cent.
 19 "It should be noted that the majority of
 20 pre-hospital resuscitative thoracotomy survivors were
 21 from penetrating trauma from knife wounds rather than
 22 gunshot wounds. The survival rate from pre-hospital
 23 resuscitative thoracotomy has not significantly changed
 24 since 2015."
 25 Sir, finally under the heading "Recommendations"

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1 I read this paragraph, 5.1:
 2 "The only single recommendation I would make
 3 regarding emergency care and treatment of Mr Baker would
 4 be in relation to the attempted use of chest seals.
 5 Whilst chest seals have an important role to play in the
 6 treatment of penetrating chest trauma, I would recommend
 7 that police medic training emphasises that in cases of
 8 catastrophic external torso haemorrhage, the immediate
 9 action is to apply direct pressure and then progress
 10 directly to using haemostatic gauze. The application of
 11 a chest seal will not stop catastrophic haemorrhage.
 12 Continued direct pressure and the use of trauma and
 13 haemostatic dressings are the primary treatments. Chest
 14 seals should only be used where there is no evidence of
 15 ongoing catastrophic haemorrhage. In my opinion,
 16 earlier use of haemostatic dressings would not have
 17 changed Mr Baker's outcome."
 18 Sir, we are now after that up to date on the
 19 evidence to read.
 20 THE CHAIRMAN: I know that there are no members of the
 21 family present today, and it may be that even if Covid
 22 had not intervened they would have understandably chosen
 23 to absent themselves but through Ms Murphy they will be,
 24 I know, heartened insofar as they could possibly be by
 25 the entirety of the evidence which we have heard both

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1 live and read this morning.
 2 MR MOSS: Sir, I do know that there is a number of family
 3 members who are present virtually, even if they are not
 4 all present.
 5 THE CHAIRMAN: Very good. I am glad to hear that they will
 6 have in turn been able to hear what you have said.
 7 Thank you very much.
 8 Thank you Ms Murphy.
 9 MS MURPHY: Thank you, sir.
 10 THE CHAIRMAN: I believe uncharacteristically in the life of
 11 this inquiry, that is as far as we can go today?
 12 MR MOSS: Sir, yes, it is. That is the end of business for
 13 today.
 14 THE CHAIRMAN: Were it a Thursday or a Friday, that would be
 15 greeted with even more glee than it will be, but we will
 16 resume tomorrow at 10.00.
 17 MR MOSS: Yes.
 18 THE CHAIRMAN: I think we have a rather fuller day.
 19 MR MOSS: Slightly fuller, yes.
 20 THE CHAIRMAN: Thank you very much indeed.
 21 (11.01 am)
 22 (The Inquiry adjourned until 10.00 am the following day)
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 3 I N D E X
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 5 MS AMANDA DUNWELL (sworn)1
 6 Questions from MS BLACKWELL1
 7 DR DANNY SHARPE (sworn)11
 8 Questions from MS BLACKWELL11
 9 Evidence of MS JANE GYFORD (read)22
 10 Evidence of MS JUDY LEVOIR (read)24
 11 Evidence of PROFESSOR RICHARD M LYON25
 (read)
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