Monday, 26 July 2021
(10.00 am)
(Proceedings delayed)
(10.18 am)
THE CHAIRMAN: Good morning, everybody.
I will just check whether Ms Murphy can see or hear me. Ms Murphy?
MS MURPHY: Yes, good morning, I can indeed, thank you very much.
THE CHAIRMAN: Not at all.
Yes.
MS BLACKWELL: May the witness be sworn, please?
THE CHAIRMAN: Certainly.
MS AMANDA DUNWELL (sworn)
Questions from MS BLACKWELL
MS BLACKWELL: Thank you.
Is your full name Amanda Dunwell?
**A. It is.**
Q. Were you previously known as Amanda Goodhead?
**A. Yes.**
Q. I think that is the name in which you made your witness statement for this inquiry?
**A. That's correct.**
Q. Do you work for the London Ambulance Service NHS trust?
**A. Yes.**



Q. For how long have you worked there?
**A. Now?**
Q. Yes.
**A. It has been nearly 16 years.**
Q. Right.
As at 11 December 2015, what was your role within the ambulance service?
**A. I was a senior paramedic.**
Q. For how long had you held that role at that time?
**A. So the senior paramedic title, only a few months -- it was a new role, which has since been closed, so I have reverted back to being a paramedic, but I had been a paramedic 10 years --**
Q. Right.
**A. -- then.**
Q. Thank you.
You were working on 11 December on an ambulance call sign H102, alongside apprentice paramedic Sam Skillin, is that right?
**A. Correct.**
Q. At 09.03 hours, whilst at Bounds Green ambulance station, were you activated onto, is it CAD 1206?
**A. That's correct.**
Q. What does that stand for?
**A. Computer aided dispatch, that is the job number.**



Q. The information that you were given at that time was:
"30 year old male, gunshots, condition unclear at present, location Olympus Grove, N22."
**A. That's right.**
Q. Did you then, together with Mr Skillin, make your way to the location, as you were instructed, by your emergency operations centre?
**A. We did. We asked our -- well, the emergency operation centre radioed us and asked us to hold back until they knew that the police were on scene, so we that knew that it was safe for us to arrive, so we proceeded not on blue lights and sirens, just to get closer to the location because we were quite near anyway, and then once we were given the confirmation that the police were on scene, proceeded to arrive on scene on blue lights.**
Q. Is that procedure --
**A. Yes.**
Q. -- that you wait until the police are on site?
**A. That's right.**
Q. Is that a usual procedure in circumstances like these?
**A. Yes.**
Q. All right.
You arrived on the scene at 09.12 hours, and were you the first London Ambulance Service in attendance?
**A. Yes.**



Q. As you have indicated, there were police officers present when you arrived?
**A. That's right.**
Q. Upon arrival, did you see the patient lying on the tarmac with police officers standing around him?
**A. Yes. As we have pulled up, next to the patient, there was police officers standing around him and kneeling next to him performing CPR.**
Q. Right. How many officers were performing CPR?
**A. I don't remember.**
Q. Did you notice a large pool of blood to the patient's right-hand side?
**A. Yes, so there would have been one officer doing the chest compressions, but there were others stood around and another officer was holding an oxygen mask on to the patient's face.**
Q. Right, thank you.
In your witness statement, you say they had placed 100 per cent oxygen mask on his face that was attached to an oxygen cylinder set to full-flow rate.
**A. Yes.**
Q. What is a 100 per cent oxygen mask?
**A. So it is an oxygen mask that delivers between 10 and 15 litres of oxygen, it's usually used for patients who are alive and breathing.**

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



**A. Those were the words that they said to us.**
Q. Okay.
With the police officers performing chest compressions, alternating regularly, and Sam Skillin managing the airway with a bag valve mask initially, then a supraglottic airway you attempted to gain intraosseous access to the right proximal tibial tuberosity, I'm just going to ask you about those words, if I may.
THE CHAIRMAN: I think supraglottal is above the tongue, correct?
**A. So it sits above the trachea, it's an airway device that sits about the trachea.**
THE CHAIRMAN: Thank you.
MS BLACKWELL: Just to recap the types of treatment that were being provided to Mr Baker at this point, the police were performing chest compressions, Mr Skillin was managing the airway with a bag valve mask, what does that do?
**A. So that delivers artificial ventilations.**
Q. Right, then a supraglottic airway?
**A. That's an airway device that sits just above the trachea to helps provide more effective artificial ventilation.**
Q. You attempted to gain intraosseous access; what is that?
**A. That is access directly to the bone marrow.**



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



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

appears in Mr Skillin's witness statement, we don't need to display this, it is simply to confirm that at paragraph 5 of his witness statement he says that Mr Baker was unresponsive with a Glasgow Coma Score of 3. Could you explain to us what the Glasgow Coma Score would be on the scale?

**A. That is the lowest number there is, it means that there is no motor response, there is no verbal response, there is no eye movement.**

Q. What does the scale run to?

**A. 15.**

Q. From 3 up to 15?

**A. Yes.**

Q. At about this time, did the Helicopter Emergency Medical Service arrive?

**A. Yes, as I intubated.**

Q. As you were intubating, and I think you were also present whilst the doctor from the Helicopter Emergency Medical Service performed a thoracotomy, internal cardiac massage and direct blood transfusion.

**A. That's correct, I continued with the ventilations.**

Q. Whilst that was all going on?

**A. Yes.**

Q. Thank you very much. I am not going to ask you any more questions on that because, as you know, we are about to



hear from the doctor himself.

But I would just like to display for the sake of completeness, IPC338, please, Mr Coates.

Page 2.

Thank you.

You will be grateful to hear I am not going to ask you to take us through this, but could you explain to us, please, what this document is and the manner in which it is created?

**A. So this is the patient report form that is written at the time of the incident, whilst we were on scene. We were in the ambulance. My crewmate, Sam Skillin, he has written this.**

Q. Right, and it looks as if there are a series of tick boxes and then the second line up from the bottom, if we look, sideways along, is that more of a running commentary as to what has happened?

**A. Yes.**

MS BLACKWELL: All right, thank you very much.

Other than to put that into the record, sir, I don't have any questions relating to it, nor do I have any more questions for this witness.

THE CHAIRMAN: No, very good.

MS MURPHY: Sir, if I might.

THE CHAIRMAN: Yes, of course, Ms Murphy.



MS MURPHY: Ms Dunwell, on behalf of Jermaine's family, may I extend to you and to your colleagues in the London Ambulance Service their gratitude for your efforts that morning. The family do fully appreciate the circumstances must have been extremely difficult and they are very grateful.

Thank you very much.

**A. Thank you.**

THE CHAIRMAN: You know, you may not be a senior by name but you are certainly a senior by performance and thank you very much indeed.

**A. Thank you.**

THE CHAIRMAN: The next witness is?

MS BLACKWELL: The next witness is Dr Danny Sharpe, sir.

THE CHAIRMAN: Thank you.

DR DANNY SHARPE (sworn)

Questions from MS BLACKWELL

THE CHAIRMAN: Yes.

MS BLACKWELL: Are you Dr Danny Sharpe?

**A. I am.**

Q. Dr Sharpe, I am going to ask you some questions about your involvement in an emergency on 11 December 2015. At that time, were you employed by the British Army?

**A. Yes.**

Q. Currently, as at that time, seconded to Bart's



Healthcare NHS trust and working with London's air ambulance?

**A. Yes, that's correct.**

Q. What were your qualifications at that time, please?

**A. In 2015, I had been qualified as a doctor for eight years, at that point, I held membership of the Royal College of Emerging Medicine and a diploma in immediate medical care from the Royal College of Surgeons of Edinburgh and I had deployed experience in Afghanistan and East Africa at that point.**

Q. Thank you.

Whilst on duty that day, were you tasked to an incident at 0909 hours by the London Ambulance Service?

**A. Yes, that's correct.**

Q. Thank you.

I am going to just display on the screen, so that we can see, the background to the organisation, the witness statement of Dr Thomas Peter Hurst, which is at LAA1, and page 1. Can we highlight paragraph 2, please, Mr Coates:

"London's air ambulance is a service operated by London's air ambulance charity, Bart's Health NHS trust and London Ambulance Service NHS trust. The service is tasked by paramedics in the London Ambulance Service

control room and responds by helicopter or fast-response car 24 hours a day. The service always sends a crew consisting of at least one doctor and one paramedic to every call. The doctors working for the service are all senior, being at least seven years post qualification. The paramedics are also senior, being at least five years post qualification. The accountability for patient care delivered by the LAA team is held by Bart's Health NHS trust. London's air ambulance responds almost exclusively to patients who have suffered major trauma (ie severe physical injury] and has pioneered a number of developments in the treatment of such patients."

Could we now go to paragraph 6 of the same document. We are going to read from paragraph 6 to paragraph 9:

"All injury-related 999 calls that are received by the London Ambulance Service control room are reviewed by a paramedic seconded to London's air ambulance, who has authority to launch the aircraft. Calls such as this meet our criteria for dispatch of a medical team, with a target time of seven minutes, and this was achieved.

"London's air ambulance operates an MD902 aircraft which for Helicopter Emergency Medical Services (or HEMS) missions is always flown in a two-pilot



configuration. When operating from the helipad on the roof of the Royal London Hospital, fire safety is provided at all times by a team of two aviation firefighters."

Thank you:

"Our target time from activation to being airborne is two to four minutes and this was achieved. While responding to a HEMS mission, our aircraft receives air traffic priority and will be cleared to take a direct route to the incident site and to land at the captain's discretion. The overriding priority in selecting a landing site is the safety of the general public and the crew. In built-up areas of London, it is common to land a few hundred metres from the incident and to be conveyed that distance by the police, by other emergency services or to proceed on foot.

"The exact landing site was not recorded but document LAA 34991/2 states that the landing was a class 'C' landing, indicating that it was greater than 200 metres from the incident and the medical team were conveyed to the scene by the Metropolitan Police Service. This process took a further three minutes."

Thank you, you can take that down now.

Does that accord with your recollection, Dr Sharpe?

**A. Yes, it does.**



Q. Were you conveyed from the place that the helicopter landed to the scene in a vehicle?

**A. Yes, when we landed we were waved to by some police officers and we boarded an unmarked transit van, which was being driven by another police officer.**

Q. You and who else?

**A. The team consisted of myself, a London Ambulance Service paramedic, Clare Brady, and we also had a medical observer, Dr Ryan Newberry, who was visiting from the USA.**

Q. The three of you travelled in the van to the scene?

**A. Yes, I travelled in the front seat and my colleagues were in the rear.**

Q. Thank you, when you arrived at the scene, at 09.22, you saw Jermaine Baker, and he was receiving treatment at the time when you arrived, is that right?

**A. Yes, that's right.**

Q. He was lying on his back and CPR was in progress, by the police and also the ambulance crew?

**A. Yes, I have to admit I do not have a strong recollection of the first moment of arrival on scene, so I am not sure who was giving CPR but, yes, that was the general description of the scene.**

Q. Thank you.

Was your initial assessment that the patient,



Mr Baker, was in cardiac arrest?

**A. Yes.**

Q. You saw that he had sustained a large wound in the upper central chest, which was being compressed with a bandage and a Celox gauze?

**A. Yes, that's right.**

Q. Did you subsequently identify a second wound on the palmer side of the left wrist?

**A. Yes.**

Q. It may seem like an obvious question, what is the palmer side of the wrist?

**A. The anatomical side of the wrist, according with the palm.**

Q. Did you see superficial tissues had been removed and tendons were exposed in that area?

**A. Yes, that's correct.**

Q. Had the London Ambulance Service already intubated Mr Baker?

**A. Yes, they had.**

Q. By placing an endotracheal tube into his windpipe in order to breath for him?

**A. That's correct.**

Q. What did you then do?

**A. So just to take you one step back, whilst we were on the way to the scene, I identified via the police driver**

**that a person had been shot and was in cardiac arrest. I then, through the window, spoke to my paramedic colleague and alerted her to the fact we were likely to need to perform this operation, the resuscitative thoracotomy, and my primary survey or my initial assessment confirmed that fact and so we proceeded to perform that operation.**

**It is common in the role in which I was performing to keep some immediate equipment on your person, essentially in your pocket, you can begin that procedure with, whilst a more formal layout of surgical equipment is done by the paramedic, so I proceeded to open my personal kit and begin the procedure.**

Q. What did that entail?

**A. The procedure is done by making two holes in the chest wall, one on either side, and essentially connecting those holes using very, very sharp scissors and opening the chest in a linear fashion, horizontally across the chest.**

**Then, at which point I am able to get hold of some rib spreaders from the paramedic, the chest is then formally opened and I can examine the internal contents of the chest and the heart specifically.**

Q. Right.

Already when you are travelling to the scene, it



occurred to you that that was the most likely procedure that you were going to have to perform?

**A. Yes, so the idea of this procedure is that it is done as quickly as possible and the standard operating procedure suggests you really should be almost complete with the procedure by 90 seconds of arrival on the scene, so it is very quick decision making.**

**The history of a gunshot wound and cardiac arrest, there is essentially no other likely treatment that was going to be successful, and so in order to progress that decision making more quickly, and allow everyone's mental model to be aligned, I started that process while we were on the way.**

Q. Once the chest had been opened, what did you do?

**A. So the next stage after the chest is opened is to examine the heart and it is commented in the notes that I have used the phrase "Deliver the heart". That essentially means to open the pericardial sack, which is a fine fibrous sack that sits around the heart and to remove the heart from inside that sack.**

**The reason for doing so is the primary goal of this procedure to is relieve a -- what is described as tamponade, which is a tight fluid-filled pressure around the heart, stopping the mechanical beat of the heart from happening, that is normally caused particularly in**



**penetrating injury by a small wound on the surface of the heart.**

Q. Yes.

**A. So in order to examine the surface of the heart, one must open that sack and remove the heart from within the sack.**

**Unfortunately on this occasion, there was no injury to the heart and therefore removal of the heart from that sack did not reverse the problem.**

**So that was complete, I observed the heart -- physically observed the heart for a matter of seconds and originally there was no cardiac activity at all, there was no movement of the heart.**

Q. There was no movement of the heart?

**A. At that point, no. Within about 20 seconds, I witnessed one single beat of the heart, and so made the decision to continue escalating treatment and as such we started internal cardiac massage, and some blood was prepared for me to transfuse into Mr Baker.**

Q. That is what you did?

**A. Yes. And normally this would be given through a vein or occasionally into a bone through a needle into a bone, but on this occasion, I believe because Mr Baker had already lost so much blood, it was essentially impossible to put a needle into a vein.**



**So I took the step of inserting that needle and tube directly into his heart and transfusing the blood directly into the heart.**

Q. What, if any, reaction was there to that treatment?

**A. Unfortunately, although I could feel that the blood inside the heart was filling, there was no improvement in his clinical condition at all, and I examined him concurrently and found a -- what I believed to be a bullet track in an area of his chest which I could repair. It is not the function of this procedure to do extensive thoracic surgery, it's simply really to reverse any immediate problems.**

Q. No.

**A. And given the lack of any clinical improvement and a wound that I could not repair, I decided to cease treatment at that point.**

Q. Despite your efforts, you were unable to resuscitate Mr Baker and his life was pronounced extinct at 09.39?

**A. That's correct.**

Q. I am just going to finally display a document which is headed "HEMS mission report". You will have seen this, Dr Sharpe, it is at LAA3, please.

Is this the report that was generated following --

**A. Yes -- sorry.**

Q. I was just going to ask you when this would have been

generated, at the time or subsequent to your treatment?
**A. This would be subsequent, the document that is generated at the time is under pamphlet 6.**
Q. Yes, and we can display that too, I think. It is LAA4, please.
Thank you.
The document on the right-hand side of our screen, is that completed contemporaneously?
**A. Correct, yes.**
Q. By you?
**A. Yes.**
Q. Thank you.
Then the report, the printed report on the left-hand side, is a subsequent record that shows us the time that you were called out, a description of the scene, the history and the primary survey?
**A. Correct.**
MS BLACKWELL: Thank you very much. We can take those down, please.
Sir, that completes my questions of Dr Sharpe, do you have any questions?
THE CHAIRMAN: I have no questions.
MS BLACKWELL: I think Ms Murphy may have something to say.
THE CHAIRMAN: I think she may.
Ms Murphy.



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



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



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

Hepplewhite and DC Stewart. They were present when W80 called the home phone and provided his location. Detective Sergeant Levoir travelled with another officer to pick up W80. They were joined by another car from SCO19, DC Hepplewhite remained on the phone with W80 to keep them updated on his location. When they reached W80, he was placed into the SCO19 vehicle and taken home. When he reached his home, he was treated for an injury to his wrist."

Evidence of PROFESSOR RICHARD M LYON (read)

MR MOSS: Sir, then carrying on from the evidence that you have heard this morning, I will read a few paragraphs from the report of Professor Richard M Lyon.

Professor Richard Lyon is a consultant in emergency medicine and pre-hospital care and he was instructed by the inquiry to provide opinion on the care given to Jermaine Baker in Bracknell Close and to comment on whether Jermaine Baker's injuries were survivable.

Sir, I will read a few paragraphs.

Paragraph 2.1 and then I will read from paragraph 2.3 to 5.1.

2.1 first, and it's headed "Summary":

"In my opinion, the MPS police officers and police medics adopted a systematic approach to caring for Mr Baker. There was evidence that they exposed him in



order to conduct a thorough clinical examination and assessment. An attempt was made to optimise the patient's airway using a standard oropharyngeal adjunct and oxygen. A step wise approach was taken to managing Mr Baker's chest wound and the police medics had appropriate first response equipment, including chest seals and haemostatic dressings. In my opinion, the care provided by the police officers on scene was appropriate and of the standard expected of serving firearms police officers in 2015.

"In my opinion, and experience, the MPS police firearms service was one of the first to use specialist medical equipment in the form of haemostatic dressings and chest seals. The first response medical equipment used in this case should be commended.

"In my opinion, from the injuries that Mr Baker had sustained, it would not have been possible to control the degree of haemorrhage purely with external compression and it would not have been possible to prevent his death once these injuries had been sustained."

Sir, I then pick it up at 2.3 under the heading of "Pathophysiology":

"The gunshot wound sustained by Mr Baker caused a catastrophic injury to his vasculature in his neck,



resulting in catastrophic haemorrhage. The wound sustained on the wrist would have contributed to this. The severe haemorrhage would have resulted in Mr Baker rapidly losing consciousness. The end tidal carbon dioxide level at the time of intubation indicated that Mr Baker had already lost a significant amount of his circulating volume of blood at the time of intubation.

"Mr Baker then suffered a cardiac arrest as a result of hypovolemia from catastrophic haemorrhage."

2.4, "Overall medical response":

"In my opinion the MPS police officers administered immediate high quality first aid care, provided CPR as well as applying direct pressure to the wound site and used appropriate medical equipment. The response of LAS was rapid, with an ambulance being dispatched within three minutes of the shooting and arriving on scene within 10 minutes. The response of London's air ambulance HEMS team was rapid. The MPS specifically requested HEMS attend the incident. HEMS were activated seven minutes after the shooting and were on scene within 22 minutes of the shooting.

2.5, "Immediate first aid provided by MPS":

"In my opinion, based on the material provided to me by the inquiry, the first aid assistance provided to Mr Baker by MPS police officers on the scene was



appropriate and was of an expected standard of serving police officers at the time of the incident.

"In my experience from 2015, police firearms medics were trained in advanced first aid techniques and equipped with emergency medical equipment, such as tourniquets, haemostatic dressings and chest seals. In my opinion there was clear evidence of a structured approach to the first aid given by MPS police officers to Mr Baker.

"In my opinion, Mr Baker suffered a catastrophic penetrating injury to major vessels in his neck as a result of a gunshot wound. This would have led to immediate catastrophic haemorrhage, leading to a rapid loss of consciousness and cardiac arrest within a matter of a few minutes prior to the arrival of emergency medical services.

"In my opinion, the police officers performed to a high standard of emergency medical care, following the gunshot injury they immediately placed Mr Baker on the floor and removed his clothing in order to perform a full examination. An officer put immediate pressure on the wound with a gloved hand in an attempt to control the bleeding. The officers should be particularly commended for a thorough patient examination, including looking on Mr Baker's back for an exit wound. The

medical response pack was immediately requested. An attempt was made to control the bleeding from the very first opportunity by putting direct pressure on the wound with tactical gloves. When medical equipment was brought to the patient within a very short space of time, attempts were made to control the bleeding using both chest seals and haemostatic gauze. Haemostatic gauze is a military-grade dressing, containing a chemical that promotes blood clotting. In my opinion, due to the catastrophic bleeding encountered from the neck it would not have been possible to completely control the haemorrhage. In my opinion, the fact that the police officers were equipped with haemostatic gauze, used it quickly and applied continuous direct pressure to the wound gave Mr Baker the best possible chance of survival. The police officers should also be commended for undertaking a thorough examination, also finding the wound on Mr Baker's wrist and treating this appropriately with a trauma dressing.

"In my opinion, Mr Baker's rapidly entered a state of traumatic cardiac arrest as a result of hypovolemia from catastrophic haemorrhage.

"The police officers correctly recognised the deterioration in clinical condition and commenced cardiopulmonary resuscitation, CPR. They should also be



commended for continuing to apply direct pressure to the wounds whilst administering CPR. In my opinion, there is noting further the police officers could have done to prevent Mr Baker from going into traumatic cardiac arrest."

Section 3, "Care provided by the London Ambulance Service":

"In my opinion, the medical care provided by the London Ambulance Service paramedics was appropriate and of an expected standard of care. LAS responded rapidly, arriving on scene within 10 minutes of the initial request. They immediately recognised Mr Baker was in traumatic cardiac arrest on their arrival and continued with appropriate resuscitation. They successfully intubated Mr Baker and ventilated him.

"In my opinion and experience, it is not uncommon to find gaining intravenous access difficult, particularly in a setting of traumatic cardiac arrest."

Section 4, "Care provided by London's air ambulance Helicopter Emergency Medical Service":

"In my opinion, the care provided by the London's air ambulance HEMS team was appropriate and of an expected standard. Mr Baker was in a state of traumatic cardiac arrest on arrival of HEMS. Witnessed traumatic cardiac arrest from a penetrating injury such



as a gunshot is an indication for pre-hospital resuscitative thoracotomy, this procedure can only be provided by highly trained doctors working within a high-performing enhanced care team, such as the London's air ambulance. Performing a resuscitative thoracotomy on scene was the only chance that Mr Baker would have had of surviving this incident.

"HEMS also gave Mr Baker a pre-hospital blood transfusion at the scene in an attempt to replace the blood that he had lost, pre-hospital blood transfusion is only available in certain regions of the UK and Mr Baker's chance of survival would have been increased by having this available.

"Survival from traumatic cardiac arrest is known to be very poor. The highest reported survival rate in patients undergoing pre-hospital resuscitative thoracotomy from a case series published in 2011 in London was 18 per cent.

"However, all of these survivers had cardiac tamponade, a condition where blood accumulates in the pericardial sack around the heart and prevents it from beating. This condition can be effectively treated by resuscitative thoracotomy. Mr Baker did not have a cardiac tamponade, he was exsanguinated. Exsanguination is associated with a particularly poor



survival rate. In a case series from 2017, which included gunshot wounds, the overall survival rate was 3 per cent of the stabbing victims but none of the gunshot wounds victims undergoing pre-hospital resuscitative thoracotomy survived. In my experience and review of the medical literature, the survival rate for a patient who had received a gunshot to the chest, had an out-of-hospital cardiac arrest from hypovolemia and who underwent pre-hospital thoracotomy is less than 1 per cent.

"In my opinion, every attempt was made to successfully resuscitate Mr Baker, but his injuries were catastrophic and there was nothing that could have been done to prevent his death. In my experience, based on research available in 2015, the survival rate for patients who underwent a pre-hospital resuscitative thoracotomy following a gunshot would be less than 1 per cent.

"It should be noted that the majority of pre-hospital resuscitative thoracotomy survivors were from penetrating trauma from knife wounds rather than gunshot wounds. The survival rate from pre-hospital resuscitative thoracotomy has not significantly changed since 2015."

Sir, finally under the heading "Recommendations"

I read this paragraph, 5.1:

"The only single recommendation I would make regarding emergency care and treatment of Mr Baker would be in relation to the attempted use of chest seals. Whilst chest seals have an important role to play in the treatment of penetrating chest trauma, I would recommend that police medic training emphasises that in cases of catastrophic external torso haemorrhage, the immediate action is to apply direct pressure and then progress directly to using haemostatic gauze. The application of a chest seal will not stop catastrophic haemorrhage. Continued direct pressure and the use of trauma and haemostatic dressings are the primary treatments. Chest seals should only be used where there is no evidence of ongoing catastrophic haemorrhage. In my opinion, earlier use of haemostatic dressings would not have changed Mr Baker's outcome."

Sir, we are now after that up to date on the evidence to read.

THE CHAIRMAN: I know that there are no members of the family present today, and it may be that even if Covid had not intervened they would have understandably chosen to absent themselves but through Ms Murphy they will be, I know, heartened insofar as they could possibly be by the entirety of the evidence which we have heard both



live and read this morning.

MR MOSS: Sir, I do know that there is a number of family members who are present virtually, even if they are not all present.

THE CHAIRMAN: Very good. I am glad to hear that they will have in turn been able to hear what you have said.

Thank you very much.

Thank you Ms Murphy.

MS MURPHY: Thank you, sir.

THE CHAIRMAN: I believe uncharacteristically in the life of this inquiry, that is as far as we can go today?

MR MOSS: Sir, yes, it is. That is the end of business for today.

THE CHAIRMAN: Were it a Thursday or a Friday, that would be greeted with even more glee than it will be, but we will resume tomorrow at 10.00.

MR MOSS: Yes.

THE CHAIRMAN: I think we have a rather fuller day.

MR MOSS: Slightly fuller, yes.

THE CHAIRMAN: Thank you very much indeed.

(11.01 am)

(The Inquiry adjourned until 10.00 am the following day)



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