Manchester Arena Inquiry

Day 3

September 9, 2020

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Wednesday, 9 September 2020

(9.00 am)

Opening statement by MR GREANEY (continued)

SIR JOHN SAUNDERS: Mr Greaney.

MR GREANEY: We will turn finally in our opening statement on the emergency response to deal with Greater Manchester Fire and Rescue Service and North West Fire Control.

Greater Manchester Fire and Rescue Service provides fire and rescue services on behalf of the Greater Manchester Combined Authority. To be clear, GMCA is representing the interests of that body and no other in this inquiry, but will also assist to the extent that the inquiry requires any information or assistance from the Mayor of Manchester.

North West Fire Control is run by NWFC Limited and is responsible for receiving emergency calls and mobilising fire and rescue service resources in response to incidents according to preset criteria depending on the type of incident that is reported. In effect, NWFC operate the control room for GMFRS and also for other fire and rescue services in the north-west.

As we've set out, the expert evidence in relation to the Fire and Rescue Service and NWFC is provided by Matthew Hall. Mr Hall's first report dated 1 October of

last year considers the policies, principles, systems and practices that are relevant to the expected response of the Fire and Rescue Service to terrorist and mass casualty incidents. His second report, dated 6 May of this year, evaluates the preparation of the Fire and Rescue Service and NWFC for terrorist and mass casualty incidents and considers the adequacy of the response of those organisations to the arena attack on 22 May.

A short appendix was provided with Mr Hall's second report. Mr Hall has provided a further addendum report, dated 15 July, responding to core participants' questions and observations.

It is relevant at the outset of our opening on this part of chapter 10 to summarise the views expressed by Mr Hall in his first report. That is to say, his overview of the expected response of a fire and rescue service to terrorist and mass casualty incidents.

Mr Hall explains his views as follows:

"As a category 1 responder within the Civil Contingencies Act 2004, the Fire and Rescue Service of Greater Manchester was required to assess the risk of emergencies occurring, write plans, share information, and cooperate and coordinate with a wide range of other organisations."

As we've explained already, local coordination and

planning was expected to be achieved through the resilience forum. Mr Hall echoes the views of other experts by making plain that effective coordination between responder organisations is achieved through the use of the JESIP principles of effective joint working. This encompasses, as we all now well-understand, the use of METHANE messages or the passing of incident information in a timely manner between services and their control rooms.

Mr Hall, in that first report, confirms that the declaration of a major incident triggers a predetermined strategic tactical and operational response from each emergency service. The joint decision model should be used to facilitate the sharing of information between different agencies and the reconciliation of potentially differing priorities. All of this is now familiar to all of us, but is worth repeating as we draw to the close of our opening statement on chapter 10.

Mr Hall explains that the control rooms of the emergency services play a vital role in managing the early stages of a multi-agency incident and the control room guidance set out in the JESIP doctrine focuses on communication, shared situational awareness, joint understanding of risk, and coordination and co-location.

The overarching aim of the control room supervisor

is, or should be, to ensure that rapid and effective actions are implemented in order to save lives, minimise harm, and lessen the effects of the incident. That, in the view of counsel to the inquiry, is an important opinion which will be relevant to the inquiry's assessment of the reaction of NWFC on the night.

Joint operating principles, as we have said, known as the JOPs, were in place at the time of the arena attack, and Mr Hall makes clear that those principles should also be followed by emergency services in responding to a MTFA or MTA as it's now known.

At the time of the Manchester attack the third edition of the JOPs were in place and provided guidance to responders dealing with MTFA incidents.

The JOPs outline a specific role for fire and rescue service personnel and provide guidance on the management of firefighting and fire hazards within the context of an MTFA. Under the JOPs, explains Mr Hall, a key role in a major incident response is played by the national inter-agency liaison officer, the NILO, a term we've used many times, who acts as a tactical adviser to tactical and strategic commanders.

In responding to a major incident, intra-agency working, effective training and effective communication are vital, as Mr Hall states:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

second, multi-agency communication; and third, the response from 22.50.

We can deal with the essential facts briefly given the level of detail that we provided yesterday.

1. Initial notification and response. The first notification to NWFC of an incident at the arena came at 22.34, so just 3 minutes after the detonation by Salman Abedi of his bomb. NWFC control room operator -- and we will refer to such people in this role as "CRO" -- David Ellis was informed of reports of an explosion in the foyer of the arena whilst talking to GMP about an unrelated incident. During the same call, GMP advised him that a bomb had exploded. Later in the call, GMP told NWFC that injuries at the arena appeared to have been caused by shrapnel, that it was believed there were between 30 and 40 casualties, but that was unconfirmed, and they were still looking for a secondary device.

Accordingly, it is clear that NWFC had very early notice that a shrapnel bomb appeared to have exploded in the foyer to the arena, in other words the City Room, resulting in multiple casualties.

At 22.37 NWFC CRO Joanne Haslam received a call from NWAS Control stating that a bomb had gone off at the arena. Between 22.43 and 22.46, during that same call,

NWAS informed NWFC that there were reports of an active shooter, that there were potential gunshot injuries, and that there were approximately 60 casualties.

NWFC, in common with other emergency responders, had what are described as action cards, which dictated particular responses to particular events. CRO Ellis initially accessed the explosion action card. A short time later, on the initial accounts of the NWFC witnesses, it appears that NWFC duty team leader Michelle Gregson and her colleague, team leader Lisa Owen, instead reverted to following the bomb action card. If correct, this choice was significant, as the two cards dictated different responses. Had the explosion card been adopted, as counsel to the inquiry currently understand the evidence, NWFC would have directed GMFRS resources, including the specialist technical rescue units, TRU, and a NILO directly to the arena, whereas the bomb action card required the duty NILO first to obtain an RVP before any GMFRS resources were mobilised to that location.

We have said "on the initial accounts" because further statements of the relevant witnesses have been served on the inquiry by NWFC in which it is explained that NWFC did not in fact open or follow the bomb action card, and it appears that there is independent support

for that from the records of NWFC.

As with all issues of fact, this will need to be explored in the evidence and a determination made on that basis and only on that basis. As we have said a number of times now, no one should jump to conclusions.

A determination about the decision-making within the control room of NWFC will need to be made on the basis of an assessment of the evidence that is actually given by the relevant witnesses and by reference to the contemporaneous documentation.

At 22.40, so just 9 minutes after the explosion, while NWFC's calls to GMP and NWAS continued, NWFC duty team leader Michelle Gregson contacted station manager, or SM, Andy Berry. He was the GMFRS on-call duty NILO. SM Berry was informed that there had been an explosion at the arena, that there were 30 casualties reported, that the police had declared an RVP at Cathedral Car Park and he was asked to get in touch with GMP, which in context, seems likely to have been a request to contact the GMP FDO, Inspector Sexton, about whom we had much to say yesterday.

In that call, SM Berry rejected the Cathedral Car Park RVP and suggested that GMFRS would normally "muster". He added that the RVP should, and again we

quote his words, "not be that close, we would not want central". Instead, he suggested Philips Park Fire Station, some 3 miles from the scene, and Michelle Gregson accepted that.

It is important to stress that Philips Park was not a multi-agency RVP. The reasons for GMFRS locating there will need to be scrutinised during the course of the evidence, along with NWFC's reasons for agreeing to that.

SIR JOHN SAUNDERS: And we have recordings of the various phone calls?

MR GREANEY: Sir, we're about to play, in about 30 seconds, one of the calls.

SIR JOHN SAUNDERS: Okay, thank you.

MR GREANEY: We'll play, as I have just indicated, this call in a moment. As we play the call we should bear in mind that in his witness statement SM Berry states that he was concerned that the RVP at Cathedral Car Park was a predetermined RVP and would not be safe. He states, and we use his words:

"It was a bit quick for an RVP to be issued if the explosion had just occurred."

However, the explosion had, of course, occurred nearly 10 minutes earlier.

SM Berry suggests in his witness statement that NWFC

had made a decision that GMFRS would not mobilise, but we'll now play the call to inform our understanding of what in fact happened within it.

Mr Lopez, could we play, please, {INQ00449/1}. This is the call, it's made at 22.40, between NWFC Duty Team Leader Michelle Gregson and Station Manager Andy Berry, who was the GMFRS on-call duty NILO.

(Audio played to the inquiry)

SIR JOHN SAUNDERS: Mr Greaney, before you go on, and because I will forget, I helpfully have had a note of what you're going to say. I have, I think, an earlier edition, which is why I was not aware that the call was going to be played. If I could have that part up to date, it would be helpful.

MR GREANEY: Of course, sir. I'm sorry you haven't received (overspeaking) --

SIR JOHN SAUNDERS: Please don't apologise. These things are subject to amendment, obviously.

MR GREANEY: It has been updated overnight as we have reflected on what has happened in the (overspeaking) --

SIR JOHN SAUNDERS: That is very helpful and it is very helpful to hear the call, if I may say so, too.

MR GREANEY: Indeed, sir, we were about to observe that that call appears to be critical to an understanding of why it was that it was not until 2 hours and 6 minutes after

the explosion that fire engines arrived on the scene and, as a result, it will be most important to scrutinise with Deputy Team Leader Michelle Gregson and Station Manager Andy Berry when they give their evidence what their thought processes were during that call.

SIR JOHN SAUNDERS: And indeed whether the action cards are actually sufficient to discriminate between an explosion and a bomb.

MR GREANEY: We've merely summarised at the moment the action cards, but during the course of the evidence we will scrutinise what they are, which action card was used, and whether they are fit for purpose.

SIR JOHN SAUNDERS: Thank you.

MR GREANEY: In due course, SM Berry made efforts to contact, as he indicated at the end of that call he would, the GMP FDO, but he was without success.

At the same time, SM Berry ordered four fire engines and three additional NILOs to attend the RVP at Philips Park Fire Station. SM Berry decided to travel to Philips Park, leaving home at approximately 22.47. His location at the time was some 22 miles from the incident. Sir, I think we've just been provided with a copy of the updated opening statement.

SIR JOHN SAUNDERS: That's a very instant response. Thank you very much.

MR GREANEY: I think it was probably coincidental, but nonetheless welcome.

SIR JOHN SAUNDERS: Okay, thank you very much.

MR GREANEY: I'll just repeat that because it's important.

In due course, SM Berry made efforts to contact the GMP FDO but without success. At the same time, SM Berry ordered four fire engines and three additional NILOs to attend the RVP at Philips Park Fire Station. SM Berry decided to travel to Philips Park, leaving home at approximately 22.47. His location at the time was some 22 miles from the incident.

As SM Berry was identifying Philips Park as the RVP for GMFRS and was commencing his journey, a number of calls were taking place. At 22.41, NWFC received a call from a member of the public who stated that there had been a bomb blast that had caused shrapnel injuries. The caller suggested that, based on looking at the casualties, the blast may have been the result of "a dirty bomb of some description".

While on the line to SM Berry, NWFC asked whether he wanted the information that had been received from this member of the public at that moment, but SM Berry replied "no".

At 22.42, NWFC received a call from GMP confirming that there had indeed been an explosion at the arena.

At 22.44, NWFC received a call from BTP, requesting confirmation of the number of Fire Service units being deployed to the arena. The NWFC CRO confirmed that none had been deployed and stated that they would call BTP back once they had further information.

At 22.44, NWFC CRO Rochelle Fallon called SM Berry and left a voicemail message relaying reports from NWAS that people were being shot. At 22.45, NWFC contacted Philips Park advising that it was to act as the GMFRS RVP. NWFC stated, it seems, that there were confirmed gunshot wounds.

At 22.48, SM Berry called NWFC and spoke to CRO Dean Casey. CRO Casey stated that they had received reports of a bomb exploding, 60 casualties, and reports of an active shooter. SM Berry stated that further GMFRS resources were going to rendezvous at Philips Park until:

"... we are instructed otherwise and we get some more information about this incident."

Whilst travelling to Philips Park, SM Berry continued his efforts to contact the GMP FDO. He was unsuccessful again. SM Berry called NWFC at approximately 22.52 and 22.57, requesting additional NILOs and MTFA capability to Philips Park.

While SM Berry was on his way to Philips Park, NWFC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

information could be obtained."

This failure was compounded by the lack of information sought and received by GMFRS and NWFC regarding changes to the applicable RVP and the failure of other emergency responders to communicate key information to GMFRS and NWFC appropriately, including RVP updates.

Fourth, Mr Hall has identified a lack of effective leadership from GMFRS in the initial stages of the response, what he describes as "an absence of strategic direction and operational grip". GMFRS NILOs at Philips Park, prior to SM Berry's arrival, did not take on SM Berry's NILO role or attend a multi-agency RVP. Senior GMFRS officers attended the headquarters of GMFRS, rather than attending the headquarters of GMP. This lack of leadership in the view of Mr Hall further undermined the Fire and Rescue Service's existing lack of situational awareness.

Reason 2. In the view of Mr Hall, the effect of the significant delay in GMFRS resources being mobilised at the scene was that the Fire and Rescue Service was unable to render assistance to casualties and engage in meaningful joint working in the early stages of the emergency response.

Specialist resources that were available to GMFRS,

including specialist response teams, SRTs, and technical rescue units, TRU, with access to enhanced first aid equipment, such as trauma dressings and rescue stretchers, known as Skeds, were not deployed to the scene and so did not contribute to the response to the arena attack.

This conclusion of the fire expert will understandably cause public concern. The inquiry will need to understand whether the conclusion of Mr Hall is correct and, if it is, establish why this failure occurred and what needs to be done to avoid such a failure occurring again.

In his conclusions Mr Hall has emphasised that no single individual within GMFRS or NWFC is wholly responsible for the failings he has identified. Rather, a sequence of key internal decisions based on incomplete and/or inaccurate information caused GMFRS to identify a separate RVP away from partner agencies. This led to an inability to access key emergency service partners who held relevant information but who had not communicated that information effectively to NWFC and GMFRS. This caused a significant delay in deployment that, in the view of Mr Hall, negatively affected the fire and rescue service response to the attack.

As will be apparent, Mr Hall has expressed some firm

views, but as we have said now a number of times, all should await the actual evidence and the witnesses, of course, will be tested, and no one should jump to conclusions.

Nonetheless, the evidence gathered by the inquiry to date does indicate that the events of the night of 22 May give rise to a need for GMFRS and NWFC to learn lessons. So we will turn next to whether they themselves have identified such lessons.

First, GMFRS. David Keelan, Assistant County Fire Officer of GMFRS, has provided a statement setting out the changes made by GMFRS since the attack on 22 May. They include the following.

First, a shared emergency services channel has been developed to address difficulties in multi-agency communications. This was implemented with effect from 26 May 2017. GMCA have also made other improvements to inter-agency communications, including communication between the GMFRS NILO, GMP's FDO and the NWAS duty NILO.

Second, changes have been made to the relevant JOPs. In February 2019 a further JOPs was released and was implemented by GMFRS in April 2019. ACFO Keelan suggests that these changes will assist GMFRS in responding to future incidents.

Third, working practices within and between GMFRS and NWFC have developed since the arena attack. The action cards for bomb and explosion have been amended to avoid confusion on which to use to provide greater prompts to the GMFRS NILO and to implement incident command without delay. The directions regarding mobilisation of the GMFRS NILO have also been changed to mobilise the nearest NILO to the incident and to avoid placing incident command responsibilities on NILOs during an incident. Other action cards relevant to other phases of Operation Plato have also been amended.

Fourth, GMFRS reviewed the NILO role following the arena attack. This has led to changes in how NILOs are deployed and the support provided to them.

Fifth, GMFRS has implemented a revised policy in respect of incident command support and undertaken further multi-agency training with a particular focus on deployment and multi-agency communication.

Sixth and finally, ACFO Keelan describes the sharing of Greater Manchester site plans with other agencies, the provision of further specialist equipment and developments within the culture of GMFRS as changes following the arena attack.

Next, the lessons learned by NWFC. Sarah-Jane Wilson, the head of NWFC, has provided

a statement on behalf of her organisation setting out the development of NWFC's policies and procedures following the arena attack. Ms Wilson states that following the publication of the Kerslake Report, to quote her words:

"NWFC determined that it would take a more proactive role in relation to the management and monitoring of communications, sharing information and establishing situational awareness in order to avoid a repetition of the failures which had occurred in the response to the arena attack."

As a result, NWFC has taken the following steps:

First, NWFC has developed a major incident action plan and produced new incident types in their response plans. These new incident types will result in new predetermined attendances, PDAs, and action plans when selected by NWFC staff. The purpose of the major incident action plan is to require control room staff to actively facilitate communications between the emergency services and to ensure that the Fire Service is involved in multi-agency communication at all operational command levels.

Second, the four fire and rescue service authorities which contract for the service provided by NWFC have met with their respective resilience forums to agree

a methodology for establishing three-way communications between the police, fire, ambulance services.

Third, NWFC have introduced a number of training initiatives relating to JESIP awareness, strategic command and training on the NWFC major incident action plan.

Against that background, the inquiry will need to consider a number of issues in relation to GMFRS and NWFC. They include, first, the planning and preparation by GMFRS and NWFC for a terrorist attack, including the adequacy of training, policies and multi-agency exercises prior to the arena attack.

Second, the implementation of JESIP on 22 May. This will include consideration of the communication of information between GMFRS, NWFC and other emergency responders, the gathering of shared situational awareness between emergency responders, and whether additional steps should have been taken by GMFRS and NWFC to obtain such situational awareness.

Third, the choice and use of action cards at NWFC, their consequences, and the adequacy of those cards, an issue which has been thrown into sharp focus by the further statements of the relevant NWFC witnesses.

Fourth, the decisions taken in relation to the RVP.

Fifth, the actions taken by the duty NILO of GMFRS,

SM Berry, including the initial decision to muster GMFRS resources at the Philips Park RVP, the difficulties in contacting the GMP FDO, Inspector Sexton, and whether any alternative steps should have been taken to gain situational awareness given the difficulties that were encountered in reaching the FDO.

Sixth, whether information received by NWFC and GMFRS was challenged and analysed and, if so, whether such challenge and analysis was adequate and, if not, whether such information should have been challenged and analysed.

Seventh, the deployment of resources including both the timing of such deployment and the nature of the resources deployed. This will include the deployment of GMFRS resources to Philips Park, the location of multiple senior GMFRS officers at the CSR at GMFRS HQ, the eventual deployment of GMFRS resources to Manchester Central and Victoria Station, and the adequacy of the GMFRS resources that were ultimately deployed to the scene.

Eighth and very importantly, the impact, if any, of GMFRS's absence from the scene on those affected by the blast and whether that absence contributed, or may have contributed, to the loss of life that occurred.

As will be apparent to everyone who is present in

this hearing room or watching remotely, from the length of our introduction to chapter 10, from the detail we've needed to go into and the number of issues we've identified, chapter 10 is going to take some time during the oral evidence hearings, but we make no apology for that. It is important in the highest degree that we understand what went well on the night of the bombing but also what did not. And if things did not go well, we need to understand whether that made any difference to the outcome in the cases of those who died.

That is to say, we need to know whether a different and better response by the emergency services would have saved more lives or even a single life. We must make plain that it is clear from the evidence obtained by the inquiry that lessons have already been learned by the emergency services from their experiences on the night of 22 May, but we will need to consider whether there are yet further lessons that must be learned. If there are, we must seek to identify them so that, in the awful event that another terrorist outrage occurs, our emergency services are able to respond as effectively as possible.

We will turn next to deal with chapters 11 and 12, although we will deal with chapter 11 and then invite the chairman to take a break.

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

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

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

given to them.

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

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

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

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

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

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

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

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

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

(Pause)

The blast wave experts go on to explain the five types of blast injury. In short, these are classified as primary through to quinary injuries. A primary blast injury is described as being caused by the shock front. Secondary blast injuries result from the impact of fragments and larger missiles accelerated by the blast. Injuries caused by the moving body impacting on other objects and the ground are termed tertiary blast injuries. The first three types of injury are illustrated by a diagram within the report.

Mr Lopez, I'm going to ask you to put figure 3 from the blast wave overview report on the screen. The reference is {INQ025364/9}.

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

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

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

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

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

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

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

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

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

In relation to each deceased, the blast wave experts

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

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

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

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

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

SIR JOHN SAUNDERS: 10.45. Thank you.

(10.13 am)

(A short break)

(10.45 am)

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

decision as to whether to remain in the hearing for it?
MR GREANEY: Sir, I have spoken to some of the families myself and they are certainly aware. My understanding is that the legal representatives of the other bereaved families have spoken to them and I believe therefore that all bereaved families will be aware of what we are about to deal with.
Mr de la Poer is in contact with Ms Cartwright at the family annex. Obviously, if any person becomes distressed here, we will stop. It will be apparent to us. If any person becomes distressed at the family annex, that will be communicated to Mr de la Poer and again we will stop.
SIR JOHN SAUNDERS: Can I check with the families' representatives that everyone is happy and content with the arrangements which have been made? Happy is the wrong word, I'm sorry.
MR COOPER: I understand. Sir, we're grateful for that and again we are grateful to counsel to the inquiry for their assistance. I have had a chance of looking at some of the text of what Mr Greaney is going to say -- not all of it, I make no criticism, but some of the text in relation to some of the families we represent. Although I have no direct instructions from the particular families and they wouldn't have seen the

text, we have obviously been aware of this for some days and I know my instructing solicitors will inform me, or you, sir, if there are any issues. I'm not aware of any issues that have arisen.
SIR JOHN SAUNDERS: Mr Weatherby?
MR WEATHERBY: Likewise, sir, we have actually checked the text -- thank you to Mr Greaney for making that available to us -- and all of the families that we represent are aware of what is about to happen.
SIR JOHN SAUNDERS: Thank you. Mr Atkinson?
MR ATKINSON: Sir, likewise, we have seen the text and we have discussed it with our families who are as prepared as can be for what is about to happen.
MR GREANEY: A member of each family counsel team has seen the full text of what is to be said.
SIR JOHN SAUNDERS: I am grateful, thank you.
MR GREANEY: We're turning now to chapter 12, the experience of each of the 22 who died.
We will deal first together with Alison Howe and Lisa Lees.
Mr Lopez, could we have on the screen, please, first of all, a photograph of Alison Howe? This is {INQ035687/1}.
On 22 May 2017, Alison Howe was 44 years old and the only daughter of Susan and George. She was a gifted

musician who played the piano and violin to a very high standard and had won a number of competitions during her younger years. Alison was employed at a care centre and had previously worked as a ward nurse. Alison was a much loved wife and mother. She was due to celebrate her 45th birthday 2 days after the concert and she and her husband, Stephen, had planned a holiday in New York later that week.
The couple had two daughters, Sasha and Darcie. When Alison married Stephen in 2003, she also became a parent to his sons, Lewis, Jack, Jordan and Harris. Her loved ones have commented on how well she looked after the six children and they remember her as successfully gelling the two families together.
Can we take the photograph of Alison from the screen just for the moment, please? We will put on the screen next a photograph of Lisa Lees. The reference is {INQ035712/1}.
On 22 May 2017, Lisa Lees was 43 years old. She was the daughter of Ivan and Elaine, and the older sister of Lee. In her later years Lisa became a mother to Lauren and India, and a wife to Anthony. She was also a grandmother to Jayden and to Dylan, who was born shortly after her death. Her loved ones remember her wide smile and infectious laugh. Lisa had a great work

ethic. She ran a successful massage business, which treated terminally ill children and won an award for excellence in practice in 2012.
She also attended university and obtained a postgraduate certificate of education, which enabled her to teach beauty therapy. Lisa was very positive and driven and she taught her daughters that they could achieve anything they put their minds to. She loved walking, animals and helping others.
We are now going to put on the screen, please, Mr Lopez, the images together, {INQ035687/1}. Thank you very much indeed for doing that so quickly.
Alison's daughter, Darcie Howe, and Lisa's daughter, India Lees, attended the concert together on 22 May. Alison and Lisa took the two girls to the arena that night, arriving shortly after 18.45. After making sure they were safely inside the stadium, Alison and Lisa went and enjoyed a meal in Manchester city centre. They returned to the arena at the end of the concert, where they had arranged to meet Darcie and India in the City Room.
Alison and Lisa entered the City Room for the final time at 22.27.01. At the time of the explosion, they were both standing approximately 4 metres away from Salman Abedi. Following the explosion, Lisa was lying

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

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

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

shortly afterwards.

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

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

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

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

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

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

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

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

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

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

approximately 4 metres away from it.

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

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

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

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

Dr Parsons concluded that Marcin died as a result of chest injuries, which were so severe that he would have passed away very quickly.

The blast wave experts concluded that the injuries of both Marcin and Angelika were unsurvivable with current advanced medical treatment.

Mr Lopez, we will now take please from the screen the photograph of Marcin and Angelika.

We will deal next with Chloe Rutherford and Liam Curry.

Could we please have on the screen a photograph of the two of them? {INQ035693/1}.

Chloe Rutherford was 17 on 22 May. She was very close to her mum and dad and to her elder brother, Scott. She was a talented songwriter and performer and had recently completed her BTEC in music performance, finishing her work for that college year ahead of schedule. Chloe had used her musical talents to raise money for several charities and she had many plans for the future, including an apprenticeship in travel and tourism which fitted well with her passion for travel.

Liam Curry was aged 19 on 22 May. He was very close to his mum and younger brother Zack. He was also very close to his dad, Andrew, who died in March 2017. Liam was a huge support to his family at this time and acted

with great dignity and courage. Liam was a talented sportsman and had been a keen cricketer since he had started to play at the age of 6. He was studying a sports degree at Northumbria University and had spoken about joining the police.

Liam and Chloe had been together since 2014. Chloe and Liam travelled together to attend the concert. Chloe had received tickets for the concert as a Christmas present. Chloe and Liam travelled to Manchester, did some shopping at the Trafford Centre, checked into their hotel, and then went for a meal before the concert. They entered the arena shortly before 19.30. They were in frequent contact with their parents throughout the day and evening, sending pictures and telling them about the good time they were having together.

Chloe and Liam entered the City Room at 22.30.49. They were walking towards the City Room exit and were approximately 4 metres from Salman Abedi at the time of the explosion. Travel Safe Officer Philip Clegg went to both Chloe and Liam following the explosion. They were both unresponsive when he spoke to them. Neither Chloe nor Liam received any medical care or intervention in the City Room. Gareth Chapman, a ticket agent, approached Chloe at 22.42.59 and covered her head and

body with concert T-shirts. He covered Liam with concert T-shirts at 22.43.10.

At 23.40.49, HART paramedic Lea Vaughan attached a document to Chloe to indicate that she was deceased. At 23.44, she attached a document to Liam to indicate that he too was deceased.

Professor Philip Lumb prepared a post-mortem report for both Chloe and Liam. He concluded that Chloe's death was caused by multiple injuries. He concluded too that the injuries would have rendered Chloe immediately unconscious and that it is very likely that she died very quickly. He concluded that Liam's death was caused by multiple injuries and that the injuries would have rendered Liam immediately unconscious and it is very likely that he too died very quickly.

The blast wave experts conclude that both Chloe and Liam's injuries were unsurvivable with current advanced medical treatment.

Mr Lopez, we'll take from the screen the photograph of Chloe and Liam.

Next, we will deal with Courtney Boyle. May we have on the screen, please, a photograph of Courtney, {INQ035694/1}.

SIR JOHN SAUNDERS: Would you want a break? You're all right? Thank you.

MR GREANEY: Courtney Boyle was 19 on 22 May. She was a student at Leeds Beckett University, where she was studying psychology and criminology, and had just submitted her first year exams. Her mum remembers Courtney loving life as a student and being the happiest she'd seen her. She'd become a confident, strong-minded and private young woman who was loving and caring.

Courtney was very close to her family and adored being a big sister to Nicole. Courtney loved music and went to Leeds Festival when she was 16, where she met her boyfriend, Callum.

After her funeral, her family learned that Courtney had earned a first in her first-year exam paper and she was awarded an honorary degree in July 2017.

Courtney attended the arena on 22 May with Philip Tron, Deborah Hutchinson, Nicole Boyle and June Tron. The group were in Manchester to take Nicole to the concert. They had collected Courtney from her student accommodation in Leeds before travelling to Manchester. They had lunch together and spent time shopping before they dropped Nicole off at the arena shortly after 6pm. They went for a meal before parking next to Victoria Railway Station. The group waited in the car for a while, chatting and laughing. Courtney went with Philip when he went to the arena to collect

Nicole at around 22.20.

Philip and Courtney entered the City Room at 22.22.11. They were standing in front of the doors to the arena and were about 4 metres from Salman Abedi at the time of the explosion. Courtney did not receive any medical care or intervention in the City Room following the explosion. She can be seen on the body cam footage of Travel Safe Officer Philip Clegg at 22.43.11, but Mr Clegg does not interact with her.

Courtney's head was covered at 22.51. Advanced Paramedic Patrick Ennis checked Courtney at 23.38 and placed a label on her wrist in order to identify her as deceased.

Dr Charles Wilson prepared the post-mortem report in relation to Courtney. Dr Wilson concludes that Courtney's death was caused by multiple injuries. He states that Courtney's death would have occurred quickly and the blast wave experts conclude that Courtney's injuries were unsurvivable with current advanced medical treatment.

Mr Lopez, could we take the photograph of Courtney from the screen, please.

We are going to deal next with Eilidh MacLeod.

Could we have the photograph of Eilidh on the screen, please? It is {INQ035709/1}.

Eilidh MacLeod was 14 on 22 May. She was a much-loved middle sister of three and she was very family orientated. Eilidh loved music, which was a big part of her life. She was a very talented bagpipe player and loved playing as part of a band, through which she made many friends. Her band enjoyed success in the World Pipe Band Championships in August 2016 and she and her family were so proud that day.

Eilidh was popular at school and had lots of good friends. People remember how she made them laugh with her great sense of humour and infectious laugh. She really cared about others and was helpful and loving. Those who knew her are sure she would have succeeded at whatever she chose to do.

As we understand it, Eilidh travelled from home in Vatersay to attend the Ariana Grande concert with her friend. Eilidh's mother, Marion, travelled with Eilidh and her friend and took them to the arena. Marion watched Eilidh and her friend go into the arena shortly after 6.15 pm.

Eilidh and her friend entered the City Room at 22.30.49. They were walking towards the City Room exit and were approximately 4 metres from the explosion. Eilidh can be seen in the body-worn video taken by Travel Safe Officer Philip Clegg shortly after the

explosion. Mr Clegg does not have any interaction with Eilidh.

Michael Williams, a member of the public, saw Eilidh as he was helping to move her friend from the City Room. He believes that Eilidh was deceased when he saw her. Eilidh did not receive any medical intervention in the City Room and the sequence of events shows that she was covered up with clothing from 22.51.

Professor Lumb prepared the post-mortem report for Eilidh. He concludes that Eilidh's death was caused by multiple injuries. He concludes that her injuries were very severe and it was very likely that she died very quickly. The blast wave experts conclude that Eilidh's injuries were unsurvivable with current advanced medical treatment.

We will take the photograph of Eilidh from the screen, please.

We will next turn to Elaine McIver and see a photograph of Elaine on the screen, {INQ035699/1}.

Elaine was born on 20 September 1973, making her 43 years of age when the attack occurred. She was the youngest sister to Paul and Lynda. Her parents were Patricia and Frank. Patricia describes Elaine as "never giving her any pains from the day she was born". She left school at 16 and initially worked for her father,

who was a roofer. However, she became interested in the police and was first a special constable before becoming a police constable in 1998.

Her mum reports her loving being in the police and that she learned sign language as she perceived there was a shortage of officers who could communicate with deaf people. She met her partner, Paul Price, in 2014 through a friend. At the time she was killed they were in the process of moving. Going to concerts together was a passion of theirs.

Paul had bought his daughter two tickets to the concert as a Christmas present. His daughter decided to go with a school friend. The three of them and Elaine travelled to the concert and the two girls were dropped off with the agreement that they were to be collected in the City Room. Paul and Elaine then spent a couple of hours together eating and talking about the house move before returning to the arena. Paul describes them as having a lovely meal together.

They entered the City Room at 22.06.23. Elaine was standing approximately 5 metres from the seat of the explosion. She is captured on the body-worn footage of Philip Clegg very shortly after the explosion at which time she may still be alive. However, when he returned to her she was no longer responsive.

The post-mortem examination was carried out by Dr Michael Parsons. He concludes that Elaine died of chest injuries. He states that the severity of her injuries would have resulted in her rapid death.

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

Mr Lopez, we'll take the photograph of Elaine from the screen.

Next, we will speak about Georgina Callander. We will have a photograph of Georgina on the screen. The reference is {INQ035702/1}.

Georgina was 18 years old at the time of her death. She was the daughter of Simon and Lesley and the youngest sister of Daniel and Harry. Her mum describes her as having been a very caring, family-orientated person who loved life and was just starting her journey into adulthood. Her dad describes her as having given so much love and having so much love to give. She had just passed her driving test and had won a place at university to study paediatrics. She was always smiling

and loved the normal things in life such as pizza, chips and chocolate.

Georgina attended the concert with her mother Lesley. They had booked into the Travelodge together and Lesley stayed with her while she got ready. At the arena, she met up with her friend, Aliya Rule, while Lesley spent the time with her friend Vanessa before returning to the arena with the intention of picking Georgina up. Aliya describes taking photographs and videos during the concert as they watched it together.

Georgina entered the City Room at 22.30.51. She was approximately 4 metres away at the time the bomb went off. Approximately 20 minutes after the blast a member of the public, Thomas Owen, is captured being with Georgina. Shortly after he is joined by an ETUK medic, Kristina Deakin. Mr Owen remained with Georgina after Ms Deakin moved on, so she was not alone.

At 23.04, Mr Owen is recorded on body-worn footage encouraging Georgina to breathe and talk. At 23.05, Mr Owen is recorded as stating that she is breathing. She was assessed by Advanced Paramedic Ennis a minute later, who says that she will be moved as soon as possible.

At 23.18, Georgina was assessed by HART paramedics Vaughan and Hargreaves, who had arrived in the City Room

a few minutes earlier, and Georgina was designated a priority casualty by them. A priority casualty, according to the ambulance experts, is a time-critical patient in need of immediate intervention or extrication.

Shortly thereafter, Georgina was assisted by Bethany Crook, who had returned to the City Room and who did so much to help that night. At 23.25, Georgina was placed on an advertising board and was carried out of the City Room over the raised footbridge through the station and placed on Station Approach, at which point she was treated by paramedics.

Highly distressingly, in the course of that journey to Station Approach, Lesley encountered the party who were carrying Georgina. Lesley accompanied Georgina from then on all the way to hospital, departing the arena at 23.40.49. By the time Georgina reached hospital she was already in cardiac arrest, which was not reversed, despite extensive treatment. She was declared dead at 00.05.

Dr Michael Parsons carried out the post-mortem examination. He concluded that Georgina had died of a head injury. He states that it is likely Georgina would have been immediately rendered unconscious. The blast wave experts conclude that Georgina's injuries

were unsurvivable with current advanced medical treatment.

Mr Lopez, would you take the photograph of Georgina from the screen, please?

We are next going to turn to Jane Tweddle. The photograph of Jane is {INQ035690/1}.

Jane was 51 years old when she died. She was one of two children, born to Margaret and Alan Tweddle, and she grew up in Hartlepool. She later moved to Blackpool with her then partner, Mark Taylor. Together they had three daughters, Harriet, Lily and Isabelle.

At the time of her death, Jane was working as a receptionist. She's remembered by those closest to her as a person who treated everyone with kindness, decency and respect. She was someone who loved to make people laugh. She taught her daughters to be kind. She is described as both caring and loyal.

On 22 May Jane was accompanying her friend, Joanne Aaron, whose daughter and daughter's friend were attending the concert. The tickets for the two girls had been a birthday present from Ms Aaron to her daughter when she turned 14. Jane and Joanne dropped the children off and then went for some food. Joanne recalls it being a good night during which Jane had talked about the future.

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

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

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

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

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

Next, John Atkinson. A photograph of John will be

placed on the screen, {INQ035707/1}.

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

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

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

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

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

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

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

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

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

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

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

By reason of the comments by Dr Carter and the fact

that the blast wave experts consider the impact of John's heart disease as being outside their expertise, the inquiry instructed Dr Paul Rees, an expert in cardiology, about whom we'll say some more a little later.

Mr Lopez, we will take John's photograph from the screen.

Next we will speak about Kelly Brewster. The photograph of Kelly is {INQ035695/1}.

On 22 May, Kelly was 32 years of age. She was the daughter of Kim and Kevin, and sister of Claire and Adam. Her family meant the world to her and she was a devoted auntie to Demi and Hollie, who both adored Kelly and would fight for her attention. She was a loving partner to Ian and was close to his daughter, Phoebe, having taken them both on a surprise trip to London and Disneyland Paris. The couple planned to have a baby and purchase a new house, and they were excited to build a future together.

Kelly was very bright and had worked as an insurance claims assessor for 8 years. She was conscientious and a great team player and had passed her accountancy course with flying colours. She was keen to see the world and had spent time travelling around Australia and America and her friend Jen describes Kelly's great love

for life.

Kelly attended the concert with her sister Claire Booth and another relative. They travelled by car to Manchester where they all enjoyed a meal together in Pizza Express. Kelly messaged her mother, Kim Brewster, to let her know they had arrived safely in Manchester. At 19.20 she sent a text to her partner, Ian Winslow, telling him that she loved him.

They all enjoyed the concert and left their seats shortly after the last song. Kelly, Claire and their relative walked out of the concert in a line with their relative in the middle of the two adults so they didn't lose sight of her.

Kelly entered the City Room at 22.30.53 just behind her companions and only 7 seconds before the bomb was detonated. At the time of the explosion, Kelly was approximately 9 metres away from the killer.

Following the explosion, Kelly was lying on the ground on her left side. Arena medic Ian Parry of ETUK tended to her at approximately 22.38, before concluding that Kelly had an unsurvivable head injury. Between approximately 22.43 and 23.11, Michael Buckley, an off-duty police officer, and BTP officer PC Danielle Ayers administered first aid to Kelly and repeatedly performed CPR. They were assisted by several

individuals including Sergeant Hare, Constable Johnson, Marianne Gibson of ETUK, and Megan Balmer, an employee of ShowSec.

During this time Kelly appeared to show intermittent signs of life. However, she then became unresponsive and T-shirts were used to cover her body at 23.11.28.

At approximately 23.45, NWAS paramedic Patrick Ennis attached a label to Kelly's arm, identifying her as deceased.

On 26 May, Dr Naomi Carter carried out a post-mortem examination of Kelly's body. She found that Kelly died due to the combined effects of head and abdominal injuries. The location of her injuries indicated that the blast had struck her from her back and right-hand side. In Dr Carter's view, the severity of Kelly's injuries would have rendered her rapidly unconscious and she would have died shortly afterwards, although Dr Carter was not able to specify for precisely how long Kelly survived.

The blast wave experts concluded that Kelly's injuries were unsurvivable with current advanced medical treatment.

We will take the photograph of Kelly from the screen, please.

We will turn to Martyn Hett. His photograph is

{INQ035696/1}.

Martyn Hett was 29 on 22 May. He was a much-loved son, stepson, brother and uncle. Martyn loved spending time with his family, both at home and abroad, and they had memorable holidays together. Martyn's family remember Martyn as being tremendous fun. His love of being centre stage was apparent from when he was young and he was a talented pianist and performer. Martyn was successfully working as a social media manager and he had a significant social media profile himself. Martyn's family have no doubt that he had a bright future ahead of him in this field. Martyn had many friends and was outgoing, sociable and entertaining. Martyn's family also remember how caring and supportive he was.

Martyn went to the concert with friends to celebrate one of their birthdays. It was also a good time for the friends to meet because Martyn was planning to fly to America later that week. Martyn arrived at the arena with his friends shortly after 20.45. He met other friends once he took his seat for the concert. He met another friend, Lewis Conroy, in passing at a bar during the interval. Martyn was a big fan of Ariana Grande and was singing and dancing from the first song played. He danced with his friends and people nearby he'd met for

the first time that evening.

Martyn saw Lewis again as they were leaving and arranged to meet him in the City Room so that Lewis could join Martyn and his friends for a drink. Martyn entered the City Room at 22.28.42. A member of the public remembers him laughing and joking with security staff. He then walked around the City Room and walked into a corner of the City Room shortly before the explosion. He was approximately 4 metres from the explosion.

Travel Safe Officer Philip Clegg approached Martyn shortly after the explosion. Martyn did not respond to Mr Clegg speaking to him and gently shaking his shoulder. Emergency Training UK medic Ryan Billington recalls giving very limited treatment to a male who he believes may have been Martyn. Although he states that person was breathing, Mr Billington did not think he had any chance of survival, and he had died when Mr Billington returned later.

Martyn's head was covered by 22.53 and a foil blanket was placed over him at 23.34. HART paramedics Lea Vaughan and Christopher Hargreaves checked upon Martyn at 23.42. Mr Hargreaves returned to Martyn at 23.43. At this time it appears he was identifying those who had died.

Dr Charles Wilson prepared the post-mortem report for Martyn. He concluded that Martyn's death was caused by multiple injuries. Dr Wilson concludes that he would expect Martyn's injuries to have been rapidly fatal.

The blast wave experts concluded that Martyn's injuries were unsurvivable with current advanced medical treatment.

We will take the photograph of Martyn from the screen, please.

We turn to speak of Megan Hurley, whose photograph is {INQ035708/1}.

Megan Hurley was 15 on 22 May. Megan was very family-orientated and had lots of friends, some that she'd known since nursery. She was very close to her elder brother Bradley. They had many interests in common and made each other laugh hysterically. Megan was kind and caring and loved to help others. She loved photography and shared pictures with her family. Megan's headteacher recalls how well she did at school and her real sense of fun.

Megan's smile was infectious and her boyfriend, Kieran, says Megan was one of a kind, someone who could make you happy in an instant no matter what mood you were in before just by showing her beautiful smile.

Megan had been a fan of Ariana Grande since she was

a young girl. Her parents bought her tickets for the concert as Christmas presents and Megan was very excited about the show. Bradley offered to take her and their parents drove them to Manchester. Bradley and Megan attended the arena at about 6.40 pm. They had a good time before the concert, taking selfies, which they sent to their parents. Their parents recall how happy they looked in these photographs.

Bradley remembers how much he and Megan enjoyed the concert and they were laughing and talking as they left. Bradley and Megan entered the City Room at 22.30.49. They were approximately 3 metres from the explosion. Megan and Bradley fell to the ground immediately following the explosion. Bradley saw Megan lying on the ground. He did not see her breathing and thought she had died.

Megan's father found Bradley and Megan in the City Room at approximately 22.55. GMP Sergeant Hare approached Megan at 22.58 and was joined by Constable Dawson. At 23.00, ETUK medic Marianne Gibson instructed PC Dawson to start CPR upon Megan, which he did, assisted by other officers.

At 23.06.26, Patrick Ennis instructed the officers to stop CPR because Megan was not breathing. The officers did stop and Megan was covered up.

Professor Lumb carried out the post-mortem examination for Megan. He concludes that Megan's death was caused by multiple injuries. Professor Lumb comments that injuries to Megan's brain would have rendered her immediately unconscious and it was very likely that she died quickly.

The blast wave experts conclude that Megan's injuries were unsurvivable with current advanced medical treatment.

We will take the photograph of Megan from the screen, please.

We turn to Michelle Kiss. The photograph of Michelle is {INQ035692/1}.

Michelle Kiss was 45 on 22 May. Her husband, Tony, describes how she was his guiding light from the moment he met her when they were both teenagers. They married in 1995 and created a family home together. Michelle and Tony had three children. Michelle loved her children deeply and looked forward to making happy memories with them. Michelle enjoyed planning things to do with her family and friends and had a natural ability to bring people together. Tony describes his pride in how his children have love and drive in everything they do, a quality he remembers in Michelle.

Michelle went to the arena on 22 May with a family

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

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

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

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

At 22.48, Michelle was covered with a black sheet.

Professor Philip Lumb prepared the post-mortem report for Michelle. He concludes that Michelle's death was caused by a head injury. He states that given the severe nature of the head and brain injury, it was very likely that Michelle was immediately unconscious and her death followed shortly afterwards. The blast wave experts concluded that Michelle's injuries were unsurvivable with current advanced medical treatment.

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

The photograph of Nell is {INQ035703/1}.

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

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

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

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

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

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

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

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

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

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

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

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

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

MR GREANEY: Thank you, sir.

(12.00 pm)

(A short break)
(12.15 pm)
SIR JOHN SAUNDERS: Mr Greaney.
MR GREANEY: Sir, we are turning next to Olivia Campbell-Hardy. The photograph of Olivia is at {INQ035711/1}.

On 22 May 2017, Olivia Campbell-Hardy was 15 years old. She was the daughter of Charlotte and Andrew and sister of Catriona, Chloe and Seana. From a young age Olivia was a talented performer with a beautiful singing voice. She had passed all her dancing exams, sang in choirs, and auditioned for Britain's Got Talent. She had dreams of becoming a singer in the West End or a music teacher. Olivia also did extremely well academically and is remembered by her teachers as a motivated, well-behaved pupil, with an excellent attitude to her studies.

She loved making her friends and family laugh and she wanted everyone around her to be happy. Her loved ones remember her as someone who put 100% into everything she did, with a smile on her face, and as someone who could achieve anything she turned her mind to.

Olivia attended the concert with her friend, who had been given two tickets as a Christmas present. They

travelled on the Metro into Manchester, the two friends had a McDonald's for tea, which was Olivia's favourite meal, before going to the arena and finding their seats. Olivia kept her mum updated by text message throughout the evening until around 9 pm when Ariana came on to the stage. The two friends had a great time singing and dancing to all her songs.

At 22.30.51, Olivia and her friend entered the City Room. As they walked through the room her friend asked Olivia what her favourite song had been at the concert, but before she could answer that question, the explosion occurred. At that moment, Olivia was approximately 5 metres away.

Following the explosion, Olivia was lying on the ground on her left-hand side. At 22.45.15, she was assessed by Ken O'Connor, a first-aider for ETUK, and Police Constable Jessica Bullough. Olivia showed no signs of life and a poster was used to cover her head and upper body.

At approximately 23.45, Patrick Ennis attached a label to Olivia's arm, identifying her as deceased.

On 26 May, Dr Michael Parsons carried out a post-mortem examination of Olivia's body. He found that Olivia had been facing away from the origin of the explosion and that the overwhelming majority of injuries

were sustained to the right side of her body. Dr Parsons concluded that Olivia died as the result of multiple injuries which would have resulted in her immediate unconsciousness and very rapid death. The blast wave experts found that Olivia's injuries were unsurvivable with current advanced medical treatment.

We will take Olivia's photograph from the screen, please, and next we will turn to Philip Tron.

The photograph of Philip is {INQ035714/1}.

Philip Tron was 32 on 22 May. He lived in Gateshead and worked as a water conservation engineer. One of five siblings, Philip was a much-loved member of his family with whom he loved socialising and holidaying. He was hugely likeable and his family remember him as a bit of a joker who had made people laugh since his school days. He particularly liked winding up his mum, June.

Philip was kind and considerate, he looked after his nana, Sadie, when she was ill and his practical skills meant he was relied upon by family and friends to help with odd jobs. Everyone was pleased with the work Philip did for them.

His family remember his friendly voice on the phone agreeing to help them. Above all, Philip wanted to have a happy family life. He attended the arena that night

with Deborah Hutchinson, Courtney Boyle, Nicole Boyle and June Tron. The group were in Manchester to take Nicole to the concert. Philip, Deborah, June and Nicole had driven together from Gateshead, collecting Courtney on their way to Manchester. The group spent the day together before the concert. They had dropped Nicole off at the arena shortly after 6 pm, then they went for a meal, before parking their car next to Victoria Station.

The group waited in the car for a while, chatting and laughing. Philip and Courtney then went back to the arena at 22.20 to collect Nicole.

Philip and Courtney entered the City Room at 22.22.11. They were standing in front of the doors to the arena and were about 4 metres from Salman Abedi at the time of the explosion. Philip did not receive any medical care or intervention in the City Room following the explosion. He can be seen on the body cam footage of Travel Safe Officer Philip Clegg at 22.36.10, but Mr Clegg did not interact with Philip.

A pink blanket was placed over Philip's head at 22.45 by Constable Jessica Bullough. Paramedic Patrick Ennis checked Philip at 23.38 and placed a label on his wrist in order to identify him as deceased.

Dr Charles Wilson prepared the post-mortem report of

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

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

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

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

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

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

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

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

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

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

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

A passing ambulance was flagged down on Trinity Way

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

examinations alone.

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

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

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

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

any difference to whether or not John would have died.

As we have said already, survivability is therefore an issue of considerable importance in the case of John Atkinson.

Finally by way of medical evidence, at the sensible request of those representing one other of those who died and because of the particular circumstances of that person's case, the inquiry has supported the instruction by their legal team of Dr Gareth Davies, a consultant in pre-hospital emergency medicine and former medical director for the London Air Ambulance, and Dr Claire Park, consultant in anaesthesia, critical care and pre-hospital care.

The inquiry understands that they are to be instructed to report on the care received and to contribute to the question of whether or not the particular person's injuries were survivable. We have been deliberately opaque in how we have framed what we just said by not naming the person to whom this report or these reports will relate. We do so at the express request of that person's representative or that person's family's representative, rather, and for reasons which are both good and, we dare say, obvious.

However, so that there may be no misunderstanding, we make clear that at this stage, given the state of the

evidence which currently exists and given that it is wholly unknown whether Dr Davies and Dr Park will say anything which casts doubt on that evidence, it would be both unhelpful and highly distressing to the family concerned if, in the act of naming them at this stage, what we say is taken by anyone as suggesting that there is uncertainty. We hope that is clear. As matters stand, there is not. Whether there will in due course be is a matter for the inquiry to investigate.

We turn now to set out in summary form what issues appear to counsel to the inquiry to arise in relation to chapters 11 and 12.

Firstly, these chapters will serve as an investigation as to how and in what circumstances each of those who were killed died. It will aim to answer the questions which would have arisen as a matter of law in the event that this inquiry had remained 22 inquests.

Secondly, in doing so, the inquiry will consider the issue of survivability in the case of each of those who died. This is a very important question as it will be capable of bearing on the consequences of any failure in the adequacy and/or effectiveness of the emergency response.

Thirdly, as a function of the two previous issues, the inquiry will examine what care each person did

receive and will hear live evidence from many of those who provided it and from those who helped the three people who were moved out of the City Room prior to their death.

Fourthly, in the context of examining this third issue, the inquiry will consider what care was not provided. This will involve examining the actions of the paramedics in terms of how many went into the City Room, when they went into the City Room, and what they did once they were there.

Furthermore, it will consider the question of the removal of the injured from the City Room from the perspective of what was not available, but which should have been by way of stretchers and other equipment if that is the inquiry's finding.

The investigation of all of these issues will have its origin in chapters 9 and 10. Chapter 12 will provide the opportunity to continue, and we hope, conclude those enquiries so that the answers that each of the families of the deceased deserve can be given.

Sir, that would be a convenient moment to break for lunch. But may we suggest a slightly shorter lunch today so that we can be confident that we will conclude this opening address?

SIR JOHN SAUNDERS: I will say we'll resume at 1.45. That's

a couple of minutes over an hour. If that causes any difficulty to anyone, would you mention it to a member of the team, who will then tell me, and I will then consider whether we can start a bit later.

MR GREANEY: Thank you, sir.

(12.43 pm)

(Lunch adjournment)

(1.45 pm)

SIR JOHN SAUNDERS: Mr Greaney, just before you start again, it may be worthy of explanation to people who were mystified that during the section we've just done, where you referred on a number of occasions to people attending with a friend --

MR GREANEY: I did.

SIR JOHN SAUNDERS: -- rather than giving their names. It's not, as I understand it, that they don't want their names mentioned, but it is because they were victims of the attempted murder charge and under a Contempt of Court Act order made by Mr Justice Jeremy Baker in the trial of Hashem Abedi they can't actually be named. But for the purposes of the hearing hereafter, we are seeking from Mr Justice Jeremy Baker permission, if he thinks it appropriate, to name them subsequently.

MR GREANEY: Indeed, sir. Thank you very much for the clarification.

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

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

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

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

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

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

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

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

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

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

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

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

conclusions.

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

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

Operation Manteline.

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

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

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

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

in the year leading up to the attack and before. We wish to understand whether he, Abdalraouf Abdallah, had any role in the development of Salman Abedi's world view or if he can shed any light on how it was formed. We have no doubt that Abdalraouf Abdallah is a witness with important evidence to give. He was interviewed by the inquiry legal team on 26 June of this year, but refused to give any answers to our questions, relying upon the privilege of self-incrimination set out in section 22 of the Inquiries Act 2005. We are continuing to pursue this line of enquiry.

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

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

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

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

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

However, he also gives evidence about the

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

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

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

His first report explains the key features of

Islamist extremism as opposed to mainstream Islam or ideological Islamism and the distinctive characteristics including its attitudes to violence. It also gives an overview of the recognised pathways to radicalisation into Islamist extremism, the type of person vulnerable to such pathways, the main influences which might radicalise a person, the steps or activities which lead to radicalisation, and signs or indicators of radicalisation, how these can be spotted, and what can be done to prevent further radicalisation or deradicalise a person.

Finally, Dr Wilkinson's first report contains an overview of the problem of radicalisation in UK prisons and a summary of the known Islamist extremist organisations which operate in or have influence in the UK.

Dr Wilkinson's second report on which he's currently working will apply the knowledge and expertise set out in his first report to the specific evidence about Salman Abedi, which we've summarised already.

We will turn next to the facts in further detail. We are going to set out the key facts on issues of radicalisation insofar as it is possible to do so at this stage given that significant pieces of evidence, such as a response from Hashem Abedi and Dr Wilkinson's

second report, are still awaited.

In relation to Salman Abedi's family, the Operation Manteline team gathered information from various relatives, including Rabaa Abedi, Salman Abedi's aunt who lives in Canada. From the statements obtained by GMP and other investigations done we know that Ramadan Abedi, Salman Abedi's father, fled Libya with his family in 1993 and then applied for asylum on the basis that his life was at risk from Libyan state security.

After several appeals, he was granted refugee status in 1997 and he subsequently obtained indefinite leave to remain and UK citizenship, as did his family. Ramadan Abedi changed his name to Hannah Joseph in 2002, but currently it's not known why he did this.

He was reported to be associated with exiled Libyans linked to the Libya Islamic Fighting Group, or LIFG, which was a banned or proscribed organisation under UK terrorism legislation between October 2005 and November 2019.

The Abedi family returned to Libya in 2011 during the uprising against Colonel Gaddafi. Photographs obtained by GMP show Salman Abedi at around this time with military vehicles and weapons. It appears that Salman Abedi and Hashem Abedi then came back to the UK

in 2012 in order to pursue their education, but they did not engage very well with their schooling and started taking drugs.

Ismale Abedi told GMP when he was interviewed in the aftermath of the attack that their parents had asked him to keep an eye on his younger brothers but he found this very difficult.

Salman Abedi and Hashem Abedi travelled back to Libya in July 2014, but the situation in the country at that time was chaotic and they were evacuated back to the UK along with others aboard HMS Enterprise via Malta.

Images of Salman Abedi and Hashem Abedi in Libya over this period have been recovered from the social media account of their brother Ismale Abedi and we'll show two such photographs at this stage.

First of all, on the screen, please, Mr Lopez, {INQ031259/13}. What we're able to see on the screen is an image of Hashem Abedi in, we believe, Libya, with a rocket launcher.

Next on the screen, the same INQ reference, {INQ031259/14}.

This is a photograph of Salman Abedi raising a finger to the sky. At one time this was undoubtedly a legitimate gesture used by many followers of the

Islamic faith to state that there is only one God, but it has been strongly reported that Islamic State has adopted it as a gesture. It is now often used by supporters of Islamic State to demonstrate adherence to what it describes as its caliphate and to its caliph who, in 2017 when this attack occurred, was Abu Bakr al-Baghdadi. We will need to consider whether this photograph of Salman Abedi in combination with other evidence indicates that what motivated Salman Abedi to do what he did was adherence to the Islamic State and/or its ideology.

SIR JOHN SAUNDERS: Do we have any way of dating that photograph?

MR GREANEY: We have no way of dating that photograph.

SIR JOHN SAUNDERS: Thank you.

MR GREANEY: It can be removed from the screen, please.

Salman Abedi and Hashem Abedi flew to Saudi Arabia via Jordan in 2015 to carry out the Hajj pilgrimage to Mecca. Several friends and associates of theirs have commented that it was subsequent to this, from around late 2015, that the brothers started to change their behaviour.

Ramadan Abedi stayed in Libya and, apart from brief visits to the UK, has remained there ever since. It is not clear what the status of the relationship between

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DCS Barraclough explains that it has been difficult to pursue this line of inquiry because no investigations can currently be carried out in Libya.

Another possible link is Mansoor Al-Anezi, a Kuwaiti national who led prayers at a mosque in Plymouth, but who initially came to Manchester when he arrived in the United Kingdom in 2000. Mr Al-Anezi was arrested and interviewed as part of the investigation into a failed suicide terrorist attack in 2008 in Exeter because he was a close associate of the failed bomber, Nicky Reilly.

No charges were brought against Al-Anezi. He died of cancer on 17 January 2017 and Salman Abedi was with him when he died. The funeral was held on 17 January 2017 and, in order to attend it, Salman Abedi missed a planned visit to Abdalraouf Abdullah in prison.

After the 22 May attack on the arena various items of property relating to Al-Anezi were recovered from 21 Elsmore Road, the family home of the Abedis.

GMP's analysis of mobile phone data indicates that there was frequent contact between Al-Anezi and Hashem Abedi and Salman Abedi, particularly between the end of October 2016 and mid-November 2016, but it does not reveal what they were talking about.

As for the possible influence of religious

instruction on Salman Abedi, we know, as we have said a short time ago, that the Abedi family attended Didsbury Mosque for some time. Ramadan Abedi performed the call to prayer on occasion, and Ismale Abedi volunteered with the IT system and provided some private tutoring on Islamic teaching.

GMP took a statement from Akram Ramadan, who said his cousin had been present at the mosque when the imam preached a sermon criticising Islamic State, and that Salman Abedi had approached the imam with a killer look in his eyes. But none of the main leaders at the mosque who have given statements to GMP or the inquiry recall Salman Abedi being a regular or committed member, nor any particular trouble arising with him.

The only exception to this is Mohammed El-Saeiti, head of Sharia Law and imam at Didsbury Mosque, who told GMP that he recalled Salman Abedi attending the mosque, although not regularly. He described one encounter with Salman Abedi which has some similarities to the account given by Mr Ramadan.

Around the end of 2014, Mr El-Saeiti delivered a sermon which was critical of Islamic State. When he saw Salman Abedi at the mosque a month or so later, he reports that Salman Abedi stared at him with a look of hate. He also said that he had raised concerns about

one relative of the Abedi brothers, but would not disclose who.

The inquiry legal team has followed up with Mr El-Saeiti about this information and it is hoped that we will receive his evidence.

There have been, as is widely known, some broader concerns raised about the Didsbury Mosque. One of the imams, Mustafa Graf, was suspended on 26 May 2017 as a consequence of a photograph of him surfacing which showed him wearing combat gear in Libya. It appears that Mr Graf also encouraged protests outside the UAE embassy in London on 9 September 2015 against the arrest of men for being members of Islamic State and it appears that Salman Abedi also attended that protest.

In August 2018, Counter-terrorism Policing obtained an audio recording of a sermon apparently given by Mr Graf at Didsbury Mosque in December 2016 in which he appeared, on the face of it, to encourage participation in the war in Syria. However, following an expert assessment of the sermon by Robert Gleave, professor of Arabic studies at Exeter University, who considered that Mr Graf was using rhetoric to encourage charitable donations to help Syrians in distress, Counter-terrorism Policing reached the conclusion that there was no prospect or reasonable prospect of conviction and so

Mr Graf was not arrested or interviewed.

It is not known whether Salman Abedi was at the mosque at the time of the sermon and Mr Graf has said that he did not know him. It's only fair that we should point out that Mr Haffar, the mosque chairman, has expressed concern that the BBC reporting of Mr Graf's sermon was unfair and inaccurate and that other media reporting linking Salman Abedi and another Islamist extremist, Raphael Hostey, who joined Islamic State and is believed to have been killed in an air strike in Syria, with the mosque has also been unfair and misleading. We assure all that we will be looking at all of these issues concerning Didsbury Mosque.

It appears that Salman Abedi may have attended several other mosques in the months and years leading up to the attack as well, including the Al-Furqan Mosque and the Salaam Community Association and Masjid. However, he does not seem to have been an active member or regular attendee at either.

In terms of Salman Abedi's education, Ian Fenn, the head teacher of Burnage Academy describes how Salman Abedi was not a good student at school. He attended that school from August 2009 until May 2011. He was on one occasion excluded for several days for theft. Mr Fenn's recollection is that Salman Abedi was

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

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

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

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

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

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

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

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

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

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

attack.

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

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

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

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

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

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

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

internal reviews.

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

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

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

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

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

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

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

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

The context of the broader terrorism threat in May 2017.

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

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

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

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

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

investigate him were not taken at the time.

So we will repeat that: in the open evidence, to the extent possible, we will explore what MI5 and CTP knew about Salman Abedi before the attack and why further steps to investigate him were not taken at the time. And the evidence will address what lessons have been learned as a result of the post-attack review process and what changes have been made in response.

At least two other witnesses in the open hearing will also be relevant to preventability issues. The first is Shaun Hipgrave of the Home Office, who we have already mentioned in relation to chapter 7, security arrangements, and chapter 13, radicalisation. His statement also covers the regulation of explosive precursor chemicals and the use of travel monitoring and border control tools. These were both issues identified as requiring further work by the ISC in their report and we will explore with him what more, if anything, could have been done or should have been done to use these measures to identify Salman Abedi's plans or track him at the time of his return to the United Kingdom on 18 May 2017.

The second witness is Paul Mott of HMPPS, the prison and probation service. Much of his statement is, as we described earlier, relevant to the issues of

radicalisation in chapter 13. However, what he says about the processes and procedures that could have been used to monitor or stop prison visits and telephone contact between Salman Abedi and Abdalraouf Abdallah may be of interest in relation to preventability and will need to be investigated further. We know that the chairman will keep under close review whether any other witnesses whose evidence is relevant to preventability are able to give evidence in open. Any witness whose evidence can be heard in open will be heard in open.

We turn now to set out the key facts on issues of preventability in a little more detail insofar as it is possible to do that publicly.

We will hear, as we indicated, from Witness J and DCS Scally about how Salman Abedi was known to MI5 and CT Policing prior to the attack and indeed was due to be considered for further investigation when the attack took place. We will hear how information about Salman Abedi was first passed to the security service by the North-west Counter-terrorism Unit in December 2010 because his details were linked to another subject of interest.

It was assessed that there was nothing suspicious at that time and so there was no further investigation. However, on 18 March 2014, Salman Abedi was designated

as an SOI and began to be investigated by MI5 as a telephone number registered to him was in contact with another SOI thought to be involved in planning travel to Syria for extremist purposes. That investigation ceased on 21 July 2014 as Salman Abedi was assessed not to be a national security risk.

Salman Abedi was identified as having met with or been in telephone contact with two other SOIs in 2015. He was also identified as a second-level contact, that is to say a contact of a contact of SOIs in 2016 and 2017.

On two occasions between 2011 and 2016, MI5 and Counter-terrorism Policing made checks due to information received about Salman Abedi's travel overseas as there was concern he may be travelling to Syria. However, it was determined that he had in fact gone to Europe on the first occasion and Libya on the second, and it was assessed there was nothing to indicate he posed a risk at that time.

MI5 also held information that indicated Salman Abedi had visited a known extremist in prison on more than one occasion. But after further information was sought, it was assessed that this did not justify re-opening Salman Abedi as an SOI.

Probably of most interest to all, in particular the

bereaved families, we will hear how on two separate occasions in the months prior to the attack MI5 received intelligence about Salman Abedi, the significance of which was not fully appreciated at the time, but which, in retrospect, can be seen to be highly relevant to the planned attack.

Finally, we will hear that on 3 March 2017, Salman Abedi was one of 685 closed SOIs who hit a priority indicator under the Clematis process. Following triage on 1 May 2017, Salman Abedi was assessed as meeting the threshold to be considered for further investigation. He was due to be considered for referral at a meeting scheduled for 31 May, but tragically this was overtaken by the events of 9 days earlier.

All of those matters of evidence will be explored. It is not possible to describe the additional evidence to be heard in the closed hearing in any detail for obvious reasons. However, we will explore the evidence given by Witness J and DCS Scally as corporate witnesses fully, including the information contained in the underlying documentation which was the subject of a successful application for public interest immunity.

We will also hear factual evidence from those in MI5 and Counter-terrorism Policing who were directly

involved in the relevant decision-making.

Moreover, and importantly, the chairman is in the process of instructing an expert to assist him in considering whether the assessments and decisions made were reasonable given what was known at the time and whether those would have been different had other information been available and what actions would have been taken had different assessments or decisions been made. That expert will necessarily need to give evidence in closed.

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

programme at any stage, and what difference that might have made; and whether travel monitoring or travel restriction capabilities should have been utilised in relation to Salman Abedi in 2017.

Other issues include: whether Salman Abedi's visits to a known extremist prisoner should have led to any further investigation; why the intelligence received on two occasions in the months prior to the attack was not assessed as being more significant at the time; and what other actions could have been taken in response to that intelligence and whether it should have stopped the attack.

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

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

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

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

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

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

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

Mr Greaney, I'm extremely grateful. Thank you very much. See you all at 9.30 on Monday morning.

(2.43 pm)

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

I N D E X