

OPUS2

Manchester Arena Inquiry

Day 3

September 9, 2020

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Phone: +44 (0)20 3008 5900

Email: transcripts@opus2.com

Website: <https://www.opus2.com>

1 Wednesday, 9 September 2020
 2 (9.00 am)
 3 Opening statement by MR GREANEY (continued)
 4 SIR JOHN SAUNDERS: Mr Greaney.
 5 MR GREANEY: We will turn finally in our opening statement
 6 on the emergency response to deal with
 7 Greater Manchester Fire and Rescue Service and
 8 North West Fire Control.
 9 Greater Manchester Fire and Rescue Service provides
 10 fire and rescue services on behalf of the
 11 Greater Manchester Combined Authority. To be clear,
 12 GMCA is representing the interests of that body and no
 13 other in this inquiry, but will also assist to the
 14 extent that the inquiry requires any information or
 15 assistance from the Mayor of Manchester.
 16 North West Fire Control is run by NWFC Limited and
 17 is responsible for receiving emergency calls and
 18 mobilising fire and rescue service resources in response
 19 to incidents according to preset criteria depending on
 20 the type of incident that is reported. In effect, NWFC
 21 operate the control room for GMFRS and also for other
 22 fire and rescue services in the north-west.
 23 As we've set out, the expert evidence in relation to
 24 the Fire and Rescue Service and NWFC is provided by
 25 Matthew Hall. Mr Hall's first report dated 1 October of

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1 last year considers the policies, principles, systems
 2 and practices that are relevant to the expected response
 3 of the Fire and Rescue Service to terrorist and mass
 4 casualty incidents. His second report, dated 6 May of
 5 this year, evaluates the preparation of the Fire and
 6 Rescue Service and NWFC for terrorist and mass casualty
 7 incidents and considers the adequacy of the response of
 8 those organisations to the arena attack on 22 May.
 9 A short appendix was provided with Mr Hall's second
 10 report. Mr Hall has provided a further addendum report,
 11 dated 15 July, responding to core participants'
 12 questions and observations.
 13 It is relevant at the outset of our opening on this
 14 part of chapter 10 to summarise the views expressed by
 15 Mr Hall in his first report. That is to say, his
 16 overview of the expected response of a fire and rescue
 17 service to terrorist and mass casualty incidents.
 18 Mr Hall explains his views as follows:
 19 "As a category 1 responder within the Civil
 20 Contingencies Act 2004, the Fire and Rescue Service of
 21 Greater Manchester was required to assess the risk of
 22 emergencies occurring, write plans, share information,
 23 and cooperate and coordinate with a wide range of other
 24 organisations."
 25 As we've explained already, local coordination and

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1 planning was expected to be achieved through the
 2 resilience forum. Mr Hall echoes the views of other
 3 experts by making plain that effective coordination
 4 between responder organisations is achieved through the
 5 use of the JESIP principles of effective joint working.
 6 This encompasses, as we all now well-understand, the use
 7 of METHANE messages or the passing of incident
 8 information in a timely manner between services and
 9 their control rooms.
 10 Mr Hall, in that first report, confirms that the
 11 declaration of a major incident triggers a predetermined
 12 strategic tactical and operational response from each
 13 emergency service. The joint decision model should be
 14 used to facilitate the sharing of information between
 15 different agencies and the reconciliation of potentially
 16 differing priorities. All of this is now familiar to
 17 all of us, but is worth repeating as we draw to the
 18 close of our opening statement on chapter 10.
 19 Mr Hall explains that the control rooms of the
 20 emergency services play a vital role in managing the
 21 early stages of a multi-agency incident and the control
 22 room guidance set out in the JESIP doctrine focuses on
 23 communication, shared situational awareness, joint
 24 understanding of risk, and coordination and co-location.
 25 The overarching aim of the control room supervisor

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1 is, or should be, to ensure that rapid and effective
 2 actions are implemented in order to save lives, minimise
 3 harm, and lessen the effects of the incident. That,
 4 in the view of counsel to the inquiry, is an important
 5 opinion which will be relevant to the inquiry's
 6 assessment of the reaction of NWFC on the night.
 7 Joint operating principles, as we have said, known
 8 as the JOPs, were in place at the time of the arena
 9 attack, and Mr Hall makes clear that those principles
 10 should also be followed by emergency services in
 11 responding to a MTFA or MTA as it's now known.
 12 At the time of the Manchester attack the third
 13 edition of the JOPs were in place and provided guidance
 14 to responders dealing with MTFA incidents.
 15 The JOPs outline a specific role for fire and rescue
 16 service personnel and provide guidance on the management
 17 of firefighting and fire hazards within the context of
 18 an MTFA. Under the JOPs, explains Mr Hall, a key role
 19 in a major incident response is played by the national
 20 inter-agency liaison officer, the NILO, a term we've
 21 used many times, who acts as a tactical adviser to
 22 tactical and strategic commanders.
 23 In responding to a major incident, intra-agency
 24 working, effective training and effective communication
 25 are vital, as Mr Hall states:

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1 "No single agency has the necessary capability to
 2 resolve a major incident on its own due to its
 3 complexity, number of casualties, and other associated
 4 threats and risks that may be present. Joint working,
 5 co-location, coordination and communication between all
 6 agencies attending is therefore essential."

7 We'll repeat that. Mr Hall's view is:

8 "No single agency has the necessary capability to
 9 resolve a major incident on its own due to its
 10 complexity, number of casualties, and other associated
 11 threats and risks that may be present. Joint working,
 12 co-location, coordination and communication between all
 13 agencies attending is therefore essential."

14 As counsel to the inquiry currently understand the
 15 evidence, this appears to be a clear and important
 16 expression of principle. As we've emphasised, there can
 17 be no doubt that there was a need for such joint working
 18 on the night of 22 May 2017 in Manchester.

19 With those matters of overview in mind, we'll turn
 20 to address the actual preparedness for a terrorist
 21 attack of GMFRS and NWFC and how they responded on the
 22 night. Preparedness first. GMFRS.

23 Key GMFRS personnel involved in the response to the
 24 attack on 22 May had received relevant and appropriate
 25 training. Indeed, several of the key GMFRS officers

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1 involved in the response to the attack had worked in the
 2 Fire and Rescue Service's contingency planning unit and
 3 were involved in the development and implementation of
 4 GMFRS's plans, policies and procedures. Nonetheless, if
 5 there were failures on the night by the Fire and Rescue
 6 Service, the inquiry will need to consider whether
 7 a lack of training and/or a lack of understanding of
 8 that training formed part of the explanation.

9 As a member of the Greater Manchester Resilience
 10 Forum, GMFRS had attended planning meetings and, as we
 11 explained yesterday, in the lead-up to the attack,
 12 a senior officer of GMFRS was the chair of the
 13 resilience forum. The Fire and Rescue Service also
 14 participated in multi-agency exercises. Several
 15 multi-agency training exercises had been carried out
 16 prior to the attack.

17 As we have already identified, the Winchester Accord
 18 exercise held in May 2016 at the Trafford Centre in
 19 Manchester raised serious concerns about the interaction
 20 between police commanders and their communications with
 21 other responding emergency services, leading to
 22 significant delays in the deployment of GMFRS and NWAS
 23 resources to the scene.

24 Winchester Accord also identified concerns regarding
 25 the communication of key information, three-way

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1 communication in the early phases of an incident, and
 2 the communication of key locations such as a safe RVP,
 3 the designation of hot, warm and cold zones, and the
 4 location of forward command posts or FCPs.

5 We do understand that we are drawing attention to
 6 Exercise Winchester Accord again, but we do so now
 7 in the context of GMFRS, and it is obviously important
 8 to recognise that this exercise raised many of the
 9 issues that it will be necessary to explore in the
 10 inquiry, and that, in turn, means that we need to
 11 explore whether the lessons of Winchester Accord were
 12 learned by all of the emergency services.

13 In that regard Mr Hall, the fire expert, observes
 14 that the learning points from the Winchester Accord
 15 exercise do not appear to have been rectified
 16 immediately by GMFRS. Indeed, rather than being
 17 clarified and resolved, they appear to have led to
 18 negative expectations on behalf of some GMFRS officers
 19 as to what to expect from GMP in the event of an MTFA
 20 incident.

21 The inquiry will need to explore whether that is as
 22 disturbing as it seems given that a number of the
 23 concerns that arose during Winchester Accord appear to
 24 have arisen again during the actual response to the
 25 arena attack. We emphasised yesterday that whether

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1 lessons were learned by the emergency services from
 2 exercises and then implemented was an important issue
 3 for the inquiry to explore, and the views of Mr Hall
 4 reinforce the importance of that.

5 We will turn next to the preparedness of NWFC.
 6 Within NWFC, JESIP and MTFA protocols had been
 7 implemented. NWFC had a JESIP lead who was responsible
 8 for ensuring that all control staff were compliant with
 9 current JESIP training. Prior to 22 May 2017, regular
 10 dialogue took place between GMFRS and NWFC. GMP visits
 11 to NWFC had been arranged and issues relevant to
 12 inter-agency cooperation had been discussed, including
 13 the use of a multi-agency talk group.

14 In addition, NWFC had participated in multi-agency
 15 training exercises. As we'll set out in further detail
 16 shortly, it is Mr Hall's view that NWFC staff were
 17 trained and ready to respond to any reasonable worst
 18 case scenario, so if things went wrong on the night of
 19 the 22nd, training does not seem to have been the
 20 explanation, but this will need to be explored in the
 21 evidence.

22 Having dealt with preparedness, we will turn next to
 23 deal with the actual response of NWFC and GMFRS on the
 24 night of the bombing. We will deal with the response in
 25 three phases: first, initial notification and response;

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1 second, multi-agency communication; and third, the
 2 response from 22.50.
 3 We can deal with the essential facts briefly given
 4 the level of detail that we provided yesterday .
 5 1. Initial notification and response. The first
 6 notification to NWFC of an incident at the arena came at
 7 22.34, so just 3 minutes after the detonation by
 8 Salman Abedi of his bomb. NWFC control room operator --
 9 and we will refer to such people in this role as
 10 "CRO" -- David Ellis was informed of reports of an
 11 explosion in the foyer of the arena whilst talking to
 12 GMP about an unrelated incident. During the same call ,
 13 GMP advised him that a bomb had exploded. Later in the
 14 call , GMP told NWFC that injuries at the arena appeared
 15 to have been caused by shrapnel , that it was believed
 16 there were between 30 and 40 casualties , but that was
 17 unconfirmed, and they were still looking for a secondary
 18 device .
 19 Accordingly, it is clear that NWFC had very early
 20 notice that a shrapnel bomb appeared to have exploded
 21 in the foyer to the arena, in other words the City Room,
 22 resulting in multiple casualties .
 23 At 22.37 NWFC CRO Joanne Haslam received a call from
 24 NWAS Control stating that a bomb had gone off at the
 25 arena . Between 22.43 and 22.46, during that same call ,

1 NWAS informed NWFC that there were reports of an active
 2 shooter, that there were potential gunshot injuries , and
 3 that there were approximately 60 casualties .
 4 NWFC, in common with other emergency responders, had
 5 what are described as action cards, which dictated
 6 particular responses to particular events. CRO Ellis
 7 initially accessed the explosion action card. A short
 8 time later , on the initial accounts of the NWFC
 9 witnesses , it appears that NWFC duty team leader
 10 Michelle Gregson and her colleague , team leader
 11 Lisa Owen, instead reverted to following the bomb action
 12 card. If correct , this choice was significant , as the
 13 two cards dictated different responses. Had the
 14 explosion card been adopted, as counsel to the inquiry
 15 currently understand the evidence, NWFC would have
 16 directed GMFRS resources, including the specialist
 17 technical rescue units , TRU, and a NILO directly to the
 18 arena, whereas the bomb action card required the duty
 19 NILO first to obtain an RVP before any GMFRS resources
 20 were mobilised to that location .
 21 We have said "on the initial accounts" because
 22 further statements of the relevant witnesses have been
 23 served on the inquiry by NWFC in which it is explained
 24 that NWFC did not in fact open or follow the bomb action
 25 card, and it appears that there is independent support

1 for that from the records of NWFC.
 2 As with all issues of fact , this will need to be
 3 explored in the evidence and a determination made on
 4 that basis and only on that basis . As we have said
 5 a number of times now, no one should jump to
 6 conclusions .
 7 A determination about the decision -making within the
 8 control room of NWFC will need to be made on the basis
 9 of an assessment of the evidence that is actually given
 10 by the relevant witnesses and by reference to the
 11 contemporaneous documentation.
 12 At 22.40, so just 9 minutes after the explosion ,
 13 while NWFC's calls to GMP and NWAS continued, NWFC duty
 14 team leader Michelle Gregson contacted station manager,
 15 or SM, Andy Berry. He was the GMFRS on-call duty NILO.
 16 SM Berry was informed that there had been an explosion
 17 at the arena, that there were 30 casualties reported ,
 18 that the police had declared an RVP at Cathedral Car
 19 Park and he was asked to get in touch with GMP, which in
 20 context, seems likely to have been a request to contact
 21 the GMP FDO, Inspector Sexton, about whom we had much to
 22 say yesterday .
 23 In that call , SM Berry rejected the Cathedral Car
 24 Park RVP and suggested that GMFRS would normally
 25 "muster". He added that the RVP should, and again we

1 quote his words, "not be that close , we would not want
 2 central ". Instead, he suggested Philips Park Fire
 3 Station, some 3 miles from the scene, and
 4 Michelle Gregson accepted that .
 5 It is important to stress that Philips Park was not
 6 a multi-agency RVP. The reasons for GMFRS locating
 7 there will need to be scrutinised during the course of
 8 the evidence, along with NWFC's reasons for agreeing to
 9 that .
 10 SIR JOHN SAUNDERS: And we have recordings of the various
 11 phone calls ?
 12 MR GREANEY: Sir, we're about to play, in about 30 seconds,
 13 one of the calls .
 14 SIR JOHN SAUNDERS: Okay, thank you.
 15 MR GREANEY: We'll play, as I have just indicated , this call
 16 in a moment. As we play the call we should bear in mind
 17 that in his witness statement SM Berry states that he
 18 was concerned that the RVP at Cathedral Car Park was
 19 a predetermined RVP and would not be safe. He states ,
 20 and we use his words:
 21 "It was a bit quick for an RVP to be issued if the
 22 explosion had just occurred."
 23 However, the explosion had, of course, occurred
 24 nearly 10 minutes earlier .
 25 SM Berry suggests in his witness statement that NWFC

1 had made a decision that GMFRS would not mobilise, but
 2 we'll now play the call to inform our understanding of
 3 what in fact happened within it .
 4 Mr Lopez, could we play, please, {INQ00449/1}. This
 5 is the call, it's made at 22.40, between NWFC Duty Team
 6 Leader Michelle Gregson and Station Manager Andy Berry,
 7 who was the GMFRS on-call duty NILO.
 8 (Audio played to the inquiry)
 9 SIR JOHN SAUNDERS: Mr Greaney, before you go on, and
 10 because I will forget, I helpfully have had a note of
 11 what you're going to say. I have, I think, an earlier
 12 edition, which is why I was not aware that the call was
 13 going to be played. If I could have that part up to
 14 date, it would be helpful .
 15 MR GREANEY: Of course, sir. I'm sorry you haven't received
 16 (overspeaking) --
 17 SIR JOHN SAUNDERS: Please don't apologise. These things
 18 are subject to amendment, obviously.
 19 MR GREANEY: It has been updated overnight as we have
 20 reflected on what has happened in the (overspeaking) --
 21 SIR JOHN SAUNDERS: That is very helpful and it is very
 22 helpful to hear the call, if I may say so, too.
 23 MR GREANEY: Indeed, sir, we were about to observe that that
 24 call appears to be critical to an understanding of why
 25 it was that it was not until 2 hours and 6 minutes after

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1 the explosion that fire engines arrived on the scene
 2 and, as a result, it will be most important to
 3 scrutinise with Deputy Team Leader Michelle Gregson and
 4 Station Manager Andy Berry when they give their evidence
 5 what their thought processes were during that call .
 6 SIR JOHN SAUNDERS: And indeed whether the action cards are
 7 actually sufficient to discriminate between an explosion
 8 and a bomb.
 9 MR GREANEY: We've merely summarised at the moment the
 10 action cards, but during the course of the evidence
 11 we will scrutinise what they are, which action card was
 12 used, and whether they are fit for purpose.
 13 SIR JOHN SAUNDERS: Thank you.
 14 MR GREANEY: In due course, SM Berry made efforts to
 15 contact, as he indicated at the end of that call he
 16 would, the GMP FDO, but he was without success.
 17 At the same time, SM Berry ordered four fire engines
 18 and three additional NILOs to attend the RVP at
 19 Philips Park Fire Station. SM Berry decided to travel
 20 to Philips Park, leaving home at approximately 22.47.
 21 His location at the time was some 22 miles from the
 22 incident. Sir, I think we've just been provided with
 23 a copy of the updated opening statement.
 24 SIR JOHN SAUNDERS: That's a very instant response.
 25 Thank you very much.

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1 MR GREANEY: I think it was probably coincidental, but
 2 nonetheless welcome.
 3 SIR JOHN SAUNDERS: Okay, thank you very much.
 4 MR GREANEY: I'll just repeat that because it's important.
 5 In due course, SM Berry made efforts to contact the
 6 GMP FDO but without success. At the same time, SM Berry
 7 ordered four fire engines and three additional NILOs to
 8 attend the RVP at Philips Park Fire Station. SM Berry
 9 decided to travel to Philips Park, leaving home at
 10 approximately 22.47. His location at the time was some
 11 22 miles from the incident .
 12 As SM Berry was identifying Philips Park as the RVP
 13 for GMFRS and was commencing his journey, a number of
 14 calls were taking place. At 22.41, NWFC received a call
 15 from a member of the public who stated that there had
 16 been a bomb blast that had caused shrapnel injuries .
 17 The caller suggested that, based on looking at the
 18 casualties, the blast may have been the result of
 19 "a dirty bomb of some description".
 20 While on the line to SM Berry, NWFC asked whether he
 21 wanted the information that had been received from this
 22 member of the public at that moment, but SM Berry
 23 replied "no".
 24 At 22.42, NWFC received a call from GMP confirming
 25 that there had indeed been an explosion at the arena.

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1 At 22.44, NWFC received a call from BTP, requesting
 2 confirmation of the number of Fire Service units being
 3 deployed to the arena. The NWFC CRO confirmed that none
 4 had been deployed and stated that they would call BTP
 5 back once they had further information .
 6 At 22.44, NWFC CRO Rochelle Fallon called SM Berry
 7 and left a voicemail message relaying reports from NWAS
 8 that people were being shot. At 22.45, NWFC contacted
 9 Philips Park advising that it was to act as the GMFRS
 10 RVP. NWFC stated, it seems, that there were confirmed
 11 gunshot wounds.
 12 At 22.48, SM Berry called NWFC and spoke to
 13 CRO Dean Casey. CRO Casey stated that they had received
 14 reports of a bomb exploding, 60 casualties, and reports
 15 of an active shooter. SM Berry stated that further
 16 GMFRS resources were going to rendezvous at Philips Park
 17 until :
 18 "... we are instructed otherwise and we get some
 19 more information about this incident ."
 20 Whilst travelling to Philips Park, SM Berry
 21 continued his efforts to contact the GMP FDO. He was
 22 unsuccessful again. SM Berry called NWFC at
 23 approximately 22.52 and 22.57, requesting additional
 24 NILOs and MTFA capability to Philips Park.
 25 While SM Berry was on his way to Philips Park, NWFC

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1 received updates indicating that GMP officers and
2 ambulances were travelling to the scene and that
3 casualties were receiving treatment. In other words,
4 NWFC received information that some emergency services
5 were deploying to the arena.

6 The inquiry will plainly need to consider what
7 impact this should have had on the decision-making of
8 GMFRS and NWFC. In other words, should they have
9 thought other emergency services are deploying to the
10 scene, would it be sensible for the Fire and Rescue
11 Service to do the same? Whether that is a fair question
12 will need to be answered once the evidence has been
13 heard.

14 SM Berry arrived at Philips Park at approximately
15 23.41, an hour after first being informed of the
16 incident, following delays caused by roadworks and
17 traffic difficulties en route. That was, as will be
18 obvious, 1 hour and 10 minutes after the explosion.

19 2. Multi-agency communication. Although Cathedral
20 Car Park had been the initial multi-agency RVP nominated
21 by GMP at 22.37, the RVP was updated to Hunts Bank at
22 approximately 22.54. The RVP was further updated by GMP
23 to the Old Boddington's Brewery at approximately 23.20.
24 The time at which NWFC and GMFRS were made aware of
25 these RVP changes will need to be considered thoroughly

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1 given GMFRS's lengthy absence from any multi-agency RVP.

2 As we have explained already, BTP declared a major
3 incident at 22.39. NWSA made a similarly timely
4 declaration. And the GMP FDO declared Operation Plato
5 at 22.47. At 22.54, an NWSA officer at the scene
6 provided METHANE information relating to scene
7 situational awareness, casualty numbers, and the types
8 of injuries sustained. That is the recording that we
9 heard yesterday.

10 At 22.58 -- forgive me, it's the next recording that
11 we heard yesterday.

12 At 22.58, BTP sent a METHANE message from the scene
13 containing information regarding the specific location
14 of the incident, the approximate number of casualties
15 involved, the nature and type of injuries sustained,
16 existing resources already at the scene, and those that
17 were required to assist. As we just indicated, we heard
18 that yesterday.

19 Evidence from GMFRS and NWFC staff indicates that
20 this information was not communicated to GMFRS and NWFC
21 until significantly later. The time at which NWFC and
22 GMFRS were made aware of this information and the
23 reasons for any delay will require careful examination
24 by the inquiry. There was plainly, from an early stage,
25 much information to provide and that should have been

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1 provided to GMFRS and NWFC. When was it provided? If
2 not promptly, as currently appears to be the case, why
3 not?

4 These are issues we will need to explore given that
5 the procedures, and indeed good sense, require the
6 emergency services to be working together to respond to
7 the arena attack.

8 3. The GMFRS and NWFC response from 22.50 onwards.
9 At 22.52, NWFC notified Dean Nankivell, the GMFRS duty
10 group manager, of what had happened at the arena. He
11 proceeded to GMFRS Headquarters to begin setting up the
12 command support room, or CSR, as a number of witnesses
13 describe it. Several other GMFRS senior officers also
14 attended the command support room, including the then
15 chief fire officer, Peter O'Reilly, and he is referred
16 to by many witnesses as the CFO, CFO Peter O'Reilly.

17 At 23.35, Station Manager, SM, Mick Lawlor, who was
18 off duty and at home, mobilised to GMP Headquarters, to
19 gain situational awareness directly with GMP, and to
20 support the GMFRS deployment. As will be apparent, that
21 was approaching an hour and a half after the explosion.

22 Indeed, SM Lawlor arrived at GMP HQ at 00.04. He
23 obtained accurate operational information, which he
24 transmitted to the GMFRS NILO talk group. Meanwhile,
25 the team of GMFRS NILOs and responders who were still

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1 assembled at Philips Park RVP, a little under 3 miles
2 from the arena, had already become aware that NWSA was
3 using Manchester Central Fire Station as a holding area
4 prior to deployment to the scene. Conversations were
5 held between those at Philips Park and the CSR and it
6 was eventually agreed that they would travel to
7 Manchester Central station and co-locate with NWSA.
8 They arrived at Central Station at approximately 00.13.

9 At approximately 00.12, a minute earlier, the CFO,
10 Mr O'Reilly, contacted Steve Hynes, who, as we heard
11 yesterday, had taken over as NWSA Bronze Commander from
12 Dan Smith and was therefore at the arena. Mr Hynes told
13 the CFO, Mr O'Reilly, that approximately
14 12 firefighters, three fire appliance crews, were
15 required. The CFO then ordered SM Berry and three fire
16 engines to attend the Victoria Railway Station.

17 Between 00.37 and 00.39 three fire engines and
18 SM Berry arrived at Victoria Railway Station. This was
19 the first GMFRS deployment to the scene. This
20 attendance was subsequently supplemented by the
21 attendance of two further engines and another officer.
22 GMFRS's specialist resources were never deployed to the
23 scene.

24 As will therefore be obvious, and as we observed
25 yesterday, and indeed the day before, fire engines did

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1 not arrive at the scene until more than 2 hours after
 2 the bomb had been detonated. This has been the subject
 3 of much public concern and comment by Lord Kerlake.
 4 We will need to consider during the oral evidence
 5 hearings whether that concern is well-founded or whether
 6 instead the actions of the Fire and Rescue Service are
 7 understandable.

8 Once at the scene, GMFRS assisted with casualties
 9 and scene management. GMFRS staff remained until about
 10 3 am on 23 May. When released, they returned to
 11 Manchester Central Station, where a debrief was carried
 12 out, and we will hear from witnesses about that process.

13 We will turn next to the expert evaluation of the
 14 response of the Fire and Rescue Service. In the report
 15 subsequent to his overview report, Mr Hall evaluates
 16 GMFRS and NWFC's preparation for terrorist and mass
 17 casualty incidents and considers the adequacy of the
 18 GMFRS and NWFC response to the arena attack. He
 19 concludes that GMFRS had an appropriate operational
 20 response capability available to respond to expected
 21 day-to-day demands and incidents, including major or
 22 complex incidents.

23 Both GMFRS as an organisation and its individual
 24 officers actively and regularly participated in planning
 25 and preparing for a mass casualty incident. Similarly,

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1 NWFC were trained, in the view of the expert, and ready
 2 to respond to any reasonable worst case scenario
 3 eventuality with a suitable number of properly trained
 4 staff on duty, appropriately supported by managers.

5 In short, Mr Hall considers that both GMFRS and NWFC
 6 were in a position on 22 May to provide an adequate and
 7 effective fire and rescue service response to the arena
 8 attack.

9 Set against this background, Mr Hall describes the
 10 overall fire and rescue service response on 22 May,
 11 certainly within the first two hours of the incident, as
 12 "inadequate and ineffective". That is for a number of
 13 reasons in his judgment, including the following.

14 Reason 1. GMFRS resources were significantly
 15 delayed in arriving at the scene. The time between the
 16 initial notification to NWFC and the first meaningful
 17 GMFRS resources arriving on scene was just shy of
 18 2 hours. Mr Hall has observed that:

19 "This is against an average incident response time
 20 in 2017 of less than 6 minutes from mobilisation to
 21 attendance at the incident."

22 Mr Hall has identified a number of reasons for this
 23 delay. First, Mr Hall is critical of the decision
 24 within NWFC following initial reports of the arena
 25 attack to follow the bomb action card rather than the

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1 explosion action card, if indeed that is what happened.
 2 These cards resulted in different predetermined
 3 responses, and Mr Hall concludes that following the bomb
 4 action card was:

5 "The wrong decision because it introduced an
 6 unnecessary delay into the GMFRS response."

7 In Mr Hall's view, had the explosion card been
 8 followed, the outcome would have been significantly
 9 different and more positive in terms of the operational
 10 response from GMFRS. GMFRS resources would have been
 11 mobilised directly to an RVP or direct to the incident
 12 scene and a standard PDA, predetermined attendance,
 13 would have ensured the correct command and control
 14 assets were deployed simultaneously to the incident.

15 In light of this opinion of Mr Hall and given the
 16 development in the accounts of the key NWFC witnesses,
 17 it is plainly important that the inquiry should
 18 establish the facts of what happened in the NWFC control
 19 room once the first notification of the arena attack
 20 came in.

21 As part of that, Mr Hall will need to reflect upon
 22 the recent developments of the NWFC witnesses, as
 23 we have described it. If they did use what he considers
 24 the correct card, how still did a delay of 2 hours
 25 occur?

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1 Second, Mr Hall has expressed concern that both NWFC
 2 and GMFRS staff did not question and test the
 3 information they were receiving. In Mr Hall's view, the
 4 impact of unqualified, untested information and
 5 intelligence led to poor decision-making.

6 Third, Mr Hall is critical of the decision to use
 7 a rendezvous point different from that used by other
 8 emergency responders. He observes, and we use his
 9 words:

10 "Had GMFRS resources initially co-located at any of
 11 the nominated RVPs, shared situational awareness would
 12 have developed more quickly, an accurate assessment of
 13 risk could have taken place, and suitable resources
 14 requested to the scene to aid those affected. Equally,
 15 the GMFRS officers responding would have been better
 16 able to communicate with partners and plan using the
 17 joint decision model to develop a more effective
 18 response plan."

19 In the view of Mr Hall, this did not occur because
 20 of GMFRS's location at a different, and indeed distant
 21 and detached, RVP. Mr Hall describes this as a systemic
 22 failure caused by:

23 "The discounting of other RVPs in favour of the
 24 decision to follow the GMFRS NWFC bomb action plan and
 25 muster resources away from the incident until further

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1 information could be obtained."
 2 This failure was compounded by the lack of
 3 information sought and received by GMFRS and NWFC
 4 regarding changes to the applicable RVP and the failure
 5 of other emergency responders to communicate key
 6 information to GMFRS and NWFC appropriately, including
 7 RVP updates.
 8 Fourth, Mr Hall has identified a lack of effective
 9 leadership from GMFRS in the initial stages of the
 10 response, what he describes as "an absence of strategic
 11 direction and operational grip". GMFRS NILOs at
 12 Philips Park, prior to SM Berry's arrival, did not take
 13 on SM Berry's NILO role or attend a multi-agency RVP.
 14 Senior GMFRS officers attended the headquarters of
 15 GMFRS, rather than attending the headquarters of GMP.
 16 This lack of leadership in the view of Mr Hall further
 17 undermined the Fire and Rescue Service's existing lack
 18 of situational awareness.
 19 Reason 2. In the view of Mr Hall, the effect of the
 20 significant delay in GMFRS resources being mobilised
 21 at the scene was that the Fire and Rescue Service was
 22 unable to render assistance to casualties and engage in
 23 meaningful joint working in the early stages of the
 24 emergency response.
 25 Specialist resources that were available to GMFRS,

1 including specialist response teams, SRTs, and technical
 2 rescue units, TRU, with access to enhanced first aid
 3 equipment, such as trauma dressings and rescue
 4 stretchers, known as Skeds, were not deployed to the
 5 scene and so did not contribute to the response to the
 6 arena attack.
 7 This conclusion of the fire expert will
 8 understandably cause public concern. The inquiry will
 9 need to understand whether the conclusion of Mr Hall is
 10 correct and, if it is, establish why this failure
 11 occurred and what needs to be done to avoid such
 12 a failure occurring again.
 13 In his conclusions Mr Hall has emphasised that no
 14 single individual within GMFRS or NWFC is wholly
 15 responsible for the failings he has identified. Rather,
 16 a sequence of key internal decisions based on incomplete
 17 and/or inaccurate information caused GMFRS to identify
 18 a separate RVP away from partner agencies. This led to
 19 an inability to access key emergency service partners
 20 who held relevant information but who had not
 21 communicated that information effectively to NWFC and
 22 GMFRS. This caused a significant delay in deployment
 23 that, in the view of Mr Hall, negatively affected the
 24 fire and rescue service response to the attack.
 25 As will be apparent, Mr Hall has expressed some firm

1 views, but as we have said now a number of times, all
 2 should await the actual evidence and the witnesses,
 3 of course, will be tested, and no one should jump to
 4 conclusions.
 5 Nonetheless, the evidence gathered by the inquiry to
 6 date does indicate that the events of the night of
 7 22 May give rise to a need for GMFRS and NWFC to learn
 8 lessons. So we will turn next to whether they
 9 themselves have identified such lessons.
 10 First, GMFRS. David Keelan, Assistant County Fire
 11 Officer of GMFRS, has provided a statement setting out
 12 the changes made by GMFRS since the attack on 22 May.
 13 They include the following.
 14 First, a shared emergency services channel has been
 15 developed to address difficulties in multi-agency
 16 communications. This was implemented with effect from
 17 26 May 2017. GMCA have also made other improvements to
 18 inter-agency communications, including communication
 19 between the GMFRS NILO, GMP's FDO and the NWAS duty
 20 NILO.
 21 Second, changes have been made to the relevant JOPs.
 22 In February 2019 a further JOPs was released and was
 23 implemented by GMFRS in April 2019. ACFO Keelan
 24 suggests that these changes will assist GMFRS in
 25 responding to future incidents.

1 Third, working practices within and between GMFRS
 2 and NWFC have developed since the arena attack. The
 3 action cards for bomb and explosion have been amended to
 4 avoid confusion on which to use to provide greater
 5 prompts to the GMFRS NILO and to implement incident
 6 command without delay. The directions regarding
 7 mobilisation of the GMFRS NILO have also been changed to
 8 mobilise the nearest NILO to the incident and to avoid
 9 placing incident command responsibilities on NILOs
 10 during an incident. Other action cards relevant to
 11 other phases of Operation Plato have also been amended.
 12 Fourth, GMFRS reviewed the NILO role following the
 13 arena attack. This has led to changes in how NILOs are
 14 deployed and the support provided to them.
 15 Fifth, GMFRS has implemented a revised policy in
 16 respect of incident command support and undertaken
 17 further multi-agency training with a particular focus on
 18 deployment and multi-agency communication.
 19 Sixth and finally, ACFO Keelan describes the sharing
 20 of Greater Manchester site plans with other agencies,
 21 the provision of further specialist equipment and
 22 developments within the culture of GMFRS as changes
 23 following the arena attack.
 24 Next, the lessons learned by NWFC.
 25 Sarah-Jane Wilson, the head of NWFC, has provided

1 a statement on behalf of her organisation setting out
 2 the development of NWFC's policies and procedures
 3 following the arena attack. Ms Wilson states that
 4 following the publication of the Kerslake Report, to
 5 quote her words:
 6 "NWFC determined that it would take a more proactive
 7 role in relation to the management and monitoring of
 8 communications, sharing information and establishing
 9 situational awareness in order to avoid a repetition of
 10 the failures which had occurred in the response to the
 11 arena attack."
 12 As a result, NWFC has taken the following steps:
 13 First, NWFC has developed a major incident action
 14 plan and produced new incident types in their response
 15 plans. These new incident types will result in new
 16 predetermined attendances, PDAs, and action plans when
 17 selected by NWFC staff. The purpose of the major
 18 incident action plan is to require control room staff to
 19 actively facilitate communications between the emergency
 20 services and to ensure that the Fire Service is involved
 21 in multi-agency communication at all operational command
 22 levels.
 23 Second, the four fire and rescue service authorities
 24 which contract for the service provided by NWFC have met
 25 with their respective resilience forums to agree

1 a methodology for establishing three-way communications
 2 between the police, fire, ambulance services.
 3 Third, NWFC have introduced a number of training
 4 initiatives relating to JESIP awareness, strategic
 5 command and training on the NWFC major incident action
 6 plan.
 7 Against that background, the inquiry will need to
 8 consider a number of issues in relation to GMFRS and
 9 NWFC. They include, first, the planning and preparation
 10 by GMFRS and NWFC for a terrorist attack, including the
 11 adequacy of training, policies and multi-agency
 12 exercises prior to the arena attack.
 13 Second, the implementation of JESIP on 22 May. This
 14 will include consideration of the communication of
 15 information between GMFRS, NWFC and other emergency
 16 responders, the gathering of shared situational
 17 awareness between emergency responders, and whether
 18 additional steps should have been taken by GMFRS and
 19 NWFC to obtain such situational awareness.
 20 Third, the choice and use of action cards at NWFC,
 21 their consequences, and the adequacy of those cards,
 22 an issue which has been thrown into sharp focus by the
 23 further statements of the relevant NWFC witnesses.
 24 Fourth, the decisions taken in relation to the RVP.
 25 Fifth, the actions taken by the duty NILO of GMFRS,

1 SM Berry, including the initial decision to muster GMFRS
 2 resources at the Philips Park RVP, the difficulties in
 3 contacting the GMP FDO, Inspector Sexton, and whether
 4 any alternative steps should have been taken to gain
 5 situational awareness given the difficulties that were
 6 encountered in reaching the FDO.
 7 Sixth, whether information received by NWFC and
 8 GMFRS was challenged and analysed and, if so, whether
 9 such challenge and analysis was adequate and, if not,
 10 whether such information should have been challenged and
 11 analysed.
 12 Seventh, the deployment of resources including both
 13 the timing of such deployment and the nature of the
 14 resources deployed. This will include the deployment of
 15 GMFRS resources to Philips Park, the location of
 16 multiple senior GMFRS officers at the CSR at GMFRS HQ,
 17 the eventual deployment of GMFRS resources to
 18 Manchester Central and Victoria Station, and the
 19 adequacy of the GMFRS resources that were ultimately
 20 deployed to the scene.
 21 Eighth and very importantly, the impact, if any, of
 22 GMFRS's absence from the scene on those affected by the
 23 blast and whether that absence contributed, or may have
 24 contributed, to the loss of life that occurred.
 25 As will be apparent to everyone who is present in

1 this hearing room or watching remotely, from the length
 2 of our introduction to chapter 10, from the detail we've
 3 needed to go into and the number of issues we've
 4 identified, chapter 10 is going to take some time during
 5 the oral evidence hearings, but we make no apology for
 6 that. It is important in the highest degree that we
 7 understand what went well on the night of the bombing
 8 but also what did not. And if things did not go well,
 9 we need to understand whether that made any difference
 10 to the outcome in the cases of those who died.
 11 That is to say, we need to know whether a different
 12 and better response by the emergency services would have
 13 saved more lives or even a single life. We must make
 14 plain that it is clear from the evidence obtained by the
 15 inquiry that lessons have already been learned by the
 16 emergency services from their experiences on the night
 17 of 22 May, but we will need to consider whether there
 18 are yet further lessons that must be learned. If there
 19 are, we must seek to identify them so that, in the awful
 20 event that another terrorist outrage occurs, our
 21 emergency services are able to respond as effectively as
 22 possible.
 23 We will turn next to deal with chapters 11 and 12,
 24 although we will deal with chapter 11 and then invite
 25 the chairman to take a break.

1 As will be remembered, chapter 11 deals with the
 2 evidence of the blast wave experts and chapter 12 deals
 3 with the experience of each of the 22 deceased. This
 4 will be a very important part of the oral evidence
 5 hearings. We will be dealing, during this stage of our
 6 opening statement, with paragraphs 3.2, 6 and 7 of the
 7 inquiry's terms of reference.

8 In chapter 11 experts in the effect of the impact of
 9 a blast wave from the detonation of a bomb will be
 10 called. We will be referring to these experts as "the
 11 blast wave experts"; we have used that term already. In
 12 chapter 11 their evidence will be confined to giving an
 13 overview of the effect of a detonation in order to
 14 provide context to the following chapter.

15 Chapter 12 is concerned with the experience of each
 16 of those who died. It will involve the calling of
 17 evidence relating to each of the deceased. This will
 18 include evidence about them, about how they came to be
 19 in the City Room, and about them after the explosion.
 20 There will be evidence from the pathologists who
 21 performed the post-mortem examinations. The blast wave
 22 experts will also be recalled to give their evidence
 23 about whether or not the injuries which were sustained
 24 by each of those who died were or may have been
 25 survivable if different or earlier attention had been

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1 given to them.

2 In the course of the next section of this opening
 3 statement, we'll provide a summary of the blast wave
 4 experts' overview evidence before turning to each of the
 5 deceased and providing a thumbnail sketch only of the
 6 evidence the inquiry will hear about each of them.

7 The experts. To assist with its investigation into
 8 the deaths that occurred on 22 May, the inquiry has
 9 instructed a team of experts. The team is headed by
 10 Professor Anthony Bull. Professor Bull is the head of
 11 the Department of Bioengineering at Imperial College and
 12 director of the Royal Legion Centre for Blast Injury
 13 Studies. Professor Bull has extensive experience of
 14 trauma research and was awarded for this work
 15 a fellowship of the Royal Academy of Engineering in 2014
 16 and, in 2016, fellowship of the American Institute of
 17 Medical and Biological Engineering. He is one of just
 18 40 members of the World Council of Biomechanics.

19 Also in the blast wave expert team is
 20 Professor Jon Casper, a colonel in the British Army, and
 21 a fellow of the Royal College of Surgeons of Edinburgh
 22 and London. Professor Casper has extensive experience
 23 of military trauma between 1988 and 2014 and has treated
 24 and researched injuries from military conflicts in
 25 Afghanistan and Iraq.

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1 A third member of the blast wave expert team is
 2 Alan Hepper, a principal engineer in the Physical
 3 Services Group at the Defence Science and Technology
 4 Laboratory at Porton Down. His main responsibilities
 5 relate to human vulnerability, injury assessment and
 6 injury modelling.

7 The fourth member of the blast wave expert team is
 8 Peter Mahoney, a colonel in the British Army, emeritus
 9 professor at the Royal Centre of Defence Medicine and
 10 a fellow of the Royal College of Anaesthetists. Prior
 11 to his current academic role he was defence professor of
 12 anaesthesia and critical care, undertaking research into
 13 the care of blast and ballistic injured casualties.

14 A fifth and final member of the blast wave expert
 15 team is Mark Ballard, a lieutenant colonel in the
 16 British Army Royal Medical Corps. He is a consultant
 17 radiologist and fellow of the Royal College of
 18 Radiologists. His clinical subspecialty interest is
 19 head and neck trauma imaging.

20 In their report, the blast wave experts set out how
 21 an explosion affects the environment in which it occurs.
 22 They explained that an explosion creates a shock front
 23 of high pressure which moves out from the seat of
 24 detonation faster than sound. Behind it sits the blast
 25 wind, a mass of air and explosive products. Together,

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1 these are known as the blast wave. In their report they
 2 detail how the type of explosive and the environment it
 3 detonates in can affect the blast wave.

4 We will pause for a moment to indicate that we are
 5 next going to deal with the nature of injuries caused by
 6 a bomb. We will show a diagram on the screen. It is
 7 a drawing, but nonetheless it may upset some. So before
 8 we deal with this evidence, we'll pause, as we've done
 9 now many times, to allow anyone that wants to leave the
 10 room or to switch off a feed to do so. we anticipate
 11 that the next part of this opening statement will take
 12 no more than 10 minutes, following which we will take
 13 a break until about 10.45, I anticipate. I will pause
 14 for a moment.

(Pause)

15 The blast wave experts go on to explain the five
 16 types of blast injury. In short, these are classified
 17 as primary through to quinary injuries. A primary blast
 18 injury is described as being caused by the shock front.
 19 Secondary blast injuries result from the impact of
 20 fragments and larger missiles accelerated by the blast.
 21 Injuries caused by the moving body impacting on other
 22 objects and the ground are termed tertiary blast
 23 injuries. The first three types of injury are
 24 illustrated by a diagram within the report.
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1 Mr Lopez, I'm going to ask you to put figure 3 from
 2 the blast wave overview report on the screen. The
 3 reference is {INQ025364/9}.

4 We see there: primary blast injury, shock wave and
 5 reflecting shock waves; the secondary blast injury,
 6 namely that caused by primary and secondary fragments of
 7 the bomb; and tertiary blast injury, described as bodily
 8 displacement, but in other words the body being thrown
 9 against a wall or other object or the ground. We will
 10 just leave that on the screen for the time being.

11 So as we have said, we see there the way in which
 12 primary blast injuries are caused, namely through the
 13 shock wave, the way in which secondary blast injuries
 14 are caused, namely through damage caused by fragments of
 15 the bomb, and the way in which tertiary blast injuries
 16 are caused, namely the body being blown against an
 17 object or the floor.

18 Quaternary blast injuries are those caused by the
 19 heat of the explosion.

20 Finally, quinary blast injuries, which do not arise
 21 in the circumstances with which we are concerned, are
 22 caused by post-detonation environmental contaminants
 23 such as radiation.

24 We can take that from the screen now, please,
 25 Mr Lopez.

1 Building on this classification of blast injuries,
 2 the blast wave experts consider the effect of
 3 environment and proximity on the nature and severity of
 4 the injuries which are caused.

5 The experts will also explain internal blast
 6 injuries, that is to say injuries where there is no
 7 external evidence of trauma. Very importantly, they
 8 will also address the question of how blast injuries
 9 should be managed, which provides the foundation for the
 10 subsequent analysis of the circumstances of each of the
 11 22 deceased.

12 We shall deal with the blast wave experts'
 13 conclusions as they apply to each of those that died
 14 individually when we turn to look at each deceased.
 15 However, in summary, the blast wave experts found
 16 evidence of primary blast injury, so injury caused by
 17 the high pressure shock front, in only one case. The
 18 most prevalent cause of injury was secondary blast
 19 injury, the majority of which were caused by flying
 20 projectiles.

21 The experts didn't find any evidence of tertiary
 22 blast injury, so a moving body striking objects on the
 23 ground, and only two occasions of quaternary blast
 24 injuries, so injury caused by heat.

25 In relation to each deceased, the blast wave experts

1 have provided an opinion falling into one of three
 2 categories: unsurvivable injuries, meaning that they
 3 were so severe that even with the most comprehensive and
 4 advanced medical treatment, even if such treatment had
 5 been initiated immediately after injury, survival was
 6 deemed impossible; unlikely to be survivable, meaning
 7 that the injuries were so severe that even if the most
 8 comprehensive and advanced medical treatment was
 9 initiated immediately after injury, survival would not
 10 be expected, although it would not be impossible; and
 11 potentially survivable, meaning injuries that could
 12 prove fatal but where the experts are aware of or have
 13 direct experience of individuals who have survived such
 14 injuries.

15 We are going to turn next, although we anticipate
 16 after the break, to provide what is a short summary only
 17 of the evidence that we'll hear in chapter 12
 18 in relation to the experience of each deceased. We will
 19 take each in alphabetical order based on forename and
 20 we will refer to them by the name preferred by their
 21 families. We should make clear that we will be
 22 providing some background information about each
 23 deceased, their movements on the night, the injuries
 24 they sustained in general terms, and our current
 25 understanding of the cause of their death.

1 In some cases, as will be the approach when we come
 2 to the evidence during chapter 12, where two individuals
 3 are strongly linked by reasons of their shared
 4 experience at the arena prior to the explosion, we will
 5 deal with them together. Again, we do so having
 6 consulted the relevant bereaved families in relation to
 7 this.

8 This part of our opening statement will be difficult
 9 to hear and also difficult to deliver. So we warn those
 10 who are watching that it may be distressing, so that
 11 they can make a decision about whether to listen or not.

12 Sir, would this be an appropriate moment for our
 13 break?

14 SIR JOHN SAUNDERS: 10.45. Thank you.
 15 (10.13 am)

16 (A short break)

17 (10.45 am)

18 SIR JOHN SAUNDERS: Mr Greaney, before we start, it is
 19 apparent from what you have already said that this part
 20 of your opening is likely to be distressing to
 21 everybody, but of course most distressing to the
 22 families of the deceased. Can I just check with you,
 23 and indeed with the counsel representing the families,
 24 that the families are entirely aware of what this
 25 section will contain so they can make a fully informed

1 decision as to whether to remain in the hearing for it?
 2 MR GREANEY: Sir, I have spoken to some of the families
 3 myself and they are certainly aware. My understanding
 4 is that the legal representatives of the other bereaved
 5 families have spoken to them and I believe therefore
 6 that all bereaved families will be aware of what we are
 7 about to deal with.

8 Mr de la Poer is in contact with Ms Cartwright
 9 at the family annex. Obviously, if any person becomes
 10 distressed here, we will stop. It will be apparent to
 11 us. If any person becomes distressed at the family
 12 annex, that will be communicated to Mr de la Poer and
 13 again we will stop.

14 SIR JOHN SAUNDERS: Can I check with the families'
 15 representatives that everyone is happy and content with
 16 the arrangements which have been made? Happy is the
 17 wrong word, I'm sorry.

18 MR COOPER: I understand. Sir, we're grateful for that and
 19 again we are grateful to counsel to the inquiry for
 20 their assistance. I have had a chance of looking at
 21 some of the text of what Mr Greaney is going to say --
 22 not all of it, I make no criticism, but some of the text
 23 in relation to some of the families we represent.
 24 Although I have no direct instructions from the
 25 particular families and they wouldn't have seen the

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1 text, we have obviously been aware of this for some days
 2 and I know my instructing solicitors will inform me, or
 3 you, sir, if there are any issues. I'm not aware of any
 4 issues that have arisen.

5 SIR JOHN SAUNDERS: Mr Weatherby?

6 MR WEATHERBY: Likewise, sir, we have actually checked the
 7 text -- thank you to Mr Greaney for making that
 8 available to us -- and all of the families that we
 9 represent are aware of what is about to happen.

10 SIR JOHN SAUNDERS: Thank you. Mr Atkinson?

11 MR ATKINSON: Sir, likewise, we have seen the text and
 12 we have discussed it with our families who are as
 13 prepared as can be for what is about to happen.

14 MR GREANEY: A member of each family counsel team has seen
 15 the full text of what is to be said.

16 SIR JOHN SAUNDERS: I am grateful, thank you.

17 MR GREANEY: We're turning now to chapter 12, the experience
 18 of each of the 22 who died.

19 We will deal first together with Alison Howe and
 20 Lisa Lees.

21 Mr Lopez, could we have on the screen, please, first
 22 of all, a photograph of Alison Howe? This is
 23 {INQ035687/1}.

24 On 22 May 2017, Alison Howe was 44 years old and the
 25 only daughter of Susan and George. She was a gifted

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1 musician who played the piano and violin to a very high
 2 standard and had won a number of competitions during her
 3 younger years. Alison was employed at a care centre and
 4 had previously worked as a ward nurse. Alison was
 5 a much loved wife and mother. She was due to celebrate
 6 her 45th birthday 2 days after the concert and she and
 7 her husband, Stephen, had planned a holiday in New York
 8 later that week.

9 The couple had two daughters, Sasha and Darcie.
 10 When Alison married Stephen in 2003, she also became
 11 a parent to his sons, Lewis, Jack, Jordan and Harris.
 12 Her loved ones have commented on how well she looked
 13 after the six children and they remember her as
 14 successfully gelling the two families together.

15 Can we take the photograph of Alison from the screen
 16 just for the moment, please? We will put on the screen
 17 next a photograph of Lisa Lees. The reference is
 18 {INQ035712/1}.

19 On 22 May 2017, Lisa Lees was 43 years old. She was
 20 the daughter of Ivan and Elaine, and the older sister of
 21 Lee. In her later years Lisa became a mother to Lauren
 22 and India, and a wife to Anthony. She was also
 23 a grandmother to Jayden and to Dylan, who was born
 24 shortly after her death. Her loved ones remember her
 25 wide smile and infectious laugh. Lisa had a great work

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1 ethic. She ran a successful massage business, which
 2 treated terminally ill children and won an award for
 3 excellence in practice in 2012.

4 She also attended university and obtained
 5 a postgraduate certificate of education, which enabled
 6 her to teach beauty therapy. Lisa was very positive and
 7 driven and she taught her daughters that they could
 8 achieve anything they put their minds to. She loved
 9 walking, animals and helping others.

10 We are now going to put on the screen, please,
 11 Mr Lopez, the images together, {INQ035687/1}. Thank you
 12 very much indeed for doing that so quickly.

13 Alison's daughter, Darcie Howe, and Lisa's daughter,
 14 India Lees, attended the concert together on 22 May.
 15 Alison and Lisa took the two girls to the arena that
 16 night, arriving shortly after 18.45. After making sure
 17 they were safely inside the stadium, Alison and Lisa
 18 went and enjoyed a meal in Manchester city centre. They
 19 returned to the arena at the end of the concert, where
 20 they had arranged to meet Darcie and India in the
 21 City Room.

22 Alison and Lisa entered the City Room for the final
 23 time at 22.27.01. At the time of the explosion, they
 24 were both standing approximately 4 metres away from
 25 Salman Abedi. Following the explosion, Lisa was lying

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1 on her back, she was approached by Robert Grew, a member
2 of the public, at 22.38.02, who checked for a pulse in
3 her wrist. He didn't find one, and by 22.43.11, Lisa's
4 head and upper body had been covered with T-shirts. At
5 approximately 23.40, Nwas Advanced Paramedic
6 Patrick Ennis attached a label to Lisa's arm identifying
7 her as deceased.

8 Following the explosion, Alison was initially lying
9 on her back, before moving on to her right side. At
10 22.43.35, ShowSec employee Usman Ahmed observed that she
11 was still breathing but was severely injured. He tried
12 to clear her airway. Between 22.55.56 and 22.57.06,
13 Jade Samuels, a ShowSec employee also, and BTP
14 PC Jane Bridgewater took turns to perform CPR. Alison
15 was unresponsive and a T-shirt was placed over her head
16 at 22.57.21. Shortly before 23.45, Nwas Paramedic
17 Patrick Ennis attached a label to Alison's arm
18 identifying her too as deceased.

19 On 25 May 2017, Professor Philip Lumb, the
20 consultant forensic pathologist, carried out
21 a post-mortem examination of Lisa's body. He found that
22 the blast had struck Lisa from her left side and that
23 her death was caused by multiple injuries. In his view,
24 the severity of her injuries meant that Lisa would have
25 been rendered unconscious immediately before dying

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1 shortly afterwards.

2 On 26 May 2017, Dr Naomi Carter, another consultant
3 forensic pathologist, carried out a post-mortem
4 examination of Alison's body. She found that the blast
5 had struck Alison from her left side and that her death
6 was caused by a head injury. In her view, the severity
7 of her injuries meant that Alison would have been
8 rendered unconscious immediately. She was likely to
9 have died shortly afterwards, although Dr Carter was
10 unable to say for precisely how long Alison might have
11 survived.

12 The blast wave experts concluded that the injuries
13 to both Lisa and Alison were unsurvivable with current
14 advanced medical treatment.

15 We will take, please, the photographs of Lisa and
16 Alison from the screen now.

17 We are next going to deal with Angelika and
18 Marcin Klis. May we have on the screen, please,
19 {INQ035705/1}.

20 On 22 May 2017, Marcin Klis was 42 years of age; his
21 partner, Angelika Klis, was 39. They both grew up in
22 Poland before meeting and falling in love in the early
23 1990s. Their daughter, Aleksandra, was born in 1997,
24 followed by Patrycja in 2003. Aleksandra and Patrycja
25 describe the two as sharing a deep bond. They were both

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1 very caring people who always put their children's needs
2 before their own and did everything they could to
3 provide for them.

4 The family lived together in York, where Marcin
5 worked as a taxi driver and Angelika was a customer
6 services assistant. They were keen travellers and had
7 recently been to Rome and Egypt. Angelika liked to go
8 shopping and to watch films, whilst Marcin enjoyed
9 photography and rock music. Most of all, they loved to
10 spend time with their daughters and would plan a family
11 day out every few weeks.

12 On 22 May, Marcin and Angelika travelled to the
13 arena with their two daughters, Aleksandra and Patrycja,
14 as we have said. The family arrived at the arena
15 shortly before 18.40. Marcin and Angelika then went
16 into the city centre whilst Aleksandra and Patrycja
17 attended the concert.

18 Their parents had a happy evening out in Manchester
19 where they took some photographs together before
20 returning to the arena to pick up their daughters
21 shortly before 10 pm.

22 Marcin and Angelika entered the City Room for the
23 final time at 22.23.45 where they stood with their arms
24 around one another as they waited for the concert to
25 finish. At the time of the explosion, they were both

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1 approximately 4 metres away from it.

2 Following the blast, Marcin and Angelika lay on the
3 ground on their right-hand sides, with their heads
4 facing down towards the floor. Neither showed any signs
5 of life.

6 Nearly 6 minutes after the explosion, a member of
7 the public checked on Angelika and a member of the ETUK
8 staff crouched beside her at 22.42.59. Just before
9 23.00 hours their bodies were covered with T-shirts and
10 posters. At approximately 23.40, Patrick Ennis attached
11 labels to their arms, identifying both Marcin and
12 Angelika as deceased.

13 On 27 May, Dr Charles Wilson, another consultant
14 forensic pathologist, carried out a post-mortem
15 examination of Angelika. He concluded that she had died
16 as a result of multiple injuries. The pattern of her
17 injuries indicated that her left side was facing towards
18 the origin of the explosion. In Dr Wilson's view,
19 Angelika would have died relatively quickly.

20 On the same day, 27 May, a fourth consultant
21 forensic pathologist, Dr Michael Parsons, carried out
22 a post-mortem examination of Marcin. He found that the
23 overwhelming majority of injuries were sustained to the
24 left side of his body, indicating that he was facing
25 slightly towards the origin of the explosion.

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1 Dr Parsons concluded that Marcin died as a result of
 2 chest injuries , which were so severe that he would have
 3 passed away very quickly .
 4 The blast wave experts concluded that the injuries
 5 of both Marcin and Angelika were unsurvivable with
 6 current advanced medical treatment.
 7 Mr Lopez, we will now take please from the screen
 8 the photograph of Marcin and Angelika.
 9 We will deal next with Chloe Rutherford and
 10 Liam Curry.
 11 Could we please have on the screen a photograph of
 12 the two of them? {INQ035693/1}.
 13 Chloe Rutherford was 17 on 22 May. She was very
 14 close to her mum and dad and to her elder brother,
 15 Scott. She was a talented songwriter and performer and
 16 had recently completed her BTEC in music performance,
 17 finishing her work for that college year ahead of
 18 schedule. Chloe had used her musical talents to raise
 19 money for several charities and she had many plans for
 20 the future , including an apprenticeship in travel and
 21 tourism which fitted well with her passion for travel .
 22 Liam Curry was aged 19 on 22 May. He was very close
 23 to his mum and younger brother Zack. He was also very
 24 close to his dad, Andrew, who died in March 2017. Liam
 25 was a huge support to his family at this time and acted

1 with great dignity and courage. Liam was a talented
 2 sportsman and had been a keen cricketer since he had
 3 started to play at the age of 6. He was studying
 4 a sports degree at Northumbria University and had spoken
 5 about joining the police .
 6 Liam and Chloe had been together since 2014. Chloe
 7 and Liam travelled together to attend the concert .
 8 Chloe had received tickets for the concert as
 9 a Christmas present . Chloe and Liam travelled to
 10 Manchester, did some shopping at the Trafford Centre,
 11 checked into their hotel , and then went for a meal
 12 before the concert . They entered the arena shortly
 13 before 19.30. They were in frequent contact with their
 14 parents throughout the day and evening, sending pictures
 15 and telling them about the good time they were having
 16 together .
 17 Chloe and Liam entered the City Room at 22.30.49.
 18 They were walking towards the City Room exit and were
 19 approximately 4 metres from Salman Abedi at the time of
 20 the explosion . Travel Safe Officer Philip Clegg went to
 21 both Chloe and Liam following the explosion . They were
 22 both unresponsive when he spoke to them. Neither Chloe
 23 nor Liam received any medical care or intervention
 24 in the City Room. Gareth Chapman, a ticket agent,
 25 approached Chloe at 22.42.59 and covered her head and

1 body with concert T-shirts . He covered Liam with
 2 concert T-shirts at 22.43.10.
 3 At 23.40.49, HART paramedic Lea Vaughan attached
 4 a document to Chloe to indicate that she was deceased.
 5 At 23.44, she attached a document to Liam to indicate
 6 that he too was deceased.
 7 Professor Philip Lumb prepared a post-mortem report
 8 for both Chloe and Liam. He concluded that Chloe's
 9 death was caused by multiple injuries . He concluded too
 10 that the injuries would have rendered Chloe immediately
 11 unconscious and that it is very likely that she died
 12 very quickly . He concluded that Liam's death was caused
 13 by multiple injuries and that the injuries would have
 14 rendered Liam immediately unconscious and it is very
 15 likely that he too died very quickly .
 16 The blast wave experts conclude that both Chloe and
 17 Liam's injuries were unsurvivable with current advanced
 18 medical treatment.
 19 Mr Lopez, we'll take from the screen the photograph
 20 of Chloe and Liam.
 21 Next, we will deal with Courtney Boyle. May we have
 22 on the screen , please , a photograph of Courtney,
 23 {INQ035694/1}.
 24 SIR JOHN SAUNDERS: Would you want a break? You're all
 25 right? Thank you.

1 MR GREANEY: Courtney Boyle was 19 on 22 May. She was
 2 a student at Leeds Beckett University , where she was
 3 studying psychology and criminology , and had just
 4 submitted her first year exams. Her mum remembers
 5 Courtney loving life as a student and being the happiest
 6 she'd seen her. She'd become a confident, strong-minded
 7 and private young woman who was loving and caring.
 8 Courtney was very close to her family and adored
 9 being a big sister to Nicole. Courtney loved music and
 10 went to Leeds Festival when she was 16, where she met
 11 her boyfriend , Callum.
 12 After her funeral , her family learned that Courtney
 13 had earned a first in her first -year exam paper and she
 14 was awarded an honorary degree in July 2017.
 15 Courtney attended the arena on 22 May with
 16 Philip Tron, Deborah Hutchinson, Nicole Boyle and
 17 June Tron. The group were in Manchester to take Nicole
 18 to the concert . They had collected Courtney from her
 19 student accommodation in Leeds before travelling to
 20 Manchester. They had lunch together and spent time
 21 shopping before they dropped Nicole off at the arena
 22 shortly after 6pm. They went for a meal before parking
 23 next to Victoria Railway Station. The group waited
 24 in the car for a while, chatting and laughing. Courtney
 25 went with Philip when he went to the arena to collect

1 Nicole at around 22.20.
 2 Philip and Courtney entered the City Room at
 3 22.22.11. They were standing in front of the doors to
 4 the arena and were about 4 metres from Salman Abedi
 5 at the time of the explosion. Courtney did not receive
 6 any medical care or intervention in the City Room
 7 following the explosion. She can be seen on the body
 8 cam footage of Travel Safe Officer Philip Clegg at
 9 22.43.11, but Mr Clegg does not interact with her.
 10 Courtney's head was covered at 22.51. Advanced
 11 Paramedic Patrick Ennis checked Courtney at 23.38 and
 12 placed a label on her wrist in order to identify her as
 13 deceased.
 14 Dr Charles Wilson prepared the post-mortem report
 15 in relation to Courtney. Dr Wilson concludes that
 16 Courtney's death was caused by multiple injuries. He
 17 states that Courtney's death would have occurred quickly
 18 and the blast wave experts conclude that Courtney's
 19 injuries were unsurvivable with current advanced medical
 20 treatment.
 21 Mr Lopez, could we take the photograph of Courtney
 22 from the screen, please.
 23 We are going to deal next with Eilidh MacLeod.
 24 Could we have the photograph of Eilidh on the
 25 screen, please? It is {INQ035709/1}.

1 Eilidh MacLeod was 14 on 22 May. She was
 2 a much-loved middle sister of three and she was very
 3 family orientated. Eilidh loved music, which was a big
 4 part of her life. She was a very talented bagpipe
 5 player and loved playing as part of a band, through
 6 which she made many friends. Her band enjoyed success
 7 in the World Pipe Band Championships in August 2016 and
 8 she and her family were so proud that day.
 9 Eilidh was popular at school and had lots of good
 10 friends. People remember how she made them laugh with
 11 her great sense of humour and infectious laugh. She
 12 really cared about others and was helpful and loving.
 13 Those who knew her are sure she would have succeeded at
 14 whatever she chose to do.
 15 As we understand it, Eilidh travelled from home in
 16 Vatersay to attend the Ariana Grande concert with her
 17 friend. Eilidh's mother, Marion, travelled with Eilidh
 18 and her friend and took them to the arena. Marion
 19 watched Eilidh and her friend go into the arena shortly
 20 after 6.15 pm.
 21 Eilidh and her friend entered the City Room at
 22 22.30.49. They were walking towards the City Room exit
 23 and were approximately 4 metres from the explosion.
 24 Eilidh can be seen in the body-worn video taken by
 25 Travel Safe Officer Philip Clegg shortly after the

1 explosion. Mr Clegg does not have any interaction with
 2 Eilidh.
 3 Michael Williams, a member of the public, saw Eilidh
 4 as he was helping to move her friend from the City Room.
 5 He believes that Eilidh was deceased when he saw her.
 6 Eilidh did not receive any medical intervention in the
 7 City Room and the sequence of events shows that she was
 8 covered up with clothing from 22.51.
 9 Professor Lumb prepared the post-mortem report for
 10 Eilidh. He concludes that Eilidh's death was caused by
 11 multiple injuries. He concludes that her injuries were
 12 very severe and it was very likely that she died very
 13 quickly. The blast wave experts conclude that Eilidh's
 14 injuries were unsurvivable with current advanced medical
 15 treatment.
 16 We will take the photograph of Eilidh from the
 17 screen, please.
 18 We will next turn to Elaine McIver and see
 19 a photograph of Elaine on the screen, {INQ035699/1}.
 20 Elaine was born on 20 September 1973, making her
 21 43 years of age when the attack occurred. She was the
 22 youngest sister to Paul and Lynda. Her parents were
 23 Patricia and Frank. Patricia describes Elaine as "never
 24 giving her any pains from the day she was born". She
 25 left school at 16 and initially worked for her father,

1 who was a roofer. However, she became interested in the
 2 police and was first a special constable before becoming
 3 a police constable in 1998.
 4 Her mum reports her loving being in the police and
 5 that she learned sign language as she perceived there
 6 was a shortage of officers who could communicate with
 7 deaf people. She met her partner, Paul Price, in 2014
 8 through a friend. At the time she was killed they were
 9 in the process of moving. Going to concerts together
 10 was a passion of theirs.
 11 Paul had bought his daughter two tickets to the
 12 concert as a Christmas present. His daughter decided to
 13 go with a school friend. The three of them and Elaine
 14 travelled to the concert and the two girls were dropped
 15 off with the agreement that they were to be collected in
 16 the City Room. Paul and Elaine then spent a couple of
 17 hours together eating and talking about the house move
 18 before returning to the arena. Paul describes them as
 19 having a lovely meal together.
 20 They entered the City Room at 22.06.23. Elaine was
 21 standing approximately 5 metres from the seat of the
 22 explosion. She is captured on the body-worn footage of
 23 Philip Clegg very shortly after the explosion at which
 24 time she may still be alive. However, when he returned
 25 to her she was no longer responsive.

1 The post-mortem examination was carried out by
 2 Dr Michael Parsons. He concludes that Elaine died of
 3 chest injuries. He states that the severity of her
 4 injuries would have resulted in her rapid death.
 5 In their first report the blast wave experts
 6 characterised Elaine as being unlikely to survive from
 7 her injuries. However, in an addendum report,
 8 dated March 2020, prepared following the consideration
 9 of further material, they conclude that Elaine's
 10 injuries were unsurvivable with current advanced medical
 11 treatment.
 12 Mr Lopez, we'll take the photograph of Elaine from
 13 the screen.
 14 Next, we will speak about Georgina Callander.
 15 We will have a photograph of Georgina on the screen.
 16 The reference is {INQ035702/1}.
 17 Georgina was 18 years old at the time of her death.
 18 She was the daughter of Simon and Lesley and the
 19 youngest sister of Daniel and Harry. Her mum describes
 20 her as having been a very caring, family-orientated
 21 person who loved life and was just starting her journey
 22 into adulthood. Her dad describes her as having given
 23 so much love and having so much love to give. She had
 24 just passed her driving test and had won a place at
 25 university to study paediatrics. She was always smiling

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1 and loved the normal things in life such as pizza, chips
 2 and chocolate.
 3 Georgina attended the concert with her mother
 4 Lesley. They had booked into the Travelodge together
 5 and Lesley stayed with her while she got ready. At the
 6 arena, she met up with her friend, Aliya Rule, while
 7 Lesley spent the time with her friend Vanessa before
 8 returning to the arena with the intention of picking
 9 Georgina up. Aliya describes taking photographs and
 10 videos during the concert as they watched it together.
 11 Georgina entered the City Room at 22.30.51. She was
 12 approximately 4 metres away at the time the bomb went
 13 off. Approximately 20 minutes after the blast a member
 14 of the public, Thomas Owen, is captured being with
 15 Georgina. Shortly after he is joined by an ETUK medic,
 16 Kristina Deakin. Mr Owen remained with Georgina after
 17 Ms Deakin moved on, so she was not alone.
 18 At 23.04, Mr Owen is recorded on body-worn footage
 19 encouraging Georgina to breathe and talk. At 23.05,
 20 Mr Owen is recorded as stating that she is breathing.
 21 She was assessed by Advanced Paramedic Ennis a minute
 22 later, who says that she will be moved as soon as
 23 possible.
 24 At 23.18, Georgina was assessed by HART paramedics
 25 Vaughan and Hargreaves, who had arrived in the City Room

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1 a few minutes earlier, and Georgina was designated
 2 a priority casualty by them. A priority casualty,
 3 according to the ambulance experts, is a time-critical
 4 patient in need of immediate intervention or
 5 extrication.
 6 Shortly thereafter, Georgina was assisted by
 7 Bethany Crook, who had returned to the City Room and who
 8 did so much to help that night. At 23.25, Georgina was
 9 placed on an advertising board and was carried out of
 10 the City Room over the raised footbridge through the
 11 station and placed on Station Approach, at which point
 12 she was treated by paramedics.
 13 Highly distressingly, in the course of that journey
 14 to Station Approach, Lesley encountered the party who
 15 were carrying Georgina. Lesley accompanied Georgina
 16 from then on all the way to hospital, departing the
 17 arena at 23.40.49. By the time Georgina reached
 18 hospital she was already in cardiac arrest, which was
 19 not reversed, despite extensive treatment. She was
 20 declared dead at 00.05.
 21 Dr Michael Parsons carried out the post-mortem
 22 examination. He concluded that Georgina had died of
 23 a head injury. He states that it is likely Georgina
 24 would have been immediately rendered unconscious. The
 25 blast wave experts conclude that Georgina's injuries

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1 were unsurvivable with current advanced medical
 2 treatment.
 3 Mr Lopez, would you take the photograph of Georgina
 4 from the screen, please?
 5 We are next going to turn to Jane Tweddle. The
 6 photograph of Jane is {INQ035690/1}.
 7 Jane was 51 years old when she died. She was one of
 8 two children, born to Margaret and Alan Tweddle, and she
 9 grew up in Hartlepool. She later moved to Blackpool
 10 with her then partner, Mark Taylor. Together they had
 11 three daughters, Harriet, Lily and Isabelle.
 12 At the time of her death, Jane was working as
 13 a receptionist. She's remembered by those closest to
 14 her as a person who treated everyone with kindness,
 15 decency and respect. She was someone who loved to make
 16 people laugh. She taught her daughters to be kind. She
 17 is described as both caring and loyal.
 18 On 22 May Jane was accompanying her friend,
 19 Joanne Aaron, whose daughter and daughter's friend were
 20 attending the concert. The tickets for the two girls
 21 had been a birthday present from Ms Aaron to her
 22 daughter when she turned 14. Jane and Joanne dropped
 23 the children off and then went for some food. Joanne
 24 recalls it being a good night during which Jane had
 25 talked about the future.

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1 At 22.23.45, Jane and Joanne re-entered the
2 City Room. Jane was standing approximately 13 metres
3 from the explosion when it occurred. In the seconds
4 following the blast, Jane managed to move herself
5 further away before stopping close to the Fifty Pence
6 staircase into the City Room. A member of the public,
7 Sean Gardner, came across her shortly after she'd
8 reached that destination. He describes perceiving signs
9 of life, as do PC Jessica Bullough and ETUK medic
10 Craig Seddon.

11 Jane was subsequently administered CPR by police
12 officers. However, they describe this as not producing
13 any signs of life and it was stopped.

14 The post-mortem examination was carried out by
15 Dr Charles Wilson. He discovered that Jane had been hit
16 by a single projectile. His other findings are
17 consistent with Jane having been alive for a period of
18 time. He found that the cause of her death was a neck
19 injury.

20 The blast wave experts conclude that Jane's injury
21 was unsurvivable with current advanced medical
22 treatment.

23 Mr Lopez, would you take Jane's photograph from the
24 screen, please?

25 Next, John Atkinson. A photograph of John will be

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1 placed on the screen, {INQ035707/1}.

2 John was the third of four children to Daryl Price.
3 He describes him being much loved, well respected and
4 hard working. John was someone who would help anyone.
5 He was 28 years old when he died. He was brought up by
6 his mum and Kevan Price, to whom he referred as dad.
7 He was, as we have said, the third child of four
8 siblings, all the others sisters.

9 At the age of 16 he got together with Michael, with
10 whom he was until he died. His caring nature led him to
11 work as a healthcare assistant and he subsequently
12 devoted his working life to the care system, helping
13 young adults with autism and Asperger's syndrome and
14 working at a coronary stroke unit.

15 Ariana Grande was one of John's favourite artists.
16 He attended her concert at the arena on 22 May with his
17 lifelong friend Gemma O'Donnell, Michael's sister. The
18 tickets were a Christmas present and he'd been looking
19 forward to going for months. Gemma describes the
20 concert as being really good and that they had both had
21 a lovely time.

22 John entered the City Room at 22.30.49. When the
23 bomb went off, he was approximately 6 metres away.
24 Immediately following the explosion, John managed to
25 drag himself away in the direction of the Fifty Pence

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1 staircase. Fewer than 2 minutes after the explosion,
2 John was being tended to by Ron Blake. Earlier we heard
3 the recording of Ron Blake's 999 call, made at a very
4 early stage.

5 Mr Blake was at the arena to pick up his daughter.
6 He stayed with John for just short of an hour until John
7 started to receive treatment from paramedics. He
8 applied a tourniquet to John's leg. A number of people
9 interacted with John whilst he was in the City Room.
10 During this period he was conscious and able to speak.
11 At approximately 23.17, John was placed on an
12 advertising board and dragged by a number of people out
13 of the City Room. The intention was to take him in the
14 lift, but it proved to be unsuitable. As a result, he
15 spent a period of time on the raised footbridge whilst
16 a metal crowd barrier was found and placed under the
17 advertising board.

18 He finally reached the war memorial entrance to
19 Victoria Railway Station at 23.25.47, just under
20 10 minutes after he had left the City Room. John was
21 then treated by a number of paramedics. At 23.34 his
22 pulse was recorded as 62 beats per minute. At 23.48,
23 John suffered a cardiac arrest.

24 At 23.59, the ambulance he was subsequently placed
25 in departed for Manchester Royal Infirmary, where he

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1 arrived 7 minutes later. Despite the efforts of those
2 treating him, John was declared dead at 00.24.

3 Conducting the post-mortem examination,
4 Dr Naomi Carter found that John had sustained very
5 severe leg injuries. He had also sustained abdominal
6 injuries. Dr Carter concludes that John's collapse from
7 hypovolemic shock, that is to say cardiac arrest due to
8 inadequate blood volume filling the circulation, would
9 accord with a history of initial consciousness when
10 first formally treated by NNAS staff, followed by
11 a cardiac arrest. In the course of her examination
12 Dr Carter identified that John had significant heart
13 disease, known medically as ischaemic heart disease.
14 Dr Carter considers that this may have contributed to
15 John's death by making his heart more susceptible to
16 failure and/or that it potentially reduced the chance of
17 resuscitation. As such, she recorded it as
18 a contributing factor to his death.

19 The blast wave experts characterised John's injuries
20 as being potentially survivable, subject to the extent
21 to which his ischaemic heart disease may bear upon this
22 question. The blast wave experts state that the impact
23 of the heart disease is a matter outside their
24 expertise.

25 By reason of the comments by Dr Carter and the fact

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1 that the blast wave experts consider the impact of
 2 John's heart disease as being outside their expertise ,
 3 the inquiry instructed Dr Paul Rees, an expert in
 4 cardiology , about whom we'll say some more a little
 5 later .
 6 Mr Lopez, we will take John's photograph from the
 7 screen .
 8 Next we will speak about Kelly Brewster. The
 9 photograph of Kelly is {INQ035695/1}.
 10 On 22 May, Kelly was 32 years of age. She was the
 11 daughter of Kim and Kevin, and sister of Claire and
 12 Adam. Her family meant the world to her and she was
 13 a devoted auntie to Demi and Hollie, who both adored
 14 Kelly and would fight for her attention . She was
 15 a loving partner to Ian and was close to his daughter,
 16 Phoebe, having taken them both on a surprise trip to
 17 London and Disneyland Paris. The couple planned to have
 18 a baby and purchase a new house, and they were excited
 19 to build a future together .
 20 Kelly was very bright and had worked as an insurance
 21 claims assessor for 8 years. She was conscientious and
 22 a great team player and had passed her accountancy
 23 course with flying colours . She was keen to see the
 24 world and had spent time travelling around Australia and
 25 America and her friend Jen describes Kelly's great love

1 for life .
 2 Kelly attended the concert with her sister
 3 Claire Booth and another relative . They travelled by
 4 car to Manchester where they all enjoyed a meal together
 5 in Pizza Express. Kelly messaged her mother,
 6 Kim Brewster, to let her know they had arrived safely in
 7 Manchester. At 19.20 she sent a text to her partner ,
 8 Ian Winslow, telling him that she loved him.
 9 They all enjoyed the concert and left their seats
 10 shortly after the last song. Kelly, Claire and their
 11 relative walked out of the concert in a line with their
 12 relative in the middle of the two adults so they didn't
 13 lose sight of her .
 14 Kelly entered the City Room at 22.30.53 just behind
 15 her companions and only 7 seconds before the bomb was
 16 detonated. At the time of the explosion , Kelly was
 17 approximately 9 metres away from the killer .
 18 Following the explosion , Kelly was lying on the
 19 ground on her left side . Arena medic Ian Parry of ETUK
 20 tended to her at approximately 22.38, before concluding
 21 that Kelly had an unsurvivable head injury . Between
 22 approximately 22.43 and 23.11, Michael Buckley, an
 23 off-duty police officer , and BTP officer
 24 PC Danielle Ayers administered first aid to Kelly and
 25 repeatedly performed CPR. They were assisted by several

1 individuals including Sergeant Hare, Constable Johnson,
 2 Marianne Gibson of ETUK, and Megan Balmer, an employee
 3 of ShowSec.
 4 During this time Kelly appeared to show intermittent
 5 signs of life . However, she then became unresponsive
 6 and T-shirts were used to cover her body at 23.11.28.
 7 At approximately 23.45, NWS paramedic Patrick Ennis
 8 attached a label to Kelly's arm, identifying her as
 9 deceased .
 10 On 26 May, Dr Naomi Carter carried out a post-mortem
 11 examination of Kelly's body. She found that Kelly died
 12 due to the combined effects of head and abdominal
 13 injuries . The location of her injuries indicated that
 14 the blast had struck her from her back and right-hand
 15 side . In Dr Carter's view, the severity of Kelly's
 16 injuries would have rendered her rapidly unconscious and
 17 she would have died shortly afterwards , although
 18 Dr Carter was not able to specify for precisely how long
 19 Kelly survived .
 20 The blast wave experts concluded that Kelly's
 21 injuries were unsurvivable with current advanced medical
 22 treatment .
 23 We will take the photograph of Kelly from the
 24 screen , please .
 25 We will turn to Martyn Hett. His photograph is

1 {INQ035696/1}.
 2 Martyn Hett was 29 on 22 May. He was a much-loved
 3 son, stepson, brother and uncle. Martyn loved spending
 4 time with his family, both at home and abroad, and they
 5 had memorable holidays together . Martyn's family
 6 remember Martyn as being tremendous fun. His love of
 7 being centre stage was apparent from when he was young
 8 and he was a talented pianist and performer. Martyn was
 9 successfully working as a social media manager and he
 10 had a significant social media profile himself .
 11 Martyn's family have no doubt that he had a bright
 12 future ahead of him in this field . Martyn had many
 13 friends and was outgoing, sociable and entertaining .
 14 Martyn's family also remember how caring and supportive
 15 he was .
 16 Martyn went to the concert with friends to celebrate
 17 one of their birthdays . It was also a good time for the
 18 friends to meet because Martyn was planning to fly to
 19 America later that week. Martyn arrived at the arena
 20 with his friends shortly after 20.45. He met other
 21 friends once he took his seat for the concert. He met
 22 another friend , Lewis Conroy, in passing at a bar during
 23 the interval . Martyn was a big fan of Ariana Grande and
 24 was singing and dancing from the first song played. He
 25 danced with his friends and people nearby he'd met for

1 the first time that evening.
 2 Martyn saw Lewis again as they were leaving and
 3 arranged to meet him in the City Room so that Lewis
 4 could join Martyn and his friends for a drink. Martyn
 5 entered the City Room at 22.28.42. A member of the
 6 public remembers him laughing and joking with security
 7 staff. He then walked around the City Room and walked
 8 into a corner of the City Room shortly before the
 9 explosion. He was approximately 4 metres from the
 10 explosion.
 11 Travel Safe Officer Philip Clegg approached Martyn
 12 shortly after the explosion. Martyn did not respond to
 13 Mr Clegg speaking to him and gently shaking his
 14 shoulder. Emergency Training UK medic Ryan Billington
 15 recalls giving very limited treatment to a male who he
 16 believes may have been Martyn. Although he states that
 17 person was breathing, Mr Billington did not think he had
 18 any chance of survival, and he had died when
 19 Mr Billington returned later.
 20 Martyn's head was covered by 22.53 and a foil
 21 blanket was placed over him at 23.34. HART paramedics
 22 Lea Vaughan and Christopher Hargreaves checked upon
 23 Martyn at 23.42. Mr Hargreaves returned to Martyn at
 24 23.43. At this time it appears he was identifying those
 25 who had died.

1 Dr Charles Wilson prepared the post-mortem report
 2 for Martyn. He concluded that Martyn's death was caused
 3 by multiple injuries. Dr Wilson concludes that he would
 4 expect Martyn's injuries to have been rapidly fatal.
 5 The blast wave experts concluded that Martyn's
 6 injuries were unsurvivable with current advanced medical
 7 treatment.
 8 We will take the photograph of Martyn from the
 9 screen, please.
 10 We turn to speak of Megan Hurley, whose photograph
 11 is {INQ035708/1}.
 12 Megan Hurley was 15 on 22 May. Megan was very
 13 family-orientated and had lots of friends, some that
 14 she'd known since nursery. She was very close to her
 15 elder brother Bradley. They had many interests in
 16 common and made each other laugh hysterically. Megan
 17 was kind and caring and loved to help others. She loved
 18 photography and shared pictures with her family.
 19 Megan's headteacher recalls how well she did at school
 20 and her real sense of fun.
 21 Megan's smile was infectious and her boyfriend,
 22 Kieran, says Megan was one of a kind, someone who could
 23 make you happy in an instant no matter what mood you
 24 were in before just by showing her beautiful smile.
 25 Megan had been a fan of Ariana Grande since she was

1 a young girl. Her parents bought her tickets for the
 2 concert as Christmas presents and Megan was very excited
 3 about the show. Bradley offered to take her and their
 4 parents drove them to Manchester. Bradley and Megan
 5 attended the arena at about 6.40 pm. They had a good
 6 time before the concert, taking selfies, which they sent
 7 to their parents. Their parents recall how happy they
 8 looked in these photographs.
 9 Bradley remembers how much he and Megan enjoyed the
 10 concert and they were laughing and talking as they left.
 11 Bradley and Megan entered the City Room at 22.30.49.
 12 They were approximately 3 metres from the explosion.
 13 Megan and Bradley fell to the ground immediately
 14 following the explosion. Bradley saw Megan lying on the
 15 ground. He did not see her breathing and thought she
 16 had died.
 17 Megan's father found Bradley and Megan in the
 18 City Room at approximately 22.55. GMP Sergeant Hare
 19 approached Megan at 22.58 and was joined by
 20 Constable Dawson. At 23.00, ETUK medic Marianne Gibson
 21 instructed PC Dawson to start CPR upon Megan, which he
 22 did, assisted by other officers.
 23 At 23.06.26, Patrick Ennis instructed the officers
 24 to stop CPR because Megan was not breathing. The
 25 officers did stop and Megan was covered up.

1 Professor Lumb carried out the post-mortem
 2 examination for Megan. He concludes that Megan's death
 3 was caused by multiple injuries. Professor Lumb
 4 comments that injuries to Megan's brain would have
 5 rendered her immediately unconscious and it was very
 6 likely that she died quickly.
 7 The blast wave experts conclude that Megan's
 8 injuries were unsurvivable with current advanced medical
 9 treatment.
 10 We will take the photograph of Megan from the
 11 screen, please.
 12 We turn to Michelle Kiss. The photograph of
 13 Michelle is {INQ035692/1}.
 14 Michelle Kiss was 45 on 22 May. Her husband, Tony,
 15 describes how she was his guiding light from the moment
 16 he met her when they were both teenagers. They married
 17 in 1995 and created a family home together. Michelle
 18 and Tony had three children. Michelle loved her
 19 children deeply and looked forward to making happy
 20 memories with them. Michelle enjoyed planning things to
 21 do with her family and friends and had a natural ability
 22 to bring people together. Tony describes his pride in
 23 how his children have love and drive in everything they
 24 do, a quality he remembers in Michelle.
 25 Michelle went to the arena on 22 May with a family

1 member, a friend and a relative of her friend.
 2 Michelle's family member and her friend's relative
 3 attended the Ariana Grande concert and she and her
 4 friend planned to collect them afterwards. The group
 5 arrived at the arena at approximately 8 pm. Michelle
 6 and her friend went to the door to the arena in the
 7 City Room with those who were attending. After they had
 8 gone into the arena, Michelle and her friend went into
 9 the city centre for a meal. They returned to the arena
 10 shortly after 22.15.

11 Michelle and her friend entered the City Room at
 12 22.18. They walked across the room and stood at the
 13 bottom of the steps that lead down from the upper
 14 platform in the City Room and the company JD Williams.
 15 At 22.29, they both walked up the steps. At the time of
 16 the explosion Michelle was standing at the top of the
 17 steps, just over 20 metres away from the explosion. Her
 18 friend was to her left.

19 Michelle fell immediately to the ground. Her friend
 20 saw Michelle and recalls that she was not murmuring or
 21 groaning. Her friend believed that Michelle had died.
 22 Michelle's family member went to her and was
 23 understandably upset and distressed. They were taken
 24 away from the steps and looked after by a police
 25 officer. A member of the public stayed with Michelle

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1 and attempted to stem blood that was coming from a wound
 2 to her head. He also believed that Michelle had died.

3 At 22.48, Michelle was covered with a black sheet.
 4 Professor Philip Lumb prepared the post-mortem
 5 report for Michelle. He concludes that Michelle's death
 6 was caused by a head injury. He states that given the
 7 severe nature of the head and brain injury, it was very
 8 likely that Michelle was immediately unconscious and her
 9 death followed shortly afterwards. The blast wave
 10 experts concluded that Michelle's injuries were
 11 unsurvivable with current advanced medical treatment.

12 Thank you. We'll take the photograph of Michelle
 13 from the screen and turn to Nell Jones.

14 The photograph of Nell is {INQ035703/1}.

15 On 22 May, Mary Nell Jones was 14 years of age. She
 16 was the youngest child and only daughter of Jayne and
 17 Ernie and the little sister of Sam, Joe and William.
 18 She was loved and cherished by her family and a close
 19 circle of friends and was known to everyone as Nell.

20 Her friends describe how loyal she was as a friend
 21 and how fun she was. Nell excelled academically in all
 22 areas. She was hard-working and a gifted mathematician
 23 and she made her parents extremely proud. She was also
 24 a talented performer who shone on the stage and she
 25 loved ballet, contemporary dance and musical theatre.

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1 Despite her achievements she was very modest and
 2 would always offer support and encouragement to other
 3 children. Nell is remembered by her loved ones as
 4 a warm, vibrant and passionate individual with a wicked
 5 sense of humour and a big heart.

6 Nell attended the concert with her friend, who had
 7 given her a ticket as a birthday present. The two girls
 8 got ready together and were driven to the arena by the
 9 friend's father. They were both very excited and sang
 10 along to an Ariana Grande CD all the way.

11 Nell and her friend arrived at the arena at 7.30 pm.
 12 They went to the merchandise stand, where Nell bought
 13 a poster and a wristband, and her friend bought
 14 a T-shirt. They had a happy time at the concert,
 15 singing and dancing to the music, and from the moment
 16 Ariana came on stage, Nell would not let her friend sit
 17 down.

18 At 22.30.44, Nell and her friend walked into the
 19 City Room where they had arranged to meet her friend's
 20 father. As they walked through the room, Nell told her
 21 friend that she loved her and her friend said the same
 22 back. At the time of the explosion, Nell was
 23 approximately 2 metres away from Salman Abedi.

24 Following the explosion, Nell was lying face down on
 25 the ground. At 22.36.43 and again at 22.43.05

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1 Travel Safe Officer Philip Clegg attempted to rouse her,
 2 but she was unresponsive.

3 At 22.53.28, Constable Leon McLaughlin checked
 4 Nell's neck for a pulse but he could not find one.
 5 A pink jumper was then used to cover her up.

6 At 23.41.54, HART paramedic Lea Vaughan attached
 7 a label to Nell's right wrist identifying her as
 8 deceased.

9 On 27 May, Dr Charles Wilson carried out
 10 a post-mortem examination of Nell's body. He found that
 11 the blast had struck her from her left side and that her
 12 death was caused by multiple injuries. Other findings
 13 indicated that Nell died relatively quickly, and the
 14 blast wave experts concluded that Nell's injuries were
 15 unsurvivable with current advanced medical treatment.

16 We will not finish dealing with chapter 12 within
 17 90 minutes and this feels to me like an appropriate
 18 moment for a break, but a short one.

19 SIR JOHN SAUNDERS: Right. We will have a quarter of
 20 an hour's break. It's not only very difficult evidence
 21 to listen to, obviously for relatives in particular, but
 22 I have no doubt it is a very difficult part of the
 23 opening to read as well.

24 MR GREANEY: Thank you, sir.
 25 (12.00 pm)

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1 (A short break)
 2 (12.15 pm)
 3 SIR JOHN SAUNDERS: Mr Greaney.
 4 MR GREANEY: Sir, we are turning next to
 5 Olivia Campbell-Hardy. The photograph of Olivia is at
 6 {INQ035711/1}.
 7 On 22 May 2017, Olivia Campbell-Hardy was 15 years
 8 old. She was the daughter of Charlotte and Andrew and
 9 sister of Catriona, Chloe and Seana. From a young age
 10 Olivia was a talented performer with a beautiful singing
 11 voice. She had passed all her dancing exams, sang in
 12 choirs, and auditioned for Britain's Got Talent. She
 13 had dreams of becoming a singer in the West End or
 14 a music teacher. Olivia also did extremely well
 15 academically and is remembered by her teachers as
 16 a motivated, well-behaved pupil, with an excellent
 17 attitude to her studies.
 18 She loved making her friends and family laugh and
 19 she wanted everyone around her to be happy. Her loved
 20 ones remember her as someone who put 100% into
 21 everything she did, with a smile on her face, and as
 22 someone who could achieve anything she turned her mind
 23 to.
 24 Olivia attended the concert with her friend, who had
 25 been given two tickets as a Christmas present. They

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1 travelled on the Metro into Manchester, the two friends
 2 had a McDonald's for tea, which was Olivia's favourite
 3 meal, before going to the arena and finding their seats.
 4 Olivia kept her mum updated by text message throughout
 5 the evening until around 9 pm when Ariana came on to the
 6 stage. The two friends had a great time singing and
 7 dancing to all her songs.
 8 At 22.30.51, Olivia and her friend entered the
 9 City Room. As they walked through the room her friend
 10 asked Olivia what her favourite song had been at the
 11 concert, but before she could answer that question, the
 12 explosion occurred. At that moment, Olivia was
 13 approximately 5 metres away.
 14 Following the explosion, Olivia was lying on the
 15 ground on her left-hand side. At 22.45.15, she was
 16 assessed by Ken O'Connor, a first-aider for ETUK, and
 17 Police Constable Jessica Bullough. Olivia showed no
 18 signs of life and a poster was used to cover her head
 19 and upper body.
 20 At approximately 23.45, Patrick Ennis attached
 21 a label to Olivia's arm, identifying her as deceased.
 22 On 26 May, Dr Michael Parsons carried out
 23 a post-mortem examination of Olivia's body. He found
 24 that Olivia had been facing away from the origin of the
 25 explosion and that the overwhelming majority of injuries

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1 were sustained to the right side of her body.
 2 Dr Parsons concluded that Olivia died as the result of
 3 multiple injuries which would have resulted in her
 4 immediate unconsciousness and very rapid death. The
 5 blast wave experts found that Olivia's injuries were
 6 unsurvivable with current advanced medical treatment.
 7 We will take Olivia's photograph from the screen,
 8 please, and next we will turn to Philip Tron.
 9 The photograph of Philip is {INQ035714/1}.
 10 Philip Tron was 32 on 22 May. He lived in Gateshead
 11 and worked as a water conservation engineer. One of
 12 five siblings, Philip was a much-loved member of his
 13 family with whom he loved socialising and holidaying.
 14 He was hugely likeable and his family remember him as
 15 a bit of a joker who had made people laugh since his
 16 school days. He particularly liked winding up his mum,
 17 June.
 18 Philip was kind and considerate, he looked after his
 19 nana, Sadie, when she was ill and his practical skills
 20 meant he was relied upon by family and friends to help
 21 with odd jobs. Everyone was pleased with the work
 22 Philip did for them.
 23 His family remember his friendly voice on the phone
 24 agreeing to help them. Above all, Philip wanted to have
 25 a happy family life. He attended the arena that night

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1 with Deborah Hutchinson, Courtney Boyle, Nicole Boyle
 2 and June Tron. The group were in Manchester to take
 3 Nicole to the concert. Philip, Deborah, June and Nicole
 4 had driven together from Gateshead, collecting Courtney
 5 on their way to Manchester. The group spent the day
 6 together before the concert. They had dropped Nicole
 7 off at the arena shortly after 6 pm, then they went for
 8 a meal, before parking their car next to
 9 Victoria Station.
 10 The group waited in the car for a while, chatting
 11 and laughing. Philip and Courtney then went back to the
 12 arena at 22.20 to collect Nicole.
 13 Philip and Courtney entered the City Room at
 14 22.22.11. They were standing in front of the doors to
 15 the arena and were about 4 metres from Salman Abedi
 16 at the time of the explosion. Philip did not receive
 17 any medical care or intervention in the City Room
 18 following the explosion. He can be seen on the body cam
 19 footage of Travel Safe Officer Philip Clegg at 22.36.10,
 20 but Mr Clegg did not interact with Philip.
 21 A pink blanket was placed over Philip's head at
 22 22.45 by Constable Jessica Bullough. Paramedic
 23 Patrick Ennis checked Philip at 23.38 and placed a label
 24 on his wrist in order to identify him as deceased.
 25 Dr Charles Wilson prepared the post-mortem report of

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1 Philip. He concludes that Philip's death was caused by
2 multiple injuries. Dr Wilson states that Philip's death
3 would have occurred very quickly and the blast wave
4 experts conclude that Philip's injuries were
5 unsurvivable with current advanced medical treatment.

6 Mr Lopez, would you take Philip's photograph from
7 the screen, please?

8 We will turn next to Saffie-Rose Roussos. Her
9 photograph is {INQ035689/1}.

10 Saffie-Rose was born on 4 July 2008, so she was
11 a couple of months shy of her ninth birthday when she
12 was killed. She was daughter to Andrew and Lisa Roussos
13 and little sister to Ashlee and Xander.

14 Saffie-Rose was a joyful child who loved to be
15 around people and make them laugh. She had a sense of
16 mischief and fun and loved pranks. She had charisma and
17 confidence, together with determination and a daring
18 streak. At the time of her death, Saffie-Rose attended
19 Tarleton Community Primary School in Tarleton,
20 Lancashire, where she exhibited her curiosity, kindness
21 and imagination.

22 She had received the tickets for the Ariana Grande
23 concert from her parents as a Christmas present and had
24 counted down the days since then. Saffie-Rose attended
25 the concert with her mum, Lisa, and sister, Ashlee. Her

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1 sister describes them as having a good view of the
2 stage. She says they had a good time and she and
3 Saffie-Rose got up and danced. They really enjoyed the
4 concert.

5 They entered the City Room at 22.30.45. Saffie-Rose
6 was standing approximately 5 metres from the explosion.

7 About 4 minutes after the blast, Saffie-Rose was
8 approached by Paul Reid, who was present at the arena
9 with a view to selling posters after the concert had
10 finished. Mr Reid was to stay with Saffie-Rose until
11 she was taken to hospital in an ambulance. He was
12 joined by a member of staff from SMG. Approximately
13 10 minutes after the explosion, two ETUK medics,
14 Marianne Gibson and Elizabeth Woodcock started to tend
15 to Saffie-Rose.

16 At 22.53.07, Bethany Crook began to help. As
17 we have observed already, Ms Crook's behaviour on that
18 night was nothing short of extraordinary.

19 In Saffie-Rose's case, she, Bethany Crook, took
20 charge of the situation and sought to assist
21 Saffie-Rose, together with a number of police officers.
22 A piece of advertising hoarding was used as a makeshift
23 stretcher and Saffie-Rose was carried, as we heard
24 during the CCTV summary, through the Trinity Way tunnel.

25 A passing ambulance was flagged down on Trinity Way

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1 and Saffie-Rose was taken to hospital, leaving the area
2 of the arena at 23.15.51, and arriving at hospital at
3 approximately 23.25.

4 Once at hospital, Saffie-Rose received treatment,
5 but it was to no avail and she was declared dead at
6 23.40.

7 The post-mortem examination was carried out by
8 Professor Philip Lumb. He concluded that Saffie-Rose's
9 death was the result of multiple injuries.

10 In their first report, the blast wave experts
11 characterised Saffie-Rose as being unlikely to survive
12 from her injuries. However, in an addendum report dated
13 March 2020, prepared following the consideration of
14 further material, they conclude that Saffie-Rose's
15 injuries were unsurvivable with current advanced medical
16 treatment.

17 We will take the photograph of Saffie-Rose from the
18 screen.

19 We are next going to turn to Sorrell Leczkowski.
20 The photograph of Sorrell is {INQ035713/1}.

21 On 22 May, Sorrell was 14 years of age. She lived
22 in North Leeds with her mum Samantha, older brother
23 Sebastian, and her younger sister, Sophie. Sorrell was
24 close to her family, including her nana and grandad and
25 her uncles and aunties. Sorrell's mum remembers her as

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1 a positive and caring girl who created a very happy
2 house. Sorrell was hard-working and loved school. She
3 particularly enjoyed maths, music, and was a gifted
4 designer, who used her creative talents to decorate her
5 bedroom and make her own accessories.

6 Her ambition was to study architecture at the
7 University of Columbia in New York. Sorrell had lots of
8 friends and she made everyone feel valued. Sorrell's
9 deputy headteacher, Dave Hewitt, describes her as
10 holding her friendship group together and as always
11 being willing to help solve their problems.

12 On 22 May, Sorrell travelled to Manchester with her
13 mum, Samantha, her grandmother, Pauline Healey, her
14 sister, Sophie, and her sister's friend, Lauren. They
15 spent the day shopping in the city centre, where
16 Samantha purchased tickets to the concert for Sophie and
17 Lauren.

18 They went to the arena to drop the two girls off,
19 arriving shortly after 1800 hours. Sorrell then went
20 back into the city centre with her mum and grandmother,
21 where they did some more shopping before returning to
22 the arena at about 10.15.

23 Sorrell entered the City Room at 22.17.56 where she
24 waited for several minutes with her mum and grandmother.
25 Whilst they waited, Sorrell made her family laugh by

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1 singing and dancing along to the music. At the time of
2 the explosion, Sorrell was approximately 6 metres away
3 from Salman Abedi, the bomber.

4 Following the explosion, Sorrell was lying on the
5 ground on her right-hand side. Her mother administered
6 first aid to her. She was assisted in those efforts by
7 several individuals, including Philip Clegg, a number of
8 police officers, and ETUK medic Marianne Gibson.
9 Together, they repeatedly attempted to revive Sorrell
10 with CPR for over half an hour, which that included the
11 use of a defibrillator.

12 Sorrell did not show signs of life at any point and
13 a police jacket was used to cover her at approximately
14 23.13.

15 Shortly after 23.45, Patrick Ennis attached a label
16 to Sorrell's arm, identifying her as deceased.

17 On 28 May, Professor Lumb carried out a post-mortem
18 examination of Sorrell's body. He found that her death
19 was caused by a neck injury and that she would have died
20 shortly after the explosion. The pattern of Sorrell's
21 injuries indicated that at the time of the explosion,
22 her back and right side were turned towards the blast.

23 The blast wave experts concluded that Sorrell's
24 injuries were unsurvivable with current advanced medical
25 treatment.

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1 Mr Lopez, we'll take the photograph of Sorrell from
2 the screen and turn next to Wendy Fawell. Her
3 photograph is at {INQ035700/1}.

4 Wendy was born on 12 December 1966 in Leeds. She
5 was 50 years old when she died and she had one older
6 brother. She went to school in Leeds and, upon leaving,
7 worked in a number of places, including a wool factory,
8 Wilkinson's butchers, a playgroup, and an after-school
9 club. She was the life and soul of the party and
10 a brilliant cook, who loved to feed people. She had
11 recently found love with a man called Nigel.

12 She also had a daughter, Charlotte, who was 15
13 at the time of her mum's death. Wendy attended the
14 concert in order to take and collect her daughter,
15 Charlotte, for whom the ticket was a Christmas present.
16 Also in Wendy's party were Charlotte's boyfriend, his
17 brother and their mother, Caroline, who describes
18 herself as being like a sister to Wendy.

19 Caroline describes how she and Wendy filled the time
20 between the start and end of the concert having a coffee
21 and eating some food. Wendy entered the City Room at
22 22.30.24. At the time of the explosion, she was
23 standing about 5 metres away.

24 Approximately 10 minutes after the blast,
25 Travel Safe Officer Philip Clegg approached Wendy and

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1 attempted to rouse her, but this elicited no response
2 from Wendy.

3 At 22.53, Wendy was approached by a member of staff
4 from ShowSec, Meghan Balmer. Ms Balmer is recorded as
5 saying that she thought she could detect a pulse. She
6 sought to roll Wendy over, at which point it was
7 apparent to her and a police officer who was assisting
8 that Wendy was dead.

9 The post-mortem examination was carried out by
10 Dr Naomi Carter. She concludes that Wendy died of the
11 effects of a head injury. Dr Carter's opinion is that
12 this would have rendered Wendy unconscious virtually
13 instantaneously and that she would have died shortly
14 thereafter. The blast wave experts found that Wendy's
15 injuries were unsurvivable with current advanced medical
16 treatment.

17 Thank you. We will take Wendy's photograph from the
18 screen, please.

19 In addition to the blast wave experts and those
20 pathologists who carried out a post-mortem examination,
21 the inquiry has instructed Professor Philip Lumb and
22 professor Jack Crane to conduct a review of all of the
23 post-mortem evidence in the light of the audiovisual
24 footage with a view to reviewing the conclusions which
25 had been reached on the basis of the post-mortem

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1 examinations alone.

2 Over and above this, there are two further areas of
3 medical evidence which relate to evidence the inquiry
4 will hear during the course of chapter 12.

5 Firstly, in the light of the conclusions relating to
6 John Atkinson, the inquiry has instructed Dr Paul Rees
7 to consider the specific question of whether or not
8 John's heart condition made a material impact on whether
9 or not he may have survived the explosion.

10 Dr Rees is a consultant in cardiology, general
11 internal medicine and pre-hospital emergency medicine.
12 He holds the rank of surgeon commander in the Royal Navy
13 and, among other things, he is the co-lead for the
14 British Cardiovascular Intervention Society Focus Group
15 on out-of-hospital cardiac arrest. He's also the lead
16 for the Defence Resuscitation Committee and the defence
17 lead for endovascular resuscitation.

18 Dr Rees has considered the circumstances of John's
19 death by particular reference to what effect John's
20 ischaemic heart condition may have had. His conclusions
21 are stark. On the balance of probabilities, Dr Rees
22 considers that John's heart condition did not contribute
23 to John's blood loss, cardiac arrest or to the inability
24 successfully to resuscitate John. In short, in the
25 opinion of Dr Rees, John's heart condition did not make

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1 any difference to whether or not John would have died.
 2 As we have said already, survivability is therefore
 3 an issue of considerable importance in the case of
 4 John Atkinson.
 5 Finally by way of medical evidence, at the sensible
 6 request of those representing one other of those who
 7 died and because of the particular circumstances of that
 8 person's case, the inquiry has supported the instruction
 9 by their legal team of Dr Gareth Davies, a consultant in
 10 pre-hospital emergency medicine and former medical
 11 director for the London Air Ambulance, and
 12 Dr Claire Park, consultant in anaesthesia, critical care
 13 and pre-hospital care.
 14 The inquiry understands that they are to be
 15 instructed to report on the care received and to
 16 contribute to the question of whether or not the
 17 particular person's injuries were survivable. We have
 18 been deliberately opaque in how we have framed what we
 19 just said by not naming the person to whom this report
 20 or these reports will relate. We do so at the express
 21 request of that person's representative or that person's
 22 family's representative, rather, and for reasons which
 23 are both good and, we dare say, obvious.
 24 However, so that there may be no misunderstanding,
 25 we make clear that at this stage, given the state of the

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1 evidence which currently exists and given that it is
 2 wholly unknown whether Dr Davies and Dr Park will say
 3 anything which casts doubt on that evidence, it would be
 4 both unhelpful and highly distressing to the family
 5 concerned if, in the act of naming them at this stage,
 6 what we say is taken by anyone as suggesting that there
 7 is uncertainty. We hope that is clear. As matters
 8 stand, there is not. Whether there will in due course
 9 be is a matter for the inquiry to investigate.
 10 We turn now to set out in summary form what issues
 11 appear to counsel to the inquiry to arise in relation to
 12 chapters 11 and 12.
 13 Firstly, these chapters will serve as an
 14 investigation as to how and in what circumstances each
 15 of those who were killed died. It will aim to answer
 16 the questions which would have arisen as a matter of law
 17 in the event that this inquiry had remained 22 inquests.
 18 Secondly, in doing so, the inquiry will consider the
 19 issue of survivability in the case of each of those who
 20 died. This is a very important question as it will be
 21 capable of bearing on the consequences of any failure
 22 in the adequacy and/or effectiveness of the emergency
 23 response.
 24 Thirdly, as a function of the two previous issues,
 25 the inquiry will examine what care each person did

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1 receive and will hear live evidence from many of those
 2 who provided it and from those who helped the three
 3 people who were moved out of the City Room prior to
 4 their death.
 5 Fourthly, in the context of examining this third
 6 issue, the inquiry will consider what care was not
 7 provided. This will involve examining the actions of
 8 the paramedics in terms of how many went into the
 9 City Room, when they went into the City Room, and what
 10 they did once they were there.
 11 Furthermore, it will consider the question of the
 12 removal of the injured from the City Room from the
 13 perspective of what was not available, but which should
 14 have been by way of stretchers and other equipment if
 15 that is the inquiry's finding.
 16 The investigation of all of these issues will have
 17 its origin in chapters 9 and 10. Chapter 12 will
 18 provide the opportunity to continue, and we hope,
 19 conclude those enquiries so that the answers that each
 20 of the families of the deceased deserve can be given.
 21 Sir, that would be a convenient moment to break for
 22 lunch. But may we suggest a slightly shorter lunch
 23 today so that we can be confident that we will conclude
 24 this opening address?
 25 SIR JOHN SAUNDERS: I will say we'll resume at 1.45. That's

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1 a couple of minutes over an hour. If that causes any
 2 difficulty to anyone, would you mention it to a member
 3 of the team, who will then tell me, and I will then
 4 consider whether we can start a bit later.
 5 MR GREANEY: Thank you, sir.
 6 (12.43 pm)
 7 (Lunch adjournment)
 8 (1.45 pm)
 9 SIR JOHN SAUNDERS: Mr Greaney, just before you start again,
 10 it may be worthy of explanation to people who were
 11 mystified that during the section we've just done, where
 12 you referred on a number of occasions to people
 13 attending with a friend --
 14 MR GREANEY: I did.
 15 SIR JOHN SAUNDERS: -- rather than giving their names. It's
 16 not, as I understand it, that they don't want their
 17 names mentioned, but it is because they were victims of
 18 the attempted murder charge and under a Contempt of
 19 Court Act order made by Mr Justice Jeremy Baker in the
 20 trial of Hashem Abedi they can't actually be named. But
 21 for the purposes of the hearing hereafter, we are
 22 seeking from Mr Justice Jeremy Baker permission, if he
 23 thinks it appropriate, to name them subsequently.
 24 MR GREANEY: Indeed, sir. Thank you very much for the
 25 clarification.

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1 We will turn in a moment to deal with chapter 13,
2 radicalisation , and then with chapter 14,
3 preventability . But before we do so, we want to
4 acknowledge that people, particularly the bereaved
5 families , may feel uncomfortable that we are moving with
6 only a short break, namely the lunch break, from
7 considering each life that was lost in the bombing to
8 matters relating to the person who caused all of that
9 dreadful loss . However, we hope that everyone will
10 understand that there are issues relating to
11 radicalisation and preventability that we think is
12 important to set out publicly at this early stage of our
13 process .

14 So first then, chapter 13, radicalisation and an
15 overview of the evidence .

16 One of the most difficult and also important
17 questions the inquiry must try to answer about the
18 Manchester Arena attack is: why? Why did Salman Abedi
19 carry out that evil act on 22 May? What could possibly
20 cause a young man of 22 years deliberately to kill so
21 many innocent people in such a horrific act of violence?
22 This is a question that the chairman drew specific
23 attention to in his introductory remarks on Monday .

24 We will grapple with those issues in chapter 13 when
25 we turn to consider evidence about Salman Abedi's

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1 radicalisation , as is required by paragraphs 1.1 and 1.2
2 of the terms of reference .

3 In seeking to understand how Salman Abedi arrived at
4 a position in which he was willing to do what he did,
5 we will hear evidence touching on various aspects of his
6 life . As we explained earlier , an overview of much of
7 the relevant material will be given by Detective
8 Chief Superintendent Simon Barraclough, the SIO for
9 Operation Manteline, but we will then consider each
10 aspect in more detail during the evidence .

11 What follows today, and follows now, is still very
12 much a provisional indication of the evidence which will
13 be heard because responses to some requests for
14 statements are still outstanding, some disclosure still
15 needs to be made to core participants , and the proposed
16 list of witnesses is still in the process of being drawn
17 up. A full plan will be shared with core participants
18 as soon as possible and their comments sought in the
19 same way as with other chapters of the evidence .

20 Whilst the vast majority of the evidence relating to
21 radicalisation will be heard in open, it is also likely
22 that there will be some evidence heard in the closed
23 hearings , which will inform the chairman's findings and
24 conclusions on these issues , but that will be kept to
25 the absolute minimum .

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1 As we wish to stress , this inquiry has no desire to
2 hear evidence in closed . We want as much to be in open
3 as is possible . We emphasise that the inquiry will only
4 hear evidence in closed where to do so would make
5 terrorist attacks more likely or more deadly .

6 We will turn then to summarise the areas we intend
7 to address during chapter 13 before turning to some of
8 the evidence in a little more detail .

9 First , we'll consider the aspects of Salman's life
10 relating to his immediate family . Statements have been
11 requested, as we indicated yesterday, from Salman's
12 parents, Ramadan Abedi and Samia Tabbal, as well as from
13 his older brother, Ismale, and younger sister , Jomana .
14 A statement has also been sought from his brother ,
15 Hashem Abedi .

16 So far , no member of Salman Abedi's family has
17 provided a substantive response . Ismale has provided an
18 unsigned statement asserting his privilege against
19 self - incrimination or asserted privilege against
20 self - incrimination but no more . Ramadan has indicated
21 that he does not intend to assist the inquiry . As will
22 be obvious, this is most unhelpful and we hope that
23 Salman Abedi's family will reflect and understand that
24 they have a moral obligation to provide the information
25 we require in order to enable the chairman to reach his

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1 conclusions .

2 The inquiry legal team is in the process of
3 following up on its requests, although this is made more
4 complex by the fact that Ramadan, Samia and Jomana
5 currently reside , as we understand it, in Libya, and so
6 are outside the jurisdiction . We have challenged
7 Ismale's claim of privilege , but he has reasserted it .
8 The inquiry legal team will continue to press him for
9 answers . But in any event, whatever the ultimate level
10 of cooperation, or non-cooperation, by the Abedi family
11 with the inquiry , we will consider the evidence about
12 the Abedi family obtained by Greater Manchester Police
13 through Operation Manteline, which includes accounts
14 from others who can provide relevant background about
15 Salman Abedi and his family, transcripts of police
16 interviews with Ismale Abedi, and material recovered
17 from mobile phones and hard drives linked to Salman,
18 Ramadan, Ismale and Hashem Abedi .

19 Second, we will also hear evidence about Salman's
20 friends and associates , including his wider family and
21 relatives . Detective Chief Superintendent Barraclough
22 has provided a summary of the information that was
23 obtained by GMP from a long list of individuals
24 connected with Salman Abedi during a trace , interview
25 and evaluate , or TIE, process carried out during

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1 Operation Manteline.

2 As we've indicated, the SIO will give evidence in
3 chapter 8 about the planning and preparation for the
4 attack, but he will be recalled to give this further
5 evidence in chapter 13.

6 The focus of the TIE process was on determining
7 whether there were any other persons involved in the
8 attack or in its preparation. But in the course of that
9 process certain interviewees gave evidence which sheds
10 some light upon the mindset of Salman Abedi and offers
11 an indication as to how his violent extremist world view
12 may have developed.

13 We will hear evidence in the course of chapter 8
14 from Ahmed Taghdi, a close friend of Salman Abedi,
15 Asam Nami, one of his cousins, and Trial Witness 3,
16 another associate of the Abedis. All three of these
17 witnesses also have something to say about
18 Salman Abedi's changes in behaviour in the months
19 leading up to the bombing. All of that evidence will be
20 relevant to the issues in chapter 13.

21 Considerable efforts are also being made to obtain
22 evidence from a man called Abdalraouf Abdallah. He is
23 currently serving a prison sentence for terrorism
24 offences and was visited by Salman Abedi in prison and
25 contacted by him by telephone on numerous occasions

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1 in the year leading up to the attack and before. We
2 wish to understand whether he, Abdalraouf Abdallah, had
3 any role in the development of Salman Abedi's world view
4 or if he can shed any light on how it was formed.

5 We have no doubt that Abdalraouf Abdallah is a witness
6 with important evidence to give. He was interviewed by
7 the inquiry legal team on 26 June of this year, but
8 refused to give any answers to our questions, relying
9 upon the privilege of self-incrimination set out in
10 section 22 of the Inquiries Act 2005. We are continuing
11 to pursue this line of enquiry.

12 As we have just said, the inquiry legal team
13 considers that he may have evidence of very considerable
14 importance to give. We hope that on reflection he will
15 cooperate, but in any event counsel to the inquiry will
16 press for him to give evidence before this inquiry.

17 Third, we will explore Salman Abedi's education.
18 We will hear evidence about his time in secondary school
19 at Burnage Academy for Boys and a further education
20 college at Manchester College and Trafford College and
21 then studying for a BSc in business and management
22 at the University of Salford. We will consider whether
23 there were any warning signs while he was at any of
24 these institutions and, in particular, whether anything
25 more could or should have been done to follow up with

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1 him when he suddenly dropped out of his university
2 course in December 2016.

3 Fourth, we will consider the influence of
4 Salman Abedi's religious community. It has been widely
5 reported that the Abedi family had links to the
6 Manchester Islamic Centre, otherwise known as
7 Didsbury Mosque. We will hear from Fawzi Haffar,
8 chairman of the mosque, about the extent of those links
9 and whether anyone was aware of Salman or others in his
10 family espousing extremist views. We are likely to hear
11 other evidence about the operation of the mosque also,
12 but that will need to await the calling of witnesses
13 during chapter 13.

14 Fifth, and finally, the inquiry has obtained
15 statements on behalf of various public authorities
16 dealing with the systems and processes which are in
17 place to identify persons vulnerable to radicalisation
18 and attempt to intervene. We will hear from
19 Shaun Hipgrave, director of Protect and Prepare in the
20 Office for Security and Counter-terrorism, OSCT, within
21 the Home Office. Mr Hipgrave's evidence is primarily
22 focused on security arrangements around crowded spaces
23 and so will be heard in chapter 7, as we mentioned
24 previously.

25 However, he also gives evidence about the

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1 government's Prevent programme, which seeks to stop
2 people being drawn into extremism or to deradicalise
3 those who have started down that road and so we will
4 explore this with him.

5 We will also hear from Paul Mott, head of the joint
6 extremism unit at HM Prison and Probation Service.
7 Mr Mott explains how extremism is tackled within prison
8 and what is done to monitor or restrict visits to
9 prisoners who are known to have extremist views or to
10 have been involved in radicalising others. We'll
11 consider whether enough was done in relation to such
12 matters in Salman Abedi's case. This is an important
13 issue and it may well be that lessons need to be
14 learned.

15 The question that we'll pose is: how was
16 Salman Abedi able to visit a prisoner such as
17 Abdalraouf Abdallah? In drawing all of this information
18 together, and analysing it, the chairman will be
19 assisted by two reports from Dr Matthew Wilkinson.
20 Dr Wilkinson is a senior research fellow in contemporary
21 Islam at the School of Oriental and African Studies
22 at the University of London and a frequent expert
23 witness in counter-terrorism or hate crime cases
24 involving Islamic theology or Islamist extremism.

25 His first report explains the key features of

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1 Islamist extremism as opposed to mainstream Islam or
 2 ideological Islamism and the distinctive characteristics
 3 including its attitudes to violence. It also gives an
 4 overview of the recognised pathways to radicalisation
 5 into Islamist extremism, the type of person vulnerable
 6 to such pathways, the main influences which might
 7 radicalise a person, the steps or activities which lead
 8 to radicalisation, and signs or indicators of
 9 radicalisation, how these can be spotted, and what can
 10 be done to prevent further radicalisation or
 11 deradicalise a person.
 12 Finally, Dr Wilkinson's first report contains an
 13 overview of the problem of radicalisation in UK prisons
 14 and a summary of the known Islamist extremist
 15 organisations which operate in or have influence in the
 16 UK.
 17 Dr Wilkinson's second report on which he's currently
 18 working will apply the knowledge and expertise set out
 19 in his first report to the specific evidence about
 20 Salman Abedi, which we've summarised already.
 21 We will turn next to the facts in further detail.
 22 We are going to set out the key facts on issues of
 23 radicalisation insofar as it is possible to do so at
 24 this stage given that significant pieces of evidence,
 25 such as a response from Hashem Abedi and Dr Wilkinson's

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1 second report, are still awaited.
 2 In relation to Salman Abedi's family, the
 3 Operation Manteline team gathered information from
 4 various relatives, including Rabaa Abedi, Salman Abedi's
 5 aunt who lives in Canada. From the statements obtained
 6 by GMP and other investigations done we know that
 7 Ramadan Abedi, Salman Abedi's father, fled Libya with
 8 his family in 1993 and then applied for asylum on the
 9 basis that his life was at risk from Libyan state
 10 security.
 11 After several appeals, he was granted refugee status
 12 in 1997 and he subsequently obtained indefinite leave to
 13 remain and UK citizenship, as did his family.
 14 Ramadan Abedi changed his name to Hannah Joseph in 2002,
 15 but currently it's not known why he did this.
 16 He was reported to be associated with exiled Libyans
 17 linked to the Libya Islamic Fighting Group, or LIFG,
 18 which was a banned or proscribed organisation under UK
 19 terrorism legislation between October 2005 and
 20 November 2019.
 21 The Abedi family returned to Libya in 2011 during
 22 the uprising against Colonel Gaddafi. Photographs
 23 obtained by GMP show Salman Abedi at around this time
 24 with military vehicles and weapons. It appears that
 25 Salman Abedi and Hashem Abedi then came back to the UK

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1 in 2012 in order to pursue their education, but they did
 2 not engage very well with their schooling and started
 3 taking drugs.
 4 Ismaele Abedi told GMP when he was interviewed in the
 5 aftermath of the attack that their parents had asked him
 6 to keep an eye on his younger brothers but he found this
 7 very difficult.
 8 Salman Abedi and Hashem Abedi travelled back to
 9 Libya in July 2014, but the situation in the country at
 10 that time was chaotic and they were evacuated back to
 11 the UK along with others aboard HMS Enterprise via
 12 Malta.
 13 Images of Salman Abedi and Hashem Abedi in Libya
 14 over this period have been recovered from the social
 15 media account of their brother Ismaele Abedi and we'll
 16 show two such photographs at this stage.
 17 First of all, on the screen, please, Mr Lopez,
 18 {INQ031259/13}. What we're able to see on the screen is
 19 an image of Hashem Abedi in, we believe, Libya, with
 20 a rocket launcher.
 21 Next on the screen, the same INQ reference,
 22 {INQ031259/14}.
 23 This is a photograph of Salman Abedi raising
 24 a finger to the sky. At one time this was undoubtedly
 25 a legitimate gesture used by many followers of the

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1 Islamic faith to state that there is only one God, but
 2 it has been strongly reported that Islamic State has
 3 adopted it as a gesture. It is now often used by
 4 supporters of Islamic State to demonstrate adherence to
 5 what it describes as its caliphate and to its caliph
 6 who, in 2017 when this attack occurred, was Abu Bakr
 7 al-Baghdadi. We will need to consider whether this
 8 photograph of Salman Abedi in combination with other
 9 evidence indicates that what motivated Salman Abedi to
 10 do what he did was adherence to the Islamic State and/or
 11 its ideology.
 12 SIR JOHN SAUNDERS: Do we have any way of dating that
 13 photograph?
 14 MR GREANEY: We have no way of dating that photograph.
 15 SIR JOHN SAUNDERS: Thank you.
 16 MR GREANEY: It can be removed from the screen, please.
 17 Salman Abedi and Hashem Abedi flew to Saudi Arabia
 18 via Jordan in 2015 to carry out the Hajj pilgrimage to
 19 Mecca. Several friends and associates of theirs have
 20 commented that it was subsequent to this, from around
 21 late 2015, that the brothers started to change their
 22 behaviour.
 23 Ramadan Abedi stayed in Libya and, apart from brief
 24 visits to the UK, has remained there ever since. It is
 25 not clear what the status of the relationship between

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1 him and Samia Tabbal now is. Ramadan appears to have
2 married another woman in Libya. Salman and Hashem Abedi
3 visited their father in Libya again in 2016 and in 2017.
4 Shortly after, Salman Abedi returned to the UK to carry
5 out his attack on 22 May.

6 As we've indicated, various friends and associates
7 of Salman Abedi have said that they noticed that he
8 began to express more extremist views and act
9 differently from 2015. By way of example only, at the
10 trial of Hashem Abedi, the uncle of both Salman and
11 Hashem Abedi, Adel Forjani, explained that from around
12 late 2015 he noticed a distinct change in Salman Abedi's
13 behaviour. He described how Salman started wearing more
14 traditional clothing, left his education, began to act
15 strangely towards others, and talked about supporting
16 ISIS, another name for Islamic State.

17 A friend of Salman Abedi's, Ibrahim Khalifa, gave
18 a statement to GMP and testified at the trial of
19 Hashem Abedi. He described losing touch with
20 Salman Abedi for a while but then seeing him and
21 Hashem Abedi again in April 2017, just a month before
22 the attack. Mr Khalifa was surprised to see that
23 Salman Abedi and Hashem Abedi had started wearing
24 a beard and traditional Islamic clothing and that
25 Salman Abedi told him that he and his brother had, to

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1 use his words, "sacked off" university and were going to
2 Libya.

3 The witness also recalled that on one occasion when
4 he was watching television with Salman Abedi, and a news
5 item came on about ISIS and Iraq, Salman Abedi showed
6 some sympathy for their aims.

7 Both Salman Abedi's cousin, Asam, and Trial
8 Witness 3, told Greater Manchester Police that
9 Salman Abedi had been quite rough in his teenage years,
10 smoking a lot of cannabis and getting into fights. He
11 then seemed to mature and became happier, though a year
12 or so before the attack they noticed that he was
13 becoming more overtly religious and Asam's mother warned
14 them his views were too strong and they should not
15 listen to him. Trial Witness 3 described Salman Abedi
16 speaking about martyrdom and jihad to him in positive
17 terms.

18 The links between Salman Abedi and
19 Abdalraouf Abdallah are of significant interest to the
20 inquiry. Abdalraouf Abdallah is a British Libyan
21 national who took part in the uprising against Gaddafi
22 in 2011 and was shot in the back causing him to be
23 paralysed. Shortly after this, Abdalraouf Abdallah was
24 investigated for extremist Islamist activity. He was
25 arrested on 28 November 2014 and charged with assisting

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1 others in committing acts of terrorism by facilitating
2 travel and raising money to enable various others to
3 participate in the Syrian Civil War.

4 Although initially remanded into custody at
5 HMP Belmarsh, Abdalraouf Abdallah was subsequently
6 released on bail on 29 July 2015. On 11 May 2016 he was
7 convicted and sentenced to a nine-and-a-half-year
8 extended determinate sentence. He remains in prison.

9 Abdalraouf Abdallah appears to have been in regular
10 telephone contact with Salman Abedi from 2014. We know
11 from the analysis by GMP of Abdalraouf Abdallah's phone
12 as part of the investigation into his visits that in the
13 period between 24 July and 28 November 2014,
14 Salman Abedi and Abdalraouf Abdallah conversed about
15 martyrdom, including the martyrdom of a senior Al Qaeda
16 figure.

17 This is something we seek better to understand with
18 the assistance of Abdalraouf Abdallah so as to enable
19 the inquiry to understand whether there exists an
20 innocent explanation for these conversations. But, as
21 we have indicated, so far he has refused to assist.

22 Salman Abedi visited Abdalraouf Abdallah at
23 HMP Belmarsh whilst he was on remand on
24 26 February 2015. He was then in regular contact with
25 the prisoner whilst he was on bail. Salman Abedi then

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1 visited Abdalraouf Abdallah in prison again on
2 18 January 2017, and was due to visit him on
3 6 March 2017 but did not attend.

4 On 17 February of that year, Abdalraouf Abdallah was
5 found to be in possession of an illicit mobile phone
6 at the prison he was then at namely, HMP Altcourse.
7 When analysed this telephone was found to have been used
8 to make calls and attempted calls to Salman Abedi's
9 number. As will be obvious, this was just months before
10 the attack.

11 It seems to counsel to the inquiry that
12 Salman Abedi's relationship with Abdalraouf Abdallah was
13 one of some significance in the period prior to the
14 bombing and we are determined to get to the bottom of
15 it.

16 There are some other associates or friends of
17 Salman Abedi who might also have had some influence on
18 his radicalisation but about whom we have significantly
19 less information available because they are deceased or
20 outside the jurisdiction.

21 In an interview between the Times reporter
22 David Collins and Abdalla Forjani, one of Salman's
23 cousins, Mr Forjani said he believed that Salman may
24 have been radicalised, at least in part, whilst he was
25 in Libya by the children of Abu Anas al-Libi.

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1 DCS Barraclough explains that it has been difficult to
 2 pursue this line of inquiry because no investigations
 3 can currently be carried out in Libya.
 4 Another possible link is Mansoor Al-Anezi, a Kuwaiti
 5 national who led prayers at a mosque in Plymouth, but
 6 who initially came to Manchester when he arrived in the
 7 United Kingdom in 2000. Mr Al-Anezi was arrested and
 8 interviewed as part of the investigation into a failed
 9 suicide terrorist attack in 2008 in Exeter because
 10 he was a close associate of the failed bomber,
 11 Nicky Reilly .
 12 No charges were brought against Al-Anezi. He died
 13 of cancer on 17 January 2017 and Salman Abedi was with
 14 him when he died. The funeral was held on
 15 17 January 2017 and, in order to attend it , Salman Abedi
 16 missed a planned visit to Abdalraouf Abdullah in prison .
 17 After the 22 May attack on the arena various items
 18 of property relating to Al-Anezi were recovered from
 19 21 Elsmore Road, the family home of the Abedis.
 20 GMP's analysis of mobile phone data indicates that
 21 there was frequent contact between Al-Anezi and
 22 Hashem Abedi and Salman Abedi, particularly between the
 23 end of October 2016 and mid-November 2016, but it does
 24 not reveal what they were talking about.
 25 As for the possible influence of religious

1 instruction on Salman Abedi, we know, as we have said
 2 a short time ago, that the Abedi family attended
 3 Didsbury Mosque for some time. Ramadan Abedi performed
 4 the call to prayer on occasion, and Ismale Abedi
 5 volunteered with the IT system and provided some private
 6 tutoring on Islamic teaching.
 7 GMP took a statement from Akram Ramadan, who said
 8 his cousin had been present at the mosque when the imam
 9 preached a sermon criticising Islamic State, and that
 10 Salman Abedi had approached the imam with a killer look
 11 in his eyes. But none of the main leaders at the mosque
 12 who have given statements to GMP or the inquiry recall
 13 Salman Abedi being a regular or committed member, nor
 14 any particular trouble arising with him.
 15 The only exception to this is Mohammed El-Saeiti,
 16 head of Sharia Law and imam at Didsbury Mosque, who told
 17 GMP that he recalled Salman Abedi attending the mosque,
 18 although not regularly . He described one encounter with
 19 Salman Abedi which has some similarities to the account
 20 given by Mr Ramadan.
 21 Around the end of 2014, Mr El-Saeiti delivered
 22 a sermon which was critical of Islamic State. When he
 23 saw Salman Abedi at the mosque a month or so later, he
 24 reports that Salman Abedi stared at him with a look of
 25 hate. He also said that he had raised concerns about

1 one relative of the Abedi brothers, but would not
 2 disclose who.
 3 The inquiry legal team has followed up with
 4 Mr El-Saeiti about this information and it is hoped that
 5 we will receive his evidence.
 6 There have been, as is widely known, some broader
 7 concerns raised about the Didsbury Mosque. One of the
 8 imams, Mustafa Graf, was suspended on 26 May 2017 as
 9 a consequence of a photograph of him surfacing which
 10 showed him wearing combat gear in Libya. It appears
 11 that Mr Graf also encouraged protests outside the
 12 UAE embassy in London on 9 September 2015 against the
 13 arrest of men for being members of Islamic State and it
 14 appears that Salman Abedi also attended that protest .
 15 In August 2018, Counter-terrorism Policing obtained
 16 an audio recording of a sermon apparently given by
 17 Mr Graf at Didsbury Mosque in December 2016 in which he
 18 appeared, on the face of it , to encourage participation
 19 in the war in Syria . However, following an expert
 20 assessment of the sermon by Robert Gleave, professor of
 21 Arabic studies at Exeter University , who considered that
 22 Mr Graf was using rhetoric to encourage charitable
 23 donations to help Syrians in distress , Counter-terrorism
 24 Policing reached the conclusion that there was no
 25 prospect or reasonable prospect of conviction and so

1 Mr Graf was not arrested or interviewed .
 2 It is not known whether Salman Abedi was at the
 3 mosque at the time of the sermon and Mr Graf has said
 4 that he did not know him. It's only fair that we should
 5 point out that Mr Haffar, the mosque chairman, has
 6 expressed concern that the BBC reporting of Mr Graf's
 7 sermon was unfair and inaccurate and that other media
 8 reporting linking Salman Abedi and another Islamist
 9 extremist, Raphael Hostey, who joined Islamic State and
 10 is believed to have been killed in an air strike in
 11 Syria, with the mosque has also been unfair and
 12 misleading. We assure all that we will be looking at
 13 all of these issues concerning Didsbury Mosque.
 14 It appears that Salman Abedi may have attended
 15 several other mosques in the months and years leading up
 16 to the attack as well , including the Al-Furqan Mosque
 17 and the Salaam Community Association and Masjid.
 18 However, he does not seem to have been an active member
 19 or regular attendee at either .
 20 In terms of Salman Abedi's education, Ian Fenn, the
 21 head teacher of Burnage Academy describes how
 22 Salman Abedi was not a good student at school. He
 23 attended that school from August 2009 until May 2011.
 24 He was on one occasion excluded for several days for
 25 theft . Mr Fenn's recollection is that Salman Abedi was

1 badly behaved and arrogant and that he gave the
 2 impression of not responding to discipline from his
 3 father. However, there was no strong sign of strong
 4 religious feelings, nor any indication of extremist
 5 views, as Mr Fenn recalls it.

6 Rachel Pilling, head of department for student
 7 support at the Manchester College, which Salman Abedi
 8 attended from 18 September 2012 to 18 December 2013,
 9 describes Salman Abedi as a poor student who exhibited
 10 problem behaviours, including intimidating a female
 11 student. On one occasion he was disciplined for
 12 assaulting a female student. However, his behaviour did
 13 improve, he says, after Salman Abedi's older brother,
 14 Ismale Abedi, intervened, and, moreover, she says there
 15 was nothing to suggest any extremist views over that
 16 period.

17 Michelle Leslie, vice principal at Trafford College,
 18 which Salman Abedi attended from September 2014 until
 19 June 2015 explains that he was unremarkable. Once
 20 again, he was unimpressive but he gave no cause for any
 21 serious concern. On one occasion a tutor saw an image
 22 on Salman Abedi's computer of him holding a gun whilst
 23 in Tripoli, but his explanation that his family had lots
 24 of land in Libya and he used to go shooting there was
 25 accepted.

1 Finally on this topic, Andrew Hartley, general
 2 counsel at the University of Salford has provided
 3 a statement describing how Salman Abedi did not stand
 4 out in any way whilst he was studying for a BSc in
 5 business and management and had limited interaction with
 6 other students and staff. However, as Mr Hartley
 7 explains, Salman Abedi essentially dropped out of his
 8 course from around December 2016 and failed even to
 9 attempt his exams in January 2017.

10 Following the arena attack, the university
 11 commissioned an independent review of its response to
 12 Salman Abedi and whether the university's
 13 responsibilities under the Prevent duty were met. The
 14 review found that the university had discharged
 15 its Prevent duty adequately. However, it also found
 16 that there was a missed opportunity to intervene with
 17 Salman Abedi in early 2017 after he disengaged from his
 18 course but that it was impossible to say whether any
 19 such intervention would have made a difference. Again,
 20 this is an issue the inquiry will explore.

21 What then are the issues for consideration by the
 22 inquiry in chapter 13? In evaluating the evidence on
 23 radicalisation, we'll seek to understand, with the
 24 expert assistance of Dr Wilkinson, how and when
 25 Salman Abedi's world view became radicalised into one of

1 violent Islamist extremism considering, in particular,
 2 the role of his family, religious education and
 3 instruction, material available on the internet, and
 4 friends and associates.

5 We will consider too whether there were any signs of
 6 Salman Abedi becoming radicalised during his time at
 7 Burnage Academy, Manchester College, Trafford College or
 8 the University of Salford. We'll assess whether there
 9 were any signs of Salman Abedi becoming radicalised at
 10 Didsbury Mosque or other religious institutions, and
 11 we will consider what form of intervention, if any,
 12 could have been made to deradicalise him and, if so, who
 13 should have taken it and when.

14 We turn next to chapter 14, preventability.

15 Chapter 14 is the final substantive section of evidence
 16 which the inquiry will hear. It relates to the issues
 17 set out at paragraphs 1.3 to 1.11 and 2.4 of the terms
 18 of reference, namely whether the attack on 22 May could
 19 have been prevented by the authorities. We have called
 20 this set of issues "preventability" for short throughout
 21 the course of our process.

22 In this, the 14th chapter of the evidence, we will
 23 examine what intelligence or information was or should
 24 have been available to the security service, MI5, and/or
 25 police about Salman Abedi and his plans prior to the

1 attack.

2 We will look at how that intelligence or information
 3 was assessed, investigated and shared and what steps
 4 were taken as a result. We will consider whether
 5 what was done was reasonable in all the circumstances
 6 and whether the systems, policies and procedures in
 7 place were working as they should have done. In short,
 8 we will look at whether the authorities missed an
 9 opportunity or opportunities to prevent the attack upon
 10 the arena.

11 We, as counsel to the inquiry and solicitor to the
 12 inquiry, are very conscious that preventability is of
 13 acute interest to the bereaved families and indeed to
 14 the public at large. One of the most important roles of
 15 this inquiry is to understand whether anything more
 16 could and should have been done to stop Salman Abedi
 17 before he attacked and to make recommendations that
 18 might help the authorities stop anyone doing something
 19 similar again in the future.

20 As is already known, we will hear live evidence from
 21 a very senior officer of MI5 of what was known by MI5
 22 about Salman Abedi and Hashem Abedi before the attack.
 23 He will give as much evidence as is possible in open,
 24 subject only to the constraints of national security.
 25 We will give the same intense scrutiny to evidence of

1 the decisions and actions of MI5 as we will give to all
 2 the critical evidence given to the inquiry. In order to
 3 do that, it will be necessary for part of that evidence
 4 to be given in a closed hearing. To do otherwise would
 5 risk assisting terrorists to carry out further attacks
 6 and make them more deadly, which no right-thinking
 7 person wants.

8 So may we be plain: the only reason that part of
 9 this inquiry will take place in a closed session is
 10 because of our determination to ensure that future
 11 attacks are prevented to the extent that that is
 12 possible.

13 Preventability is, of course, also of very
 14 significant interest to the authorities themselves.
 15 Efforts have already been made to understand whether
 16 there is anything to be learned from the attack in
 17 Manchester which would strengthen and improve the work
 18 of MI5, Counter-terrorism Police and other authorities
 19 in the future.

20 The Intelligence and Security Committee of
 21 Parliament published a report entitled "The 2017
 22 Attacks: What Needs to Change". It did so in
 23 November 2018, to which the government responded in
 24 January 2019. Moreover, the intelligence agencies and
 25 Counter-terrorism Policing also conducted their own

1 internal reviews.

2 These reviews were overseen by David Anderson QC,
 3 now Baron Anderson of Ipswich, who was the independent
 4 reviewer of terrorism legislation between 2011 and 2017.
 5 He published a report setting out his own assessment of
 6 the reviews in December 2017.

7 Lord Anderson concluded that it is conceivable that
 8 the Manchester attack might have been averted "had the
 9 cards fallen differently". Although he emphasised that
 10 there is a high degree of inherent uncertainty in
 11 speculating as to what might or might not have been
 12 discovered had MI5 and CT Policing investigated
 13 Salman Abedi in early 2017.

14 This inquiry will have regard to the findings and
 15 conclusions of all of these previous pieces of work,
 16 but, we emphasise, will conduct its own independent
 17 investigation, taking into account further information
 18 that has come to light in the past 2 years. The inquiry
 19 will make its own finding in relation to preventability
 20 and be bound by no one and no organisation.

21 The inquiry is committed to the maximum possible
 22 transparency and openness in all it does. However, it
 23 is important to say that it is intrinsic to the
 24 functions of MI5 and Counter-terrorism Policing that
 25 much of their work must, to achieve our safety, be

1 carried out in secret. As has been extensively
 2 canvassed in the course of several preliminary hearings,
 3 if details of the techniques, procedures and processes
 4 used by these organisations were made public or the
 5 particulars of the intelligence obtained through them,
 6 there is a significant danger that this could assist
 7 future would-be attackers to carry out further or more
 8 deadly atrocities. It is therefore necessary in the
 9 interests of national security for much of the evidence
 10 in chapter 14 to be heard in a closed hearing, as
 11 we have said. That was also true of the ISC. Their
 12 published report contains numerous redactions to protect
 13 national security sensitive information.

14 It was also true of Lord Anderson's work. Although
 15 his report was published, the underlying reviews have
 16 remained classified and it must be true also of this
 17 inquiry. We repeat: we wish to do what we can to
 18 prevent future attacks, not facilitate them. So whilst
 19 we will do everything that we properly can in open,
 20 there will have to be a portion of the evidence that
 21 must be heard in closed hearings.

22 Despite the fact that much of the preventability
 23 chapter must be dealt with in closed, two open witness
 24 statements have been provided on behalf of MI5 and
 25 Counter-terrorism Policing. Oral evidence will be heard

1 in an open hearing from Witness J and
 2 DCS Dominic Scally. Insofar as it is possible to do so
 3 in public, this will cover the following.

4 The context of the broader terrorism threat in
 5 May 2017.

6 The procedures and processes which were in place at
 7 that time to investigate and disrupt potential terrorist
 8 attacks, including how MI5 and Counter-terrorism
 9 Policing work together and share information.

10 It will include a description of how persons are
 11 designated as subjects of interest by MI5, that is to
 12 say as someone who is to be investigated as a possible
 13 threat to national security and how and why persons
 14 cease being SOIs.

15 The evidence will address how previous or closed
 16 SOIs are monitored to see if the investigation into them
 17 should be re-opened, including a process codenamed
 18 Clematis.

19 The evidence will address the Prevent strand of the
 20 government's counter-terrorism CONTEST strategy, how it
 21 works and how referrals are made.

22 It will look also at the history of Salman Abedi's
 23 past interactions with police and those of his family,
 24 at what MI5 and Counter-terrorism Policing knew about
 25 Salman Abedi before the attack and why further steps to

1 investigate him were not taken at the time.
 2 So we will repeat that: in the open evidence, to the
 3 extent possible, we will explore what MI5 and CTP knew
 4 about Salman Abedi before the attack and why further
 5 steps to investigate him were not taken at the time.
 6 And the evidence will address what lessons have been
 7 learned as a result of the post-attack review process
 8 and what changes have been made in response.
 9 At least two other witnesses in the open hearing
 10 will also be relevant to preventability issues. The
 11 first is Shaun Hipgrave of the Home Office, who we have
 12 already mentioned in relation to chapter 7, security
 13 arrangements, and chapter 13, radicalisation. His
 14 statement also covers the regulation of explosive
 15 precursor chemicals and the use of travel monitoring and
 16 border control tools. These were both issues identified
 17 as requiring further work by the ISC in their report and
 18 we will explore with him what more, if anything, could
 19 have been done or should have been done to use these
 20 measures to identify Salman Abedi's plans or track him
 21 at the time of his return to the United Kingdom on
 22 18 May 2017.
 23 The second witness is Paul Mott of HMPPS, the prison
 24 and probation service. Much of his statement is, as we
 25 described earlier, relevant to the issues of

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1 radicalisation in chapter 13. However, what he says
 2 about the processes and procedures that could have been
 3 used to monitor or stop prison visits and telephone
 4 contact between Salman Abedi and Abdalraouf Abdallah may
 5 be of interest in relation to preventability and will
 6 need to be investigated further. We know that the
 7 chairman will keep under close review whether any other
 8 witnesses whose evidence is relevant to preventability
 9 are able to give evidence in open. Any witness whose
 10 evidence can be heard in open will be heard in open.
 11 We turn now to set out the key facts on issues of
 12 preventability in a little more detail insofar as it is
 13 possible to do that publicly.
 14 We will hear, as we indicated, from Witness J and
 15 DCS Scally about how Salman Abedi was known to MI5 and
 16 CT Policing prior to the attack and indeed was due to be
 17 considered for further investigation when the attack
 18 took place. We will hear how information about
 19 Salman Abedi was first passed to the security service by
 20 the North-west Counter-terrorism Unit in December 2010
 21 because his details were linked to another subject of
 22 interest.
 23 It was assessed that there was nothing suspicious at
 24 that time and so there was no further investigation.
 25 However, on 18 March 2014, Salman Abedi was designated

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1 as an SOI and began to be investigated by MI5 as
 2 a telephone number registered to him was in contact with
 3 another SOI thought to be involved in planning travel to
 4 Syria for extremist purposes. That investigation ceased
 5 on 21 July 2014 as Salman Abedi was assessed not to be
 6 a national security risk.
 7 Salman Abedi was identified as having met with or
 8 been in telephone contact with two other SOIs in 2015.
 9 He was also identified as a second-level contact,
 10 that is to say a contact of a contact of SOIs in 2016
 11 and 2017.
 12 On two occasions between 2011 and 2016, MI5 and
 13 Counter-terrorism Policing made checks due to
 14 information received about Salman Abedi's travel
 15 overseas as there was concern he may be travelling to
 16 Syria. However, it was determined that he had in fact
 17 gone to Europe on the first occasion and Libya on the
 18 second, and it was assessed there was nothing to
 19 indicate he posed a risk at that time.
 20 MI5 also held information that indicated
 21 Salman Abedi had visited a known extremist in prison on
 22 more than one occasion. But after further information
 23 was sought, it was assessed that this did not justify
 24 re-opening Salman Abedi as an SOI.
 25 Probably of most interest to all, in particular the

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1 bereaved families, we will hear how on two separate
 2 occasions in the months prior to the attack MI5 received
 3 intelligence about Salman Abedi, the significance of
 4 which was not fully appreciated at the time, but which,
 5 in retrospect, can be seen to be highly relevant to the
 6 planned attack.
 7 Finally, we will hear that on 3 March 2017,
 8 Salman Abedi was one of 685 closed SOIs who hit
 9 a priority indicator under the Clematis process.
 10 Following triage on 1 May 2017, Salman Abedi was
 11 assessed as meeting the threshold to be considered for
 12 further investigation. He was due to be considered for
 13 referral at a meeting scheduled for 31 May, but
 14 tragically this was overtaken by the events of 9 days
 15 earlier.
 16 All of those matters of evidence will be explored.
 17 It is not possible to describe the additional evidence
 18 to be heard in the closed hearing in any detail for
 19 obvious reasons. However, we will explore the evidence
 20 given by Witness J and DCS Scally as corporate witnesses
 21 fully, including the information contained in the
 22 underlying documentation which was the subject of
 23 a successful application for public interest immunity.
 24 We will also hear factual evidence from those in MI5
 25 and Counter-terrorism Policing who were directly

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1 involved in the relevant decision-making.
 2 Moreover, and importantly, the chairman is in the
 3 process of instructing an expert to assist him in
 4 considering whether the assessments and decisions made
 5 were reasonable given what was known at the time and
 6 whether those would have been different had other
 7 information been available and what actions would have
 8 been taken had different assessments or decisions been
 9 made. That expert will necessarily need to give
 10 evidence in closed.

11 The issues for consideration by the inquiry
 12 in relation to preventability will be as follows: why
 13 the decision was taken to close Salman Abedi as an SOI
 14 in July 2014 and whether that decision was reasonable
 15 given the information available; why Salman Abedi was
 16 not re-opened as an SOI after October 2015 and whether
 17 that was reasonable given the information available;
 18 whether there was other information or intelligence
 19 which could or should have been available to MI5 or
 20 Counter-terrorism Policing that would have led to
 21 Salman Abedi being re-opened as an SOI; whether any
 22 further disruptive action would or should have been
 23 taken in relation to Salman Abedi if a different
 24 assessment had been made, in particular whether
 25 Salman Abedi should have been referred to the Prevent

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1 programme at any stage, and what difference that might
 2 have made; and whether travel monitoring or travel
 3 restriction capabilities should have been utilised
 4 in relation to Salman Abedi in 2017.
 5 Other issues include: whether Salman Abedi's visits
 6 to a known extremist prisoner should have led to any
 7 further investigation; why the intelligence received on
 8 two occasions in the months prior to the attack was not
 9 assessed as being more significant at the time; and what
 10 other actions could have been taken in response to that
 11 intelligence and whether it should have stopped the
 12 attack.

13 All of those issues will be subject to the most
 14 intense scrutiny.

15 That brings us to the end of our opening statement.
 16 It has taken some time to introduce the facts that the
 17 chairman will need to consider and the issues that he
 18 will need to decide. We wish to emphasise what the
 19 chairman said in his introductory remarks: this is
 20 a search for the truth. As will be obvious, the process
 21 of hearing the evidence to enable the decisions to be
 22 made by the chairman will be lengthy. That process will
 23 start with the critically important commemorative
 24 hearing, which will commence on Monday next, and we will
 25 sit each day during that hearing at 9.30 am.

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1 SIR JOHN SAUNDERS: Mr Cooper, are you going first with the
 2 commemorative hearings?

3 MR COOPER: As I understand it, yes. There's a list that's
 4 been given to us and we're all aware of it. We're also
 5 going to employ a collaborative approach between the
 6 family CPs to ensure that all have access to those
 7 hearings when it matters to them.

8 SIR JOHN SAUNDERS: Is 9.30 a convenient time for the
 9 families to start?

10 MR COOPER: As I understand it, yes. There's been nothing
 11 raised with me to the contrary and I know questions of
 12 that nature have already been asked, so thank you.

13 SIR JOHN SAUNDERS: Thank you. And that's true of the other
 14 teams as well? Thank you very much.

15 Mr Greaney, I'm extremely grateful. Thank you very
 16 much. See you all at 9.30 on Monday morning.
 17 (2.43 pm)

(The inquiry adjourned until 9.30 am
 on Monday, 14 September 2020)

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 2 Opening statement by MR GREANEY1
 3 (continued)
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